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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 07/10/24 to 07/11/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 2 of 5 sampled residents (#2 and #4) related to medication monitoring for a blood thinning medication (#2) and a missed laboratory order (#4). The findings are: 1. Review of Resident #2's current FL2 dated 08/11/23 revealed: -Diagnoses included paroxysmal atrial-fibrillation and presence of a pacemaker. -There was an order for warfarin (an anticoagulant/blood thinner) 5.5mg daily. Review of Resident #2's physician's order dated 11/20/23 revealed an order to increase warfarin to 7mg daily. Review of Resident #2's laboratory result dated 05/11/24 revealed an International Normalized	D 273		

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Ratio (INR)(a laboratory test to determine blood clotting time) result of 1.96 (normal reference range for an anticoagulated patient was 2.0 to 3.0)

Review of Resident #2's physician's order dated 05/14/24 revealed an order to continue the current dose of warfarin and recheck INR in two weeks.

Review of Resident #2's laboratory result dated 05/29/24 revealed an INR result of 1.80; there was no physician's order in response to the INR result available for review on 07/10/24.

Review of Resident #2's laboratory result dated 06/07/24 revealed an INR result of 1.88; there was no physician's order in response to the INR result available for review on 07/10/24.

Review of Resident #2's laboratory result dated 06/14/24 revealed an INR result of 1.97; there was no physician's order in response to the INR result available for review on 07/10/24.

Review of Resident #2's laboratory result dated 06/20/24 revealed an INR result of 1.64; there was no physician's order in response to the INR result available for review on 07/10/24.

Review of Resident #2's laboratory result dated 07/09/24 revealed an INR result of 1.82.

Review of Resident #2's physician's order dated 07/09/24 revealed an order to increase warfarin to 8mg daily and recheck INR every week on Tuesdays.

Review of Resident #2's progress notes for May, June, and July 2024 revealed there was no

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documented communication with Resident #2's primary care provider (PCP) regarding her INR results on 05/29/24, 06/07/24, 06/14/24, or 06/20/24.

Interview with Resident #2 on 07/10/24 at 2:55pm revealed:
-She had been on the same dose of warfarin for the previous few months despite having her INR drawn every couple of weeks.
-Her PCP stopped by her room one or two days prior to tell her that she was increasing her warfarin dose due to her most recent INR laboratory result.
-She could not remember seeing her PCP for any visits in June 2024.

Telephone interview with Resident #2's PCP on 07/11/24 at 2:12pm revealed:
-Resident #2 was receiving warfarin therapy due to a diagnosis of atrial-fibrillation.
-Resident #2 had appointments with the PCP's designee on 07/02/24 to review blood pressures and on 07/09/24 to review warfarin dosing based on her INR result.
-Prior to July 2024 her last visit with the PCP was on 04/04/24.
-She was the provider who reviewed Resident #2's INR results and gave orders for warfarin dosing and when to re-check INR based on those results.
-She did not remember receiving any INR results for Resident #2 in June 2024.
-If she had been notified of Resident #2's INR result of 1.80 on 05/29/24 or of 1.64 on 06/20/24, she would have increased Resident #2's dose of warfarin.
-An INR result of 1.80 or lower could place Resident #2 at risk for blood clots.
-She expected the facility to notify her of every

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INR result as soon as the result was available so that she could dose Resident #2's warfarin accordingly and let the facility know when to schedule the next INR laboratory draw.
-She was not aware of Resident #2 having any symptoms of blood clots.

Interview with a medication aide (MA) on 07/11/24 at 2:40pm revealed:
-Resident #2 had been receiving warfarin 7mg daily for months until 07/09/24 when the dose increased to 8mg daily.
-Resident #2 did not have any symptoms of bleeding or blood clots in the previous few months.
-The MAs were not responsible for scheduling laboratory draws or forwarding laboratory results to the PCP; that was the responsibility of the Healthcare Director (HCD).
-The facility did not have a current HCD and she did not know who was responsible for taking over the responsibilities of the HCD until a new HCD was hired.

Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 5:30pm revealed:
-She had been at the facility since Monday, 07/08/24, to take over the responsibilities of the HCD until a new one could be hired.
-The HCD had been responsible for ensuring that all ordered laboratory work was completed.
-The laboratory automatically forwarded results to the ordering physician.
-If no PCP acknowledgement of the laboratory result was received by the facility, the HCD was responsible to follow-up with the PCP for acknowledgement of the result or any new orders.
-She had not seen any documentation from the HCD that he had followed up with Resident #2's

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PCP regarding her INR results from 05/29/24 through 06/20/24.

Telephone interview with the Administrator on 07/11/24 at 6:30pm revealed:
-The HCD had been responsible for tracking Resident #2's INR laboratory results and ensuring the PCP received and reviewed each INR result.
-The PCP was at the facility every week and should have been provided with Resident #2's INR results during her visits to the facility if the results were not critical.
-If Resident #2's INR results were critical or outside of her goal range, the HCD was responsible for contacting the PCP for orders and documenting the communication.
-The MAs were responsible to check the fax machine once per shift to check for any new orders received, but if there had been an order regarding Resident #2's INR result and warfarin dosing they would have been responsible for giving it to the HCD to follow up on.
-If the HCD had communicated with the PCP regarding Resident #2's INR results, he would have been responsible for documenting the communication and any new orders received.

2. Review of Resident #4's current FL2 dated 01/25/24 revealed diagnoses included hyperlipidemia.

Review of Resident #4's physician's order dated 05/14/24 revealed an order to check Resident #4's lipid panel in the month of May 2024 due to hyperlipidemia.

Review of Resident #4's record revealed there were no laboratory results in the month of May 2024 available for review.

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Interview with the facility's contracted laboratory on 07/11/24 at 10:17am revealed:
-Resident #4 did not have a lipid panel test in the month of May 2024.
-The only laboratory results available for Resident #4 were from 06/07/24 and it was not a lipid panel.
-The last time Resident had a lipid panel test was 11/02/22.

Interview with a medication aide (MA) on 07/11/24 at 3:14pm revealed:
-The MAs received laboratory orders from the facility's primary care provider (PCP) after her visit with residents in the secured unit and sent the orders to the laboratory.
-She did not remember seeing an order for a lipid panel test for Resident #4.
-MAs were supposed to place the laboratory orders for residents in the laboratory order notebook, but there were no orders for Resident #4 in the notebook.

Interview with the Secured Unit Manager on 07/11/24 at 3:15pm revealed:
-The facility did not have the best system for processing laboratory orders.
-Facility staff were able to place laboratory orders in the laboratory portal to request service from the laboratory.
-There had been issues with getting into the portal to place laboratory orders.
-Whoever received the order could have called the laboratory to request the lipid panel, but there was no request made.

Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 5:28pm revealed:
-The former Healthcare Director (HCD) or a designee was responsible for ensuring laboratory

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tests were completed for residents, but she was currently assisting with conducting duties of the HCD.
-The laboratory order should have been written in the laboratory notebook and a laboratory ticket should have been completed.
-The original copy of the laboratory ticket should have been given to the laboratory representative when they picked up the specimen and the yellow copy of the laboratory ticket should have been filed.

Telephone interview with Resident #4's PCP on 07/11/24 at 2:24pm revealed:
-Resident #4 had a diagnosis of hyperlipidemia and was on a medication to lower cholesterol.
-The goal was to lower the dose of the cholesterol medication.
-Lipid panels were ordered every 6 months to monitor cholesterol levels and to possibly lower medication doses.
-The PCP wrote the orders for laboratory testing, but the facility was responsible for completing a laboratory sheet and notifying the laboratory to come to the facility and collect a blood sample for the laboratory test.
-She expected the facility to contact the laboratory and send them the order for lipid panel testing for Resident #4 within the month of May 2024.
-She expected for the results to be placed in Resident #4's record.

Telephone interview with the Administrator on 07/11/24 at 6:06pm revealed:
-She did not know a lipid panel test for Resident #2 was not completed.
-The former HCD was responsible for ensuring laboratory orders were completed.
-If the facility PCP wrote the order for a laboratory

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D 273	Continued From page 7 test, she expected the PCP to communicate with staff that the laboratory test had not been completed. _____ The facility failed to ensure healthcare referral and follow-up for a resident who was administered warfarin daily and there was no followed up with the PCP regarding INR laboratory results that were outside of the resident's goal range placing the resident at risk of developing blood clots or increased risk of bleeding (#2); and a resident who did not have a lipid panel laboratory test completed to monitor cholesterol levels (#4). This failure was detrimental to the health, safety, and welfare of the residents and constitutes an unabated Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on July 11, 2024.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to fingerstick blood sugars	D 276		

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D 276	Continued From page 8 (FSBS). The findings are: Review of Resident #1's current FL2 dated 07/11/24 revealed: -Diagnoses included diabetes. -There was an order to check FSBS 3 times daily. Review of Resident #1's FL2 dated 04/11/24 revealed an order to check FSBS 3 times daily. Review of Resident #1's electronic treatment administration record (eTAR) for May 2024 revealed: -There was an entry for FSBS check FSBS 3 times daily scheduled for 7:45am, 4:45pm, and 8:00pm. -There was no documentation Resident #1's FSBS was checked on 05/02/24 at 4:45pm and 8:00pm and on 05/06/24 and 05/07/24 at 8:00pm; the reasons why Resident #1's FSBSs were not checked included found in audit and resident wants FSBS checked at 9:30pm. -There was an entry for FSBS check FSBS 3 times daily scheduled for 7:45am, 4:45pm, and 9:30pm. -There was no documentation Resident #1's FSBS was checked on 05/12/24, 05/17/24 05/20/24, 05/22/24, 05/23/24, 05/25/24, 05/26/24, and 05/30/24 at 9:30pm; the reasons why Resident #1's FSBSs were not checked included found in audit, family member forgot, and refused. Review of Resident #1's eTAR for June 2024 revealed: -There was an entry for FSBS check FSBS 3 times daily scheduled for 7:45am, 4:45pm, and 9:30pm.	D 276		

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-There was no documentation Resident #1's FSBS was checked on 06/03/24, 06/06/24, 06/23/24, and 06/30/24 at 4:45pm; and 06/04/24 ,06/05/24, 06/11/24 and 06/19/24 at 9:30pm; the reasons why Resident #1's FSBSs were not checked included leave of absence, out of range, ??, family member forgot, missed, and found in audit.

Review of Resident #1's eTAR for 07/01/24 through 07/10/24 revealed:
-There was an entry for FSBS check FSBS 3 times daily scheduled for 7:45am, 4:45pm, and 9:30pm.
-There was no documentation Resident #1's FSBS was checked on 07/09/24 at 4:45pm and 07/01/24 at 9:30pm; the reasons why Resident #1's FSBS were not checked included missed and family member forgot.

Observation of Resident #1's diabetic supplies on the medication cart on 07/11/24 at 3:45pm revealed:
-There was a container with Resident #1's name on it.
-In the container was an insulin pen and alchohl wipes.
-There was not a glucometer available for Resident #1.

Observation of Resident #1's room on 07/11/24 at 11:39am revealed:
-There was a glucometer for Resident #1.
-There was a notebook containing FSBS readings for Resident #1.

Review of the notebook of FSBSs readings for Resident #1 revealed:
-All the FSBS readings in the months of May, June, and July 2024 did not match the FSBS

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reading on the eTAR for May, June, and July 2024 with examples as follows:
-Between 05/01/24 and 05/10/24, the readings in Resident #1's FSBS notebook did not match the readings on the eTAR for 4 of 10 opportunities at 7:45am, 3 of 10 opportunities at 4:45pm, and 8 of 10 opportunities at 8:30pm/9:30pm.
-Between 06/10/24 and 06/19/24, the readings in Resident #1's FSBS notebook did not match the readings on the eTAR for 2 of 10 opportunities at 4:45pm and 7 of 10 opportunities at 9:30pm.
-Between 07/01/24 and 07/09/24, the readings in Resident #1's FSBS notebook did not match the readings on the eTAR for 2 of 9 opportunities at 7:45pm. 6 of 9 opportunities at 4:45pm, and 6 of 9 opportunities at 9:30pm.

Interview with Resident #1's family member on 07/11/24 at 11:40am revealed:
-She checked Resident #1's FSBS daily before breakfast, dinner, and bedtime.
-When she left the room to go to the dining hall for meals, she stopped by the desk where the medication aides (MA) were located and told them what Resident #1's FSBS reading was.
-Sometimes the MAs were not at the desk and did not come to ask her what Resident #1's FSBS reading was, especially at the 9:30pm administration time.
-Staff did not tell her that they needed to check Resident #1's FSBSs themselves.

Interview with Resident #1 on 07/11/24 at 12:10pm revealed his family member checked his FSBSs.

Interview with a MA on 07/11/24 at 2:30pm revealed:
-Resident #1's family member checked his FSBSs daily and reported to her and the other

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MAs what his FSBS readings were.
-After Resident #1's family member told her what his FSBS reading was, she documented the reported reading on the eTAR.

Interview with a second MA on 07/11/24 at 3:36pm revealed:
-She did not check Resident #1's FSBS.
-She did what the other MAs were doing in allowing Resident #1's family member to check his FSBS and reported it to her.
-She documented the FSBS on the eTAR that Resident #1's family member reported to her.
-There was not a glucometer for Resident #1 on the medication cart for MAs to use for him.

Interview with the Corporate Clinical Specialist on 07/11/24 at 5:28pm revealed:
-MAs were expected to check Resident #1's FSBS and not Resident #1's family member.
-She did not know if Resident #1's family member was capable of checking his FSBS correctly to avoid issues with infection control.

Interview with the Administrator on 07/11/24 at 6:06pm revealed:
-Resident #1's family member had trust issues surrounding his medications, but she thought the MAs were checking Resident #1's FSBSs.
-There had been recent trainings provided to MAs regarding medication administration including checking FSBS.
-She thought Resident #1's family member was cognitive to check his FSBSs, but she expected the MAs to check them.

Attempted interview with Resident #1's primary care provider on 07/11/24 at 4:28pm was unsuccessful.

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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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#1 and #6) observed during the medication pass including errors with a digestive supplement and a topical ointment (#1), and an inhaler for chronic obstructive pulmonary disease (#6), and 1 of 5 sampled residents for record review for a steroid nasal spray, a supplement, and insulin (#1). The findings are: The medication error rate was 10% as evidenced by observation of 3 errors out of 28 opportunities during the 8:00am morning medication pass on 07/11/24. 1. Review of Resident #1's current FL2 dated 03/09/23 revealed diagnoses included Alzheimer's disease, diabetes, and hypertension. Observation on 07/11/24 at 7:50am revealed that Resident #1 shared a room with his family member.	D 358		

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D 358	Continued From page 13 a. Review of Resident #1's physician order dated 07/08/24 revealed an order for pancrelipase (Creon) 24000 unit capsules delayed release (DR) particles 2 capsules three times daily with meals, and one capsule with each snack. (Creon is used to increase food digestion). Observation of the morning medication pass on 07/11/24 at 7:40am revealed: -The morning medication aide (MA) prepared 2 Creon 24000 units capsules from a bubble pack bingo card into a plastic souffle cup for Resident #1. -The MA took the prepared souffle cup into Resident #1's room, along with the bingo card into Resident #1's room. -The MA showed the bingo card to Resident #1's spouse, left the souffle cup with Resident #1's spouse, and returned to the medication cart. -The MA returned to the medication cart and documented Creon 24000 unit capsules were administered to the resident. Review of Resident #1's July 2024 electronic medication administration record (eMAR) from 07/01/24 to 07/11/24 revealed: -There was an entry for Creon DR 24,000 units take 2 capsules 3 times a day with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -There was documentation Creon 24000 units capsules were administered at 8:00am on 07/11/24. Observation of medication on hand for Resident #1 on 07/11/24 at 8:00am revealed: -There was a bubble pack bingo card labeled for Creon 24000 units capsules take 2 capsules three times daily with meals, and one capsule with each snack on the medication cart available	D 358		

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for administration.
-The bingo card had 8:00am handwritten at the upper left corner of the card.
-There were 17 bubbles, containing 2 capsules in each bubble, remaining from 20 doses dispensed on the card.
-The card was labeled as dispensed on 07/08/24 for 160 capsules.

Interview with the morning MA on 07/11/24 at 7:55am revealed:
-She routinely prepared Resident #1's medications for administration and showed the spouse the medications cards used to prepare the medications.
-Resident #1's family member had a list of the medications for Resident #1 and liked to ensure all the medications were correct.
-Resident #1's family member administered Resident #1's medications most of the time.
-She was trained in January 2024 by another MA that Resident #1's family member wanted to administer his medications, but not always while the MA was present.
-She documented the 8:00am Creon 24000 units capsules as administered because she felt confident the family member would make sure the resident's medications were administered.

Observation of Resident #1 and his family member on 07/11/24 at 8:00am revealed:
-Resident #1 and his family member were exiting their room with rolling walkers.
-Resident #1's souffle cup containing 2 Creon 24000 units was placed on the seat of the rolling walker.

Interview with Resident #1's family member on 07/11/24 at 8:00am revealed:
-The residents were headed to the dining room.

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D 358	Continued From page 15 -Resident #1's Creon 24000 units was to be administered with meals and she would administer his medications during breakfast. Observation of Resident #1 and his family member on 07/11/24 at 8:20am revealed they were seated in the dining room with the souffle cup containing 2 Creon 24000 capsules on the table between the residents. Interview with Resident #1's family member on 07/11/24 at 8:20am revealed she planned to administer Resident #1's medication (Creon 24000) during the meal, but was waiting a little longer for him to eat some more food. Second interview with the morning MA on 07/11/24 at 2:40pm revealed she asked the previous Health Care Director (HCD) about leaving medications in Resident #1's room for his family member to administer and was told that was "Okay" for this resident. Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 4:30pm revealed: -The HCD was responsible for ensuring medications were administered as ordered. -Currently, the facility had no HCD due to staff turnover. -She had been at the facility since Monday, 07/08/24, to take over the responsibilities of the HCD until a new one could be hired. -The MAs were to prepare medications, watch medications be administered, and document administration of medications on the eMAR according to the directions on the eMAR. -Creon 24000 was not administered by the MA and according to the directions on the eMAR regarding meals.	D 358		

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D 358	Continued From page 16 Telephone interview with a representative from the contracted pharmacy on 07/11/24 at 4:55pm revealed Resident #1 was dispensed 160 capsules of Creon 24000 units on 07/08/24 with directions for 2 capsules with meals 3 times a day and one capsule with snacks. Telephone interview with the Administrator on 07/11/24 at 6:00pm revealed: -MAs should prepare medications for administration and observe residents take the medications prior to documenting administration on the eMAR. -Resident #1's and his family member shared a room. -Resident #1's family member kept a list of Resident #1's medications and requested to see the resident's medications prepared to ensure all medications were prepared correctly. -She did not know MAs were leaving medications for the family member to administer to the resident. -The facility had more than 2 in-services directly related to medication administration and documentation within the last 3 months to ensure MAs read the eMAR, prepared, and administrated medications correctly. b. Review of Resident #1's signed physicians orders dated 04/11/24 revealed an order for Vaseline (a skin barrier used to protect minor skin cuts or tears) ointment apply a small amount of Vaseline to left arm and right hand daily unless bleeding is more frequent. Observation of the morning medication pass on 07/11/24 at 7:40am revealed: -The morning MA prepared an oral medication from a bubble pack bingo card into a plastic souffle cup for Resident #1.	D 358		

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-The morning MA removed a plastic bag labeled Vaseline petroleum jelly containing a 49-gram jar of Vaseline petroleum jelly labeled use as directed per treatment order for Resident #1.
-The MA took the prepared souffle cup, along with and the plastic bag containing Vaseline, into Resident #1's room
-The MA returned to the medication cart and documented Vaseline was applied to the resident.
-The MA rolled the medication cart to the next resident.

Review of Resident #1's July 2024 eMAR from 07/01/24 to 07/11/24 revealed:
-Vaseline ointment apply a small amount of Vaseline to left arm and right hand daily unless bleeding is more frequent scheduled for administration at 8:00am.
-There was documentation Vaseline ointment was applied at 8:00am on 07/11/24.

Observation of medication on hand for Resident #1 on 07/11/24 at 11:00am revealed:
-There was a plastic bag labeled Vaseline petroleum jelly containing a 49-gram jar of Vaseline petroleum jelly labeled use as directed per treatment order with a dispensing date of 03/30/24.
-The Vaseline ointment jar was opened and the contents appeared to not have been used.

Interview with the morning MA on 07/11/24 at 7:55am revealed:
-She routinely prepared Resident #1's medications for administration and showed the family member the medications cards or contained used to prepare the medications.
-Resident #1's family member had a list of the medications for Resident #1 and liked to ensure all the medications were correct.

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-Resident #1's family member administered Resident #1's medications most of the time.
-She was trained in January 2024 by another MA that Resident #1's spouse wanted to administer his medications but not always while the MA was present.
-She documented Vaseline ointment as applied because she felt confident the family would make sure the resident's medications were administered.

Interview with Resident #1's family member on 07/11/24 at 8:00am revealed:
-She had a list of Resident #1's medications used to ensure Resident #1 received his medications.
-She administered Resident #1's medications if the MA left the medication for her and if it was on his list of medications.

Interview with the CCS on 07/11/24 at 4:30pm revealed:
-The HCD was responsible for ensuring medications were administered as ordered.
-Currently, the facility had no HCD due to staff turnover.
-She had been at the facility since Monday, 07/08/24, to take over the responsibilities of the HCD until a new one could be hired.
-The MAs were to prepare medications, watch medications be administered, and document administration of medications on the eMAR according to the directions on the eMAR.
-If the Vaseline ointment jar contents appeared unused, the medication must not have been applied.

Telephone interview with a representative from the contracted pharmacy on 07/11/24 at 5:08pm revealed:
-Resident #1 was dispensed Vaseline petroleum

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Jelly one time on 03/30/24 for 49 grams.
-There was no documentation for subsequent dates for dispensing.

Telephone interview with the Administrator on 07/11/24 at 6:00pm revealed:
-MAs should prepare medications for administration and observe residents take the medications prior to documenting administration on the eMAR.
-Resident #1 and his family member shared a room.
-Resident #1's family member kept a list of Resident #1's medications and requested to see the resident's medications prepared to ensure all medications were prepared correctly.
-She did not know MAs were administering Resident #1's medications incorrectly
-The facility had more than 2 in-services directly related to medication administration and documentation within the last 3 months to ensure MAs read the eMAR, prepared, and administrated medications correctly.
-Resident #1's Vaseline petroleum jelly was not administered as ordered if the ointment jar was not used.(Same comment)

2. Review of Resident #6's current FL2 dated 02/27/24 revealed diagnoses including emphysema.

Review of Resident #6's physician's orders revealed:
-There was an order dated 04/23/24 for Trelegy Ellipta 100-62.5-25 (an oral inhaler used to treat shortness of breath from emphysema or chronic obstructive pulmonary disease (COPD)) one puff inhaled daily.
-There was a signed physicians' order dated 05/09/24 for Trelegy Ellipta 100-62.5-25 one puff

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D 358	Continued From page 20 inhaled daily. Observation of the morning medication pass on 07/11/24 at 8:10am revealed: -The morning medication aide (MA) prepared 12 oral medications (capsules and tablets) and one powder for reconstitution for administration to Resident #6. -The MA entered Resident #6's room and administered the medications. -Trelegy Ellipta 100-62.5-25 was not prepared for Resident #6 or administration observed. -The MA returned to the medication cart and documented administration of the medication. -The MA brought a manufacturer's box containing Trelegy Ellipta 100-62.5-25 inhaler back from the resident's room and returned the box to the resident's room. Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Trelegy Ellipta 100-62.5-25 one puff inhaled daily scheduled for administration at 8:00am. - Trelegy Ellipta 100-62.5-25 one puff inhaled daily was documented as administered with "self-administered" documented on the eMAR notes section. Observation of the manufacturer's box for Trelegy Ellipta 100-62.5-25 on 07/11/24 at 2:14pm revealed: -The box was labeled as dispensed on 06/11/24 for 30 doses with instructions for one puff daily for COPD. -The inhaler inside the box had a counter incorporated on the inhaler for tracking inhalations used from the inhaler with one (1) remaining on the counter.	D 358		

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D 358	Continued From page 21 Interview with the morning MA on 07/11/24 at 8:10am revealed: -Resident #6 self-administers her Trelegy Ellipta 100-62.5-25. -The MA had seen the medication in the resident's room earlier this morning. -She brought the Trelegy Ellipta 100-62.5-25 box and inhaler to the medication cart for documenting administration of the medication. -She did not watch the resident administer Trelegy Ellipta 100-62.5-25. Review of Resident #6's order for Trelegy Ellipta 100-62.5-25 dated 04/23/24 and signed physician's orders dated 05/09/24 revealed no self-administration order. Telephone interview with a representative at the contracted pharmacy on 07/11/24 at 12:10pm revealed: -The pharmacy had no order for Resident #6 to self-administer Trelegy Ellipta 100-62.5-25. -The pharmacy would list on the eMAR if a resident had an order to self-administer or may keep at bedside. - Trelegy Ellipta 100-62.5-25 was dispensed on 06/11/24 for 30 doses. Interview with Resident #6 on 07/11/24 at 4:20pm revealed: - Trelegy Ellipta 100-62.5-25 was left in her room sometimes by the MA on duty. -She administered Trelegy Ellipta 100-62.5-25 one time a day, in the morning, if it was left in her room. -If the MA returned Trelegy Ellipta 100-62.5-25 to the medication cart, she was not upset. -It depended on the MA on duty if Trelegy Ellipta 100-62.5-25 was left in her room or returned to	D 358		

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the med cart.

Second interview with the morning MA on 07/11/24 at 2:40pm revealed she asked the previous Health Care Director (HCD) about leaving medications in Resident #1's room for his spouse to administer and was told that was OK for this resident.

Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 4:30pm revealed:
-The HCD was responsible for ensuring medications were administered as ordered.
-Currently the facility had no HCD due to staff turnover.
-She had been at the facility since Monday, 07/08/24, to take over the responsibilities of the HCD until a new one could be hired.
-The MAs were to prepare medications, watch medications be administered, and document administration of medications on the eMAR according to the directions on the eMAR.
-Resident #6's Trelegy Ellipta 100-62.5-25 should have been on the medication cart and administered as ordered by the MA, and documented as administered.

Telephone interview with the Administrator on 07/11/24 at 6:00pm revealed:
-MAs should prepare medications for administration and observe residents take the medications prior to documenting administration on the eMAR.
-She did not know MAs were administering Resident #6's medications incorrectly by leaving the medication in the resident's room.
-The facility had more than 2 in-services directly related to medication administration and documentation within the last 3 months to ensure MAs read the eMAR, prepared, and administrated

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D 358	Continued From page 23 medications correctly. -The MA should have administered Resident #6's Trelegy Ellipta 100-62.5-25 and documented the medication as administered on the eMAR. 3. Review of Resident #1's current FL2 dated 07/11/24 revealed diagnoses included Alzheimer's disease, impaired mobility, depression, hypertension, hyperlipidemia, diabetes, and benign prostatic hyperplasia. a. Review of Resident #1's physician's orders dated 04/11/24 revealed an order for fluticasone 50mcg (used to treat allergies) 1 spray in each nostril daily. Review of Resident #1's electronic medication administration record (eMAR) for June 2024 revealed: -There was an entry for fluticasone 50mcg 1 spray in each nostril daily scheduled at 10:00am. -There was documentation fluticasone was administered for 25 of 30 opportunities. -There was documentation fluticasone was not administered 5 times on 06/08/24 and 06/11/24 due to resident refused, and on 06/21/24, 06/22/24, and 06/23/24 due to self-administered. Review of Resident #1's eMAR for 07/01/24 through 07/10/24 revealed: -There was an entry for fluticasone 50mcg 1 spray in each nostril daily scheduled at 10:00am. -There was documentation fluticasone was administered for 4 of 10 opportunities. -There was documentation fluticasone was not administered for 6 times on 07/01/24, 07/02/24, 07/03/24, 07/04/24, 07/05/24, and 07/10/24 due to self-administered.	D 358		

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D 358	Continued From page 24 Observation of Resident #1's room on 07/11/24 at 11:39am revealed fluticasone was not available in Resident #1's room. Observation of medications available for Resident #1 on the medication cart on 07/11/24 at 3:45pm revealed fluticasone was not available. Interview with a representative from the facility's contracted pharmacy on 07/11/24 at 4:41pm revealed: -Resident #1 had a current order for fluticasone 50mcg 1 spray in each nostril daily, however, the prescription expired on 06/10/24. -Fluticasone was last dispensed for Resident #1 on 06/12/23 and should have lasted for 30 days. -There was no order to discontinue fluticasone. Interview with Resident #1's family member on 07/11/24 at 11:39am revealed: -Resident #1 had not been administered fluticasone in a long time, but she could not remember how long. -The medication aides (MA) did not bring fluticasone to Resident #1's room to administer and there was no fluticasone in Resident #1's room. -There was no medication in Resident #1's room. -She had not noticed Resident #1 had any issues with allergies. Interview with a MA on 07/11/24 at 2:30pm revealed: -Resident #1 saw an outside PCP and his family took him to his appointments. -She had not had any after visit paperwork submitted to her by Resident #1's family members. -The former Healthcare Director (HCD) handled processing new orders from outside providers.	D 358		

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-Resident #1 did not have any order to self-administer any of his medications, but she was told by other MAs that his nasal spray was self-administered.
-Resident #1's fluticasone was not on the medication cart.
-She did not administer fluticasone to Resident #1.

Interview with a second MA on 07/11/24 at 3:36pm revealed:
-She thought Resident #1 had fluticasone in his room and that it was self-administered.
-Fluticasone was not on the medication cart, and she had not administered it to Resident #1.

Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 5:28pm revealed:
-The MAs should have reported any changes reported by Resident #1's family members to the former HCD.
-The former HCD would have been responsible for following up with Resident #1's primary care provider (PCP) regarding medication orders.
-MAs should not have stopped administering Resident #1's fluticasone without an order to discontinue the medication.

Telephone interview with the Administrator on 07/11/24 at 6:06pm revealed:
-Resident #1 did not have orders to self-administer his medication.
-She expected staff to administer Resident #1's fluticasone unless there was an order to discontinue it.
-The former HCD was responsible for following up on information and medications orders received from outside providers.
-MAs should have told the former HCD, the Administrator, or the Secured Unit Manager, who

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assisted on the Assisted Living Unit when needed, about any issues with Resident #1's medications.

b. Review of Resident #1's physician's orders dated 04/11/24 revealed an order for magnesium oxide 400mg (used to treat hypomagnesemia) 1 tablet daily.

Review of Resident #1's eMAR for 07/01/24 through 07/10/24 revealed:
-There was an entry for magnesium oxide 400mg 1 tablet daily scheduled for administration at 10:00am.
-There was documentation magnesium oxide was administered for 6 of 10 opportunities.
-There was documentation magnesium oxide was not administered 4 times on 07/05/24, 07/08/24, 07/09/24, and 07/10/24, and there was no documented reason why magnesium oxide was not administered.

Observation of medications available for Resident #1 on 07/11/24 at 3:45pm revealed:
-Magnesium oxide 400mg 1 tablet daily was available and was dispensed to the facility on 06/29/24 with a quantity of 30 tablets.
-There were 28 tablets remaining.

Interview with a representative from the facility's contracted pharmacy on 07/11/24 at 4:41pm revealed:
-Resident #1 had a current order for magnesium oxide 400mg 1 tablet daily.
-Magnesium oxide was dispensed to the facility on 05/21/24 and 06/29/24 with a 30 day supply each time.
-There were no orders to discontinue magnesium oxide.

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D 358	Continued From page 27 Interview with Resident #1's family member on 07/11/24 at 11:39am revealed: -She was told by Resident #1's primary care provider (PCP) that Resident #1's magnesium oxide was to be held until further notice, but she did not remember the date of the visit when she was told. -She did not remember why Resident #1's PCP wanted to hold his magnesium oxide. Interview with a MA on 07/11/24 at 2:30pm revealed: -Resident #1's family told her on 07/10/24 that he was not supposed to be administered magnesium oxide, so she did not administer the medication. -She did not tell anyone in management that Resident #1's family member tole her Resident #1 was not supposed to be administered magnesium oxide. -She knew there should have been a discontinue order in place to stop administering medication to residents and there were no discontinue orders for magnesium oxide on the eMAR. -She did not know why she did not administer magnesium oxide or why she did not tell anyone in management. Interview with a second MA on 07/11/24 at 3:36pm revealed: -Resident #1's family member said to hold magnesium oxide, but she did not know when. -She had not administered magnesium oxide to Resident #1 since his family member told her to hold it. -She had not seen any orders to discontinue or hold magnesium oxide. -She did not think magnesium oxide was still on Resident #1's eMAR. Interview with the CCS on 07/11/24 at 5:28pm	D 358		

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revealed:
-The MAs should have reported any changes reported by Resident #1's family members to the former Healthcare Director (HCD).
-The former HCD would have been responsible for following up with Resident #1's primary care provider (PCP) regarding medication orders.
-MAs should not have stopped administering Resident #1's magnesium oxide without an order to discontinue the medication.

Telephone interview with the Administrator on 07/11/24 at 6:06pm revealed:
-When a resident had a medical appointment outside of the facility, she expected that a copy of the after-visit summary be given to the MA.
-The former HCD informed families upon admission that after visit summary and orders were to be submitted to the MA or him upon the resident's return to the facility.
-There had also been a mass email sent out to residents' families concerning submitting paperwork after outside medical appointments.
-The MA and the former HCD were responsible for reviewing any documents and orders from outside providers and placing them in the resident's record.
-The former HCD was responsible for following up on information and medications orders received from outside providers.
-MAs should have told the former HCD, the Administrator, or the locked unit manager, who assisted on the assisted living side when needed, that Resident #1's family member stated to hold his magnesium oxide.
-Resident #1's magnesium oxide should have been administered until an order to discontinue the medication was received.

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

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dated 04/11/24 revealed an order for lantus 100unit/ml (a long-acting insulin used to lower elevated blood sugar levels) inject 10 units daily.

Review of Resident #1's eMAR for June 2024 revealed:
-There was an entry for lantus 100unit/ml inject 10 units daily scheduled at 10:00am.
-There was documentation fluticasone was administered for 21 of 30 opportunities.
-There was documentation fluticasone was not administered 9 times on 06/21/24 due to medication on hold, 06/22/24 due to hold per family request, 06/23/24 due to hold, 06/24/24, 06/25/24, 06/26/24, 06/27/24, 06/28/24, and 06/30/24 due to resident refused medication.

Review of Resident #1's electronic treatment administration record (eTAR) for June revealed Resident #1's fingerstick blood sugars (FSBS) ranged from 79 to 258.

Review of the notebook of FSBSs readings for Resident #1 revealed Resident #1's fingerstick blood sugar (FSBS) readings for June 2024 ranged from 70 to 284.

Review of Resident #1's eMAR for 07/01/24 through 07/11/24 revealed:
-There was an entry for lantus 100unit/ml inject 10 units daily scheduled at 10:00am.
-There was documentation lantus was administered for 9 of 11 opportunities.
-There was documentation lantus was not administered 2 times on 07/08/24 due to family wanted medication held until further notice and on 07/11/24 due to medication on hold.

Review of Resident #1's eTAR for June revealed Resident #1's FSBS ranged from 121 to 232.

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D 358	Continued From page 30 Review of the notebook of FSBSs readings for Resident #1 revealed Resident #1's FSBS readings for 07/01/24 through 07/10/24 ranged from 112 to 316. Observation of medications available for Resident #1 on 07/11/24 at 3:45pm revealed: -There was one pen of Lantus 100unit/ml 10 units every day available on the medication cart, and there was documentation the pen was opened on 05/20/24 with an expiration date of 06/17/24. -There were 4 unopened pens remaining in the medication refrigerator. Interview with a representative from the facility's contracted pharmacy on 07/11/24 at 4:41pm revealed: -Resident #1 had a current order for lantus 100unit/ml 10 units daily. -Lantus was dispensed to the facility on 03/28/24 with a quantity of 5 pens with 3ml in each pen. -The five pens should have lasted 140 days in total, and each pen was good for 28 days after opening. -There were no orders to discontinue lantus. Interview with Resident #1's family member on 07/11/24 at 11:39am revealed: -Resident #1's primary care provider (PCP) wanted to discontinue his insulin. -Resident #1's PCP told her that his FSBSs were good and he wanted Resident #1 to try going without his insulin. -She did not remember the date of the visit when Resident #1's PCP stated to stop his insulin. -The MAs used to administer Resident #1's insulin, but they had not since she told them he was not to have insulin. -Resident #2's FSBS have been good since he	D 358		

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D 358	Continued From page 31 stopped taking insulin. Interview with a MA on 07/11/24 at 2:30pm revealed: -Resident #1's family told her on 07/08/24 that he was not supposed to be administered Lantus insulin so she did not administer the medication. -She did not tell anyone in management that Resident #1's family member stated he was not supposed to be administered insulin. -She knew there should have been a discontinue order in place to stop administering medication to residents and there were no discontinue orders for Lantus on the eMAR. -She did not know why she did not administer Lantus or why she did not tell anyone in management. Interview with a second MA on 07/11/24 at 3:36pm revealed: -Resident #1's family member requested that his Lantus insulin be held, but she did not remember when. -The MAs administered Resident #1's insulin and he had never refused it. -If she documented Resident #1's insulin was refused, it was because his family member said that he was not supposed to have it. -She had not seen any orders to discontinue or hold Resident #1's insulin and it still populated on his eMAR. Interview with the CCS on 07/11/24 at 5:28pm revealed: -The MAs should have reported any changes reported by Resident #1's family members to the former HCD. -The former Healthcare Director (HCD) would have been responsible for following up with Resident #1's primary care provider (PCP)	D 358		

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D 358	Continued From page 32 regarding medication orders. -MAs should not have stopped administering Resident #1's lantus without an order to discontinue the medication. Telephone interview with the Administrator on 07/11/24 at 6:06pm revealed: -When a resident had a medical appointment outside of the facility, she expected that a copy of the after-visit summary be given to the MA. -The former HCD informed families upon admission that after visit summary and orders were to be submitted to the MA or him upon the resident's return to the facility. -There had also been a mass email sent out to residents' families concerning submitting paperwork after outside medical appointments. -The MA and the former HCD were responsible for reviewing any documents and orders from outside providers and placing them in the resident's record. -The former HCD was responsible for following up on information and medications orders received from outside providers. -MAs should have told the former HCD, the Administrator, or the Secured Unit Manager, who assisted on the Assisted Living Unit when needed, that Resident #1's family member stated to hold his lantus. -Resident #1's lantus should have been administered until an order to discontinue the medication was received. Attempted interview with Resident #1's PCP on 07/11/24 at 4:28pm was unsuccessful.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 33 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides (MA) observed residents (#1 and #7) take their medications related to the residents' medications were left in a medication cup in the residents' room. The findings are: 1. Review of Resident #1's current FL2 dated 07/11/24 revealed: -Diagnoses included Alzheimer's disease, impaired mobility, depression, hypertension, hyperlipidemia, diabetes, and benign prostatic hyperplasia. -There was an order for amlodipine besylate 10mg (used to treat hypertension) 1 tablet daily. -There was an order for lutein 40mg (used to prevent eye diseases) 1 capsule daily. -There was an order for magnesium oxide 400mg (used to treat magnesium deficiency) daily. -There was an order for memantine 10mg (used to treat memory loss) 1 tablet twice daily. -Thee was an order for metformin 500mg (used to manage diabetes) 2 tablets twice daily. -There was an order for myrbetriq 25mg (used to treat overactive bladder) 1 tablet daily. -There was an order for potassium gluconate	D 366		

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D 366	Continued From page 34 550mg (used to treat low potassium levels) 1 tablet daily. -There was an order for sertraline100mg (used to treat depression) 1 and ½ tablet daily. -There was an order for slow release iron 45mg (used to treat iron deficiency) 1 tablet every other day. -There was an order for tamsulosin 0.4mg (used to treat benign prostatic hyperplasia) 1 capsule daily. -There was an order for vitafusion calcium gummy 500mg (used as a supplement) 1 gummy daily. -There was an order for vitamin B-12 1,000mcg (used as a supplement) 1 tablet daily. Review of Resident #1's physician's order date 05/22/24 revealed an order for amlodipine besylate 5mg 1 tablet daily. Review of Resident #1's previous FL2 dated 4/11/24 revealed: -Diagnoses included Alzheimer's disease, impaired mobility, depression, hypertension, hyperlipidemia, diabetes, and benign prostatic hyperplasia. -There was an order for amlodipine besylate 5mg 1 tablet daily. -There was an order for lutein 40mg 1 capsule daily. -There was an order for magnesium oxide 400mg daily. -There was an order for memantine 10mg 1 tablet twice daily. -Thee was an order for metformin 500mg 2 tablets twice daily. -There was an order for myrbetriq 25mg 1 tablet daily. -There was an order for potassium gluconate 550mg 1 tablet daily.	D 366		

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-There was an order for sertraline100mg 1 and ½ tablet daily.
-There was an order for slow release iron 45mg 1 tablet every other day.
-There was an order for tamsulosin 0.4mg 1 capsule daily.
-There was an order for vitafusion calcium gummy 500mg 1 gummy daily.
-There was an order for vitamin B-12 1,000mcg 1 tablet daily.

Review of Resident #1's electronic medication administration record (eMAR) for 07/01/24 through 07/11/24 revealed:
-Diagnoses included Alzheimer's disease, impaired mobility, depression, hypertension, hyperlipidemia, diabetes, and benign prostatic hyperplasia.
-There was an entry for amlodipine besylate 10mg 1 tablet daily scheduled for administration at 9:00am.
-There was an entry for lutein 40mg 1 capsule daily scheduled for administration at 10:00am.
-There was an entry for magnesium oxide 400mg daily scheduled for administration at 10:00am.
-There was an entry for memantine 10mg 1 tablet twice daily scheduled for administration at 10:00am and 8:00pm.
-There was an entry for metformin 500mg 2 tablets twice daily scheduled for administration at 10:00am and 8:00pm.
-There was an entry for myrbetriq 25mg 1 tablet daily scheduled for administration at 10:00am.
-There was an entry for potassium gluconate 550mg 1 tablet daily scheduled for administration at 10:00am.
-There was an entry for sertraline100mg 1 and ½ tablet daily scheduled for administration at 10:00am.
-There was an entry for slow release iron 45mg 1

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tablet every other day scheduled for administration at 10:00am.
-There was an entry for tamsulosin 0.4mg 1 capsule daily scheduled for administration at 10:00am.
-There was an entry for vitafusion calcium gummy 500mg 1 gummy daily scheduled for administration at 9:00am.
-There was an entry for vitamin B-12 1,000mcg 1 tablet daily scheduled for administration at 10:00am.

Observation of Resident #1's room on 07/11/24 at 11:39am revealed:
-Resident #1 was seated on the couch in his living room area.
-Resident #1's family member was standing at his side and had a hand full of his medications in her hand.
-There was an empty medication cup was on a side table and Resident #1's vitafusion calcium gummy had been placed on the side table.
-Resident #1's family member was administering medication to him 1 tablet at a time and gave him the vitafusion calcium gummy last.

Interview with Resident #1's family member on 07/11/24 at 11:40am revealed:
-The medication aide (MA) brought Resident #1's medications to his room at 9:45am, but he was working with therapy so the MA said she would come back.
-The MA just brought Resident #1's medications back to the room.
-When Resident #1 was first admitted to the facility in 2023, there was a mix up with his medication and he was administered medications that he was not supposed to be administered.
-Since then, she had been keeping a list of Resident #1's medications and she preferred to

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administer Resident #1's medication to him.
-The MAs brought the medication cards to the room at each administration time.
-The MAs punched the medication into the medication cup as she checked the medication off her sheet.
-The family member poured the medications out into her hand to make sure the total number of pills matched the number on Resident #1's medication list.
-Once the MA punched the medications into the medication cup, the MA left the room leaving the cup of medications for her to administer to Resident #1.
-The MAs did not watch her administer medications to Resident #1.

Interview with Resident #1 on 07/11/24 at 12:10pm revealed his family member gave him his medications daily.

Interview with a MA on 07/11/24 at 2:30pm revealed:
-Resident #1 did not have an order to self-administer his medications.
-Resident #1's family member printed out a medication list for him.
-She was trained that the MAs were to take Resident #1's medication cards to his room and his family member checked the medications off from her list for the day.
-The MA popped Resident #1's medications into a cup and left the cup in the room for Resident #1's family member to administer to him.
-She usually went back later to make sure that Resident #1 had taken his medication.
-The previous Healthcare Director (HWD) told her it was "Okay" to leave the medications in Resident #1's room for him.
-She left medications in Resident #1's room on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

(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 366	Continued From page 38 07/11/24 and did not watch him take them. Interview with a second MA on 07/11/24 at 3:36pm revealed: -She was taught to pull the medication cards for Resident #1 and take them to his room. -She popped Resident #1's medication into a cup and his family member checked the medications against Resident #1's medication list. -When she first started working in the facility, all the MAs were leaving medication in Resident #1's room for him, so she thought it was "okay" for her to leave the medications in his room as well. -The previous HCD was aware that medications were being left in Resident #1's room. Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 5:28pm revealed: -MAs were to watch residents take their medications before leaving the resident's room. -If a resident did not want the medication at that time, the MA should have taken the medication back with them, wasted it, and documented. -Resident #1's family member wanted to look at the medications that were to be administered to Resident #1. -The MAs should have popped Resident #1's medications into a cup, allowed Resident #1's family member to check. -The MAs should have administered Resident #1's medication and watched him take them -She was not aware MAs were leaving medications in Resident #1's room for his family member to administer to him. -MAs had a training and an in-service regarding medication administration within the last 3 months. -She did not know why MAs were leaving medications in Resident #1's room.	D 366		

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Telephone interview with the Administrator on 07/11/24 at 6:06pm revealed:
-Resident #1's family member was very aware of all of Resident #1's medications.
-Resident #1's family member liked to be very involved with his medications and wanted to stay independent with administering his medications as long as possible.
-Although Resident #1's family member like to be involved with his medication administration, she expected staff to watch Resident #1 take his medications.
-There had been many disciplinary actions for leaving medications in the room and there had been countless hours of training.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/11/24 at 4:28pm was unsuccessful.

2. Review of Resident #7's current FL2 dated 01/09/24 revealed:
-Diagnoses included atrial-fibrillation, chronic kidney disease stage 4, hypertension, and hyperlipidemia.
-There was an order for Eliquis (a blood-thinning medication) 2.5mg twice daily.
-There was an order for vitamin C (a vitamin C supplement) 250mg daily.
-There was an order for calcium carbonate-vitamin D (a calcium and vitamin D supplement) 600-400mg tablet daily.
-There was an order for magnesium oxide (a magnesium supplement) 400mg daily.
-There was an order for Preservision AREDS (a vitamins and minerals supplement) 1 capsule twice daily.
-There was an order for omeprazole (used to treat acid reflux and heartburn) 40mg daily.
-There was an order for potassium chloride (a

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potassium supplement) 10mEq daily.

Review of Resident #7's July 2024 electronic medication administration record (eMAR) from 07/01/24 through 07/10/24 revealed:
-There was an entry for Eliquis 2.5mg twice daily scheduled at 10:00am and 8:00pm.
-There was documentation Eliquis was administered at 10:00am on 07/11/24.
-There was an entry for vitamin C 250mg daily scheduled at 10:00am.
-There was documentation vitamin C was administered at 10:00am on 07/11/24.
-There was an entry for calcium carbonate-vitamin D 600-400mg daily scheduled at 10:00am.
-There was documentation calcium carbonate-vitamin D was administered at 10:00am on 07/11/24.
-There was an entry for magnesium oxide 400mg daily scheduled at 10:00am.
-There was documentation magnesium oxide was administered at 10:00am on 07/11/24.
-There was an entry for Preservision AREDS 1 capsule twice daily scheduled at 10:00am and 8:00pm.
-There was documentation Preservision AREDS was administered at 10:00am on 07/11/24.
-There was an entry for omeprazole 40mg daily scheduled at 10:00am.
-There was documentation omeprazole was administered at 10:00am on 07/11/24.
-There was an entry for potassium chloride 10mEq daily scheduled at 10:00am.
-There was documentation potassium chloride was administered at 10:00am on 07/11/24.

Observation of Resident #7 in her room on 07/11/24 at 11:45am revealed:
-There was a clear cup of medication sitting on

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the kitchen counter.
-After Resident #7 gave her family member his medication, she grabbed the clear cup of medication from the counter and said, "These are mine."
-Resident #7 sat the cup of medications on a side table, but did she not take them at that time.

Interview with Resident #7 on 07/11/24 at 11:40am revealed:
-She kept a list of her medications.
-The medication aides (MA) brought the medication cards to her room at each administration time and punched her medication into a medication cup as she checked the medication off on her list.
-Once the MA punched the medications into the medication cup, the MA left the room leaving the cup of medications for her to take.
-The MAs did not watch her take her medications.

Interview with a MA on 07/11/24 at 2:40pm revealed:
-Resident #7 did not have an order to self-administer her medications.
-When she was hired, she was trained to take all of Resident #7's medication cards into her room and pop each medication out of the medication card into a cup as Resident #7 listed each medication from her medication list.
-Resident #7 would request the MA to prepare her family member's medications.
-The MA did not watch Resident #7 take her medications.
-She had asked the facility's former Healthcare Director (HCD) if it was "okay" for her to leave Resident #7's medications in her room to take when she wanted to, and he had told her it was "okay" to do that.
-Once she left Resident #7's medications in her

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room, she would document the medications as administered on the electronic medication administration record (eMAR).
-She had never found medications in Resident #7's room that she had not taken.

Interview with a second MA on 07/11/24 at 4:05pm revealed:
-Resident #7 was alert and oriented and knowledgeable about all of her medications.
-When she administered medications to Resident #7, she took all of Resident #7's medication cards into her room, and popped the medications from the card in front of Resident #7 as she read off each medication's name from a list.
-She did not always stay in the room to watch Resident #7 take her medications.
-Resident #7 did not have an order to self-administer her medications, but since she reviewed each medication with Resident #7 prior to leaving her room, she did not think that she needed to watch Resident #7 take the medications.
-She had never found any medications left in Resident #7's room that she had not taken.

Interview with the Corporate Clinical Specialist (CCS) on 07/11/24 at 5:30pm revealed:
-Any resident who administered their own medications required a physician's order to self-administer medications along with an assessment.
-When the MA prepared medications for residents, the MA was expected to observe the resident take their medications.
-MAs were not allowed to leave medications in a resident's room.
-If a resident did not want to take their medications, the MA was expected to take the medications out of the resident's room and

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document the medications as refused.
-Resident #7 liked to look at all of her medications and the medication cards prior to the MA popping the medications out of the card.
-The MAs should let Resident #7 check her prepared medications, then stay in Resident #7's room until she finished taking all of her medications.
-The facility had an inservice for all the MAs in the previous two months which re-educated the MAs that residents needed to be observed taking all their medications.

Telephone interview with the Administrator on 07/11/24 at 6:30pm revealed:
-Resident #7 was aware of each medication she was prescribed.
-Resident #7 looked at and reviews all of her medication cards prior to the MA placing the medications into a cup for her to take.
-The MA was expected to watch every resident take their medication and to never leave medications in a resident's room.
-All the MAs had recently been re-educated on the requirement to observe residents taking their medications and not leaving medications in residents' rooms.
-She was not aware the MAs had been leaving Resident #7's medications in her room without observing her taking them.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 07/11/24 at 4:25pm was unsuccessful.