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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 10/23/19-10/25/19.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 1 of 5 sampled residents, (Resident #4), with orders for blood sugar parameters, which included notifying the physician, rechecking the fingerstick blood sugar (FSBS) and following the sliding scale insulin (SSI) coverage. The findings are: Review of Resident #4's current FL-2 dated 03/25/19 revealed: -Diagnoses included dementia and type I	D 276		

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diabetes mellitus.
-There was an order for FSBS checks five times a day.
-There was an order for Novolog insulin, (a fast acting insulin used to control high blood sugar), to be administered per sliding scale insulin (SSI) parameters.
-The sliding scale parameters included physician orders for FSBS greater than 500.
-Eight units of Novolog insulin was to be administered when the FSBS was between 501 and 600, the physician was to be notified, the FSBS should be repeated in one hour, and if the BS was less than 600, administer SSI coverage.

Review of Resident #4's Medication Review Report dated 07/01/19 revealed:
-There was an order for FSBS five times a day.
-There was an order for Novolog insulin to be administered per SSI parameters.
-The sliding scale parameters included physician orders for FSBS greater than 500.
-Eight units of Novolog insulin were to be administered to Resident #4 if the FSBS was between 501 and 600, the FSBS should be repeated in one hour, and if the FSBS was less than 600, administer SSI coverage, notify the physician and re-check the blood sugar in an hour.

Review of Resident #4's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for FSBS five times a day at 7:30am, 11:30am, 2:30pm, 4:30pm and 9:00pm.
-There was an entry for Novolog insulin 100units/ml to be administered per sliding scale parameters.
-The sliding scale parameters for FSBS greater than 500 was as follows: administer 8 units of

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Novolog insulin and notify the physician, the FSBS should be repeated in one hour, and if the FSBS was less than 600, administer SSI coverage.
-There was documentation on 08/14/19 at 7:30am, Resident #4's FSBS was 586. Eight units of insulin per SSI coverage was administered. There was no documentation the FSBS was repeated in an hour or additional insulin was administered per SSI coverage. There was documentation the physician was notified.
-There was documentation on 08/14/19 at 11:30am, Resident #4's FSBS was 588. Eight units of insulin per SSI coverage was administered. There was no documentation the physician was notified, the FSBS was repeated in an hour or additional insulin was administered per SSI coverage.
-There was documentation on 08/14/19 at 2:30pm, Resident #4's FSBS was 531. Eight units of insulin per SSI coverage was administered. There was no documentation the physician was notified, the FSBS was repeated in an hour or additional insulin was administered per SSI coverage.
-There was documentation on 08/27/19 at 7:30am, Resident #4's FSBS was 541. Eight units of insulin per SSI coverage was administered. There was no documentation the physician was notified, the FSBS was repeated in an hour or additional insulin was administered per SSI coverage.

Interview with Resident #4's primary care physician (PCP) on 10/24/19 at 12:30pm revealed:
-Resident #4 was a brittle diabetic, and her blood sugar was often high.
-She expected to be notified, per orders, and for the SSI to be administered when the FSBS was

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greater than 500.
-If Resident #4 did not receive the sliding scale coverage for blood sugar greater than 500 this could result in ketoacidosis, causing a change in the blood ph and requiring medical attention.
-It was important for the facility staff to follow the physician orders regarding blood sugar levels and parameters diligently.

Interview with the Health and Wellness Director (HWD) on 10/25/19 at 10:10am revealed:
-She did not know there were additional parameters to Resident #4's sliding scale coverage.
-The MAs were responsible for reading the order on the eMAR and implementing it fully.
-She did not know the order for additional blood sugar checks and SSI coverage was not administered to Resident #4 when her blood sugar was above 500.
-The additional insulin and recheck of the blood sugar would have been entered in the electronic progress notes.
-The medication report she reviewed would not have flagged that.
-She did not review the eMARs for accuracy aside from the medication report she was able to print.

Interview with a medication aide (MA) on 10/25/19 at 11:50am revealed:
-She worked first shift and had checked Resident #4's FSBS and administered Resident #4's sliding scale insulin.
-She knew to notify the physician if Resident #4's FSBS was above 500.
-She did not remember the physician orders to re-check the FSBS in an hour if the BS was above 500 at the scheduled reading.
-She did not know additional insulin was to be

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administered based on the SSI coverage at the re-check of the FSBS.
-If she had re-checked the FSBS or administered additional insulin she would have recorded the reading and the amount of insulin in the electronic progress notes.

Review of Resident #4's electronic progress notes on 10/17/19 revealed:
-There was no documentation on 08/1419 Resident #4's FSBS was re-checked an hour after the blood sugar was 586 at 7:30am, 588 at 11:30am or 531 at 2:30pm.
-There was no documentation additional insulin was administered per sliding scale coverage.
-There was no documentation on 08/27/19 Resident #4's FSBS was re-checked an hour after the blood sugar was 541 at 7:30am.
-There was no documentation additional insulin was administered per sliding scale coverage.

Interview with the Administrator on 10/25/19 at 12:35pm revealed:
-She did not know the MA had not followed the physician's orders for Resident #4 when her blood sugar was over 500.
-She expected the MAs to follow the complete order on the eMAR.
-She expected the MAs to document the additional blood sugar reading and insulin administered in the electronic progress notes.
-She expected the clinical staff to review the eMARs for accuracy.
-The HWD would receive additional training on the various reports that could be printed to assist in monitoring medication administration.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

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D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to serve eight ounces of pasteurized milk at least twice a day. The findings are: Interview on 10/23/19 at 9:00am with the Administrator revealed: -The facility was a Special Care Unit for residents with cognitive impairments. -The facility's current census was 46 residents. Observation on 10/23/19 at 9:30am of the walk-in cooler in the main kitchen revealed 3 ¼ gallons [416 ounces (oz.)] of 2% milk was available to be served to the residents. Observation on 10/23/19 at 9:45am revealed the facility was divided into 4 halls with each hall having a small dining room and kitchen with a full-size refrigerator. Review of the Week at a Glance menu for	D 299		

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D 299	Continued From page 6 10/23/19-10/26/19 revealed milk was to be served with all meals, but no portion size was indicated. Observation on 10/24/19 from 8:23am to 8:27am of the breakfast meal being served in dining room #1 revealed: -Nine residents were eating breakfast, and none were offered or served milk. -One hundred forty-four oz. of milk would be needed daily to serve 9 residents two 8 oz. glasses of milk. -There was 1 unopened gallon (128 oz.) of 2% milk in dining room #1's refrigerator. -The milk remained in the refrigerator and was not offered or served to the residents. Observation on 10/24/19 from 8:27am to 8:40am of the breakfast meal being served in dining room #2 revealed: -Twelve residents were eating breakfast, and none were offered or served milk. -One hundred ninety-two oz. of milk would be needed daily to serve 12 residents two 8 oz. glasses of milk. -There was 2/3 gallon (approximately 85 oz.) of 2% milk in dining room #2's refrigerator. -The milk remained in the refrigerator and was not offered or served to the residents. Observation on 10/24/19 from 8:40am to 8:54am of the breakfast meal being served in dining room #3 revealed: -Six residents were eating breakfast, and 4 of the 6 residents were served milk. -Two additional place settings, with glasses of milk, were on the tables with no residents seated. -One hundred twenty-eight oz. of milk would be needed daily to serve 8 residents two 8 oz. glasses of milk.	D 299		

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D 299	Continued From page 7 -There was ½ gallon (approximately 64 oz.) of 2% milk remaining in dining room #3's refrigerator. Observation on 10/24/19 from 8:55am to 9:08am of the breakfast meal being served in dining room #4 revealed: -Nine residents were eating breakfast, and none were offered or served milk. -One hundred forty-four oz. of milk would be needed daily to serve 9 residents two 8 oz. glasses of milk. -There was 1 unopened gallon (128 oz.) of 2% milk in dining room #4's refrigerator. -The milk remained in the refrigerator and was not offered or served to the residents. Observation on 10/24/19 from 12:15pm to 12:19pm of the lunch meal being served in dining room #1 revealed: -Nine residents were eating lunch, and none were offered or served milk. -One hundred forty-four oz. of milk would be needed daily to serve 9 residents two 8 oz. glasses of milk. -There was 1 unopened gallon (128 oz.) of 2% milk in dining room #1's refrigerator. -The milk remained in the refrigerator and was not offered or served to the residents. Observation on 10/24/19 from 12:20pm to 12:36pm of the lunch meal being served in dining room #2 revealed: -Twelve residents were eating lunch, and seven of the twelve residents were served milk. -One hundred ninety-two oz. of milk would be needed daily to serve 12 residents two 8 oz. glasses of milk. -There was 1/3 gallon (approximately 42 oz.) of 2% milk remaining in dining room #2's refrigerator.	D 299		

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D 299	Continued From page 8 Observation on 10/24/19 from 12:37pm to 12:50pm of the lunch meal being served in dining room #3 revealed: -Eight residents were eating lunch, and all eight residents were served milk. -One hundred twenty-eight oz. of milk would be needed daily to serve 8 residents two 8 oz. glasses of milk. -There was ½ gallon (approximately 64 oz.) 2% milk remaining in dining room #3's refrigerator. Observation on 10/24/19 from 12:58pm to 1:15pm of the lunch meal being served in dining room #4 revealed: -Ten residents were eating lunch, and none were offered or served milk. -One hundred sixty oz. of milk would be needed daily to serve 10 residents two 8 oz. glasses of milk. -There was one unopened gallon (128 oz.) of 2% milk in dining room #4's refrigerator. -The milk remained in the refrigerator and was not offered or served to the residents. Interview with a personal care aide (PCA) on 10/24/19 at 1:16pm revealed: -The PCAs were responsible for serving milk and water to residents. -She used to pour milk for every resident, but some residents did not want milk, so she stopped serving it to all residents. Interview with a second PCA on 10/24/19 at 1:16pm revealed: -The PCAs were responsible for serving milk to residents. -She did not serve milk to residents on 10/24/19 because she did not have enough "milk" glasses available for every resident.	D 299		

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-Drinking glasses were stored in the cabinets of each of the four kitchens.
-The facility had three different sizes of glasses.
-Small glasses were used for serving milk, medium glasses were used for serving juice, and large glasses were used for serving water and tea.
-She had glasses available, other than the "milk" glasses, but she did not serve milk.
-She did not report needing glasses to the Dining Services Coordinator or the Administrator.

Observation of the facility's milk glass supply on 10/24/19 at 1:16pm revealed:
-There were 4 milk glasses in the cabinet of dining room #1's kitchen.
-There were 2 milk glasses in the cabinet of dining room #2's kitchen.
-There were 7 milk glasses in the cabinet of dining room #3's kitchen.
-There were no milk glasses in the cabinet of dining room #4's kitchen.
-There were no milk glasses in the facility's main kitchen.

Interview with the Dining Services Coordinator on 10/24/19 at 1:25pm revealed:
-She was responsible for the overall service at meals.
-PCAs were responsible for serving milk and water to the residents.
-The PCAs were responsible for going to the main kitchen's walk-in cooler to restock the milk in each hall's kitchen.
-She took juice and tea with the hot food to each of the four dining rooms and served them at meals.
-She knew milk was to be served twice daily to all residents.
-The PCAs were "inconsistent" with serving milk

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D 299	Continued From page 10 to residents because they thought it was wasteful if residents did not drink their milk. -Drink glasses were stored in each of the four kitchens. -Drink glasses were washed in the four small kitchens, after use, by the PCAs and then brought to the main kitchen for her to sanitize. -She did not know there were not enough milk glasses to serve milk to all residents. -PCAs could use other drink glasses to serve milk. Interview with the Administrator on 10/25/19 at 10:00am revealed: -She knew milk was to be served to all residents twice daily. -The PCAs were responsible for serving milk to residents. -The Dining Services Coordinator was responsible for oversight during meals. -She knew staff were inconsistent with serving milk twice daily and had spoken to them about it in the past. -She did not know the facility did not have enough small glasses to serve milk to every resident. -She expected PCAs to communicate the need for more glasses to the Dining Services Coordinator so she could order more. -She expected the PCAs to serve milk in medium or large glasses if they did not have enough small glasses, until more could be ordered.	D 299		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Resident #1, #4, and #5) with orders for a blood pressure medication, a diuretic medication, an antibiotic medication, potassium and a vitamin supplement (Resident #1); a fast acting insulin, pain medication, a sleep aid and a thyroid medication (Resident #4); and a sedative, an antibiotic, and a medication used to treat symptoms of dementia (Resident #5).

The findings are:

Review of the facility's medications and treatments availability policy revealed "the community is responsible for obtaining newly ordered medication or refills for medications and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party in accordance with the pharmacy services agreement addendum to the residency agreement."

Review of the facility's policy regarding ordering medication revealed "if cycle refill is not available, the resident's medication supply reached 7 days, fax a refill request to the pharmacy; contact the pharmacy by phone if the newly ordered/refilled medications do not arrive in a timely manner;

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notify the resident, family or contact the physician for a new order/prescription when routine medication refill orders are depleted."

1. Review of Resident #5's current FL2 dated 12/05/18 revealed diagnoses included dementia and Alzheimer's disease.

a. Review of Resident #5's current FL2 dated 12/05/18 revealed there was a medication order for lorazepam 0.5mg take ½ tablet as needed (PRN) three times daily (a medication used as a sedative).

Review of Resident #5's physician's orders dated 02/07/19 revealed there was a medication order to discontinue the PRN lorazepam and start lorazepam 0.5mg ½ tablet three times daily to be administered at 8:00am,12:00pm, and 5:00pm.

Review of Resident #5's physician's orders dated 08/07/19 revealed there was a medication order to start lorazepam 0.5mg one tablet three times daily.

Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg ½ tablet to be administered three times daily at 8:00am, 12:00pm, and 5:00pm with a start date of 02/07/19 and a discontinue date of 08/07/19.
-There was an entry for lorazepam 0.5mg one tablet to be administered three times daily at 8:00am, 12:00pm, and 5:00pm with a start date of 08/07/19.
-There was documentation Resident #5 was not administered lorazepam 0.5mg ½ tablet for 6 of 20 opportunities on 08/01/19 at 8:00am and 12:00pm, on 08/06/19 at 8:00am and 12:00pm

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D 358	Continued From page 13 and on 08/07/19 at 8:00am and 12:00pm. Review of Resident #5's progress notes dated 08/01/19-08/07/19 revealed: -On 08/01/19 at 7:50am and 12:23pm, Resident #5 was not administered lorazepam 0.5mg ½ tablet due to "on order." -On 08/01/19 at 1:34pm, there was documentation a medication aide (MA) faxed an order for lorazepam to Resident #5's pharmacy because the pharmacy did not have "the new order." -On 08/06/19 at 8:08am, Resident #5 was not administered lorazepam due to "on order, will call pharmacy." -On 08/06/19 at 11:29am, Resident #5 was not administered lorazepam due to "on order." -On 08/07/19 at 8:27am, Resident #5 was not administered lorazepam due to "not on cart, called and faxed to pharmacy, asked RCC (Resident Care Coordinator) to follow-up on order." -On 08/07/19 at 12:20pm, Resident #5 was not administered lorazepam due to "on order, RCC is working on getting correct dose in house." Observation of Resident #5's medications on hand on 10/24/19 at 4:15pm revealed: -There was a bubble pack of lorazepam 0.5mg with a dispense date of 09/03/19 and 22 of 90 tablets remaining. -There was a bubble pack of lorazepam 0.5mg with a dispense date of 10/07/19 and 30 of 60 tablets remaining. Telephone interview with a pharmacy technician at Resident #5's pharmacy on 10/25/19 at 8:25am revealed: -Resident #5 had a current order for lorazepam 0.5mg one tablet three times daily.	D 358		

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D 358	Continued From page 14 -The pharmacy dispensed lorazepam 0.5mg 90 half tablets for Resident #5 on 06/07/19 and 07/09/19. -The pharmacy dispensed lorazepam 0.5mg 90 tablets for Resident #5 on 08/08/19 and 09/07/19. -The pharmacy dispensed lorazepam 0.5mg 60 tablets for Resident #5 on 10/07/19. Interview with a MA on 10/25/19 at 11:55am revealed: -She did not administer lorazepam to Resident #5 on 08/01/19 at 8:00am and 12:00pm, on 08/06/19 at 8:00am and 12:00pm and on 08/07/19 at 8:00am and 12:00pm because she thought Resident #5's lorazepam dose changed, and the new dose was not on the medication cart. -She notified the RCC the incorrect dose of lorazepam was on the medication cart. -She could not remember any other details of why she did not administer 6 doses of lorazepam to Resident #5. Telephone interview with a MA on 10/25/19 at 12:25pm revealed: -She administered lorazepam 0.5mg ½ tablet to Resident #5 on days the other MA had not administered the medication. -The dose of lorazepam on the medication cart matched the eMAR. -She did not know why the other MA could not locate the correct dose. Interview with the RCC on 10/25/19 at 11:05am revealed: -She did not know Resident #5 missed 6 doses of lorazepam from 08/01/19-08/07/19. -If a MA could not locate a medication on the medication cart, they should check the "summary" section of the eMAR system to read notes documented by other MAs during previous	D 358		

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administration times.
-If the MAs could not figure out why the medication was not on the cart, they should notify herself or the Health and Wellness Director (HWD) so they could follow-up.
-Cart audits were performed "sporadically" to ensure medications were on the medication carts and available for administration.
-There was no schedule for routinely performing medication cart audits.
-No one was routinely auditing the eMARs to ensure medications had been administered.

Interview with the HWD on 10/25/19 at 10:10am revealed:
-She did not know Resident #5 missed 6 doses of lorazepam from 08/01/19-08/07/19.
-If a MA could not locate a medication on the medication cart, they should notify her so she could follow-up.
-She and the RCC had performed some cart audits in the past to ensure medications were available for administration, but not routinely.
-She pulled a computer report three times weekly that would show any blanks for medication administration on the eMARs.
-The report did not show medications not administered if the MAs had added a code such as "09."
-The "09" code would be used by the MAs if a medication was not administered, and they had documented the reason for not administering the medication in the progress notes.

Interview with the Administrator on 10/25/19 at 12:35pm revealed:
-She did not know Resident #5 missed 6 doses of lorazepam from 08/01/19-08/07/19.
-MAs were responsible for following up with the pharmacy if a medication could not be located on

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the medication cart and alerting the RCC and HWD.
-The HWD was responsible for printing a missed medication report from the eMAR system three times weekly so they would be alerted if a resident was not administered their medications.
-She did not realize the HWD was printing a report that did not show all medications not administered.
-Night shift MAs, the RCC, and the HWD did cart audits sometimes, but there was no set schedule for doing so.

Interview with Resident #5's primary care provider (PCP) on 10/25/19 at 11:56am revealed:
-Resident #5 was ordered lorazepam for mental health behaviors.
-She did not know Resident #5 missed 6 doses of lorazepam from 08/01/19-08/07/19.
-Lorazepam was not a medication that should be missed or stopped abruptly due to the risk of causing seizures.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Attempted telephone interview with Resident #5's power of attorney (POA) on 10/25/19 at 12:00pm was unsuccessful.

b. Review of Resident #5's physician's orders dated 09/20/19 revealed an order to start Cipro 500mg (an antibiotic) twice daily for 5 days to treat a urinary tract infection.

Review of Resident #5's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Cipro 500mg one tablet

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to be administered twice daily at 9:00am and 6:00pm for 5 days with a start date of 09/21/19.
-There was a second entry for Cipro 500mg one tablet to be administered twice daily at 9:00am and 6:00pm with a start date of 09/21/19 and a discontinue date of 09/20/19.
-There was a third entry for Cipro 500mg one tablet to be administered twice daily at 9:00am and 6:00pm for 4 days with a start date of 09/27/19.
-There was documentation Resident #5 was not administered Cipro 500mg for 8 of 10 opportunities on 09/21/19 at 9:00am and 6:00pm, 09/22/19 at 6:00pm, 09/23/19 at 9:00am and 6:00pm, 09/24/19 at 9:00am and 6:00pm and 09/25/19 at 9:00am.
-There was documentation Resident #5 was administered Cipro 500mg on 09/22/19 at 9:00am, 09/25/19 at 6:00pm, 09/27/19 at 6:00pm, and 09/28/19-09/30/19 at 9:00am and 6:00pm.

Review of Resident #5's October 2019 eMAR revealed:
-There was an entry for Cipro 500mg one tablet to be administered twice daily at 9:00am and 6:00pm for 4 days with a start date of 09/27/19.
-There was documentation Resident #5 was administered Cipro 500mg on 10/01/19 at 9:00am.

Review of Resident #5's progress notes dated 09/21/19-09/25/19 revealed:
-On 09/21/19 at 10:01am, Resident #5 was not administered Cipro due to "on order."
-On 09/21/19 at 5:27pm, Resident #5 was not administered Cipro due to "med not in stock."
-On 09/22/19 at 11:09am, Resident #5 was not administered Cipro due to "med unavailable, I will follow up with pharmacy."
-On 09/22/19 at 6:48pm, Resident #5 was not

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administered Cipro due to "med not on cart."
-On 9/23/19 at 8:52am and 5:22pm, Resident #5 was not administered Cipro due to "on order."
-On 09/24/19 at 8:00am, there was documentation a medication aide (MA) had faxed Resident #5's Cipro order to the pharmacy on Saturday (09/21/19) because she could not call them due to the pharmacy being closed, but she would follow-up today (09/24/19).
-On 09/24/19 at 5:19pm, Resident #5 was not administered Cipro due to "on order."
-On 09/25/19 at 8:02am, there was documentation a MA had called the pharmacy on 09/24/19, and the pharmacy did not have an order for Resident #5's Cipro so she faxed it to them.

Observation of Resident #5's medications on hand on 10/24/19 at 4:15pm revealed there was no Cipro available for administration.

Telephone interview with a pharmacy technician at Resident #5's pharmacy on 10/25/19 at 8:25am revealed:
-The pharmacy received a fax on 09/25/19 with an order for Resident #5's Cipro 500mg twice daily dated 09/21/19.
-The pharmacy dispensed Cipro to the facility on 09/25/19.

Interview with a MA on 10/25/19 at 11:55am revealed:
-She was told the Health and Wellness Director (HWD) faxed the Cipro order for Resident #5 to the pharmacy on 09/21/19 (a Saturday).
-She documented on 09/21/19, Resident #5's Cipro was on order.
-She did not work again until 09/24/19.
-She remembered calling the pharmacy on 09/25/19, and they told her they never received

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the fax, so she faxed Resident #5's Cipro order to them at that time.

Interview with the HWD on 10/25/19 at 10:10am revealed:
-She and the Resident Care Coordinator (RCC) were responsible for faxing new orders to the pharmacies.
-She did not know who faxed Resident #5's Cipro order to the pharmacy.
-Resident #5 used a different pharmacy from the facility's contracted pharmacy.
-Most residents used the facility's contracted pharmacy so sometimes staff would forget and fax Resident #5's orders to the contracted pharmacy rather than the pharmacy she used.
-The contracted pharmacy had been instructed by the facility to not fill any medications for Resident #5.
-She did not know Resident #5 was not administered Cipro until 5 days after it was ordered.
-If a MA could not locate a medication on the medication cart, they should notify her so she could follow-up.
-She and the RCC had performed some cart audits in the past to ensure medications were available for administration, but not routinely.
-She pulled a computer report three times weekly that would show any blanks for medication administration on the eMARs.
-The report did not show medications not administered if the MAs had added a code such as "09."
-The "09" code would be used by the MAs if a medication was not administered, and they had documented the reason for not administering the medication in the progress notes.

Interview with the RCC on 10/25/19 at 11:05am

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D 358	Continued From page 20 revealed: -She and the HWD were responsible for faxing new orders to the pharmacies. -The MAs could also fax orders if she nor the HWD were in the facility. -She could not remember who faxed Resident #5's Cipro order to the pharmacy. -She thought Resident #5's order had been faxed to the facility's contracted pharmacy initially and then later faxed to the correct pharmacy. -Cart audits were performed "sporadically" to ensure medications were on the medication carts and available for administration. -There was no schedule for routinely performing medication cart audits. -No one was routinely auditing the eMARs to ensure medications had been administered. Interview with the Administrator on 10/25/19 at 12:35pm revealed: -She did not know Resident #5 was not administered Cipro until 5 days after it was ordered. -MAs were responsible for following up with the pharmacy if a medication could not be located on the medication cart and alerting the RCC and HWD. -The HWD was responsible for printing a missed medication report from the eMAR system three times weekly so they would be alerted if a resident was not administered their medications. -She did not realize the HWD was printing a report that did not show all medications not administered. -Night shift MAs, the RCC, and the HWD did cart audits sometimes, but there was no set schedule for doing so. Interview with Resident #5's primary care provider (PCP) on 10/25/19 at 11:56am revealed:	D 358		

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-Resident #5 was ordered Cipro 500mg for a urinary tract infection.
-She did not know Resident #5 was administered her first dose of Cipro 5 days after the original order.
-Delaying the administration of Resident #5's antibiotic for 5 days put her at risk for the infection spreading to other parts of her body, hospitalization, and sepsis (a life-threatening complication that occurs when chemicals that are released in the bloodstream to fight an infection trigger inflammation throughout the body).

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

c. Review of Resident #5's current FL2 dated 12/05/18 revealed there was a medication order for Aricept 10mg one tablet every night (a medication used to treat Alzheimer's disease).

Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Aricept 10mg one tablet to be administered daily at 7:00pm.
-There was documentation Aricept 10mg was administered to Resident #5 from 08/01/19 through 08/24/19.
-There was documentation Aricept was not administered to Resident #5 for 7 of 31 opportunities from 08/25/19-08/31/19.

Review of Resident #5's September 2019 eMAR revealed:
-There was an entry for Aricept 10mg one tablet to be administered daily at 7:00pm.
-There was documentation Aricept was not administered to Resident #5 for 6 of 30

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D 358	Continued From page 22 opportunities from 09/01/19 through 09/06/19. Review of Resident #5's progress notes dated 08/25/19-09/06/19 revealed: -On 08/25/19 at 7:50pm, Resident #5 was not administered Aricept due to "on order." -On 08/26/19 at 6:43pm, Resident #5 was not administered Aricept due to "med unavailable, will follow-up with pharmacy." -From 08/27/19-09/03/19, there was documentation Resident #5 was not administered Aricept due to "on order." -On 09/04/19, there was documentation the pharmacy had called the facility and indicated Resident #5's Aricept would be delivered on 09/07/19. Observation of Resident #5's medications on hand on 10/24/19 at 4:15pm revealed there was a bubble pack of Aricept 10mg with a dispense date of 10/02/19 and 14 of 30 tablets remaining. Telephone interview with a pharmacy technician at Resident #5's pharmacy on 10/25/19 at 8:25am revealed: -Resident #5 had a current order for Aricept 10mg one tablet every night. -The pharmacy had dispensed Aricept 10mg 30 tablets for Resident #5 on 06/14/19, 07/15/19, 09/07/19, and 10/07/19. -Aricept 10mg had been on backorder and unavailable at one time, but he could not remember if the backorder occurred in August 2019. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/24/19 at 4:30pm revealed they had no issues with dispensing Aricept.	D 358		

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Telephone interview with a MA on 10/25/19 at 12:25pm revealed:
-Resident #5 had changed from the facility's contracted pharmacy to a different pharmacy, but she could not remember when the change occurred.
-Resident #5's new pharmacy did not dispense her Aricept when ordered.
-She had contacted the pharmacy several times to inquire about Resident #5's Aricept.
-The Health and Wellness Director (HWD), the Resident Care Coordinator (RCC), and the Administrator were made aware of the issues in getting Resident #5's Aricept.

Interview with the HWD on 10/25/19 at 10:10am revealed:
-She did not know there was an issue with getting Resident #5's Aricept from the pharmacy.
-She did not know Resident #5 missed 13 consecutive doses of Aricept.
-Sometimes the MAs would attempt to order Resident #5's medications through their contracted pharmacy's computer program, forgetting she did not receive her medications from the contracted pharmacy.
-The facility's contracted pharmacy had been instructed by the facility not to fill medications for Resident #5.
-If a MA could not locate a medication on the medication cart, they should notify her so she could follow-up.
-She and the RCC had performed some cart audits in the past to ensure medications were available for administration, but not routinely.
-She pulled a computer report three times weekly that would show any blanks for medication administration on the eMARs.
-The report did not show medications not administered if the MAs had added a code such

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D 358	Continued From page 24 as "09." -The "09" code would be used by the MAs if a medication was not administered, and they had documented the reason for not administering the medication in the progress notes. Interview with the RCC on 10/25/19 at 11:05am revealed: -She did not know there was an issue with getting Resident #5's Aricept from the pharmacy. -She did not know Resident #5 missed 13 consecutive doses of Aricept. -If she knew Resident #5's pharmacy was having issues dispensing Aricept for Resident #5, she would have contacted the resident's family to ask if they could use a different pharmacy. -Cart audits were performed "sporadically" to ensure medications were on the medication carts and available for administration. -There was no schedule for routinely performing medication cart audits. -No one was routinely auditing the eMARs to ensure medications had been administered. Interview with the Administrator on 10/25/19 at 12:35pm revealed: -She did not know Resident #5 missed 13 consecutive doses of Aricept. -MAs were responsible for following up with the pharmacy if a medication could not be located on the medication cart and alerting the RCC and HWD. -If a pharmacy could not dispense a medication, the RCC and HWD were responsible for speaking with the resident's family to ask if they would agree for the facility to obtain the medication from a different pharmacy. -The HWD was responsible for printing a missed medication report from the eMAR system three times weekly so they would be alerted if a	D 358		

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resident was not administered their medications.
-She did not realize the HWD was printing a report that did not show all medications not administered.
-Night shift MAs, the RCC, and the HWD did cart audits sometimes, but there was no set schedule for doing so.

Interview with Resident #5's primary care provider (PCP) on 10/25/19 at 11:56am revealed:
-Resident #5 was ordered Aricept to treat Alzheimer's disease.
-She did not know Resident #5 was not administered Aricept for 13 consecutive doses.
-The long-term effect of Resident #5 not being administered Aricept would be a potential for increased confusion.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

2. Review of Resident #4's FL2 dated 03/25/19 revealed diagnoses included dementia, type 1 diabetes, hypertension, hypothyroidism and osteoarthritis.

a. Review of Resident #4's FL2 dated 03/25/19 revealed:
-There was an order for Novolog insulin, 100u/ml, a short acting insulin used to treat elevated blood sugar, administer 5 units three times a day before meals.
-There was an order for finger stick blood sugar checks five times a day.
-There was an order for Novolog insulin 100u/ml per sliding scale protocol as follows: 151-200=1 unit; 201-250=2 units; 251-300 =3 units; 301-350=4 units; 351-400=5 units; 401-450=6 units; 451-500=7 units; 501-600=8 units and

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notify the physician, recheck the blood sugar in 1 hour and if the blood sugar was less than 600, administer the sliding scale insulin coverage.

Review of Resident #4's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog insulin, 5 units, to be administered daily at 7:30am, 11:30am and 4:30pm.
-Novolog insulin, 5 units, was documented as administered 90 of 90 possible opportunities from 09/01/19 through 09/30/19.
-There was an entry for Novolog insulin, administer per sliding scale coverage.
-Novolog insulin, per sliding scale coverage, was documented as administered 103 out of 120 possible opportunities from 09/01/19-09/30/19.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for Novolog insulin 5 units to be administered daily at 7:30am, 11:30am and 4:30pm.
-Novolog insulin, 5 units, was documented as administered 69 out of 69 possible opportunities from 10/01/19-10/23/19.
-There was an entry for Novolog insulin, administer per sliding scale coverage.
-Novolog insulin, per sliding scale parameters, was documented as administered 75 out of 92 possible opportunities from 10/01/19-10/23/19.

Observation of Resident #4's medications on hand on 10/24/19 at 1:30pm revealed:
-There was a 10ml vial of Novolog insulin available to be administered.
-The Novolog insulin vial was approximately half full.
-The open date on the vial was 09/21/19.

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D 358	Continued From page 27 Interview with a medication aide (MA) on 10/24/19 at 4:00pm revealed: -She administered Resident #4's insulin during first shift. -The insulin vial on the medication cart was the only vial of insulin for Resident #4. -She used the insulin in the vial for both the scheduled Novolog 5 units before meals and the sliding scale insulin. -The MAs ordered insulin from the pharmacy electronically as needed. -The pharmacist who trained the MAs on the eMAR functions stressed medications should be ordered when a 7 day supply was remaining. -She usually re-ordered insulin when the vial was about one quarter remaining. Telephone interview with a representative from the facility's contracted pharmacy on 10/24/19 at 12:47pm revealed: -Resident #4 had a current order for Novolog 100u/ml, administer 5 units three times a day before meals. -Resident #4 had a current order for Novolog 100u/ml, administer per sliding scale coverage. -The facility staff ordered Resident #4's insulin as needed. -A 10ml vial was dispensed to the facility upon request on 09/21/19. -Based on the scheduled dosage of Novolog, and the sliding scale insulin administered, the Novolog vial should have provided 17 days of coverage. -Novolog insulin should have been re-ordered on 10/08/19. Interview with Resident #4's primary care provider (PCP) on 10/24/19 at 12:30pm revealed: -Resident #4 was a brittle diabetic.	D 358		

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-If she did not receive her insulin as ordered, she could become hyperglycemic, a condition where blood glucose levels are elevated.
-Chronic hyperglycemia can cause kidney damage, susceptibility to infection and neuropathy (diabetic nerve damage).

b. Review of Resident #4's FL2 dated 03/25/19 revealed there was an order for Zoloft 50mg, used to treat depression, one tablet every evening at bedtime.

Review of a subsequent physician's order for Resident #4 dated 04/25/19 revealed:
-There was an order for Zoloft 50mg one tablet daily.
-There was an order for Zoloft 50mg, one half tablet (25mg), to be administered along with 50mg to equal 75mg daily.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Zoloft 50mg, to be administered daily at 9:00am.
-Zoloft 50mg was documented as not administered 21 of 31 possible opportunities.
-There was an order for Zoloft 50mg, take one half tablet (25mg), to be administered with 50mg, to equal 75mg daily.
-Zoloft 25mg was documented as not administered 10 of 31 possible opportunities.

Review of July 2019's electronic progress notes from 07/01/19-07/31/19 revealed:
-There were entries from 07/01/19-07/03/19 documenting Zoloft 75mg was not available for administration-will follow up with the pharmacy.
-There were entries from 07/04/19-07/06/19 documenting Zoloft 50 mg was not available for

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administration-on order.
-There were entries from 07/06/19-07/13/19 documenting Zoloft 75mg was not available for administration-will follow up with pharmacy.
-There were entries from 07/16/19 documenting Zoloft 75mg was not available for administration-medication on order.
-There were entries on 07/18/19 and 07/19/19 documenting Zoloft 50mg was not available for administration-on order.
-There were entries from 07/20/19-07/31/19 documenting Zoloft 75mg was not available for administration-no refills waiting on physician.

Review of Resident #4's August 2019 eMAR revealed:
-There was an entry for Zoloft 50mg, to be administered daily at 9:00am.
- Zoloft 50mg was documented as not administered from 08/01/19-08/03/19.

Review of August 2019's electronic progress notes from 08/01/19-08/03/19 revealed there were entries documenting Zoloft 75mg was not available for administration-the physician will be in to order refills.

Interview with Resident #4's primary care provider (PCP) on 10/24/19 at 12:30pm revealed:
-Zoloft was prescribed for Resident #4 as an antidepressant.
-Zoloft should not be stopped abruptly due to side effects, which could include withdrawal symptoms such as nausea, dizziness, vomiting and headaches.
-The physicians were in the facility weekly and were able to be contacted by phone daily.
-There was a box in the medication room labeled for the physicians where orders and requests were placed for the physicians to follow up with.

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-She referred to the physicians box in the medication room every week when she arrived at the community.
-Requests could also be made by fax to the physician's office.
-She was not notified by the facility Resident #4 did not receive her Zoloft "most of the month of July".
-She would have written a prescription for Resident #4's Zoloft if she had been informed the pharmacy needed a refill prescription.

Interview with a representative at the facility's contracted pharmacy on 10/25/19 at 9:15am revealed:
-The current concern with medication dispensed to the facility was the staff did not send refill requests in a timely manner.
-The facility staff should send a signed physician order summary (POS), or refill prescriptions from the physician to the pharmacy, for continuity of service with medications for the residents.
-There had been times in the past it had taken up to a month for the facility to send refill prescriptions.
-Refill requests were sent to the facility, and the physician, from the pharmacy as a reminder.
-At times, the physician that was contacted informed the pharmacy staff the resident in question was not their patient.
-Thirty three tablets of Zoloft 50mg, 0.5 tablets (25mg) were dispensed on 07/02/19.
-Thirty tablets of Zoloft 50mg, to be administered with 25mg to equal 75mg, were dispensed on 07/31/19.

c. Review of Resident #4's FL2 dated 03/25/19 revealed there was an order for Levothyroxine Sodium 50mcg, used to treat thyroid hormone deficiency, one tablet every day.

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D 358	Continued From page 31 Review of Resident #4's October 2019 electronic Medication Administration Record (eMAR), from 10/01/19-10/25/19 revealed: -There was an entry for Levothyroxine 50mcg, to be administered daily at 9:00am. -Levothyroxine was documented as administered 26 out of 26 possible opportunities at 9:00am from 10/01/19 to 10/25/19. Observation of resident #4's medications on hand on 10/24/19 at 1:30pm revealed there were no Levothyroxine 50mcg tablets on the medication cart or in the overstock drawer. Review of the electronic progress notes on 10/24/19 at 4:05pm revealed: -There were no entries documenting Resident #4's Levothyroxine was not available for administration from 10/20/19 through 10/24/19. -There was no documentation Levothyroxine was ordered as a refill request by the facility staff. Interview with the MA on 10/24/19 at 1:40pm revealed: -She had not administered the Levothyroxine this morning to Resident #4. -She had ordered the Levothyroxine yesterday using the electronic order feature on the eMAR software. -She expected the Levothyroxine to be delivered today in the tote. -She did not know why the medication was not ordered earlier. -Sometimes the medication was ordered electronically by the MAs and the pharmacy staff would report the reorder request had not been received. -It was the MAs responsibility to order and follow up with medications they ordered, but the MAs	D 358		

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were not always on the same medication cart.

Telephone interview with a representative from the contracted pharmacy on 10/25/19 at 9:15am revealed:
-Thirty tablets of Levothyroxine 50mcg were dispensed on 09/20/19.
-The refill date should have been 10/20/19.
-The facility staff had not requested a refill of Levothyroxine 50mcg as of 10/24/19.

Attempted telephone interview with Resident #4's primary care physician on 10/25/19 at 9:10am was unsuccessful.

d. Review of Resident #4's FL2 dated 03/25/19 revealed there was an order for Trazodone HCL 50mg, used to treat insomnia, one half tablet every evening.

Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Trazodone 50mg, one half tablet (25mg) to be administered daily at 7:00pm.
-There was documentation Trazodone 25mg was administered daily from 08/01/19-08/31/19.

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for Trazodone 50mg, one half tablet (25mg) to be administered daily at 7:00pm.
-There was documentation Trazodone 25mg was administered daily from 09/01/19-09/30/19.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for Trazodone 50mg, one

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half tablet (25mg) to be administered daily at 7:00pm.
-There was documentation Trazodone 25mg was administered daily from 10/01/19-10/24/19.

Observation of Resident #4's medications on hand on 10/24/19 at 1:30pm revealed:
-There was a blister pack of Trazodone 25mg, 30 tablets dispensed on 12/08/18.
-There were 12 tablets remaining in the blister pack.
-There was a blister pack of Trazodone 25mg in the overstock drawer with 30 tablets, dispensed on 01/29/19.
-There was a blister pack of Trazodone 25mg in the overstock drawer with 30 tablets, dispensed on 07/28/19.
-There was a blister pack of Trazodone 25mg in the overstock drawer with 30 tablets, dispensed on 08/29/19.

Review of the electronic progress notes on 10/24/19 at 4:10pm revealed there were no entries for Resident #4 documenting refusals of the Trazodone medication.

Telephone interview with a representative from the contracted pharmacy on 10/25/19 at 9:10am revealed:
-Resident #4 was not on a cycle fill for Trazodone.
-The facility staff was required to fax or electronically request refill medications for Trazodone.
-The fill history for Trazodone 25mg daily was as follows: thirty tablets dispensed on 01/19/19; thirty tablets dispensed on 03/24/19; thirty tablets dispensed on 07/05/19; and thirty tablets dispensed on 10/03/19.

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D 358	Continued From page 34 Attempted telephone interview with Resident #4's primary care physician on 10/25/19 at 9:10am was unsuccessful. e. Review of Resident #4's FL2 dated 03/25/19 revealed there was an order for Melatonin 5mg, one tablet at bedtime. Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Melatonin 5mg, one tablet to be administered daily at 5:00pm. -There was documentation Melatonin was administered daily at 5:00pm from 08/01/19-08/31/19. Review of Resident #4's September 2019 eMAR revealed: -There was an entry for Melatonin 5mg one tablet to be administered daily at 5:00pm. -There was documentation Melatonin was administered daily at 5:00pm from 09/01/19-09/30/19. Review of Resident #4's October 2019 eMAR revealed: -There was an entry for Melatonin 5mg, one tablet to be administered daily at 5:00pm. -There was documentation Melatonin was administered daily at 5:00pm from 10/01/19-10/24/19. Observation of Resident #4's medications on hand on 10/24/19 at 1:30pm revealed: -There was a blister pack of Melatonin 5mg thirty tablets dispensed on 12/08/18 in the medication cart. -There was a blister pack of Melatonin 5mg thirty tablets dispensed on 07/27/19 in the overstock	D 358		

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D 358	Continued From page 35 drawer. -There was a blister pack of Melatonin 5mg tablets thirty tablets dispensed on 09/07/19 in the overstock drawer. Based on interview, observations, and record review it was determined Resident #4 was not able to be interviewed. Attempted telephone interview with Resident #4's primary care physician (PCP) on 10/25/19 at 9:10am was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 10/25/19 at 11:15am. Refer to interview with the Health and Wellness Director (HWD) on 10/25/19 at 10:09am. Refer to interview with the Administrator on 10/25/19 at 12:30pm. 3. Review of Resident #1's FL2 dated 01/14/19 revealed diagnoses included dementia with behaviors, hypertension, congestive heart failure, overactive bladder, and osteoarthritis. a. Review of Resident #1's FL2 dated 01/14/19 revealed an order for metoprolol tartrate 25mg (used to treat high blood pressure) one tablet twice daily. Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg one tablet twice daily at 1:00pm and 9:00pm. -Metoprolol tartrate was not documented as administered 6 out of 62 opportunities from 08/01/19-08/31/19.	D 358		

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D 358	Continued From page 36 -The reasons for not administering metoprolol tartrate was documented as "refused". Review of Resident #1's September 2019 eMAR revealed: -There was an entry for metoprolol tartrate 25mg one tablet daily at 1:00pm and 9:00pm. -Metoprolol tartrate was not documented as administered 18 out of 60 opportunities from 09/01/19-09/30/19. -The reasons for not administering metoprolol tartrate was documented as "refused" and "on order". Review of Resident #1's October 2019 eMAR revealed: -There was an entry for metoprolol tartrate 25mg one tablet daily at 1:00pm and 9:00pm. -Metoprolol tartrate was not documented as administered 11 out of 46 opportunities from 10/01/19-10/23/19. -The reasons for not administering metoprolol tartrate was documented as "refused". Observation of Resident #1's medications on hand on 10/24/19 at 11:45am revealed: -Metoprolol tartrate 25mg was available to be administered. -There were 60 tablets of metoprolol dispensed on 10/15/19. -There were 48 tablets remaining in bubble packs delivered on 10/15/19. Telephone interview with a representative at the contracted pharmacy on 10/24/19 at 12:47pm revealed: -The pharmacy had a current order for metoprolol tartrate 25mg one tablet twice daily. -60 tablets of metoprolol tartrate 25mg was dispensed on 07/24/19, 09/07/19, and 10/15/19.	D 358		

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D 358	Continued From page 37 -Resident #1's metoprolol tartrate was not ordered before the previous supply ran out. -The facility could order medications by requesting via the eMAR system or fax. -There were no requests for refills prior to the medication being dispensed. Interview with a medication aide (MA) on 10/24/19 at 2:00pm revealed: -She administered medications to Resident #1. -There were some medications that were on order with the pharmacy in July and August 2019, but she could not remember which medications were for Resident #1. -She thought she called the pharmacy regarding Resident #1's pending medications, however did not remember when she called. -She did not know Resident #1 missed several doses of her medications. -MAs were responsible for reordering medications from the pharmacy within 7 days prior to the medication running out. -Medications were only supposed to be ordered via the eMAR system as instructed by the Health and Wellness Director (HWD). -Residents were not supposed to go without their medications for 3 days. -If medications did not arrive at the facility the next day after ordered, the MAs were responsible for contacting the pharmacy to get an update and notify the HWD. -There was a "glitch" in the eMAR system "about a month ago," in which MAs thought that medications were being ordered, but it was not being received by the pharmacy. -She did not realize there was a glitch in the eMAR system and was anticipating that medications were going to be delivered. Interview with Resident #1's Responsible Party	D 358		

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D 358	Continued From page 38 (RP) on 10/24/19 at 1:01pm revealed: -Resident #1's medications were managed by the facility. -He did not bring any medications into the facility to be administered to Resident #1. Interview with Resident #1's primary care provider (PCP) on 10/24/19 at 12:11pm revealed: -Resident #1 was ordered metoprolol tartrate to treat high blood pressure. -She did not know Resident #1 missed several doses of metoprolol tartrate in August, September or October 2019. -If Resident #1 did not receive metoprolol tartrate as ordered she would be at risk for elevated blood pressure. -She expected medications to be administered as ordered. b. Review of a physician's order dated 07/09/19 for Resident #1 revealed Bumex (used to treat fluid retention) 1mg twice daily. Review of a physician's order dated 08/30/19 revealed Bumex 2mg one tablet twice daily. Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Bumex 1mg tablet twice daily at 1:00pm and 9:00pm from 08/01/19-08/29/19. -Bumex 1mg was not documented as administered 12 out of 62 opportunities with "refused" and "on order" documented as reasons. -There was an entry for Bumex 2mg tablet twice daily at 9:00am and 6:00pm from 08/29/19-08/30/19. -Bumex was documented as administered daily from 08/29/19-08/30/19.	D 358		

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D 358	Continued From page 39 Review of Resident #1 September 2019 eMAR revealed: -There was an entry for Bumex 2mg tablet twice daily at 9:00am and 6:00pm. -Bumex was not documented as administered 11 of 62 opportunities with "refused" documented as the reason. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for Bumex 2mg tablet twice daily at 9:00am and 6:00pm. -Bumex was not documented as administered 20 out of 47 opportunities from 10/01/19-10/23/19 with "refused," "put in doctor's box," will follow-up need refill," "faxed to pharmacy out of refills," unavailable," and "med not on cart" [sic]. Observation of Resident #1's medications on hand on 10/24/19 at 11:45am revealed: -Bumex 1 mg tablet was available to be administered. -There was one bubble pack of Bumex 1mg dispensed 10/10/19, there were 29 tablets remaining. -There was a second bubble pack of Bumex 1 mg dispensed on 10/10/19, there were 10 tablets remaining. Telephone interview with a representative from the contracted pharmacy on 10/24/19 at 12:47pm revealed: -The pharmacy received an order for Bumex 1 mg tablet twice daily on 07/09/19. -There were 60 tablets of Bumex 1mg dispensed on 07/17/19, 08/22/19 and 10/10/19. -There were 60 tablets of Bumex 1mg tablets dispensed on 08/30/19. -There were no other dispense dates for Bumex.	D 358		

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D 358	Continued From page 40 Based on interviews and observations, there was not enough Bumex dispensed to be available for administration to Resident #1. Interview with a medication aide (MA) on 10/24/19 at 2:00pm revealed: -She administered medications to Resident #1. -There were some medications that were on order with the pharmacy in July and August 2019, but she could not remember which medications were for Resident #1. -She thought she called the pharmacy regarding Resident #1's pending medications, however did not remember when she called. -She did not know Resident #1 missed several doses of her medications. -MAs were responsible for reordering medications from the pharmacy within 7 days prior to the medication running out. -Medications were only supposed to be ordered via the eMAR system as instructed by the Health and Wellness Director (HWD). -Residents were not supposed to go without their medications for 3 days. -If medications did not arrive at the facility the next day after ordered, the MAs were responsible for contacting the pharmacy to get an update and notify the HWD. -There was a "glitch" in the eMAR system "about a month ago," in which MAs thought that medications were being ordered, but it was not being received by the pharmacy. -She did not realize there was a glitch in the eMAR system and was anticipating that medications were going to be delivered. Interview with Resident #1's Responsible Party (RP) on 10/24/19 at 1:01pm revealed: -Resident #1's medications were managed by the	D 358		

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facility.
-He did not bring any medications into the facility to be administered to Resident #1.

Interview with Resident #1's primary care provider (PCP) on 10/24/19 at 12:47pm revealed:
-Resident #1 was ordered Bumex as a diuretic to decrease swelling in her legs.
-If Resident #1 did not receive Bumex as ordered for 5-7 days she would be at risk for increased edema in her legs which would put her at risk for infection.
-She did not know Resident #1 missed several doses of Bumex in August, September, or October 2019.
-She expected medications to be administered as ordered.

c. Review of Resident #1's current FL2 dated 01/14/19 revealed there was an order for cranberry 450mg one tablet twice daily (used to prevent urinary tract infections).

Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cranberry 450mg one tablet twice daily at 1:00pm and 9:00pm.
-Cranberry was not documented as administered 10 out of 62 opportunities with "refused", "unavailable", and "on order" documented as reasons.

Review of Resident #1's September 2019 eMAR revealed:
-There was an entry for cranberry 450mg one tablet twice daily at 1:00pm and 9:00pm.
-Cranberry was not documented as administered 32 out of 60 opportunities with "refused", "unavailable", "not in stock", "med on order"

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D 358	Continued From page 42 documented as reasons. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for cranberry 450mg one tablet twice daily at 1:00pm and 9:00pm. -Cranberry was not documented as administered 8 out of 46 opportunities with "refused" documented as reasons. Observation of Resident #1's medications on hand on 10/24/19 at 11:45am revealed there was no cranberry 450mg available. Telephone interview with a pharmacy representative at the contracted pharmacy on 10/24/19 at 12:47pm revealed: -The current order was for cranberry 450mg one tablet twice daily. -The pharmacy dispensed 60 tablets of cranberry 450mg on 06/07/19, 07/23/19, 09/16/19, and 10/23/19. -The tablets 60 tablets dispensed on 10/23/19, had been delivered to the facility. -Medications were dispensed when requested from the facility. -The pharmacy had not received any requests for cranberry 450mg in August 2019. Interview with a medication aide (MA) on 10/24/19 at 2:00pm revealed: -She administered medications to Resident #1. -There were some medications that were on order with the pharmacy in July and August 2019, but she could not remember which medications were for Resident #1. -She thought she called the pharmacy regarding Resident #1's pending medications, however did not remember when she called. -She did not know Resident #1 missed several	D 358		

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doses of her medications.
-MAs were responsible for reordering medications from the pharmacy within 7 days prior to the medication running out.
-Medications were only supposed to be ordered via the eMAR system as instructed by the Health and Wellness Director (HWD).
-Residents were not supposed to go without their medications for 3 days.
-If medications did not arrive at the facility the next day after ordered, the MAs were responsible for contacting the pharmacy to get an update and notify the HWD.
-There was a "glitch" in the eMAR system "about a month ago," in which MAs thought that medications were being ordered, but it was not being received by the pharmacy.
-She did not realize there was a glitch in the eMAR system and was anticipating that medications were going to be delivered.

Interview with Resident #1's Responsible Party (RP) on 10/24/19 at 1:01pm revealed:
-Resident #1's medications were managed by the facility.
-He did not bring any medications into the facility to be administered to Resident #1.

Interview with Resident #1's primary care provider (PCP) on 10/24/19 at 12:47pm revealed:
-Resident #1 was ordered cranberry to help prevent urinary tract infections.
-She expected medications to be administered as ordered to help prevent urinary infections.
-She had not noticed an increase in urinary infections in August, September or October 2019.
-She expected medications to be available for administration.

d. Review of Resident #1's current FL2 dated

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D 358	Continued From page 44 01/14/19 revealed there was an order for potassium chloride 20meq one tablet twice daily (used to prevent low levels of potassium). Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for potassium chloride 20meq one tablet twice daily at 1:00pm and 9:00pm. -Potassium chloride 20meq was not documented as not administered 6 out of 62 opportunities with "refused," documented as reasons. Review of Resident #1's September 2019 eMAR revealed: -There was an entry for potassium chloride 20meq one tablet twice daily at 1:00pm and 9:00pm. -Potassium chloride 20meq was not documented as administered 16 out of 60 opportunities with "refused," "unavailable," "not in stock,"and "on order" documented as reasons. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for potassium chloride 20meq one tablet twice daily at 1:00pm and 9:00pm. -Potassium chloride was not documented as administered 9 out of 46 opportunities with "refused" documented as reasons. Observation of Resident #1's medications on hand on 10/24/19 at 11:45am revealed: -Potassium chloride 20meq was available for administration. -There was a bubble pack dispensed on 09/16/19, there with 3 tablets remaining.	D 358		

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D 358	Continued From page 45 Telephone interview with the representative from the contracted pharmacy on 10/24/19 at 12:47pm revealed: -The current order was for potassium chloride 20meq one tablet twice daily. -The pharmacy dispensed 60 tablets of potassium chloride 20meq on 06/18/19, 09/16/19, and 10/23/19. -The potassium chloride dispensed on 10/23/19 had been delivered to the facility. Interview with a medication aide (MA) on 10/24/19 at 2:00pm revealed: -She administered medications to Resident #1. -There were some medications that were on order with the pharmacy in July and August 2019, but she could not remember which medications were for Resident #1. -She thought she called the pharmacy regarding Resident #1's pending medications, however did not remember when she called. -She did not know Resident #1 missed several doses of her medications. -MAs were responsible for reordering medications from the pharmacy within 7 days prior to the medication running out. -Medications were only supposed to be ordered via the eMAR system as instructed by the Health and Wellness Director (HWD). -Residents were not supposed to go without their medications for 3 days. -If medications did not arrive at the facility the next day after ordered, the MAs were responsible for contacting the pharmacy to get an update and notify the HWD. -There was a "glitch" in the eMAR system "about a month ago," in which MAs thought that medications were being ordered, but it was not being received by the pharmacy. -She did not realize there was a glitch in the	D 358		

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D 358	Continued From page 46 eMAR system and was anticipating that medications were going to be delivered. Interview with Resident #1's Responsible Party (RP) on 10/24/19 at 1:01pm revealed: -Resident #1's medications were managed by the facility. -He did not bring any medications into the facility to be administered to Resident #1. Interview with Resident #1's primary care provider (PCP) on 10/24/19 at 12:47pm revealed: -She ordered potassium chloride to prevent potassium deficiency since Resident #1 was prescribed a diuretic. -If Resident #1 had not received potassium chloride as ordered, she would be at risk muscle weakness and increased fatigue. -She expected medications to be administered as ordered. -She expected medications to be available for administration. e. Review of Resident #1's current FL2 dated 01/14/19 revealed there was an order for vitamin D3 1000 units one tablet daily (used to treat vitamin D deficiency). Review of Resident #1's September 2019 eMAR revealed: -There was an entry for vitamin D3 one tablet daily at 1:00pm. -Vitamin D3 was not documented as administered 12 out of 30 opportunities with "refused," "unavailable," and "med on order" documented as reasons. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for vitamin D3 one tablet	D 358		

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D 358	Continued From page 47 daily at 1:00pm. -Vitamin D3 was not documented as administered 7 out of 23 opportunities with "refused" and "on order" documented as reasons. Observation of Resident #1's medications on hand on 10/24/2019 at 11:45am revealed: -Vitamin D3 100 units was available for administration. -There was one bubble pack of Vitamin D3 dispensed 09/23/19 with 14 tablets remaining. Telephone interview with the a representative from the contracted pharmacy on 10/24/19 at 12:47pm revealed: -The current order for vitamin D3 100 units was for one tablet daily. -The pharmacy dispensed 30 tablets of vitamin D3 100 units on 07/30/19 and 09/23/19. Interview with a medication aide (MA) on 10/24/19 at 2:00pm revealed: -She administered medications to Resident #1. -There were some medications that were on order with the pharmacy in July and August 2019, but she could not remember which medications were for Resident #1. -She thought she called the pharmacy regarding Resident #1's pending medications, however did not remember when she called. -She did not know Resident #1 missed several doses of her medications. -MAs were responsible for reordering medications from the pharmacy within 7 days prior to the medication running out. -Medications were only supposed to be ordered via the eMAR system as instructed by the Health and Wellness Director (HWD). -Residents were not supposed to go without their medications for 3 days.	D 358		

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-If medications did not arrive at the facility the next day after ordered, the MAs were responsible for contacting the pharmacy to get an update and notify the HWD.
-There was a "glitch" in the eMAR system "about a month ago," in which MAs thought that medications were being ordered, but it was not being received by the pharmacy.
-She did not realize there was a glitch in the eMAR system and was anticipating that medications were going to be delivered.

Interview with Resident #1's Responsible Party (RP) on 10/24/19 at 1:01pm revealed:
-Resident #1's medications were managed by the facility.
-He did not bring any medications into the facility to be administered to Resident #1.

Interview with Resident #1's primary care provider (PCP) on 10/24/19 at 12:47pm revealed:
-Resident #1 was ordered vitamin D3 due to a vitamin D deficiency.
-If Resident #1 did not receive vitamin D3 as ordered she would be at risk for poor bone health and increased fatigue.
-She expected medications to be administered as ordered.
-She expected medications to be available for administration.

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

Refer to interview with the Resident Care Coordinator (RCC) on 10/25/19 at 11:15am.

Refer to interview with the Health and Wellness Director (HWD) on 10/25/19 at 10:09am.

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D 358	Continued From page 49 Refer to interview with the Administrator on 10/25/19 at 12:30pm. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 1:15pm revealed: -She was responsible for assisting the Health and Wellness Director (HWD) with overseeing the MAs and processing orders. -MAs were responsible for ordering medications on the eMAR system. -If medications were not received within 24 hours, the MAs were responsible for calling the pharmacy to get an update. -If the pharmacy is pending a refill order, she would be responsible for calling/faxing the physician for an update. -The pharmacy would also send refill order requests, and she was responsible for following up and getting the order signed. -She always got the physician to sign refill orders when received from the pharmacy. -She had not noticed there were issues with getting medications dispensed by the pharmacy. -The medication carts should be audited monthly. -She was not sure if the cart audits had been completed monthly. -Third shift MAs were supposed to do cart audits. -They were to compare the medication on the cart with the eMAR to confirm the medication is available for administration and the instructions on the label of the medication matched the eMARs. -If there were 7 or less doses of the medication remaining, the MAs should electronically reorder the medication. -The documentation was given to the HWD for her to review. -Previous cart audit documentation was not kept. -There was no process in place to determine if	D 358		

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the correct amount of medication had been administered.
-She did not know why there were medications documented as administered that did not correspond with the fill history for that medication.

Interview with the Health and Wellness Director (HWD) on 10/25/19 at 10:10am revealed:
-The facility's policy was for MAs to only reorder medications via the eMAR system.
-She instructed MAs to order medications via the eMAR system around June and July 2019.
-Prior to becoming the HWD, MAs were faxing their refill requests to the pharmacy.
-Sometime around June or July she identified there were issues with ordering medications via the eMAR system.
-She also noticed the contracted pharmacy was not communicating missing information needed to process refills.
-She expected MAs to let her or the Resident Care Coordinator (RCC) know and call the pharmacy when medications were requested and not delivered to the facility within 24 hours.
-During June and July 2019, MAs were not letting her know that some medications were not available.
-She, the RCC, and 3rd shift MAs were responsible for completing "sporadic" cart audits.
-There was an eMAR report that was available to identify missed medication administration, however she did not realize that she had access until 10/24/19.
-She expected the MAs to assure the medication was available for administration, refills were ordered when there was about 5 doses left and expired medications were removed from the cart.
-The MAs referred to the current eMARs to verify the directions on the labels matched the entries on the eMARs.

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D 358	Continued From page 51 -She did not keep a record of the cart audits. -The clinical staff had spoken of having cart audits on a more frequent and scheduled time frame. -She did not know why there were medications documented as administered that did not correspond with the fill history for that medication. Interview with the Administrator on 10/25/19 at 12:35pm revealed: -She relied on the clinical staff to oversee medication administration, re-ordering medications and cart audits. -She expected MAs to order medications 7 days prior to the medication running out. -If medications were not available, she expected the MAs to follow-up with the pharmacy. -She was not aware any residents were going without medication for an extended period of time. -She expected the HWD to review an audit report weekly to identify residents who missed medications. -She expected cart audits to be completed twice per month by the 3rd shift MAs. -She did not think the MAs who completed the cart audits observed how much medication was left in a vial or bubble pack as part of their process. -The MAs were comparing the medications available for administration with the medication orders on the eMAR. -She did not know there were medications documented as administered that did not correspond with the fill history for that medication. -She "recently" found out the 3rd shift MAs were not completing cart audits. -The RCC/HWD were responsible for completing sporadic/unscheduled cart audits to identify missing medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060085	A. BUILDING: _____ B. WING _____	R 10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SOUTH PARK	5326 PARK ROAD CHARLOTTE, NC 28209

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D 358	Continued From page 52 -The Administrator, HWD, and RCC were responsible for following up when medications were not available after the MAs had no success with getting the medication. -She did not know there were medications documented as administered that did not correspond with the fill history for that medication. --- The facility failed to assure medications were administered as ordered for 3 of 5 sampled residents which resulted in Resident #4 not receiving Novolog insulin which put the resident at risk for hyperglycemia; Zoloft stopped abruptly placing the resident at risk for increased depression and withdrawal symptoms; Resident #5 not receiving lorazepam and stopped abruptly placing the resident at risk for increased anxiety and for seizures, and Resident #1 not receiving metoprolol tartrate, Bumex, cranberry 450mg, potassium chloride, and vitamin D3 as ordered . The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 10/24/19 in accordance with G. S. 131D-34. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 9, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060085	A. BUILDING: _____ B. WING _____	R 10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 53	D912		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant state rules and regulations for medication administration.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Resident #1, #4, and #5) with orders for a blood pressure medication, a diuretic medication, an antibiotic medication, potassium and a vitamin supplement (Resident #1); a fast acting insulin, pain medication, a sleep aid and a thyroid medication (Resident #4); and a sedative, an antibiotic, and a medication used to treat symptoms of dementia (Resident #5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]