STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure section completed an annual survey on 10/29/2024-10/31/2024.	D 000		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided 14 hours of activities each week. The findings are: Observation of the facility on 10/29/24 at 8:20am revealed there was not an activities calendar posted in the common areas of the facility. Observation of resident room 27 on 10/29/24 at 9:17am revealed there was an activity calendar posted in the resident's room. Review of the facility's October 2024 activity calendar on 10/29/24 revealed: -There were not at least 14 hours of scheduled activities weekly. -There were two activities scheduled weekly for daily devotion at 9:30am to 10:30am and independent exercise at 1:00pm to 1:30pm. -There was a Resident Council scheduled on 10/29/24 from 2:00pm to 3:00pm. -There was a birthday celebration activity scheduled on 10/30/24 from 2:00pm to 3:00pm.	D 317	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth or the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law. Activity Director and Ed will review the monthly calendar together prior to posting for the residents to ensure there are 14 hours of a variety of group activities per week. ED and/or designee will monitor the residents participation in activities to ensure the activities are promoting socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills.	12-15-24 and ongoing 12-15-24 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Gilmore TITLE: Executive Director (X6) DATE: 12/9/24

Reviewed and acknowledged JJ 12/13/2024

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D 317	Continued From page 1 -There was a trick or treat activity scheduled on 10/31/24 at 7:00pm. Review of the facility's Life Jounery Program dated September 2021 revealed: -The Community will prepare a monthly calendar of planned activities and posted in a prominent location. -There shall be a minimum of 14 hours of a variety of planned activities to promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Observation of activities on 10/29/24 at 9:30am, there was no dally devotions observed. Observation of activities on 10/29/24 at 1:00pm, there was no independent exercise observed. Review of the Resident Council agenda dated 10/29/24 revealed: -All residents attended the resident council meeting. -The time of the meeting was not documented. Observation of activities on 10/30/24 at 9:30am, there was no daily devotions observed. Observation of activities on 10/30/24 at 1:00pm, there was no independent exercise observed. Observation of an activity in the dining room on 10/30/24 at 10:15am revealed there were residents participating in dancing and eating an assortment of cookies. Interview with a resident on 10/29/24 at 8:36am revealed: -The facility did not offer activities to the residents	D 317		

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D 317	Continued From page 2 daily. -The residents used to play "butter bean auction". -There was an ice cream party held for the residents last week (date not given). Interview with a second resident on 10/29/24 at 8:45am revealed: -He played cards with the residents on Wednesday. -Activities were held every two weeks. Interview with a third resident on 10/29/24 at 8:48am revealed: -The residents played bingo once a month. -He colored and stretched on his own time. Interview with a fourth resident on 10/29/24 at 9:17am revealed: -The only group activity that was offered to the residents was bingo about every two weeks. -The butterbean game was played weekly. -She could not remember the last time she and the other residents played bingo. Interview with a personal care aide (PCA) on 10/29/24 at 10:19am revealed: -She had assisted with the activities when needed. -The residents liked to play bingo and the butter bean game where the residents could purchase items with the beans they earned from the game. -She could not remember the last time she assisted with the activities. -She helped with the activities because the facility no longer had an Activity Director. Interview with the facility's contracted home health services on 10/31/24 at 10:37am revealed: -The agency provided a monthly group activity with the residents.	D 317		

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D 317	Continued From page 3 -The last activity was on 10/30/24 around 10am, "Name that Tone" and snacks were provided. Interview with the Ombudsman on 10/31/24 at 10:14am revealed: -Residents had expressed their concerns of not having activities on a regular basis and only being offered to play bingo. -The facility reduced their group activities because the corporate office phased out the Activity Director position about a year ago. -She visited the facility on 06/17/24, 08/22/24, 09/17/24 and 10/23/24 and had not observed any residents engaging in activities. -During her visit on 10/30/24 she observed the residents enjoying a dance activity. Interview with the Transportation Coordinator on 10/31/24 at 11:02am revealed: -She assisted with activities. -She facilitated bingo with some of the residents last weekend. -She had not assisted with activities on any other days. Interview with the Administrator on 10/31/24 at 9:27am revealed: -She completed the activities calendar monthly. -The facility's Activity Director position had been vacant for a year due to a Corporate decision. -She only used the corporate activity's calendar as a guide to complete the facility's activity calendar. -The staff facilitated activities with the residents. -The independent exercise activity was where residents walked laps throughout the building. -The butter bean game will restart in November 2024 because the residents liked the game and had requested to play the game. -The contracted home health agencies completed	D 317		

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D 317	Continued From page 4 group activities with the residents. -She was responsible for completing the activity calendar and ensuring the activities were carried out with the residents.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all residents were offered at least one outing every other month. The findings are: Observation of the facility on 10/29/24 at 8:20am revealed there was not an activities calendar posted in the common areas of the facility. Observation of resident room 27 on 10/29/24 at 9:17am revealed there was an activity posted in the resident's room. Review of the October 2024 activity calendar on 10/29/24 revealed there were no outings scheduled for the residents. Review of the facility's Life Jounery Program dated September 2021 revealed:	D 319	Activity Director will ensure there is at least one outing scheduled every other month for the residents to participate in. Activity Director will schedule outings based on the interest of the residents. ED will review monthly activity calendar prior to it being posted to ensure an outing has been scheduled every other month. ED and/or designee will assist Activity Director with carrying out scheduled outing.	12-15-24 and ongoing 12-15-24 and ongoing 12-15-24 and ongoing

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D 319	Continued From page 5 -Each resident will have the opportunity to participate in at least one outing every other month. -Residents who are interested in being involved in the community will be encouraged to do so. Interview with a resident on 10/29/24 at 8:36am revealed the facility did not take them shopping. Interview with a second resident on 10/29/24 at 8:45am revealed: -The facility used to take the residents to shop and out to eat. -She had not been out shopping in a while. Interview with a third resident on 10/29/24 at 8:48am revealed: -The residents went on outings sometimes. -He could not remember the last time an outing was offered to the residents. Interview with a fourth resident on 10/29/24 at 9:17am revealed: -The staff would go shopping for her when she asked. -Residents did not go out shopping often. Interview with the Ombudsman on 10/31/24 at 10:14am revealed: -Residents had expressed their concerns of not having outings. -The facility reduced their group activities because the corporate office phased out the Activity Director position. Interview with the transportation coordinator on 10/31/24 at 11:02am revealed: -She completed her schedule and would include taking the residents shopping. -She took two residents shopping on 10/26/24.	D 319		

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D 319	Continued From page 6 -She had not kept a schedule of the shopping outings. -The facility van was handicapped assessable and was equipped to transport four residents at a time with one resident being nonambulatory. -She could make decisions on what outings to offer to the residents. -The Resident Care Coordinator (RCC) was her supervisor. Interview with Business Office Manager (BOM) on 10/31/24 at 10:56am revealed the transportation coordinator only provided copies of her scheduled and completed transports of clinical appointments. Interview with the RCC on 10/31/24 at 11:10am revealed: -She had not supervised the transportation coordinator for scheduled activity outings. -She supervised the transportation coordinator for scheduled and completed medical and mental health appointments. -The transportation coordinator had taken the residents on some outings and the last outing was 10/26/24. Interview with the Administrator on 10/31/24 at 9:27am revealed: -Resident outings were scheduled on an as needed basis and on Fridays. -Only shopping outings were scheduled for the residents. -All outings were documented, and copies were given to the BOM. -The RCC supervised the transportation coordinator.	D 319		

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D 358	Continued From page 7	D 358		
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 1 of 5 residents (#5) observed during the morning medication pass including errors with medications used to treat high blood pressure, medications used to prevent heart attacks and strokes, vitamin supplements, medication used to treat depression, and medication used to treat allergy symptoms. The findings are: The medication error rate was 27% as evidenced by 8 errors out of 29 opportunities during the morning medication pass on 10/29/24. Review of Resident #5's FL-2 dated 12/26/23 revealed diagnoses included stroke, hypertension, depression, adjustment disorder, hemiplegia affecting left side, agoraphobia with panic disorder, and gastroesophageal reflux disease. a. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Amlodipine 5mg	D 358	Clinical Nurse Consultant re-educated medication aides on the 6 rights of medication administration, the appropriate timeframe for reordering medications to prevent them from running out, as well as the requirements to notify the RCC and ED if medications are not in the building per MD orders. Med techs will complete cart audits per an established facility schedule to account for the medications on hand in the facility, and will reorder meds that are low in count. Completed cart audits will be reviewed and followed up on by the RCC to ensure all re-ordered meds have arrived. Any medications that di not come in, will have follow-up by the RCC as appropriate. RCC and/or ED will print EMAR compliance reports daily to review for accurate and compliant medication administration. Report will be reviewed in management meeting daily. Any noted concerns will have immediate follow up at that time.	11-7-24 12-15-24 and ongoing 12-15-24 and ongoing

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D 358	Continued From page 8 once daily. (Amlodipine is used to treat high blood pressure.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Amlodipine 5mg available to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Amlodipine 5mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Amlodipine 5mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Amlodipine 5mg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at	D 358		

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D 358	Continued From page 9 9:40am. b. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Aspirin (ASA) 81mg enteric-coated coated once daily. (ASA is used help prevent heart attacks or strokes.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer ASA 81mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed ASA 81mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with ASA 81mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with ASA 81mg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm.	D 358		

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D 358	Continued From page 10 Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. c. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Centrum Silver 8mg, 400mg, 50mcg once daily. (Centrum Silver is used treat vitamin deficiency.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Centrum Silver to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Centrum Silver was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Centrum Silver dated 10/29/24 Tuesday morning available. -There was a bubble pack with Centrum Silver dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm.	D 358		

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D 358	Continued From page 11 Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. d. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Cholecalciferol (Vitamin D3) 50mcg once daily. (Vitamin D3 is used to treat a vitamin deficiency.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Cholecalciferol 50mcg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Cholecalciferol 50mcg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Cholecalciferol 50mcg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Cholecalciferol 50mcg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am.	D 358		

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D 358	Continued From page 12 Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. e. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Citalopram 20mg once daily. (Citalopram is used to treat depression.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Citalopram 20mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Citalopram 20mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Citalopram 20mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Citalopram 20mg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am.	D 358		

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D 358	Continued From page 13 Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. f. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Clopidogrel 75mg once daily. (Clopidogrel is a blood thinner used to prevent platelets from sticking together and to prevent blood clots, heart attacks, and strokes.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Clopidogrel 75mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Clopidogrel 75mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Clopidogrel 75mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Clopidogrel 75mg dated 10/30/24 Wednesday morning available.	D 358		

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	HAL031018	A. BUILDING: _____ B. WING _____	10/31/2024

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D 358	Continued From page 14 Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. g. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Lisinopril 7.5mg once daily. (Lisinopril is used to treat high blood pressure.) Observation of the morning medication pass on 10/29/24 revealed the medication aide (MA) did not administer Lisinopril 7.5mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Lisinopril 7.5mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold. Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Lisinopril	D 358		

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D 358	Continued From page 15 7.5mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Lisinopril 7.5mg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to telephone interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. h. Review of Resident #5's FL-2 dated 12/26/23 revealed there was an order for Loratadine 10mg once daily. (Loratadine is used to treat allergy symptoms.) Observation of the morning medication pass on 10/29/24 revealed the MA did not administer Loratadine 10mg to Resident #5. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed Loratadine 10mg was documented as administered at 8:00am daily from 10/01/24-10/28/24 and 10/29/24 was placed on hold.	D 358		

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D 358	Continued From page 16 Observation of Resident #5's medications on hand on 10/29/24 at 2:10pm revealed: -There was not a bubble pack with Loratadine 10mg dated 10/29/24 Tuesday morning available. -There was a bubble pack with Loratadine 10mg dated 10/30/24 Wednesday morning available. Refer to interview with Resident #5 on 10/29/24 at 10:00am. Refer to telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am. Refer to interviews with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm. Refer to interviews with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm. Refer to interview with the Administrator on 10/29/24 2:27pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/30/24 at 9:40am. Interview with Resident #5 on 10/29/24 at 10:00am revealed she missed getting her morning medications a couple times a month and occasionally her afternoon medications were not administered. Telephone interview with the facility's contracted pharmacy on 10/31/24 at 10:40am revealed: -The pharmacy had not received a request for the morning medications that were not given on 10/29/24. -The cycle medications for this week began on	D 358		

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D 358	Continued From page 17 Thursday 10/21/24 and the facility received a seven-day supply. Interview with the medication aide (MA) on 10/29/24 at 9:48am and 2:10pm revealed: -She was unable to locate the bubble pack for Resident #5's morning medications. -She informed Resident #5 that she was unable to locate the bubble pack for her morning medications. -She informed the Resident Care Coordinator (RCC) that she was unable to locate the bubble pack for Resident #5's morning medications. -She only administered the medications on the day they were labeled. Interview with the Resident Care Coordinator (RCC) on 10/29/24 at 9:53am and 2:15pm revealed she notified the facility's contracted pharmacy that they needed the morning medications for Resident #5 after being told they were not available; she said that when they ordered medications it would take about 6 hours for the medications to arrive. Interview with the Administrator on 10/29/24 2:27pm revealed: -The MA should have administered the morning medications on 10/29/24 using the bubble pack labeled 10/30/24. -The MA should have called the pharmacy and have them send a morning pack of medications to be administered on 10/30/24. Telephone interview with Resident #5's contracted primary care provider (PCP) on 10/30/24 at 9:40am revealed: -She was not concerned with Resident #5 only missing one dose of her scheduled morning medications.	D 358		

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D 358	Continued From page 18 -She was concerned that the morning medications were not available to be administered on Tuesday.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 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 staff who administered medications actually observed 1 of 5 residents (#5) taking their medications during the morning medication pass observed on 10/29/24. The findings are: Review of Resident #5's FL-2 dated 12/26/23 revealed diagnoses included stroke, hypertension, depression, adjustment disorder, hemiplegia affecting left side, agoraphobia with panic disorder, and gastroesophageal reflux disease. Observation of the morning medication pass on 10/29/24 at 9:50am revealed: -Resident #5 was lying in her bed. -The Medication aide (MA) prepared 2	D 366	CNC re-educated Med tech on 6 rights of medication administration, the importance of ensuring all medications are being adminstered per physician orders and signed for after watching the resident take the medications. CNC will complete random Med tech observations during med passes to ensure at least 2 observations per month are completed. This will check compliance with giving medications correctly	11-7-24 12-15-24 and ongoing

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D 366	Continued From page 19 medications to administer to Resident #5. -The MA placed the two medications in a plastic cup. -The MA set the plastic cup on Resident #5's bedside table that contained the medications and left the room. -The MA did not observe Resident #5 take her medications. -The MA did not go back into Resident #5's room after leaving medications on the bedside table. Interview with Resident #5 on 10/29/24 at 10:00am revealed that some of the MAs left her medications in her room and did not watch her swallow them. Interview with the MA on 10/29/24 at 1:07pm revealed: -She was aware she was supposed to observe residents take their medications. -She was not sure why she did not observe Resident #5 take her medications. Interview with the Resident Care Coordinator (RCC) on 10/29/24 at 2:15pm revealed: -The MAs had been trained and knew they were supposed to observe residents take all their medications. -If the MA did not observe Resident #5 take her medications the resident could discard the medications without taking or another resident could ingest the medications. Interview with the Clinical Nurse Consultant (CNC) on 10/31/24 at 9:46am revealed: -MAs had been trained not to leave medications in a resident's room. -She had provided medication administration a few months earlier which included not leaving medications in resident rooms.	D 366		

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D 366	Continued From page 20 Interview with the Administrator on 10/29/24 at 2:27pm revealed: -The MAs should observe the residents take their medications. -If Resident #5 was not observed taking her medications, the resident might not take the medications or another resident could take the medications.	D 366		