Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Twelve Oaks
Address: 1297 Galax Trail Mt Airy NC 27030
County: Surry
License Number: HAL 086-016

II. Date(s) of Visit(s): 10/10/24, 10/14/24, 10/23/24, 10/28/24, 10/30/24, 10/31/24, 11/01/24, 11/05/24, 11/07/24, 11/13/24, 11/15/24, 11/20/24, 11/21/24, 12/02/24 and 12/11/24
Purpose of Visit(s): Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 01/07/25

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004 MEDICATION ADMINISTRATION	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 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;		
Level of Non-Compliance: TYPE A2 VIOLATION		
Findings: The rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the administration of medications were in accordance with physicians' orders for 6 of 10 sampled residents (#1, #3, #4, #5, #7 and #8) not receiving medications		

for bacterial infections (#1), medication for diabetes (#3), medication for thyroid disease (#4), medication for chronic pain (#5), medications for kidney disease, blood pressure, mental health, and pain (#7), and medications for heart disease and mental health (#8) as ordered by the physician.

The findings are:

1.Review of Resident #1's current FL2 dated 01/09/24 revealed:
-Diagnoses included Alzheimer's Dementia, diabetes, hypertension, schizophrenia, leukemia, seizure disorder, depression, anxiety/panic attacks, vitamin D deficiency, and thyroid nodule.
-She required Special Care Unit level of care.
-She was constantly disoriented.
-She was non-ambulatory.
-She was non-verbal.

Review of Resident #1's physician's order dated 10/01/24 revealed an order for Doxycycline (used to treat bacterial infections) 100mg twice daily for 7 days.

Review of Resident #1's physician's order dated 10/07/24 revealed an order for Doxycycline100mg twice daily for 10 days.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2024 revealed:
-There was not an entry for Doxycycline 100mg take one tablet twice daily with a start date of 10/01/24.
-There was an entry for Doxycycline 100mg take one tablet twice daily with a start date of 10/08/24 and scheduled for administration at 8:00am and 8:00pm.
-There was documentation Doxycycline was not administered on 10/08/24 at 8:00pm, 10/09/24 at 8:00am and 8:00pm and 10/10/24 at 8:00am.
-The documented reason Doxycycline 100mg was not administered on 10/08/24 at 8:00pm was medication on hold.
-The documented reason Doxycycline 100mg was not administered on 10/09/24 at 8:00am and 8:00pm was due to condition.
-The documented reason Doxycycline 100mg was not administered on 10/10/24 at 8:00am was medication discontinued.

Review of Resident #1's hospice notes dated 10/01/24 revealed:
-Resident #1 was seen by a hospice registered nurse (RN) on 10/01/24.
-Vital signs included temperature 96.6 and oxygen level 92%.
-Resident #1 did not feel well and was put to bed after lunch.
-Resident #1 had nasal congestion and a non-productive cough.
-Breaths sounded essentially clear with scattered crackles.

-Doxycycline 100mg twice daily was ordered.
-The order was signed by the Registered Nurse (RN) and the hospice family nurse practitioner (FNP).
-The order was an electronic prescription sent to the pharmacy.

Review of Resident #1's hospice notes dated 10/07/24 revealed:
-She was seen by a hospice RN on 10/07/24.
-She was ordered Doxycycline on 10/01/24, but the order was lost and never started.
-She was congested with a non-productive cough.
-Her breathing sounded rhonchi.
-Her vital signs included temperature 101.6 and oxygen level 88%.
-A second prescription for Doxycycline 100mg twice daily was ordered.
-The second prescription was signed by the RN and hospice family nurse practitioner (FNP).

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Interview with the hospice RN on 10/11/24 at 8:40am revealed:
-She made a facility visit on 10/01/24 to see Resident #1 who had some congestion and crackling in her chest.
-She put the Doxycycline 100mg twice daily prescription on the SCU medication desk.
-The Resident Care Coordinator (RCC) was waiting outside to receive residents from a sister facility that had to be evacuated due to the hurricane.
-She told the Special Care Coordinator (SCC) she had put the Doxycycline prescription on the SCU medication desk.
-She sent the prescription electronically to the pharmacy.
-She found out later that she had escribed the prescription to the pharmacy, but it was the wrong pharmacy location.
-No one from the facility called to inform hospice staff the facility had not received the Doxycycline and Resident #1 was not taking the medication.
-It was the facility's responsibility to ensure Resident #1 received the Doxycycline.
-Hospice staff did not receive any calls from 10/01/24 through 10/06/24 to let hospice know Resident #1's symptoms were getting worse.
-On 10/07/24, the facility called and asked for a hospice comfort kit but did not inform hospice staff that Resident #1's health had declined.
-She visited Resident #1 on 10/07/24 and Resident #1 was very congested.
-She asked the medication aide (MA) if Resident #1 had been getting the Doxycycline which was prescribed on 10/01/24.

-The MA did not know anything about the Doxycycline prescription and looked on Resident #1's electronic Medication Administration Record (eMAR) and Doxycycline was not on Resident #1's eMAR.
-The MA looked through faxes to and from the pharmacy and could not find any record of the Doxycycline prescription dated 10/01/24.
-She called the hospice FNP and informed her that Doxycycline was not started on 10/01/24 and was not on the eMAR.
-The hospice FNP wrote another prescription for Doxycycline 100mg twice daily.
-She delivered a comfort kit to the facility on the afternoon of 10/09/24.
-On 10/09/24, the MA informed her the facility still had not received the Doxycycline for Resident #1.
-The MA told her that Resident #1 had spit out all her medications this morning when they tried to administer her medications.
-She called the guardian on 10/09/24 and informed her that Resident #1 was declining and did not receive the first prescription for Doxycycline on her visit earlier with Resident #1 she still had not received the Doxycycline.

Interview with Resident #1's guardian on 10/14/24 at 8:30am revealed:
-She received a call from the hospice RN on 10/09/24 informing her that Resident #1 was declining.
-The hospice RN informed her that she had wrote an order for Doxycycline on 10/01/24.
-The hospice RN informed her that on 10/07/24, she took a comfort care kit to the facility.
-ON 10/07/24, the hospice RN found out that Resident #1 had not been taking the Doxycycline.
-The hospice RN told her that on her visit on 10/09/24, Resident #1 was still not taking the Doxycycline.
-She called the facility on 10/09/24 and spoke to the Assistant Administrator and asked why Resident #1 was not receiving the Doxycycline.
-She received a call back from the Assistant Administrator on 10/09/24 who told her the facility had located Resident #1's Doxycycline.
-She was told by staff by the time the Doxycycline was located, Resident #1 was no longer taking medications by mouth.
-Resident #1 passed away on 10/12/24.

Review of Resident #1's Certificate of Death dated 11/01/24 revealed:
-Resident #1 passed away on 10/12/24.
-The cause of death was Alzheimer's dementia.

Interview with a MA on 10/29/24 at 3:05pm revealed:
-She was a MA in the SCU.

-She was working on 10/07/24 when the hospice nurse visited Resident #1. -The hospice nurse asked her about an order for Doxycycline 100mg twice daily for Resident #1 which was written on 10/01/24. -She did not know anything about the order for Doxycycline 100mg twice daily. -She reviewed the eMAR and Doxycycline was not on the eMAR. -She looked through the faxes that had been sent to the pharmacy and received from the pharmacy and she could not find any record of an order for Doxycycline 100mg twice daily for Resident #1. -The hospice nurse wrote a new order for Doxycycline 100mg twice daily on 10/07/24 and she sent it to the pharmacy. -Resident #1's guardian called the facility on 10/09/24 because the hospice nurse had called the guardian and informed her about the 2 prescriptions for Doxycycline and that Resident #1 still had not received. -She called the pharmacy representative who told her the Doxycycline 100mg twice daily was delivered to the facility on 10/07/24. -After calling the pharmacy, she went to the assisted living (AL) unit medication room where all medications were delivered. -She found Resident #1's Doxycycline 100mg lying in a corner on the counter. -She had picked up medications earlier in the evening from the AL unit of the facility and had been told there were no other medications for the SCU. -She informed a Supervisor that she located Resident #1's Doxycycline. -She tried to administer the Doxycycline but Resident #1 would not take the medications and spit it out. -Resident #1 had already started to refuse medications and had spit medications out on 10/08/24. Interview with the MA on 11/13/24 at 4:20pm revealed she did not know who was responsible for ensuring Resident #1's Doxycycline was received. Interview with a second MA on 10/10/24 at 5:45pm revealed: -She was a MA in the SCU. -She did not know about a Doxycycline order dated 10/01/24. -She knew there was an order for Doxycycline 100mg twice daily on 10/07/24. -The facility had not received Resident #1's Doxycycline until 10/09/24. -When the facility finally received Resident #1's Doxycycline 100mg twice daily on 10/09/24, Resident #1 would not take any medications by mouth.		

-She and another MA tried to administer Doxycycline 100mg to Resident #1 on the evening of 10/09/24, but Resident #1 would not take it and spit it out. -All of Resident #1's medications were discontinued the next day due to Resident #1 being unable to swallow medications. Interview with a third MA in the SCU on 11/01/24 at 1:45pm revealed: -Batch medications came in on Wednesday nights and the nighttime shift staff picked those medications up from the AL unit. -Day shift staff did not pick up batch medications. -Other medications arrived at different times and all medication were delivered to the AL unit from the pharmacy. -The AL MA's let the SCU MAs know medications had arrived and the SCU MAs went to the AL unit and picked up the medications. Interview with a MA in the AL unit on 11/21/24 at 5:00pm revealed: -She did not know what happened to Resident #1's Doxycycline when it arrived at the facility on 10/07/24. -Medications arrived at the facility every day except on Sunday. -When medications arrived at the facility, they were delivered to the AL unit medication counter and the AL MA was supposed to call the SCU MA to let her know there were medications on the AL unit that needed to be picked up. -When medications were delivered while she was working, she used the walkie talkie to call the SCU MA and inform the MA that there were medications for the SCU that needed to be picked up. -If medications had not been picked up by the MA when she got ready to leave work, she locked the medications up in the room directly behind the medication counter Interview with the SCC on 10/30/24 at 4:00pm revealed: -The facility received a prescription for Doxycycline 100mg twice daily from hospice for Resident #1 on 10/01/24. -The hospice nurse sent the order to the pharmacy electronically, but it was sent to the wrong pharmacy location. -She was not aware Resident #1's electronically prescribed order went to the wrong pharmacy until she was notified by staff that the hospice RN was asking about the prescription on 10/07/24. -She was filling in as a MA and a personal care aide (PCA) during the first of the month due to all the new admissions. She did not check to make sure the facility received Resident #1's Doxycycline 100mg written on 10/01/24. -There were no progress notes about Resident #1's Doxycycline 100mg order on 10/01/24.		

Interview with the Assistant Administrator on 12/01/24 at 1:55pm revealed:
-He received a call from Resident #1's guardian about Doxycycline on 10/09/24.
-He did not know Resident #1 had not received Doxycycline until he received the phone call from the guardian.
-The SCU MA told him she found the medication in the AL unit medication room.
-The next day, the SCC told him Resident #1 was no longer taking medications by mouth.

Attempted telephone interview with hospice FNP on 10/31/24 at 10:05am was unsuccessful.

Interview with a representative from the contracted pharmacy on 12/01/24 at 11:48am revealed:
-The pharmacy had no record of an order for Doxycycline on 10/01/24.
-The first order the pharmacy received for Doxycycline was on 10/07/24.
-The pharmacy delivered the Doxycycline to the facility on 10/07/24.

Interview with the Administrator on 10/31/24 at 2:15pm revealed:
-She was not aware Resident #1 had not received Doxycycline until 10/09/24 when the Assistant Administrator informed her the guardian called asking about the Doxycycline.
-She had been told by the SCC an order had been written on 10/01/24 and electronically prescribed to the wrong pharmacy location.
-MAs were responsible to check faxes for orders, to get orders from physicians and to send the orders to the pharmacy.
-The SCC should have reviewed the order and ensured the medication was received and, on the eMAR.

2. Review of Resident #3's current FL2 dated 01/12/24 revealed:
-Diagnoses included Alzheimer's/Dementia, psychiatric disturbance, mood disturbance and anxiety disorder.
-She required Special Care Unit (SCU) level of care.
-She was constantly disoriented.
-She was ambulatory.
-She was verbal.

Review of Resident #3's physician's order dated 04/22/24 revealed an order for Lantus Solostar U-100 inject 63 units subcutaneously (used to treat diabetes) at 8:00am.

Review of Resident #3's physician order dated 08/01/24 revealed an order for Lantus Solostar U-100 inject 55 units subcutaneously at 8:00am. Review of Resident #3's electronic Medical Administration Record (eMAR) for August 2024 revealed: -There was an entry for Lantus Solostar U-100 inject 63 units scheduled for administration at 8:00am. -There was documentation Lantus Solostar U-100 inject 63 units was administered subcutaneously daily from 08/01/24 through 08/08/24 at 8:00am. -There was documentation Lantus Solostar U-100 inject 63 units was administered subcutaneously daily from 08/10/24 through 08/31/24 at 8:00am. -There was an entry to check and record FSBS two times daily scheduled at 7:00am and 8:00pm. -There was documentation that FSBS values ranged from 76 to 214 at 7:00am -There was documentation that FSBS values ranged from 100 to 364 at 8:00pm. -There was no entry documented for Lantus Solostar U-inject 55 units subcutaneously every morning at 8:00am. Review of Resident #3's eMAR for September 2024 revealed: -There was an entry for Lantus Solostar U-100 inject 63 units scheduled for administration at 8:00am. -There was documentation Lantus Solostar U-100 inject 63 units was administered subcutaneously daily from 09/01/24 through 09/30/24 at 8:00am. -There was an entry to check and record FSBS two times daily scheduled at 7:00am and 8:00pm. -There was documentation that FSBS values ranged from 72 to 246 at 7:00am -There was documentation that FSBS values ranged from 83 to 286 at 8:00pm. -There was no entry documented for Lantus Solostar U-inject 55 units subcutaneously every morning at 8:00am. Review of Resident #3's eMAR for October 2024 revealed: -There was an entry for Lantus Solostar U-100 inject 63 units scheduled for administration at 8:00am. -There was documentation Lantus Solostar U-100 inject 63 units was administered subcutaneously daily from 10/01/24 through 10/14/24 at 8:00am. -There was an entry to check and record FSBS two times daily scheduled at 7:00am and 8:00pm. -There was documentation that FSBS values ranged from 70 to 200 at 7:00am		

-There was documentation that FSBS values ranged from 101 to 480 at 8:00pm. -There was no entry documented for Lantus Solostar U-inject 55 units subcutaneously every morning at 8:00am. Review of Resident #3's progress notes dated 08/10/24 revealed there was documentation by a MA to decrease Lantus to 55 units subcutaneously every morning. Interview with a representative from the contracted pharmacy on 11/27/24 at 2:25pm revealed there was no record of a fax ever being received with an order for Lantus 55 units subcutaneously. Interview with a MA on 11/21/24 at 6:00pm revealed: -She had put the documentation in for Lantus 55 units and faxed the order to the pharmacy. -In the past, the previous Supervisor followed up on the orders. Interview with the Special Care Coordinator (SCC) on 11/15/24 at 4:25pm revealed: -The original order for Resident #3's Lantus Solostar 55 units was faxed to the facility's contracted pharmacy on 08/01/24. -She was not aware Resident #3 had continued to receive Lantus Solostar 63 units and it had not been changed to Lantus Solostar 55 units. -She had not followed up on the order for Lantus Solostar 55 units. -She was not aware other staff had not followed up on the order for Lantus Solostar 55 units. Interview with the Administrator on 11/15/24 at 5:15pm revealed: -The SCC, Administrative Assistant and she had recently determined that the previous administration (SCC, Resident Care Coordinator (RCC), and Administrator) ensured that medications were received and on the eMARs. -The previous Administrator, RCC, and SCC ensured prescriptions were sent to the pharmacy, reviewed faxes, and ensured medications were correct and on the eMAR. -The previous management had not instructed MAs to ensure prescriptions were sent to the pharmacy, to follow up on faxes from the pharmacy and to ensure medications were received and entered on the eMAR. -She had also determined that the MAs were waiting until the physician was in the facility to get prescriptions for residents. -She and the SCC had recently instructed the MAs to ensure prescriptions were sent to the pharmacy, to follow up on faxes and to ensure medications were received and entered on the eMAR.		

-The SCC was making sure that MAs had sent prescriptions to the pharmacy, checked faxes, and ensured medications were received and on the eMAR's.

3.Review of Resident #4's current FL2 dated 04/24/24 revealed:
-Diagnoses included spinal stenosis, unspecified dementia with mild psychotic disturbance, major depressive disorder, mild cognitive impairment, essential hypertension, and hypothyroid.
-She required assisted living level of care.
-She was intermittently disoriented.
-She was ambulatory.
-She was verbal.

Review of Resident #4's physician's order dated 05/08/24 revealed an order for Levothyroxine (used to treat thyroid) 75mcg take 1 tablet every morning at 6:00am.

Review of Resident #4's electronic Medication Administration Record (eMAR) for November 2024 revealed:
-There was an entry for Levothyroxine 75mcg scheduled for administration at 6:00am.
-There was documentation Levothyroxine was administered on 11/04/24 at 6:00am.

Interview with Resident #4 on 10/30/24 at 3:15pm revealed:
-She was supposed to get her thyroid medication a couple of hours before breakfast so it would help her to swallow.
-Some of the staff did not always give it to her and some did not give it at 6:00am before breakfast.
-She had trouble swallowing and eating if she did not get her thyroid medication.
-She did not go to breakfast this morning on 10/30/24 because she did not get her medication before breakfast.

Interview with Resident #4 on 11/05/24 at 9:25am revealed:
-She was not sure if she ate breakfast yesterday on 11/04/24.
-She kept peanut butter crackers in her room to keep something on her stomach.
-She told the MAs she needed her thyroid pill.
-Sometimes, they gave her the thyroid pill real late.

Interview with Resident #4 on 11/07/24 at 5:20pm revealed:
-She did not get her thyroid medication this morning until she went to the dining room for breakfast.
-It did not do any good for her to get her thyroid medication at breakfast time.
-She needed the thyroid medication before breakfast so she could swallow.

Interview with Resident #4's family member on 11/04/24 at 2:00pm revealed:
-She had installed a video camera in Resident #4's room which was visible to staff.
-She was concerned about Resident #4 falling and she had complained about not getting her thyroid medications correctly.
-She was not sure Resident #4 was correct about not getting her thyroid medication.
-She went to visit Resident #4 on 11/04/24 around lunch time and the resident told her she had not received her thyroid medication this morning on 11/04/24 and was not going to eat lunch.
-After visiting Resident #4 on 11/04/24, she reviewed the video tape and no staff had been in Resident #4's room by lunch time.
-Staff usually came into the resident's room around 6:00am to give her the thyroid pill.
-The video camera recorded movement and there was no movement in Resident #4's room this morning until 6:30am when the resident was up moving around.
-No one came in to wake Resident #4 up for breakfast and no staff came in to help her get dressed.

Interview with Resident #4's family member on 11/05/24 at 7:50am revealed:
-She reviewed the video tape last night on 11/04/24.
-Staff came in at 5:30pm and gave Resident #4 her evening medications.
-Staff came in at 8:47pm and gave the last evening medications to the resident.

Review of video footage of Resident #4 on 12/04/24 at 11:00am revealed:
-At 6:31am, Resident #4 got out of bed and was moving about her room without her rollator walker.
-At 6:49am, she started to get dressed.
-Between 6:49am and 7:04am, she moved about her room.
-At 7:15am, she made her bed.
-At 7:20am, she left her room for breakfast with her walker.
-At 8:46am she returned to her room and two visitors stopped by her room.
-No staff entered Resident #4's room before she left her room at 7:20am.

Interview with a MA on 11/07/24 at 5:35pm revealed:
-Resident #4 received her thyroid medication daily.
-The night shift MA had usually already given the Levothyroxine to Resident #4 when she arrived to work at 6:00am.
-She could see that the Levothyroxine had been "popped" on the eMAR each day when she arrived to work at 6:00am.

Interview with a MA on 11/13/24 at 6:00pm revealed:
-She always gave Resident #4 her thyroid medication.
-She usually gave it to her around 5:00am.
-She always told Resident #4 when she was giving her the thyroid medication.
-Resident #4 had said she did not get the thyroid medication when she had given it.

Interview with a third MA on 11/22/24 at 5:40pm revealed if she had marked a medication given, she had administered the medication.

4. Review of Resident #5's current FL2 dated 09/18/24 revealed:
-Diagnoses included diabetic ketoacidosis, chronic renal failure, urinary tract infection, mild dementia, diabetes, cerebrovascular accident, chronic obstructive pulmonary disease, and hypothyroid disease
-She required assisted living level of care.
-She was not disoriented.
-She was semi-ambulatory.
-She was verbal.

Review of Resident #5's physician's order dated 07/08/24 revealed an order for Tramadol (used to treat severe or chronic pain) 50mg take one tablet three times daily.

Review of Resident #5's physician's order dated 10/14/24 revealed an order for Tramadol 50mg take one tablet three times daily.

Review of Resident #5's electronic Medical Administration Record (eMAR) for October 2024 revealed:
-There was an entry for Tramadol 50mg for administration at 8:00am, 2:00pm and 8:00pm.
-There was documentation Tramadol 50mg was not administered on 10/09/24 at 2:00pm, 10/11/24 at 8:00am, 2:00pm and 8:00pm, 10/12/24 at 8:00am, 2:00pm and 8:00pm, 10/13/24 at 8:00am, 2:00pm and 8:00pm, 10/14/24 at 8:00am, 2:00pm and 8:00pm, and 10/15/24 at 8:00am and 2:00pm.
-The documented reason Tramadol 50mg was not administered on 10/09/24 at 2:00pm, 10/11/24 at 8:00am, 2:00pm and 8:00pm, 10/12/24 at 8:00am, 2:00pm and 8:00pm, 10/13/24 at 8:00am, 2:00pm and 8:00pm, 10/14/24 at 8:00am, 2:00pm and 8:00pm, and 10/15/24 at 8:00am and 2:00pm was medication unavailable.

Interview with Resident #5 on 10/23/2024 at 12:32pm revealed she was not aware she had not received Tramadol.

Attempted interview with the RCC on 11/01/24 at 2:15pm was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 11/20/24 at 2:30pm was unsuccessful.

Interview with a representative from the contracted pharmacy representative on 11/27/24 at 3:48pm revealed:
-The pharmacy filled an order for Tramadol 50mg on 09/04/24 for 90 tablets which was delivered on 09/05/24.
-The pharmacy received a new order for Tramadol 50mg on 10/14/24 for 90 tablets which was delivered on 10/15/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-She did not remember if she had reordered Tramadol for Resident #5.
-She did not remember if she contacted the physician about a new prescription for Tramadol for Resident #5.
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

5. Review of Resident #7's current FL2 dated 04/08/24 revealed:
-Diagnoses included wound of right lower extremity, uncontrolled diabetes with hypoglycemia, hypokalemia and hypoglycemia.
-He required assisted living level of care.
-He was intermittently disoriented.
-He was semi-ambulatory.

a. Review of Resident #7's physician order dated 03/15/24 revealed an order for Allopurinol (used to treat gout and kidney stones) 100mg take one tablet by mouth once daily.

Review of Resident #7's physician order dated 10/25/24 revealed an order for Allopurinol 100mg take one tablet once daily.

Review of Resident #7's electronic Medical Administration Record (eMAR) for October 24 revealed:
-There was an entry for Allopurinol 100mg scheduled for administration at 8:00am.
-There was documentation Allopurinol 100mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Allopurinol 100mg was not administered 10/24/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Allopurinol 100mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Allopurinol 100mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.

-The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility. -The RCC's last day of employment was during the first week of November 2024. -The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the facility.		

-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster. b. Review of Resident #7's physician's order dated 03/12/24 revealed an order for Atorvastatin (used to treat high blood pressure) 20mg take one tablet at bedtime. Review of Resident #7's physician order dated 10/25/24 revealed an order for Atorvastatin 20mg take one tablet at bedtime. Review of Resident #7's eMAR for October 2024 revealed: -There was an entry for Atorvastatin 20mg scheduled for administration at 8:00pm. -There was documentation Atorvastatin 20mg was not administered on 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24 and 10/30/24 at 8:00pm. -The documented reason Atorvastatin 20mg was not administered 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24 and 10/30/24 at 8:00pm was medication was unavailable. Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed: -The pharmacy received a new prescription for Atorvastatin 20mg for Resident #7 on 10/28/24. -The medication was delivered to the facility on cycle fill on 10/31/24. -The facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.		

-The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility. -The RCC's last day of employment was during the first week of November 2024. -The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the facility.		

-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

c. Review of Resident #7's physician's order dated 04/26/24 revealed an order for Divalproex (used to seizures and mental/mood conditions) 250mg take one tablet every morning.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for Divalproex 250mg take one tablet every morning.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for Divalproex 250mg scheduled for administration at 8:00am.
-There was documentation Divalproex 250mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Divalproex 250mg was not administered 10/24/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Divalproex 250mg was not administered 10/25/24 at 8:00am was resident out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Divalproex 250mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.

-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility. -The RCC's last day of employment was during the first week of November 2024.		

-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

d. Review of Resident #7's physician's order dated 06/17/24 revealed an order for Gabapentin (used to treat nerve pain) 300mg take one tablet twice daily.

Review of Resident #7's physician's order dated 10/28/24 revealed an order for Gabapentin 300mg take one tablet twice daily.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for Gabapentin 300mg for administration at 8:00am and 8:00pm.
-There was documentation Gabapentin 300mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8;00pm, 10/26/24 at 8:00am and 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm.
-The documented reason Gabapentin 300mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable.
-The documented reason Gabapentin 300mg was not administered 10/25/24 at 8:00am was resident out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Gabapentin 300mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:

-MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.		

-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

e. Review of Resident #7's physician's order dated 03/12/24 revealed an order for Ibuprofen (used to treat pain and inflammation) 200mg take one tablet twice daily.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for Ibuprofen 200mg take one tablet twice daily.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for Ibuprofen 200mg scheduled for administration at 8:00am and 8:00pm.
-There was documentation Ibuprofen 200mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm.
-The documented reason Ibuprofen 200mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable.
-The documented reason Ibuprofen 200mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Ibuprofen 200mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.

-The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.		

-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

f. Review of Resident #7's physician's order dated 04/26/24 revealed an order for metoprolol tartrate (used to treat high blood pressure) 25mg take one tablet twice daily.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for metoprolol tartrate 25mg take one tablet twice daily.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for metoprolol tartrate scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol tartrate 25mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm.
-The documented reason metoprolol tartrate 25mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable.
-The documented reason Metoprolol Tartrate 25mg was not administered 10/25/24 at 8:00am was resident out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Metoprolol Tartrate 25mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills. Interview with representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not		

aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

g. Review of Resident #7's physician's order dated 03/12/24 revealed an order for Sertraline (used to treat depression and anxiety) 100mg take one tablet once daily.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for Sertraline 100mg take one tablet once daily.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for Sertraline 100mg scheduled for administration at 8:00am.
-There was documentation Sertraline 100mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Sertraline 100mg was not administered 10/24/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Sertraline 100mg was not administered 10/25/24 at 8:00am was resident out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:

-The pharmacy received a new prescription for Sertraline 100mg for Resident #7 on 10/28/24. -The medication was delivered to the facility on cycle fill on 10/31/24. -The facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24.		

-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Attempted interview with the RCC on 11/01/24 at 2:15pm was unsuccessful.

Attempted telephone interview with Resident #7's PCP on 11/20/24 at 2:30pm was unsuccessful.

6. Review of Resident #8's current FL2 dated 11/03/23 revealed:
-Diagnoses included fracture of upper left humerus, spinal stenosis, unspecified anemia, hyperlipidemia, anxiety disorder, hypertension, benign prostatic hyperplasia, atherosclerosis of aorta, osteoporosis, and chronic kidney disease.
-He required assisted living level of care.
-He was constantly disoriented.
-He was semi-ambulatory.
-He was verbal.

a. Review of Resident #8's physician's order dated 10/11/24 revealed an order for Clopidogrel (used to prevent heart attacks and stroke) 75mg take one tablet daily.

Review of Resident #8's physician's order dated 10/25/24 revealed an order for Clopidogrel 75mg take one tablet daily.

Review of Resident #8's electronic Medication Administration Record (eMAR) for October 2024 revealed:
-There was an entry for Clopidogrel 75mg scheduled for administration at 8:00am and 8:00pm.
-There was documentation Clopidogrel 75mg was not administered on 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Clopidogrel 75mg was not administered 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.

Attempted interview with the Resident Care Coordinator (RCC) on 11/01/24 at 2:15pm was unsuccessful.

Interview with a representative from the contracted pharmacy at 12/03/24 at 10:30am revealed:
-The previous order expired on 10/11/24.
-The facility requested a refill on 10/11/24.
-The pharmacy sent a request to the physician on 10/11/24.
-The facility requested an emergency supply on 10/25/24.
-The pharmacy sent an emergency order of 7 tablets on 10/28/24.
-The pharmacy had continued to send 7-day supply of tablets each week.
-The pharmacy had sent a total of 42 tablets of an emergency supply.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a Medication Aide (MA) on 11/21/24 at 4:30pm revealed:

-MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the Special Care Coordinator (SCC) on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living (AL) unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:15pm revealed: -This might have been one of the medications that needed a new order at the end of the month. -All of the orders had been sent to the pharmacy and Resident #1 should not need a new order for this medication. -She would call the pharmacy about a new order.		

-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility. -The RCC's last day of employment was during the first week of November 2024. -The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building. -She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster. b. Review of Resident #8's physician's order dated 09/27/24 revealed an order for Trintellix (used to treat depression) 20mg take one tablet daily. Review of Resident #8's physician's order dated 11/13/24 revealed an order for Trintellix 20mg take one tablet daily. Review of Resident #8's eMAR for November 2024 revealed: -There was an entry for Trintellix 20mg scheduled for administration at 8:00am. -There was documentation Trintellix 20mg was not administered on 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24 at 8:00am. -The documented reason Trintellix 20mg was not administered 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24 at 8:00am was medication was on hold. -There was documentation Trintellix 20mg was not administered on 11/12/24 and 11/13/24 at 12:00pm. -The documented reason Trintellix 20mg was not administered 11/12/24 and 11/13/24 at 12:00pm was medication was on hold. Interview with Resident #8 on 11/14/24 at 2:20pm revealed: -He had not received his Trintellix for a week. -He had been on Trintellix for 10 years for depression and anxiety. -He asked a staff member about the Trintellix the first day he did not get it. -He asked about it again after 5 days and still did not get an answer. -He talked to the assistant administrator yesterday who called the pharmacy.		

-His Trintellix arrived last night, and he received a dose of medication at lunch today.
-The withdrawal symptoms were bad.
-He had not slept for 5 nights.
-Last night he started itching really bad, his skin felt funny and felt awful.
-It made his sensitivity to light worse.

Interview with a representative from the contracted pharmacy at 11/21/24 at 11:52am revealed:
-The Trintellix 29mg order expired on 11/02/24.
-The pharmacy sent 7 tablets on 10/28/24.
-The pharmacy received a new physician order on 11/13/24.
-The pharmacy sent 5 tablets on 11/13/24.
-The pharmacy sent 3 tablets on 11/18/24.
-The pharmacy sent medication on cycle fill on 11/21/24.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.

-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the SCC started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

The facility failed to ensure 6 of 10 sampled residents received medications in accordance with physician's orders related to Doxycycline was never administered to a resident (#1) as ordered from 10/01/24 through 10/12/24 resulting in Resident #1's continued decline; a resident (#3) who never received Lantus Solostar that was to be reduced from 63 units to 55 units as ordered on 08/01/24 resulting in increased risk of low blood sugar; a resident (#4) who did not receive Levothyroxine as ordered resulting the in resident not being able to eat breakfast; a resident (#5) who did not receive Tramadol as ordered resulting in risk of increased pain; a resident (#7) who did not receive Allopurinol, Sertraline, Atorvastatin, Divalproex, Gabapentin, Ibuprofen and Metoprolol tartrate as ordered resulting in increased risk of gout, increased risk of high blood pressure, increased risk of pain and anxiety; and a resident (#8) who did not receive Clopidogrel and Trintellix as ordered due to medications not being available resulting in increased risk of stroke, increased anxiety and increased insomnia. This failure placed residents at substantial risk of

physical harm and neglect and constitutes a Type A2 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/01/24 for this violation.

CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED 02/06/2025.

Rule/Statute Number:
10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

☐ POC Accepted

_____
DSS Initials

Rule/Statutory Reference:
10A NCAC 13F .1010 PHARMACEUTICAL SERVICES
(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving, and administering of all medications prescribed on a routine, emergency, or as needed basis.

Level of Non-Compliance:

TYPE B VIOLATION

Findings:

The rule is not met as evidenced by:

Based on observations, record reviews and interviews the facility failed to ensure the provision of pharmaceutical services to meet the needs of 4 of 10 sampled residents (#2, #7, #8, and #10) not receiving medications for depression and diabetes (#2), medications for kidney disease, blood pressure, mental health, and pain (#7), medications for heart disease, enlarged prostate, and mental health (#8), and medications for heart attack (#10) on a consistent basis and as ordered.

The findings are:

1.Review of Resident #2's current FL2 dated 02/01/24 revealed:
-Diagnoses included Alzheimer's dementia, diabetes, chronic respiratory failure and unspecified urinary incontinence.
-She required Special Care Unit (SCU) level of care.
-She was constantly disoriented.
-She was non-ambulatory
-She was verbal.

a. Review of Resident #2's physician's order dated 02/21/2024 revealed an order for Trazadone (used to treat depression) 50mg take 1/2 tablet scheduled for administration at 8:00pm.

Review of Resident #2's electronic medication administration record (eMAR) for October 2024 revealed:
-There was an entry for Trazadone 50mg 1/2 tablet scheduled for administration at 8:00pm.
-There was documentation Trazodone 50mg ½ tablet was not administered on 10/12/24, 10/13/24, 10/14/24, 10/15/24 and 10/16/24 at 8:00pm.
-The documented reason Trazodone 50mg ½ tablet was not administered on 10/12/24, 10/13/24, 10/14/24, 10/15/24 and 10/16/24 at 8:00pm was the medication was unavailable.
-There was documentation Trazodone 50mg ½ tablet was not administered on 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00pm.
-The documented reason Trazodone 50mg ½ tablet was not administered 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00pm was the medication was unavailable.

Interview with a representative from the contracted pharmacy on 11/25/24 at 9:48am revealed:
-The prescription was written for Trazodone 50mg take ½ pill, so they sent bubble packs to the facility which contained ½ of a 50mg tablet.
-The pharmacy dispensed Trazodone 50mg ½ tablet for a 7-day supply on 10/14/24.
-On the next cycle fill date on 10/24/24, the prescription for Trazodone 50mg ½ tablet had expired.
-The pharmacy sent a fax to the facility on 10/24/24 informing the facility the prescription had expired.
-The pharmacy received a 15-day prescription for Trazodone 50mg ½ tablet on 10/25/24.
-The pharmacy did not send Trazodone 50mg ½ tablet to the facility until the next cycle fill date of 10/31/24.
-There was no documented explanation why the pharmacy did not fill the prescription before the cycle on 10/31/24.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.

-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a Medication Aide (MA) on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the Special Care Coordinator (SCC) on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:

-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

b. Review of Resident #2's physician's order dated 10/05/2024 revealed an order for Lantus Solostar U-100 (used to treat diabetes) inject 15 units subcutaneously scheduled for administration at 8:00pm.

Review of Resident #2's eMAR for October 2024 revealed:
-There was an entry for Lantus Solostar U-100inject 15 units subcutaneously scheduled for administration at 8:00pm.
-There was documentation Lantus Solostar U-100 15 units was not administered on 10/07/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, and 10/15/24 at 8:00pm.
-The documented reason Lantus Solostar 15 units was not administered was the medication on 10/07/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, and 10/15/24 at 8:00pm was medication was unavailable.

Interview with a representative from the contracted pharmacy on 11/11/24 at 11:48am revealed:
-The pharmacy received an order for Lantus Solostar U-100 units inject 15 units subcutaneously at bedtime on 10/07/24.
-The Lantus Solostar U-100 units inject 15 units was dispensed to the facility on 10/16/24.
-There was no documented explanation why the Lantus Solostar U-100 units inject 15 units was not dispensed before 10/16/24.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a pharmacist from the contracted pharmacy on 12/17/24 at 4:45pm revealed the effects for not receiving insulin for extended days could be elevated blood sugars. Interview with MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications. -There was a button on the eMAR that staff clicked to reorder. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it did not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility a medication order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the old pharmacy with getting medications to the facility. -They had a lot of problems with their current pharmacy. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility.		

-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's PCP on 11/20/24 at 2:30pm was unsuccessful.

2. Review of Resident #7's current FL2 dated 04/08/24 revealed:
-Diagnoses included wound of right lower extremity, uncontrolled diabetes with hypoglycemia, hypokalemia, and hypoglycemia.
-He required assisted living level of care.
-He was intermittently disoriented.
-He was semi-ambulatory.
-He was non-verbal.

a. Review of Resident #7's physician's order dated 03/15/2024 revealed an order for Allopurinol (used to treat gout and kidney stones) 100mg take one tablet scheduled for administration at 8:00am.

Review of Resident #7's physician's order dated 10/25/2024 revealed an order for Allopurinol 100mg take one tablet scheduled for administration at 8:00am.

Review of Resident #7's electronic Medication Administration Record (eMAR) for October 2024 revealed:
-There was an entry for Allopurinol 100mg scheduled for administration at 8:00am.
-There was documentation Allopurinol 100mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Allopurinol 100mg was not administered 10/24/24, ,10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Allopurinol 100mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Allopurinol 100mg for Resident #7 on 10/28/24.

-The medication was delivered to the facility on cycle fill on 10/31/24. -The facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility.. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not		

aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

b. Review of Resident #7's physician's order dated 03/12/2024 revealed an order for Atorvastatin (used to treat high blood pressure) 20mg take one tablet scheduled for administration at 8:00pm.

Review of Resident #7's physician's order dated 10/25/2024 revealed an order for Atorvastatin 20mg take one tablet scheduled for administration at 8:00pm.

Review of Resident #7's eMAR for October 2024 revealed:
There was an entry for Atorvastatin 20mg scheduled for administration at 8:00pm.
-There was documentation Atorvastatin 20mg was not administered on 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24 and 10/30/24 at 8:00pm.
-The documented reason Atorvastatin 20mg was not administered 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Atorvastatin 20mg for Resident #7 on 10/28/24.

-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not

aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

c. Review of Resident #7's physician order dated 04/26/2024 revealed an order for Divalproex (used to seizures and mental/mood conditions) 250mg take one tablet scheduled for administration at 8:00am.

Review of Resident #7's physician order dated 10/25/2024 revealed an order for Divalproex 250mg take one tablet scheduled for administration at 8:00am.

Review of Resident #7's eMAR for October revealed:
-There was an entry for Divalproex 250mg take one tablet scheduled for administration at 8:00am.
-There was documentation Divalproex 250mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Divalproex 250mg was not administered 10/24/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Divalproex 250mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:

-The pharmacy received a new prescription for Divalproex 250mg for Resident #7 on 10/28/24. -The medication was delivered to the facility on cycle fill on 10/31/24. -The facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility. -They had a lot of problems with their current contracted pharmacy. Interview with the SCC on 11/13/24 at 4:40pm revealed: -She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit. -Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24.		

-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

d. Review of Resident #7's physician order dated 06/17/24 for Gabapentin (used to treat nerve pain) 300mg take one tablet twice daily scheduled for administered at 8:00am and 8:00pm.

Review of Resident #7's physician order dated 10/28/24 for Gabapentin 300mg take one tablet twice daily scheduled for administered at 8:00am and 8:00pm.

Review of Resident #7's eMAR for October revealed:
-There was an entry for Gabapentin 300mg scheduled to be administered at 8:00am and 8:00pm.
-There was documentation Gabapentin 300mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8;00pm, 10/26/24 at 8:00am and 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm.
-The documented reason Gabapentin 300mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am

and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable.
-The documented reason Gabapentin300mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Gabapentin 300mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.

-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

e. Review of Resident #7's physician's order dated 03/12/24 revealed an order for Ibuprofen (used to treat pain and inflammation) 200mg take one tablet twice daily scheduled for administered at 8:00am and 8:00pm.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for Ibuprofen 200mg take one tablet twice daily scheduled for administered at 8:00am and 8:00pm.

Review of Resident #7's eMAR for October revealed:
-There was an entry for Ibuprofen 200mg twice daily scheduled for 8:00am and 8:00pm.
-There was documentation Ibuprofen 200mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am

and 8:00pm, 10/28/24 at 8:00am, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm.
-The documented reason Ibuprofen 200mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/2024 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable.
-The documented reason Ibuprofen 200mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Ibuprofen 200mg for Resident #7 on 10/28/24.
The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.

-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

f. Review of Resident #7's physician's order dated 04/26/24 revealed an order for metoprolol tartrate (used to treat high blood pressure) 25mg take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for metoprolol tartrate 25mg take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.

Review of Resident #7's eMAR for October 2024 revealed: -There was an entry for metoprolol tartrate 25mg take one tablet scheduled for administration at 8:00am and 8:00pm. -There was an entry for metoprolol tartrate (used to treat high blood pressure) 25mg take one tablet by mouth twice daily. -There was documentation metoprolol tartrate 25mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00am and 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm. -The documented reason metoprolol tartrate 25mg was not administered on 10/24/24 at 8:00am and 8:00pm, 10/25/24 at 8:00pm, 10/26/24 at 8:00pm, 10/27/24 at 8:00am and 8:00pm, 10/28/24 at 8:00am and 8:00pm, 10/29/24 at 8:00am and 8:00pm and 10/30/24 at 8:00am and 8:00pm was medication was unavailable. -The documented reason metoprolol tartrate 25mg was not administered 10/25/24 at 8:00am was out of facility. Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed: -The pharmacy received a new prescription for Metoprolol Tartrate 25mg for Resident #7 on 10/28/24. -The medication was delivered to the facility on cycle fill on 10/31/24. -The facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed. -The facility usually contacted the physician for a new order for medication. and the pharmacy did not. Interview with a MA on 11/21/24 at 4:30pm revealed: -MAs reordered medications when they had around 7 tablets left on the medication card. -There was a button on the eMAR that staff clicked to reorder medications. -Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not. -Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed. -The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed. -The facility did not always receive faxes about needing new orders. -The facility did not have many problems with the previous pharmacy with getting medications to the facility.		

-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

g. Review of Resident #7's physician's order dated 03/12/24 revealed an order for Sertraline (used to treat depression and anxiety) 100mg take one tablet scheduled at 8:00am.

Review of Resident #7's physician's order dated 10/25/24 revealed an order for Sertraline 100mg take one tablet scheduled for administration at 8:00am.

Review of Resident #7's eMAR for October 2024 revealed:
-There was an entry for Sertraline 100mg take one tablet scheduled for administration at 8:00am.
-There was documentation Sertraline100mg was not administered on 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Sertraline 100mg was not administered 10/24/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.
-The documented reason Sertraline 100mg was not administered 10/25/24 at 8:00am was out of facility.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:30pm revealed:
-The pharmacy received a new prescription for Sertraline 100mg for Resident #7 on 10/28/24.
-The medication was delivered to the facility on cycle fill on 10/31/24.
-The facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.

-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.
-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Attempted interview with the RCC on 11/01/24 at 2:15pm was unsuccessful.

Attempted telephone interview with Resident #7's PCP on 11/20/24 at 2:30pm was unsuccessful.

3. Review of Resident #8's current FL2 dated 11/3/23 revealed:
-Diagnoses included fracture of upper left humerus, spinal stenosis, unspecified anemia, hyperlipidemia, anxiety disorder, hypertension, benign prostatic hyperplasia, atherosclerosis of aorta, osteoporosis, and chronic kidney disease.
-He required assisted living level of care.
-He was constantly disoriented.
-He was semi-ambulatory.
-He was verbal.

a. Review of Resident #8's physician's order dated 10/11/24 revealed an order for Clopidogrel (used to prevent heart attacks and stroke) 75mg take one tablet daily scheduled for administration at 8:00am.

Review of Resident #8's physician's order dated 10/25/24 revealed an order for Clopidogrel 75mg take one tablet daily scheduled for administration at 8:00am.

Review of Resident #8's electronic Medication Administration Record (eMAR) for October 2024 revealed:
-There was an entry for Clopidogrel 75mg take one tablet scheduled for administration at 8:00am.
-There was documentation Clopidogrel 75mg was not administered on 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am.
-The documented reason Clopidogrel 75mg was not administered 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24 and 10/30/24 at 8:00am was medication was unavailable.

Interview with a representative from the contracted pharmacy at 12/03/24 at 10:30am revealed:
-The previous order expired on 10/11/24.
-The facility requested a refill on 10/11/24.
-The pharmacy sent a request to the physician on 10/11/24.
-The facility requested an emergency supply on 10/25/24.
-The pharmacy sent an emergency order of 7 pills on 10/28/24.

-The pharmacy had continued to send 7-day supply of tablets each week as they still did not have a prescription.
-They had sent a total of 42 pills of emergency supply.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-She had determined that an order was needed for Clopidogrel 75mg.
-She faxed the order into the pharmacy.

Interview with the Administrator on 12/04/24 at 3:15pm revealed:
-This might have been one of the medications that needed a new order at the end of the month.
-All the medication orders had been sent to the pharmacy and Resident #1 should not need a new order for this medication.
-She would call the pharmacy about a new order.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.

-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time. -She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024. -She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours. -Some residents did not get their medications for 4 days. Interview with the Administrator on 11/15/24 at 4:35pm revealed: -She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit. -The RCC's last day of employment was 11/07/24. -She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill. -The SCC contacted the physician about all the orders and faxed the orders to the pharmacy. Interview with the Administrator on 12/04/24 at 3:00pm revealed: -She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents. -She started as the new Administrator 7 months ago along with the new Care Coordinators. -It was a learning process for everyone. -The SCC occasionally informed her about problems with orders or medications, but not on a regular basis. -She had two RCCs that were no longer at the facility. -The last RCC did not informed her about any problems with getting medications into the facility. -The RCC's last day of employment was during the first week of November 2024. -The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building. -She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster. b. Review of Resident #8's physician's order dated 09/27/24 revealed an order for Tamsulosin (used to treat enlarged prostate) 0.4mg take one tablet scheduled for administration at 8:00pm.		

Review of Resident #8's physician's order dated 11/12/24 revealed an order for Tamsulosin 0.4mg take one tablet scheduled for administration at 8:00pm.

Review of Resident #8's eMAR for November 24 revealed:
-There was an entry for Tamsulosin 0.4mg take one tablet scheduled at 8:00pm.
-There was documentation Tamsulosin 0.4mg was not administered on 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24, 11/12/24, 11/13/24, and 11/14/24 at 8:00pm.
-The documented reason Tamsulosin 0.4mg was not administered 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24 at 8:00pm was medication was unavailable.
-There was no documentation as to why Tamsulosin 0.4mg was not administered on 11/12/24, 11/13/24, and 11/14/24 at 8:00pm.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/13/24 at 4:40pm revealed:
-She was the care coordinator for the Special Care Unit (SCU) but assisted with prescriptions for the assisted living AL unit.

-Near the end of October 2024, there were several residents whose medications expired and needed new prescriptions all at the same time.
-She had no warning that many of the resident's medications needed new prescriptions at the end of October 2024.
-She sent the prescriptions to the contracted pharmacy and the contracted pharmacy informed her that the medications would be received in 24 hours.
-Some residents did not get their medications for 4 days.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

c. Review of Resident #8's physician's order dated 09/27/24 revealed an order for Trintellix (used to treat depression) 20mg take one tablet scheduled for administration at 8:00am.

Review of Resident #8's physician's order entry dated 11/13/24 revealed an order for Trintellix 20mg take one tablet at 12:00pm.

Review of Resident #8's MAR for November 2024 revealed: -There was an entry for Trintellix 20mg take one tablet scheduled for administration at 8:00am. -There was documentation Trintellix 20mg was not administered on 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24 at 8:00am. -The documented reason Trintellix 20mg was not administered 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/11/24 at 8:00am was medication was on hold. -There was documentation Trintellix 20mg was not administered on 11/12/24 and 11/13/24 at 12:00pm. -The documented reason Trintellix 20mg was not administered 11/12/24 and 11/13/24 at 12:00pm was medication was on hold. Interview with Resident #8 on 11/14/24 at 2:20pm revealed: -He did not receive his Trintellix for a week. -He had been on Trintellix for 10 years for depression and anxiety. -He asked a MA about the Trintellix the first day he did not get it. -He asked about it again after 5 days and still did not get an answer. -He talked to the Assistant Administrator yesterday on 11/13/24, who called the pharmacy. -His Trintellix arrived last night, and he received a dose of medication at lunch today. -The withdrawal symptoms were bad. -He had not slept for 5 nights. -Last night he started itching bad, his skin felt funny and felt awful. -It made his light sensitivity worse. Interview with a representative from the contracted pharmacy at 11/21/24 at 11:52am revealed: -The order for Trintellix 20mg expired on 11/02/24. -The pharmacy sent 7 tablets on 10/28/24. -The pharmacy received a new physician order on 11/13/24. -The pharmacy sent 5 tablets on 11/13/24. -The pharmacy sent 3 tablets on 11/18/24. -The pharmacy sent a 30 Trintellix tablets on cycle fill on 11/21/24. Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for contacting the prescribing physician to request medication refills. Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed: -When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.		

-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.
-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.

-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

Attempted interview with the RCC on 11/01/24 at 2:15pm was unsuccessful.

Attempted telephone interview with Resident #7's PCP on 11/20/24 at 2:30pm was unsuccessful.

4. Review of Resident #10's current FL2 dated 09/26/23 revealed:
-Diagnoses included Alzheimer's/dementia, major neurocognitive disorder, depression, anxiety, Parkinson's disease, scoliosis, and gastroesophageal reflux disease.
-She required special care level of care.
-She was constantly disoriented.
-She was semi-ambulatory.
-She was verbal.

Review of Resident #10's physician's order dated 11/09/23 revealed an order for Trazadone (used to treat heart attacks and stroke) 50mg take one tablet scheduled for administration at 8:00pm.

Review of Resident #10's electronic Medication Administration Record (eMAR) for November 24 revealed:
-There was an entry for Trazadone 50mg take one tablet scheduled to be administered at 8:00pm.
-There was documentation Trazadone 50mg was not administered on 11/14/24, 11/15/24, 11/16/24, 11/17/24, and 11/18/24 at 8:00pm.
-The documented reason Clopidogrel 75mg was not administered Trazadone 50mg was not administered on 11/14/24, 11/15/24, 11/16/24, 11/17/24, and 11/18/24 at 8:00pm was medication was unavailable.

Interview with a representative from the contracted pharmacy on 11/21/24 at 12:10pm revealed:
-The pharmacy sent a 7-day supply of Trazadone on 11/04/24.
-The pharmacy received the new order for Trazadone on 11/13/24.
-Someone called from the facility on 11/16/24 requesting the medication be sent to the pharmacy.
-The pharmacy did not fill the order until batch fill day on 11/18/24.
-There was no explanation documented why the prescription was not filled until 11/18/24.

Interview with a representative from the contracted pharmacy on 11/21/24 at 1:40pm revealed the facility was responsible for

contacting the prescribing physician to request medication refills.

Interview with a representative from the contracted pharmacy on 12/03/24 at 6:00pm revealed:
-When a resident needed a new medication order, the pharmacy faxed the facility to let them know a new order was needed.
-The facility usually contacted the physician for a new order for medication. and the pharmacy did not.

Interview with a MA on 11/21/24 at 4:30pm revealed:
-MAs reordered medications when they had around 7 tablets left on the medication card.
-There was a button on the eMAR that staff clicked to reorder medications.
-Sometimes when the reorder button was clicked, it would inform staff a new order was needed but often it would not.
-Often, medications did not come in on cycle fill days and when staff called the pharmacy, they were told a new order was needed.
-The facility was supposed to receive a fax from the pharmacy to inform the facility staff an order was needed.
-The facility did not always receive faxes about needing new orders.
-The facility did not have many problems with the previous pharmacy with getting medications to the facility.
-They had a lot of problems with their current contracted pharmacy.

Interview with the SCC on 11/20/24 at 5:15pm revealed:
-She had sent a prescription to the pharmacy on 11/13/24.
-She called the pharmacy on 11/16/24 and asked them to send the Trazadone.
-The pharmacy did not send the Trazadone until cycle fill day on 11/18/24.

Interview with the Administrator on 11/15/24 at 4:35pm revealed:
-She hired a Resident Care Coordinator (RCC) whose job was to supervise the AL unit.
-The RCC's last day of employment was 11/07/24.
-She had been made aware that several resident's orders had expired around the end of October 2024 and the Supervisor was not aware until the Special Care Coordinator (SCC) started to call the pharmacy about the medications not coming in on the cycle fill.
-The SCC contacted the physician about all the orders and faxed the orders to the pharmacy.

Interview with the Administrator on 12/04/24 at 3:00pm revealed:
-She was not aware there was such a problem with getting medication orders filled and getting medications in the facility for the residents.

-She started as the new Administrator 7 months ago along with the new Care Coordinators.
-It was a learning process for everyone.
-The SCC occasionally informed her about problems with orders or medications, but not on a regular basis.
-She had two RCCs that were no longer at the facility.
-The last RCC did not informed her about any problems with getting medications into the facility.
-The RCC's last day of employment was during the first week of November 2024.
-The MAs were not sharing with the RCC or SCC that there was a big problem with getting orders filled and getting medications in the building.
-She was working with the SCC, Administrator, staff and the contracted pharmacy to get orders completed and get medications in the facility faster.

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

Attempted interview with the RCC on 11/01/24 at 2:15pm was unsuccessful.

Attempted telephone interview with Resident #10's PCP on 11/20/24 at 2:30pm was unsuccessful.

The facility failed to ensure pharmaceutical services met the needs of 4 of 10 sampled residents pertaining to resident's medications not in the facility and not being administered as ordered. A resident (#2) did not receive Trazadone as ordered for 12 days, and did not receive Lantus Solostar 15 units for 9 days; a resident (#7) did not receive Allopurinol, Atorvastatin, Divalproex and Sertraline as ordered for 6 days and did not receive, Gabapentin, Ibuprofen and Metoprolol tartrate as ordered for 7 days; a resident (#8) did not receive Clopidogrel for 10 days and, did not receive Tamsulosin for 8 days, and did not receive Trintellix for 7 days and reported increased anxiety and insomnia; and a resident (#10) did not receive Trazadone for 5 days due to medications not being available. This failure was detrimental to the health of residents and constitutes a Type B Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/02/24 for this violation.

CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED, 02/21/2025.

Rule/Statute Number: 10A NCAC 13F .0901 PERSONAL CARE AND SUPERVISON	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 10A NCAC 13F .0901 PERSONAL CARE AND SUPERVISION (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves		
Level of Non-Compliance: TYPE B VIOLATION		
Findings: The rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the provision of personal care services to meet the needs of 1 of 10 (#4) sampled residents based on the resident's care plan. The findings are: Review of Resident #4's current FL2 dated 04/24/24 revealed: -Diagnoses included spinal stenosis, unspecified dementia with mild psychotic disturbance, major depressive disorder, mild cognitive impairment, and essential hypertension -Resident #4 was intermittently disoriented. -Resident #4 was ambulatory. -Resident #4 was verbal. Review of Resident #4's Care Plan for the month of November 2024revealed: -She was approved for 27.50 hours of personal care each month. -She required extensive assistance with bathing, skin care, and nail care. -She required daily extensive assistance with putting on shoes and clothing and with removing shoes and clothing. -She required daily limited assistance with transferring and cutting her food. -She required daily total assistance with retrieving and hanging clothes. Interview with Resident #4's family member on 11/04/24 at 2:00pm revealed:		

-She had installed a video camera in her Resident #4's room which was visible to staff. -She was concerned about Resident #4 falling and she had complained about not getting her thyroid medications correctly. -After visiting her Resident #4 today, she had reviewed video tape for today and no one had been in her Resident #4's room yet today. -She stated that staff usually came into Resident #4's room around 6:00am to give her the thyroid pill. -She stated the video camera recorded movement and there was no movement in her Resident #4'sroom this morning until 6:30am when her mother was up moving around. -No one came in to wake Resident #4 up for breakfast and no one came in to help her get dressed. Interview with Resident #4's family member on 11/05/24 at 7:50am revealed: -She reviewed the video tape last night. -No one came in to tell the resident about breakfast, lunch, or dinner. -Staff came in at 5:30pm and gave the resident evening meds. -Staff came into at 8:47pm and gave the resident's last medications to her. -No one helped Resident #4 to get dressed this morning and no one helped her to get undressed and get into bed. Interview with Resident #4's family member on 11/19/24 at 11:30am revealed: -Resident #4 had another fall yesterday in her room while she was getting dressed. -She viewed the video camera and saw the resident fall. -No one was helping Resident #4 get dressed. -Resident #4 yelled for help for 20 minutes before anyone checked on her. -The resident had shut the door, and her yells were not very loud. -She went to see Resident #4 who was complaining of hip pain. -The facility ordered a mobile x-ray. Interview with Resident #4's family member on 12/04/24 at 10:55am revealed: -Resident #4 did not have any broken bones from her fall. -She had saved the videos for review. Review of video of Resident #4 on 11/04/24 at 11:00am revealed: At 6:31am, she got out of bed and was moving about her room without her rollator walker. -At 6:49am, she started to get dressed. -Between 6:49am and 7:04am, she moved about her room. -At 7:15am, she made her bed.		

-At 7:20am, she left her room for breakfast with her walker. -At 8:46am she returned to her room and two visitors stopped by her room. -At 9:58am, she moved about her room. -At 10:23am another resident stopped and visited with her. -At 11:36am, she was moving about her room. -At 12:16, her daughter visited, and she told her she was not going to lunch. -At 12:36pm, she was walking about her room. -At 2:04pm, the activity director told her about an activity. -At 2:46pm she returns from the activity. -From 2:46pm until 5:30pm, she either moved about her room or sat in her chair. -At 5:30pm, the MA came in a gave her medication. -From 5:32pm until 7:14pm, she either moved about her room or sat in her chair. -At 7:14pm, she started to change clothes to put on pajamas. -At 7:14pm, a PCA came in and got a pair of pajama bottoms from a drawer and handed them to resident. The PCA did not help her into bed. -At 7:23pm, she got clothes out ready for next day. -At 7:35pm, she put herself to bed. -At 7:53pm, she got up and located her Bible which she took back to bed and got back in bed. -At 8:57pm, the MA came in and gave her nighttime medication. Review of Resident #4's Point of Care (POC) log dated 11/04/24 revealed all personal care tasks were checked off and documented as completed at 5:48pm. Review of Resident #4's POC log dated 11/18/24 revealed all personal care tasks were checked off and documented as completed at 10:40am. Interview with the personal care aide (PCA) on 12/04/24 at 1:05pm revealed: -PCAs checked on all the residents in the morning, got them up for breakfast, and helped them to get dressed. -PCAs completed adult diaper checks on residents before and after meals and during the day. -PCAs tidied up residents' rooms and assisted them with hygiene and grooming. Second nterview with the PCA on 12/19/24 at 10:55am revealed: -She was the PCA who completed the POC check off log for Resident #4 on 11/04/24.		

-Staff rotated working with residents and working on different halls.
-She was working with a new PCA during that time who was not able to sign in to the POC log.
-She thought the new PCA had told her the tasks were completed and she checked them off for her.

Interview with a second PCA on 11/07/24 at 4:30pm revealed:
-PCAs constantly walked the halls and checked on residents.
-PCAs entered information on the computer in the POC log about tasks completed for residents.
-Each resident's POC was based on their care plan.
-All PCAs assisted with meal preparation.

Interview with a third PCA on 11/22/24 at 5:15pm revealed:
-PCAs assisted residents with changing their clothes, getting residents up and dressed and getting them ready for bed and changing adult briefs as needed.
-PCAs usually covered the whole unit, checking on residents.
-PCAs did rounds before and after meals and checked "heavy wetters" in between.

Interview with a fourth PCA on 11/22/24 at 5:30pm revealed:
-PCAs did monitoring checks, and staff worked together to divide the halls.
-PCAs delivered meals to the residents who did not eat in the dining room.
-PCAs gave baths on assigned days, made resident's beds, helped with brushing their hair and teeth, helped residents to change clothes and use the bathroom and changed adult briefs.
-PCAs documented the tasks completed on the computer on the POC log.

Attempted telephone interview on 12/19/24 at 11:20am with the PCA who signed off on the POC log for Resident #4 dated 11/18/24 was unsuccessful.

Interview with a Medication Aide (MA) on 12/19/24 at 11:10am revealed:
-She remembered working on 11/18/24 when Resident #4 had a fall.
-The Administrator had heard someone yelling and found Resident #4 in the floor.
-The Administrator yelled for someone to come help.
-She saw Resident #4 in the floor in front of her bed.
-Resident #4 stated she fell when she was getting dressed.
-They assessed Resident #4 and did not find any injuries.
-Resident #4 stated her hip was hurting.
-Staff ordered an x-ray.

-When they came to do the x-ray that evening, Resident #4 had left the facility for an outing. -Mobile x-ray came back and completed the x-ray the next day. Interview with the Administrator on 12/18/24 at 2:30pm revealed: -She was the staff person who found Resident #4 on 11/18/24 after her fall. -She arrived at the facility around breakfast before 9:00am the morning of 11/18/24. -She walked down the hall to check on things. -She heard a very faint "help me". -She yelled at staff that someone was calling for help. -She continued walking trying to locate the resident who was saying "help me". -She had yelled to the residents and said "say it again" so she could locate the resident. -It was coming from Resident #4's room. -The door to Resident #4's room was shut. -She opened the door and observed Resident #4 sitting on the floor in front of her bed. -Resident #4 stated she had fallen. -She and other staff helped Resident #4 up and completed an assessment on Resident #4. -She did not remember who the other staff were that helped to get Resident #4 out of the floor. Interview with Administrator on 12/11/24 at 12:15pm revealed: -She had talked with Resident #4's family member about making sure staff were helping Resident #4 with daily activities. -She had a recent meeting with all her PCAs to inform them of their daily tasks pertaining to assisting residents with their personal care needs. -She would be following up to make sure staff were assisting with personal care needs. The facility failed to provide personal care to 1 of 10 sampled residents (# 4) based on review of video footage on 11/04/24 which revealed staff did not assist Resident #4 with bathing, dressing, hygiene and grooming which resulted in Resident #1 completing some activities of daily living (ADLs) without assistance and other ADL's not being completed and review of video footage on 11/18/24 revealed Resident #1 getting dressed without assistance and falling due to not receiving assistance with her ADLs. This failure was detrimental to the		

health and wellbeing of residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/12/24 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED 02/21/2025.		

IV. Delivered Via:	In person	Date: 1/8/25
DSS Signature:	Chelsea Dawson	Return to DSS By: 1/30/25

V. CAR Received by:	Administrator/Designee (print name): Nilsa Aquino Rivera	
	Signature:	Date: 1/8/25.
	Title: Executive Dir	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		