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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 05/28/24 and 05/29/24.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #2) including medication for pain, high blood pressure, acid reflux, and constipation (#1) and two medications to treat mood disorders, depression, anxiety and suicidal ideation (#2). The findings are: Review of the facility Medication Management Policy effective 06/09/23 revealed: -The policy provided guidelines for assisting residents with medication management in	D 358		

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accordance with state laws and regulations.
-Medication administration should be documented on the medication administration record (MAR) at the time the medication is provided or taken.
-Medication omissions and/or refusals should be documented on the MAR, the Director of Resident Care (DRC) would be notified, interview/assess the resident and notify the resident's physician/healthcare provider.
-Resident medications are issued/dispensed by the pharmacy.

1. Review of Resident #2's current FL-2 dated 01/16/24 revealed diagnoses included anxiety disorder and fibromyalgia.

a. Review of Resident #2's mental health provider visit note dated 03/12/24 revealed:
-Resident #2 had a history of depression, anxiety, suicidal ideation, paranoia and hallucinations.
-She prescribed the resident Risperdal 0.25mg take one each evening to see if the medication helped the resident with her symptoms (Risperdal is used to treat mood disorders).

Review of Resident #2's signed medication orders revealed:
-There was an order dated 03/12/24 for Risperdal 0.25mg take one tablet each evening (Risperdal is used to treat mood disorders).
-The order was electronically signed by Resident #2's mental health provider on 03/12/24.

Review of Resident #2's medication administration records (MARs) dated 04/01/24 through 04/30/24 revealed:
-There was a printed entry for Risperdal 0.25mg, take one tablet every evening at 8:00pm.
-There was an entry with staff initials that were circled on the MAR from 04/21/24 to 04/25/24

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and 04/27/24.
-There was documentation by medication aides (MAs) on the back of the MAR with the date, time, MA signature and reason Risperdal was not administered to Resident #2.
-There was documentation by MAs on the back of the MAR that Risperdal was not administered on 04/21/24 to 04/25/24 and 04/27/24 due to awaiting pharmacy, out of medication.

Review of Resident #2's MARs dated 05/01/24 through 05/31/24 revealed:
-There was a printed entry for Risperdal 0.25mg, take one tablet every evening at 8:00pm.
-There was an entry with staff initials that were circled on the MAR on 05/05/24, 05/20/24 to 05/21/24, 05/25/24 to 05/27/24.
-There was documentation by MAs on the back of the MAR with the date, time, MA signature and reason Risperdal was not administered.
-There no was documentation by MAs on the back of the MAR that Risperdal was not administered on 05/05/24, 05/20/24 to 05/21/24, 05/25/24 to 05/27/24.

Observations of Resident #2's medications on hand on 05/28/24 at 3:20pm revealed there were no Risperdal 0.25mg tablets on hand.

Review of dispensing records faxed from the facility's contracted pharmacy to the facility on 05/29/24 for Resident #2 revealed:
-There was a quantity of 30 Risperdal 0.25mg tablets, take one tablet every evening dispensed by the facility's contracted pharmacy on 03/19/24.
-There was a quantity of 16 Risperdal 0.25mg tablets, take one tablet every evening dispensed by the facility's contracted pharmacy on 04/27/24.
-There was a quantity of 9 Risperdal 0.25mg tablets, take one tablet every evening dispensed

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by the facility's contracted pharmacy on 05/08/24.
-There was a quantity of 10 Risperdal 0.25mg tablets, take one tablet every evening dispensed by the facility's contracted pharmacy on 05/16/24.

Interview with Resident #2 on 05/29/24 at 7:30am revealed:
-She felt fine now but it took her about a month to adjust to living at the assisted living facility.
-She had a difficult time with depression and anxiety when she first moved into the facility.
-She experienced agitation at times and became irritable at times.
-She assumed the facility administered her all medications her doctors had ordered.

Interview with the MA on 05/28/24 at 3:21pm revealed:
-She did not know why Resident #2's Risperdal was not on the medication cart and available.
-She had not followed up with the facility's contracted pharmacy to ask when the resident's medication would be delivered.
-She had initialed the MAR several times and circled her initials because the resident's Risperdal was not administered because the medication was not at the facility.
-She documented on the MAR that the facility was waiting for pharmacy to deliver the resident's Risperdal.
-She should have notified the Director of Resident Care (DRC) that the resident's Risperdal was not available, but she got busy and forgot.

Review of Resident #2's mental health provider visit note dated 04/09/24 revealed:
-Resident #2 had a history of depression, anxiety, suicidal ideation, paranoia and hallucinations.
-Residents current medications included Risperdal 0.25mg, take one tablet every evening.

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-Staff reported no behavioral or mood disturbances from the resident.
-The resident's anxious behaviors seemed to be improved since the resident started taking Risperdal 0.25mg nightly.
-The mental health provider documented for staff to continue the current dose of Risperdal 0.25mg nightly.

b. Review of Resident #2's signed medication orders revealed:
-There was an order dated 05/14/24 for Depakote 250mg take one tablet twice a day (Depakote is used to treat mood disorders).
-The order was electronically signed by Resident #2's mental health provider on 05/14/24.

Review of Resident #2's medication administration record (MARs) dated 05/01/24 through 05/31/24 revealed:
-There was a handwritten entry for Depakote 250mg take one tablet twice a day for mood at 9:00am and 9:00pm.
-There was an entry with staff initials that were circled on the MAR from 05/17/24 to 05/27/24 for the 9:00am and 9:00pm, and on 05/28/24 at 9:00am.
-There was documentation by medication aides (MAs) on the back of the MAR with the date, time, MA signature and reason Depakote was not administered to Resident #2.
-There no was documentation by MAs on the back of the MAR that Depakote was not administered from 05/17/24 to 05/27/24 for 9:00am and 9:00pm due to waiting for pharmacy to fill medication.

Review of Resident #2's mental health provider visit note dated 05/14/24 revealed:
-Resident #2 had a history of depression, anxiety,

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suicidal ideation, paranoia and hallucinations.
-The resident denied suicidal ideation and hallucinations.
-The resident reported she was angry at her personal care aide (PCA) because she thought she was stealing from her.
-Staff reported that the resident was regularly mean and angry and would go from fine to angry in a few seconds.
-Staff also reported the resident regularly had agitation, irritability and significant mood swings.
-There was documentation for staff to continue to administer Risperdal 0.25mg nightly.
-Due to staff reports of the resident's significant mood swings she ordered Depakote 250mg, take twice a day for mood swings.

Telephone interview with Resident #2's primary care provider (PCP) on 05/29/24 at 9:36am revealed:
-Resident #2's psychiatrist had prescribed the resident Risperdal to help stabilize her mood.
-Staff were able to contact on call services with her company at any time.
-She expected the MAs and DRC to notify the resident's psychiatrist when her Risperdal was not delivered to the facility.

Telephone interview with Resident #2's mental health provider on 05/29/24 at 5:21pm revealed:
-She was not aware that Resident #2 had not received her Risperdal or Depakote since she had ordered it until she was notified by the Director of Resident Care (DRC) by phone on 05/28/24.
-Resident #2 had a difficult time with behaviors that were difficult to deal with such as paranoia, hallucinations and delusions.
-Resident #2 had a history of depression, anxiety and suicidal ideation.

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D 358	Continued From page 6 -She prescribed Risperdal to help the resident with her paranoia, hallucinations, depression, anxiety, and suicidal ideation. -When she had a visit with Resident #2 on 05/14/24 staff reported that the resident had increased mood swings, with anxiety, increased agitation and irritability. -She prescribed Depakote on 05/14/24 to help the resident decrease her mood swings, increased agitation and irritability because she thought the Risperdal was not effective. -Staff should have notified her that the resident was not receiving her Risperdal. Interview with the Administrator on 05/29/24 at 1:30pm revealed: -She was not aware that Resident #2 had not received her Risperdal or Depakote as her physicians had ordered. -She became aware of the issue on 05/28/24 and investigated to determine why the resident did not have her Risperdal or Depakote available for administration. -Resident #2 used to use the facility's contracted back up pharmacy when she lived at home. -Staff informed her late on 05/28/24 that the facility's contracted pharmacy when notified by MAs reported that the resident's insurance would not cover the medications and the resident's medications had been filled at another pharmacy. -The resident's Risperdal and Depakote were filled with the facility's back up pharmacy on 05/28/24. Refer to the interview with the MA on 05/29/24 at 8:00am. Refer to the interview with the DRC on 05/29/24 at 2:52pm.	D 358		

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D 358	Continued From page 7 Refer to interview with the Administrator on 05/29/24 at 5:00pm. 2. Review of Resident #1's most recent FL-2 dated 08/02/23 revealed diagnoses included chronic hyponatremia, essential hypertension, hypothyroidism, and hyperlipidemia. a. Review of Resident #1's electronically signed physician orders dated 02/26/24 and 05/22/24 revealed an order for Pantoprazole 40mg tablet delayed release two times a day. (Pantoprazole is used to treat acid reflux). Review of hospice physician orders for Resident #1 revealed: -There was a hospice physician's order review dated 02/21/24 and electronically signed physician's order dated 02/26/24 for Pantoprazole 40mg Delayed Release tablet twice a day. -There was a hospice physician's order reviewed and electronically signed physician's order on 05/22/24 for Pantoprazole 40mg Delayed Release tablet twice a day. -There were no subsequent physician's order for Pantoprazole for Resident #1. Review of Resident #1's April 2024 and May 2024 medication administration records (MARs) revealed: -There was a printed entry for Omeprazole 20mg (a medication used to treat gastric reflux with similar effects of Pantoprazole) capsule DR before breakfast. There was a diagonal line drawn through the printed entry and "D/C" (discontinue) was handwritten below the printed entry and again in the section for documentation of administration. -There was no entry printed to Resident #1's April	D 358		

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D 358	Continued From page 8 2024 or May 2024 MARs for Pantoprazole 40mg DR tablet two times a day. Observation of Resident #1's medications on hand on 05/28/24 at 3:35pm revealed there were no Pantoprazole 40mg DR capsules on hand. Interview with the medication aide (MA) on 05/28/24 at 3:40pm revealed there were no additional medications on hand for Resident #1. Interview with Resident #1 on 05/29/24 at 11:15am revealed: -She did not take any medication for her stomach. -Sometimes she had a loud burp like she was full. -She did not have any trouble with her stomach or indigestion. -She did not remember being on any medication for reflux. Telephone interview with a nurse at the hospice agency for Resident #1 on 05/29/24 at 1:45pm revealed: -There was a current physician order for Resident #1 to be administered Pantoprazole 40mg tablet two times a day with the original order date entered 11/21/23 after the resident was admitted to hospice on 11/20/23. -There had not been any changes to the Pantoprazole order. -There was no order to discontinue the Pantoprazole. -When the last order was written and sent to the facility contracted provider pharmacy, there were four refills which would have covered four months, ending somewhere around 02/2024 or 03/2024. -The hospice agency "typically" relied on the facility to inform them when a medication script	D 358		

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was needed for refills.
-The hospice nurse visiting the facility usually asked facility staff at the end of the resident visit if medication refills were needed.
-In reviewing the hospice agency notes, she did not see an entry where the Primary Care Provider (PCP) had been made aware that Resident #1 was not being administered the Pantoprazole.
-There was no documentation in the visiting nurse notes of resident complaints of any pain that would be associated with the Pantoprazole.
-The resident could have reflux if she was not administered the Pantoprazole as ordered.

b. Review of Resident #1's electronically signed physician orders dated 02/26/24 and 05/22/24 revealed an order for Hydralazine 100mg tablet two times a day. (Hydralazine is used to treat high blood pressure).

Review of Resident #1's April 2024 medication administration records (MARs) revealed:
-There was a printed entry for Hydralazine HCL 100mg tablet two times a day scheduled for 9:00am and 8:00pm.
-There were circled staff initials documented on the April 2024 MAR on 04/26/24 through 04/30/24 at 9:00am, and 04/29/24 and 04/30/24 at 8:00pm.
-There was no documentation of administration on 04/23/24, 04/25/24, 04/26/24, 04/27/24, and 04/28/24 at 8:00pm.

Review of documentation on the back of the April 2024 MARs revealed:
-There was documentation dated 04/26/24 at 8:00am, "Hydralazine awaiting fill not given."
-There was documentation dated 04/29/24 at 8:00am, "Hydralazine 100mg refill fax sent not given."
-There was documentation dated 04/30/24 at

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D 358	Continued From page 10 8:00am, "Hydralazine 100mg contacted hospice for refill not given." Observation of Resident #1's medications on hand on 05/28/24 at 3:35pm revealed there was a pharmacy labeled blister pack with printed instructions for Hydralazine HCL 100mg take one tablet two times daily for hypertension with a dispense date of 04/30/24, quantity of 60 tablets. Review of the contracted provider pharmacy prescription report for Resident #1 from 03/01/24 through 05/29/24 revealed: -On 03/05/24 Hydralazine HCL 100mg tablets quantity of 30 tablets (15-day supply) was dispensed to the facility. -On 03/30/24 Hydralazine HCL 100mg tablets quantity of 30 tablets (15-day supply) was dispensed to the facility. -On 04/30/24 Hydralazine HCL 100mg tablets quantity of 60 tablets (30-day supply) was dispensed to the facility. Interview with Resident #1 on 05/28/24 at 9:46am revealed: -She "had the most problem with medicine." -She "was not getting them sometimes". Interview with Resident #1 on 05/29/24 at 11:25am revealed: -She had an irregular pulse. -She felt like her "heart skipped a beat every once in a while". -The hospice nurse checked her blood pressure two times a week. -Her blood pressure readings ran 140-160 (systolic). Telephone interview with a nurse at the hospice agency for Resident #1 on 05/29/24 at 1:45pm	D 358		

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revealed:
-There was a current physician order for Resident #1 to be administered Hydralazine 100mg tablet two times a day with the original order date entered 11/20/23 after the resident was admitted to hospice on 11/20/23.
-There had not been any changes to the Hydralazine order.
-There was no order to hold or discontinue the Hydralazine.
-The hospice agency "typically" relied on the facility to inform them when a medication script was needed for refills.
-The facility did "not typically" show the hospice nurse the MARs for the resident.
-The hospice nurse visiting the facility usually asked facility staff at the end of the resident visit if medication refills were needed.
-Resident #1 was diagnosed with essential hypertension which was the reason for her being prescribed the Hydralazine.
-In reviewing the hospice agency notes, she did not see any notes that the hospice agency had been made aware that Resident #1 had missed being administered doses of the Hydralazine 100mg.
-Blood pressure (BP) readings obtained by the hospice nurse with Resident #1 seated were as follows: 04/22/24 = BP of 150/70, 04/25/24 = BP of 144/84, 04/29/24 = BP of 150/68.
-She could see a little bit of change in Resident #1's blood pressure.
-Resident #1's blood pressure tended to be 140-160 (systolic).
-She would expect Resident #1 to be administered the medication as ordered.

c. Review of Resident #1's electronically signed physician orders dated 02/26/24 and 05/22/24 revealed an order for Colace 100mg capsule two

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times a day at 8:00am and 8:00pm. (Colace is used to treat constipation).

Review of Resident #1's May 2024 medication administration records (MARs) revealed:
-There was a printed entry for Colace 100mg capsule two times daily scheduled at 8:00am and 8:00pm.
-There were circled staff initials documented on the May 2024 MAR on 05/20/24 through 05/27/24 at 8:00am and 8:00pm, and 05/28/24 at 8:00am.

Review of documentation on the back of the May 2024 MARs revealed:
-There was documentation dated 05/20/24 at 8:00pm, "Colace 100mg awaiting pharmacy not given."
-There was documentation dated 05/22/24 at 8:00am, "Colace 100mg awaiting pharmacy not given."
-There was documentation dated 05/25/24 at 8:00am, "Colace 100mg awaiting pharmacy not given."
-There was documentation dated 05/26/24 at 8:00am, "Colace 100mg awaiting fill not given."
-There was documentation dated 05/28/24 at 8:00am, "Colace 100mg awaiting fill not given."

Observation of Resident #1's medications on hand on 05/28/24 at 3:35pm revealed there were no Colace 100mg capsules on hand.

Interview with the medication aide (MA) on 05/28/24 at 3:40pm revealed there were no additional medications on hand for Resident #1.

Interview with the Director of Resident Care (DRC) on 05/29/24 at 11:00am revealed Resident #1's Colace 100mg capsules were delivered from the pharmacy on the evening of 05/28/24.

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D 358	Continued From page 13 Review of the contracted provider pharmacy prescription report for Resident #1 from 03/01/24 through 05/29/24 revealed: -On 04/19/24 Colace 100mg soft gel capsules quantity of 60 tablets (30-day supply) were dispensed to the facility. -On 05/28/24 Colace 100mg soft gel capsules quantity of 60 tablets (30-day supply) were dispensed to the facility. Interview with Resident #1 on 05/28/24 at 9:46am revealed: -She "had the most problem with medicine." -She "was not getting them sometimes". Interview with Resident #1 on 05/29/24 at 11:09am revealed: -She was having trouble going to the bathroom. -She did not get the Colace for a few days and her stool was hard. -The Colace made her bowels softer. -She did not get the Colace 2 - 3 days ago. The Colace was not delivered on time. The nurse would check on it but it did not get delivered. -She would go longer without having a bowel movement and her stools got harder when she did not get the Colace. Telephone interview with a nurse at the hospice agency for Resident #1 on 05/29/24 at 1:45pm revealed: -There was a current order for Colace 100mg two times a day for Resident #1. -There had not been any changes to the Colace order. -The hospice agency would not know if there were missed doses of medication administration for the resident unless the facility notified the hospice agency.	D 358		

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-She did not know why there would be missed doses of the Colace being administered to Resident #1 unless there was diarrhea.
-She was not aware of any missed doses of Colace administration to Resident #1.
-She did not see anything in the hospice nurse notes referencing diarrhea or constipation.

d. Review of physician orders for Resident #1 revealed there was a physician order dated 04/01/24 for Oxycodone 10mg tablet every four hours scheduled. (Oxycodone is a controlled substance used to treat pain).

Review of a hospice comprehensive assessment and plan of care report dated for the benefit period of 05/18/24 through 07/16/24 revealed a physician's order for Oxycodone 10mg tablet every four hours scheduled for pain.

Interview with Resident #1 on 05/28/24 at 9:46am revealed:
-She had the most problem with her medicine.
-She was not getting her medication sometimes.
-She had problems with the Oxycodone, and sometimes she did not get them.
-She had arthritis in all her joints.
-She did not get her Oxycodone "the other night."
-She thought the medication aide (MA) was new and she could not remember the exact date or name for the MA.

Review of Resident #1's May 2024 medication administration records (MARs) revealed:
-There was a printed entry for Oxycodone Immediate 10mg tablet take one tablet every four hours scheduled.
-The Oxycodone was scheduled for administration daily at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.

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D 358	Continued From page 15 -The documentation for administration of the Oxycodone 10mg tablet was blank on 05/26/24 at 2:00am and 6:00am. -There was no reason documented on the May 2024 MARs for the reason of the Oxycodone 10mg tablet omission on 05/26/24 at 2:00am and 6:00am. Review of Resident #1's controlled substance record (CSR) for Oxycodone Immediate 10mg tablet revealed: -There was a supply of Oxycodone Immediate tablets, quantity of 30 tablets, received on 05/14/24. -There was a dose of the Oxycodone Immediate 10mg tablets documented as administered on 05/24/24 at 2:00pm, 6:00pm, and 10:00pm for a total of three doses with 27 tablets remaining after the 10:00pm dose. -There was a dose of the Oxycodone Immediate 10mg tablets documented as administered on 05/25/24 at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm for a total of six doses with 21 tablets remaining after the 10:00pm dose. -The first dose of the Oxycodone Immediate 10mg tablet documented as administered on 05/26/24 was documented at 10:00am when the CSR count 21 tablets. -There was not a dose of the Oxycodone Immediate 10mg tablet documented as administered on 05/26/24 at 2:00am or 6:00am. Telephone interview with a nurse at the hospice agency for Resident #1 on 05/29/24 at 2:40pm revealed: -There was a current order for Oxycodone 10mg tablet every four hours scheduled for Resident #1. -The resident's Oxycodone order had changed a couple times.	D 358		

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D 358	Continued From page 16 -She would be concerned for Resident #1's comfort if Resident #1 missed being administered the Oxycodone 10mg tablet. -The Oxycodone 10mg tablet was ordered every four hours for a reason and was a medication that was "not just scheduled". Refer to the interview with the MA on 05/29/24 at 8:00am. Refer to the interview with the DRC on 05/29/24 at 2:52pm. Refer to the interview with the Registered Nurse on 05/29/24 at 4:08pm. Refer to the interview with the Administrator on 05/29/24 at 5:00pm. _____ Interview with the Medication Aide (MA) on 05/29/24 at 8:00am revealed: -The MAs faxed new orders to the contracted provider pharmacy. -The MAs transcribed new medication orders to the resident's MAR and documented on a facility form used to track the medication until the medication was available for administration at the facility. -If she requested a medication on the first shift at 11:00am from the contracted provider pharmacy, the medication was usually not at the facility before her shift ended at 3:00pm. -The contracted provider pharmacy delivered medications to the facility between 1:00pm and 2:00pm. -If she worked on the day after requesting a medication from the pharmacy and the medication had not been delivered to the facility, she called the pharmacy to inquire about the medication.	D 358		

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-She informed the Director of Resident Services (DRC) or Wellness Secretary when medications had not been delivered to the facility so they could contact the resident's primary care provider (PCP).
-The length of time it took for medications to arrive at the facility depended on the pharmacy or the sending provider, like hospice.

Interview with the DRC on 05/29/24 at 2:52pm revealed:
-The facility Registered Nurse (RN) audited the MARs.
-She (DRC) was not sure of the process the RN used when she audited the MARs but used the resident records to look at physician orders, and MARs for the outgoing month and upcoming month when she performed the audit.
-She did not know if the RN checked the medications on hand with the MARs and physician orders.
-The MAs were supposed to perform medication cart audits once a week by comparing the medications on hand with the MARs.
-The Wellness Secretary who was also a MA, was responsible for completing a medication cart audit weekly but sometimes delegated the cart audit to another MA.
-Medication cart audits were being completed on Mondays or Thursdays.
-She could not provide a date when the last medication cart audit had been completed.
-She expected the MAs to let the hospice nurse know when medications were needed.

Interview with the facility RN on 05/29/24 at 4:08pm revealed:
-She compared the outgoing month MARs with the upcoming month MARs.
-She did not check the medications on hand, and

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only checked the MARs for accuracy.
-She looked at the physician orders if she found a discrepancy.

Interview with the Administrator on 05/29/24 at 5:00pm revealed:
-She expected medications to be administered as ordered.
-If medications were not administered, she expected there to be a reason documented on the back of the resident MAR.
-She would not expect medications to be missed for more than three consecutive days for any reason without the MAs contacting the DRC or herself.
-The DRC was expected to notify the PCP when needed because she was the facility nurse.

_____

The facility failed to ensure Resident #1, who was on hospice and had a history of pain, hypertension, acid reflux and constipation was administered her medications; the resident had a pain medication that was scheduled to be administered every four hours for pain, which caused the resident to not be comfortable and Resident #2 who had a history of suicidal ideation, depression, anxiety, paranoia and hallucinations who did not receive her two medications to help with her mood, depression, anxiety, paranoia, and hallucinations and missed 10 doses of Risperdal and 22 doses of Depakote. This failure resulted in substantial risk for serious harm and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/24 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 28,

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D 358	Continued From page 19 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 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 ensure the medication administration records were accurate for 1 of 5 (#2) sampled residents to include two medications to treat mood disorders. The findings are: Review of the facility Medication Management Policy effective 06/09/23 revealed:	D 367		

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-The policy provided guidelines for assisting residents with medication management in accordance with state laws and regulations.
-Medication administration should be documented on the medication administration record (MAR) at the time the medication is provided or taken.
-Medication omissions and/or refusals should be documented on the MAR, the Director of Resident Care (DRC) would be notified, interview/assess the resident and notify the resident's physician/healthcare provider.
-Resident medications were issued/dispensed by the pharmacy.

Review of Resident #2's current FL-2 dated 01/16/24 revealed diagnoses included anxiety disorder and fibromyalgia.

a. Review of Resident #2's mental health provider visit note dated 03/12/24 revealed:
-Resident #2 had a history of depression, anxiety, suicidal ideation, paranoia and hallucinations.
-She prescribed the resident Risperdal 0.25mg, take one each evening to see if the medication helped the resident with her symptoms (Risperdal is used to treat mood disorders).

Review of Resident #2's signed medication orders revealed:
-There was an order dated 03/12/24 for Risperdal 0.25mg take one tablet each evening
-The order was electronically signed by Resident #2's mental health provider on 03/12/24.

Review of Resident #2's medication administration records (MARs) dated 04/01/24 through 04/30/24 revealed:
-There was a printed entry for Risperdal 0.25mg, take one tablet every evening at 8:00pm.
-There was an entry with staff initials on the MAR

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on 04/26/24 and 04/28/24 to 04/30/24 indicating that Risperdal 0.25mg had been administered.
-There was an entry with staff initials that were circled on the MAR from 04/21/24 to 04/25/24 and 04/27/24.
-There was documentation by MAs on the back of the MAR with the date, time, MA signature or a reason Risperdal was not administered on 04/21/24 to 04/25/24 and 04/27/24 due to awaiting pharmacy, out of medication.

Review of Resident #2's MARs dated 05/01/24 through 05/31/24 revealed:
-There was a printed entry for Risperdal 0.25mg, take one tablet every evening at 8:00pm.
-There was an entry with staff initials on the MAR on 05/01/24 to 05/04/24, 05/06/24 to 05/19/24, 05/22/24 to 05/24/24, and 05/28/24 indicating that Risperdal 0.25mg had been administered.
-There was an entry with staff initials that were circled on the MAR on 05/05/24, from 05/20/24 to 05/21/24, and from 05/25/24 to 05/27/24.
-There no was documentation by MAs on the back of the MAR with the date, time, MA signature or reason that Risperdal was not administered on 05/05/24, from 05/20/24 to 05/21/24, and from 05/25/24 to 05/27/24.

Observations of Resident #2's medications on hand on 05/28/24 at 3:20pm revealed there were no Risperdal 0.25mg tablets on hand.

Interview with the MA on 05/28/24 at 3:21pm revealed:
-She must have documented that she administered Risperdal to Resident #2 by mistake on the April 2024 and May 2024 MAR.
-She did not know why she did not document why the resident's Risperdal was not administered on the back of the MAR.

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-MAs were supposed to document any exceptions on the back of a resident's MAR but she evidently forgot to complete her documentation.

Refer to the interview with the Director of Resident Care (DRC) on 05/29/24 at 2:52pm.

Refer to interview with the Administrator on 05/29/24 at 5:00pm.

b. Review of Resident #2's signed medication orders revealed:
-There was an order dated 05/14/24 for Depakote 250mg take one tablet twice a day (Depakote is used to treat mood disorders).
-The order was electronically signed by Resident #2's mental health provider on 05/14/24.

Review of Resident #2's medication administration record (MAR) dated 05/01/24 through 05/31/24 revealed:
-There was a handwritten entry for Depakote 250mg take one tablet twice a day for mood at 9:00am and 9:00pm.
-There was an entry with staff initials that were circled on the MAR from 05/17/24 to 05/27/24 for 9:00am and 9:00pm, and on 05/28/24 at 9:00am.
-There no was documentation by MAs on the back of the MAR with the date, time, MA signature or reason that Depakote was not administered on 05/22/24, 05/25/24, 05/26/24, or 05/28/24.

Refer to Interview with the Director of Resident Care (DRC) on 05/29/24 at 2:52pm revealed:

Refer to interview with the Administrator on 05/29/24 at 5:00pm.

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D 367	Continued From page 23 Interview with the DRC on 05/29/24 at 2:52pm revealed: -The MAs should only document that they administered medications with their initials, when they physically administered medications to a resident and observed the resident take the medications. -MAs were expected to document exceptions on the back of the MAR. -MAs were supposed to ensure the accuracy of MARs when they administered medications. Interview with the Administrator on 05/29/24 at 1:30pm revealed: -She was not aware of the inaccuracy of MARS for Resident #2's Risperdal and Depakote. -MAs were expected to document any exceptions on the back of the MAR so staff was up to date on understanding why a resident was not administered their medication.	D 367		