STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 5/17/21 through 5/20/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# PQOS11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 5/17/21 through 5/20/21. A total of 6 allegations were investigated and all of them were unsubstantiated. Event ID # PQOS11.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of	F 563		5/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/11/2021

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F 563	Continued From page 1 residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and family interviews, the facility limited visitation time and days for 1 of 3 residents (Resident #13) reviewed for visitation. The findings included: Resident #13 was admitted to the facility on 02/24/21. Review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated 05/07/21 revealed Resident #13 was cognitively intact. On 05/19/21 at 2:00 PM, the Activity Director explained that visitation was Monday, Wednesday Thursday, and Friday visitation was 10:30 AM to 4:30 PM and Saturday and Sunday from 9:30 AM to 11:30 AM. Resident #13 was not present to hear this. An interview conducted with Resident #13 on 05/18/21 at 3:40 PM revealed that her visitation with family was one day per week for thirty minutes out in front of the facility, and after her 30-minute visitation staff would come get her. Resident #13 further revealed visitation was denied for a family member because it was after 5:00 PM and the family had to visit at Resident #13's room window which was difficult because	F 563	F000 Disclaimer Clause F563-483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors Preparation and or execution of this plan does not constitute admission or agreement by the Provider of Truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On May 19th, 2021, the Activities Director was interviewed and stated that visitation was everyday except Tuesday, which limited the visitation time for the residents. On May 21st, 2021, the Interdisciplinary Team called all the residents responsibility parties to notify them that visitation would occur every day of the week. All residents were also notified by the Activities Director and Wellness Coordinator on May 21st, 2021. All staff were in-service that visitation can occur everyday with no limitations by the Administrator, Director of Nursing and	

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F 563	Continued From page 2 she had to talk on the phone to communicate. An interview conducted with Resident #13's legal representative on 05/18/21 at 4:25 PM revealed visits at the facility were frustrating because they must be scheduled and only allowed 30 minutes to visit. It was further revealed he had called and tried to schedule a visit the same day, but the facility would not allow him to see Resident #13 until the following day. The legal representative stated he had family members show up at the facility and they visited through the window because it was not scheduled and was after 4:30 PM. An interview conducted with the Wellness Coordinator on 05/20/91 at 4:10 PM revealed she oversees visitation in the facility and resident's legal representative received an automated call which explained the visitation schedule and rules. It was further revealed family and friends contact the receptionist at the facility and schedule times to visit the resident. The Wellness Coordinator stated she does not know if the families were aware that visitation did not have to be scheduled. An interview conducted with the Administrator on 05/20/91 at 6:45 PM revealed the facility does not deny any kind of visitation but did schedule visitation so that all residents have a chance of visiting with families. It was further revealed residents' friends and families should never be turned away for any kind of visitation.	F 563	Wellness Coordinator on May 21st, 2021. Residents are re-educated daily by receiving the Daily Newsletter which has the information regarding visitation on it and by watching the facility TV channel. To ensure Quality Assurance, the Wellness Coordinator and/or designee will communicate to all new admissions and their responsible parties regarding visitation with in twenty-four hours of admission. The Wellness Coordinator and/or designee will communicate with all in-house residents regarding visitation daily for four weeks. Three residents and/or their responsible parties will be interviewed by the Administrator or designee per week as to their understanding regarding visitation for four weeks. Findings from this will be presented in the Quality Assurance meeting for a minimum of two consecutive months. All corrective action will be completed by May 21st, 2021.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		5/21/21

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F 656	Continued From page 3 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 4 section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to implement a care plan for the use of fall mats for 1 of 1 resident (Resident #14) reviewed for fall prevention. The findings included: Resident #14 was admitted to the facility on 11/07/20 with diagnosis of osteoarthritis, Alzheimer's disease, and repeated falls. Review of Resident #14's quarterly Minimum Data Set (MDS) assessment dated 03/13/21 revealed the resident was severely cognitively impaired needing extensive assistance of two staff members with transfers and bed mobility. Review of Resident #14's care plan revised on 03/16/21 indicated the resident had a history of falls with an injury and poor safety awareness. The goal was for Resident #14 to sustain from falls without an injury. Interventions in place included fall mats to reduce risk of injury of future falls. An observation was conducted on 05/17/21 at 10:15 AM which revealed Resident #14 was in bed asleep without fall mats placed on either side of the resident's bed. An observation was conducted on 05/17/21 at 3:15 PM which revealed Resident #14 was in bed asleep without fall mats placed on either side of the resident's bed.	F 656	F656-483.21(b)(1) Develop/Implement Comprehensive Care Plan CFR(s) On May 17th thru May 20th, 2021, Resident #14 did not have a fall mat in place while in bed. On May 18th thru May 19th, 2021, the Minimum Data Set Coordinators and Nursing Administration team ensured that all fall interventions were in place for every resident that had fall interventions listed on their care plan. This was completed by auditing all care planned fall interventions and matching them to what was currently in place for each resident. All Certified Nursing Assistant care guides were audited for accuracy as well. All Administration members, Certified nursing assistants, nurses and housekeeping staff were in-serviced on making sure that fall interventions were in place by the Administrator, Director of Nursing and Assistant Director of Nursing on May 18th thru May 19th, 2021. Employee signatures reflect their understanding. To ensure Quality Assurance, Administration staff or designee will make daily room rounds to ensure care planned interventions are in place. The Administrator or designee will pick five residents per week to ensure the appropriate fall interventions are in place	

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F 656	Continued From page 5 An interview conducted with Nurse Aide #2 on 05/18/21 at 3:20 PM revealed Resident #14 should have had fall mats on both sides of her bed, but stated there had been times when the facility had not had enough fall mats for all fall prevention residents and they had to share. Nurse Aide #2 further revealed she did recall coming onto shift a few times and staff had forgotten to place fall mats out for Resident #14 when she was in the bed asleep. An interview conducted with the Assistant Director of Nursing (ADON) on 05/20/21 at 10:10 AM revealed she was aware of Resident #14's history of falls and it was expected for fall mats to be used as stated in the resident's care plan. An interview conducted with the Director of Nursing (DON) on 5/20/21 at 5:00 PM revealed it was expected for Resident #14's care plan to be followed by fall mats being placed on the floor when the resident was in the bed. An interview conducted with the Administrator on 05/20/21 at 6:35 PM revealed Resident #14's care plan should have been followed by fall mats being placed in the floor when the resident was in bed to prevent injury from a potential fall.	F 656	according to the care plan for six weeks. Findings from these audits will be presented in the Quality Assurance meeting for four consecutive meetings. All corrective action will be completed by May 21st, 2021.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		5/27/21

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F 657	Continued From page 6 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to revise a care plan for the use of reclining wheelchair for 1 of 1 resident (Resident #14) reviewed for fall prevention. The findings included: Resident #14 was admitted to the facility on 11/07/20 with diagnosis of osteoarthritis, Alzheimer's disease, and repeated falls. Review of Resident #14's quarterly Minimum Data Set (MDS) assessment dated 03/13/21 revealed the resident was severaly cognitively impaired needing extensive assistance for transfers.	F 657	F657-483.21(b)(2)(i)-(iii) Care Plan Timing and Revision The facility failed to revise a care plan for the use of a reclining high back wheelchair for resident #14. On May 24th thru May 26th, 2021, the Minimum Data Set Coordinators, Director of Nursing, Administrator, Assistant Director of Nursing, Treatment Nurse and Rehabilitation Director audited all care plans for proper seating and to ensure all interventions listed were current and appropriate. Administration staff, Minimum Data Set	

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F 657	Continued From page 7 Review of Resident #14's care plan revised on 03/16/21 indicated the resident had a history of falls with an injury and poor safety awareness. The goal was for Resident #14 to sustain from falls without an injury. Interventions in place included a dump wheelchair (drop seat to prevent foward fall) to reduce risk of future falls from wheelchair. An observation was conducted on 5/18/21 at 11:40 AM which revealed Resident #14 outside of the resident's room in a standard high back wheelchair with no recline. The observation further revealed Resident #14 fidgeting with her clothes causing her to fall forward, but a staff member was able to re-adjust her before she fell out of her chair onto the floor. An observation conducted on 05/19/21 at 4:35 PM revealed Resident #14 sitting outside of her room in a standard high back wheelchair with no recline. An observation conducted on 05/20/21 at 8:20 AM revealed Resident #14 in the residents' room in a high standard back wheelchair with no recline. An interview conducted with Nurse Aide #1 on 05/20/21 at 8:30 AM revealed she was aware of Resident #14's history of falls and stated the resident should be reclined back in her wheelchair when she was not supervised to prevent falls. The Nurse Aide further revealed she could not recall why Resdient #14 wa not reclined or what type of wheelchair Resident #14 was care planned for.	F 657	Coordinators, Certified Nursing Assistants and nurses were in-serviced on recognizing and reporting to appropriate departments when an intervention is no longer needed or appropriate for a resident so that care plans can be revised timely by Minimum Data Set Coordinators on May 24th thru May 26th, 2021, by the Administrator, Director of Nursing and Assistant Director of Nursing. Upon updating the care plans, all interventions are relayed to floor staff through Certified Nursing Assistant care guides. To ensure Quality Assurance, the Administrator, Minimum Data Set Coordinators, Director of Nursing and Assistant Director of Nursing will review care plans to ensure all interventions listed are current and appropriate. Five resident care plans will be audited per week for six weeks. Findings from this audit will be presented in the Quality Assurance meeting for a minimum of four consecutive months. All corrective action will be completed by May 27th, 2021.	

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F 657	Continued From page 8 Follow up interview conducted with the Therapy Manager on 05/20/21 at 10:45 AM revealed when Resident #14 was discharged from therapy previously on 03/13/21, the resident should have been discontinued from a dump wheelchair and switched to a high back reclining wheelchair to prevent falls. It was further revealed Resident #14's current wheelchair should always be at a 30-degree angle and the resident should never be sitting unattended straight up with no recline. The Therapy Manager stated the care plan should have been revised from a dump wheelchair to a reclining wheelchair. An interview conducted with the Director of Nursing (DON) on 5/20/21 at 5:00 PM revealed it was expected for Resident #14's care plan to be followed and for the resident's wheelchair to be reclined to prevent falls. It was further revealed Resident #14's care plan should have been revised for the appropriate wheelchair for the resident. An interview conducted with the Administrator on 05/20/21 at 6:35 PM revealed Resident #14's care plan should have been revised from a dump wheelchair to a reclining wheelchair when the resident was discharged from therapy.	F 657		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		5/26/21

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F 761	Continued From page 9 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard an undated opened multi-dose vial of influenza vaccine in 1 of 1 medication room, discard an opened single-dose vial of an injectable medication, undated and opened insulin pens, and loose pills in 5 of 5 medication carts (A hall, B hall, C hall, D hall and F hall). They also failed to store undated and unopened vials of insulin per manufacturer instructions and failed to secure a narcotics drawer in 1 of 5 medication carts (B hall). The findings included: a. An observation of the medication room with the Assistant Director of Nursing (ADON) on 5/20/21 at 7:15 AM revealed an opened and undated vial of influenza vaccine in the medication room refrigerator. Half of the vial was left available for	F 761	F761-483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Loose pills, undated insulin, one vial of Lasix was found on medication carts. One vial of influenza that was not dated or labeled properly in the medication room refrigerator. One narcotic drawer was also found unlocked on the medication cart while it was in the medication room. On May 20th, 2021, the Director of Nursing and Assistant Director of Nursing checked all medication carts and medication refrigerators to make sure that all unlabeled and opened medications that needed to be discarded were discarded appropriately. AvendiRx Pharmacy came out to the facility to check all medication	

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F 761	Continued From page 10 use. An interview with the ADON on 5/20/21 at 7:18 AM revealed she was not sure when the influenza vial had been used last but it should have been dated when it was opened because it was only good for 30 days after being opened. The ADON stated the medication room was supposed to be checked every shift by the charge nurses but the log revealed it had not been checked by the night shift nurse from the night before. b. An observation of the F hall medication cart with Nurse #1 on 5/20/21 at 6:45 AM revealed an unlabeled and opened single-dose vial of Furosemide injectable, a medication used to treat edema caused by various medical problems including heart failure, pulmonary edema, kidney and liver disease, stored in the top drawer of the medication cart. Half of the vial was left available for use. An interview with Nurse #1 on 5/20/21 at 6:47 AM revealed that the vial of Furosemide must have been a stock medication that was pulled to use on a resident on F hall. He stated he was not sure for which resident it was given to. Nurse #1 also stated that the opened vial of Furosemide was only good for 28 days after being opened but he could not tell the date when it had been opened so it should have been discarded. Nurse #1 added that he checked the F hall medication cart but did not see that the Furosemide vial was not labeled or dated. An interview with the ADON on 5/20/21 at 7:20 AM revealed the vial of Furosemide should have been discarded after being used because it was a single-dose vial that should only have been used	F 761	carts on May 21st, 2021, to ensure all drawers and locks on the medication cart were functioning properly. All carts were found to be in proper working condition. All nurses and medication aides were re-educated according to the manufacturer's instructions regarding the proper labeling and storage of medications on May 21st, 2021, by the Director of Nursing and Assistant Director of Nursing. All nurses and Medication Aides were also educated to check medication carts each shift to ensure shift to ensure compliance regarding proper medication storage and labeling. All medications will be labeled and stored correctly. To ensure Quality Assurance, all medication carts will be audited daily for the first seven days to ensure proper labeling and storage of medications along with the proper functioning of medication carts drawers and locks by the Director of Nursing, Assistant Director of Nursing and Unit Coordinators, thereafter two medication carts per day will be audited for six weeks. AvendiRx Pharmacy will audit all medication carts once per month for two months. Findings will be presented in the Quality Assurance meeting for a minimum of four consecutive months. All corrective action will be completed by May 26th, 2021.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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one time.

c. An observation of the A hall medication cart with Nurse #2 on 5/20/21 at 11:05 AM revealed the following:

* An opened and undated Novolog insulin flexpen labeled with Resident #93's name was available for use.

* An opened and undated Torjeo Solostar pen labeled with Resident #20's name was available for use.

* An unopened vial of Lantus insulin, labeled with Resident #257's name with a sticker attached that read "refrigerate until opened."

An interview with Nurse #2 on 5/20/21 at 11:08 AM revealed both opened insulin pens should have been dated when opened because they were good for only 28 days after opening. The Lantus should not have been taken out of the refrigerator for storage in the medication cart until needed for use because it was good for only 28 days after opening or after being taken out of refrigeration.

d. An observation of the C hall medication cart with Medication Aide (MA) #1 on 5/20/21 at 1:15 PM revealed the following:

* An unopened vial of Lantus insulin labeled with Resident #44's name with a sticker attached that read "refrigerate until opened."

* An opened and undated Basaglar insulin pen labeled with Resident #23's name was available for use.

* Two opened and undated Basaglar insulin pens labeled with Resident #71's name were available for use.

An interview with Medication Aide (MA) #1 on

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	345246	A. BUILDING _____ B. WING _____	C 05/20/2021

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5/20/21 at 1:18 PM revealed she did not pay attention to the opened, undated insulin pens because she was not responsible for giving them. MA #1 stated Nurse #2 was assigned to help her out on C hall and gave the insulin to the residents.

An interview with Nurse #2 on 5/20/21 at 1:20 PM revealed he was helping MA #1 on C hall and he reported the unopened Lantus vial should have been dated whenever it was taken out of the refrigerator for storage in the medication cart because it was the same as opening the vial and would only be good for 28 days after opening. Nurse #2 stated all the Basaglar pens should have been dated as well when they were opened and discarded after 28 days. He did not know why the nurses did not use up Resident #23's Basaglar pen before opening another one.

e. Right after inspection of C hall medication cart with MA #1 in the medication room, the B hall medication cart was observed with the lock mechanism in the unlocked position (the push-button to lock the medication cart was protruding about an inch from the medication cart). MA #1 agreed to stay in the medication room while the surveyor inspected the B hall medication cart. An observation was made of the B hall medication cart with MA #1 on 5/20/21 at 1:25 PM revealed the following:

* An opened and undated vial of Levemir insulin labeled with Resident #90's name was available for use.

* The narcotics drawer was unlocked and popped open when the second left drawer of the B hall medication cart was pulled.

An interview with MA #1 on 5/20/21 at 1:28 PM

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revealed she was not responsible for the B hall medication cart and did not know why the narcotics drawer was unlocked and popped open after the drawer was pulled.

An interview with Nurse #3 on 5/20/21 at 2:07 PM revealed she was unaware that she had left the B hall medication cart unlocked with the narcotics drawer unlocked as well. Nurse #3 stated she should have made sure her medication cart was locked before leaving it. Nurse #3 added that she had been working on checking the insulins in the B hall medication cart but did not see the undated opened vial of Levemir for Resident #90.

An interview with the Director of Nursing (DON) on 5/20/21 at 5:57 PM revealed Nurse #3 should have made sure the narcotics drawer was locked prior to leaving the B hall medication cart.

f. An observation of the D hall medication cart with MA #2 on 5/20/21 at 1:55 PM revealed the following:

* An opened and undated Basaglar insulin pen labeled with Resident #204's name was available for use.

* A plastic medication cup with a loose pill was stored in the first drawer of the D hall medication cart.

An interview with MA #2 on 5/20/21 at 1:58 PM revealed the loose pill in the medication cup was Losartan which belonged to Resident #81 and was scheduled to be given at 9:00 AM. MA #2 stated the Losartan pill had to be pulled by Nurse #4 out of the stock medications because Resident #81 had run out of it. MA #2 disclosed that Nurse #4 gave her the Losartan pill at 12:00 PM but she did not administer it right away to

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Resident #81 because she was supposed to get a newly-ordered antibiotic pill at 1:00 PM and Resident #81 told her she wanted to take both medications at the same time. MA #2 said she was still waiting for Nurse #4 to pull the antibiotic pill out of the stock medications and decided to wait to give the Losartan with it. MA #2 stated she did not know anything about the opened and undated Basaglar insulin pen as she did not give this medication to Resident #204.

An interview with Nurse #4 on 5/20/21 at 3:04 PM revealed she pulled Resident #81's Losartan pill out of the stock medications and gave it to MA #2 at 12:00 PM. Nurse #4 stated she assumed MA #2 gave the Losartan pill to Resident #81 after she handed it to her. She was unaware that MA #2 kept the pill in the D hall medication cart while Resident #81 waited to get the antibiotic dose at 1:00 PM.

An interview with the DON on 5/20/21 at 5:57 PM revealed that all medications in the medication room and the medication carts should be labeled and dated and discarded when no longer in use. The DON stated all insulin vials and pens should be dated when they are opened as they expire after 28 days of opening.

An interview with the Administrator on 5/20/21 at 6:33 PM revealed she expected all medications in the medication room and the medication carts to be labeled and dated. The nurses should also make sure that they lock the narcotics drawer in their medication carts prior to leaving it.