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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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D 000	Initial Comments The Adult Care Licensure Section and the Wayne County Department of Social Services conducted a follow-up and complaint investigation on 07/13/21 to 07/15/21. The complaint was initiated by the Wayne County Department of Social Services on 06/25/21.	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: FOLLOW-UP TO TYPE B VIOLATION. The Type B violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 2 of 5 (#2 and #5) sampled residents regarding orders for monthly vital signs, monthly blood pressures, and daily weights (#2), and notification of primary care provider (PCP) of blood sugars outside of ordered parameters (#5). The findings are: 1.Review of Resident #2's current FL-2 dated 04/15/21 revealed: -Diagnoses included gastrointestinal reflux	D 276		

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disorder (GERD), constipation, insomnia, hypertension, and vitamin D deficiency.
-The resident was intermittently disoriented, required assistance with dressing, and was ambulatory.

Review of Resident #2's previous FL-2 dated 06/23/20 revealed diagnoses that included a history of acute hypoxemic respiratory failure (03/10/20)(respiratory failure with low oxygen to the brain), history of acute on chronic systolic heart failure (03/10/20)(inadequate heart function), history of pleural effusion (03/10/20) (collapsed lungs), and a history of encephalopathy (03/10/20)(swelling of the brain).

Review of Resident #2's most recent PCP visit notes dated 05/19/21 and 05/26/21 revealed:
-The resident had an active problem list of acute on chronic systolic (congestive) heart failure and unspecified edema.
-The resident had a past medical history that included acute respiratory failure with hypoxia, pleural effusion, alcoholic cirrhosis of the liver with ascites, and gastric ulcers with surgical treatment.

a.Review of Resident #2's primary care provider (PCP) visit notes dated 05/19/21 and 05/26/21 revealed:
-He was seen by the PCP for edema and neck pain.
-The resident complained of heart trouble, swelling, trouble sleeping, headaches, and balance issues.
-He had a history of heart failure, respiratory failure, and hospitalization on a ventilator for an extended period of time.
-He had 1+ nonpitting edema in his bilateral lower extremities (swelling of the lower legs, ankles,

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and feet).
-He required routine PCP visits for chronic disease management.
-The plan of care was to avoid fluid overload.
-There was an order to monitor daily weights and notify the PCP of a weight gain or loss of 5 pounds or more in a 72-hour period.

Observation of Resident #2's lower extremities on 07/14/21 at 11:27am revealed there was mild 1+ swelling of the ankles and feet noted.

Review of Resident #2's record revealed there were no daily weights documented or completed.

Interview with Resident #2 on 07/14/21 at 11:27am revealed:
-The staff at the facility did not weigh him daily.
-He wore his compression stockings when needed due to swelling in his feet.
-The swelling in his feet was not bad or painful that day, so he did not need his compression stockings.
-He was seeing physical therapy and performing the daily exercises they taught him.

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was no entry to obtain daily weights for Resident #2.
-There were no weights documented for Resident #2 during May 2021.

Review of Resident #2's June 2021 eMAR revealed:
-There was no entry to obtain daily weights for Resident #2.
-There were no weights documented for Resident #2 during June 2021.

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D 276	Continued From page 3 Review of Resident #2's July 2021 eMAR revealed: -There was no entry to obtain daily weights for Resident #2. -There were no weights documented for Resident #2 during July 2021. Interview with a medication aide (MA) on 07/14/21 at 12:41pm revealed: -The MAs were responsible to obtain and document resident weights. -All resident weights were done within the first five days of the month and documented on the eMAR. -Resident #2's daily weights had not been obtained because she and the other MAs were unaware of an order to do so. -There was no order in the facility's computer system to notify staff of the daily weight task on Resident #2's eMAR. Interview with the facility's contracted pharmacy on 07/15/21 at 9:26am revealed there was no order on file for Resident #2 to receive daily weights. Interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm revealed: -It was her responsibility to read Resident #2's PCP visit notes and fax his orders to the pharmacy. -She had missed the order for daily weights in Resident #2's PCP visit notes. -She had not faxed the order to the pharmacy because she had been unaware of the order. -She was not sure why the order for daily weights was not on Resident #2's eMAR. Interview with the Administrator on 07/14/21 at 2:24pm revealed:	D 276		

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D 276	Continued From page 4 -She was not aware Resident #2 had orders for daily weights until it had been brought to her attention today (07/14/21). -Resident #2 was not receiving daily weights as ordered because the orders had not been faxed to the pharmacy to be placed on his eMAR. -She was unsure why Resident #2's orders had not been processed and implemented as expected. Interview with Resident #2's PCP on 07/14/21 at 1:46pm revealed: -She was not aware that Resident #2's orders for daily weights had not been implemented and carried out. -She ordered daily weights for Resident #2 to monitor the resident due to his past medical history. -She was worried about Resident #2's edema and his risk for being in fluid overload. -If the resident had ended up with fluid overload, he would have been at risk for respiratory issues and shortness of breath. -The resident was also at risk of elevated blood pressures which could have led to kidney disease or stroke; the resident also had a history of kidney issues which concerned her. -She expected the facility to implement and carry out her orders as written and notify her of the results. Daily weight documentation during May, June, and July 2021 for Resident #2 was requested from the facility on 07/13/21 and 07/14/21 but was not provided prior to exit. Refer to interview with a MA on 07/14/21 at 12:41pm. Refer to interview with the RCC on 07/14/21 at	D 276		

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D 276	Continued From page 5 3:11pm. Refer to interview with the Administrator on 07/14/21. b. Review of Resident #2's current FL-2 dated 04/15/21 revealed: -There was an order to obtain monthly blood pressures. -There was an order for Nadolol 20mg once daily (a medication commonly used to treat high blood pressure and heart pain). Review of Resident #2's PCP visit notes dated 05/19/21 and 05/26/21 revealed a plan of care to screen the resident for high blood pressure and have follow-up documented. Review of Resident #2 current physician orders dated 06/30/21 revealed: -There was an order to obtain vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) monthly on the 7th day of the month between 7:00am and 3:00pm. -There was an order for Nadolol 20mg once daily (A medication used to control blood pressure). Interview with Resident #2 on 07/14/21 at 11:27am revealed: -The only thing the staff obtained on him were daily temperatures. -The staff did not check his heart rate, blood pressure, oxygen saturations, or respiratory rate on a monthly basis. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was no entry to obtain monthly vital signs	D 276		

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(heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) for Resident #2.
-There were no vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) documented for Resident #2 during May 2021 except for daily temperatures for COVID-19 precaution screening.

Review of Resident #2's June 2021 eMAR revealed:
-There was no entry to obtain monthly vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) for Resident #2.
-There were no vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) documented for Resident #2 during June 2021 except for daily temperatures for COVID-19 precaution screening.

Review of Resident #2's July 2021 eMAR revealed:
-There was no entry to obtain monthly vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) for Resident #2.
-There were no vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) documented for Resident #2 during July 2021 except for daily temperatures for COVID-19 precaution screening.

Review of Resident #2's vital sign report dated 06/01/21 - 07/13/21 revealed there were daily temperatures documented on the resident, but no other vital signs (heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation) had been obtained.

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D 276	Continued From page 7 Interview with a medication aide (MA) on 07/14/21 at 12:41pm revealed: -The MAs were responsible to obtain and document resident vital signs. -All resident vital signs were done within the first five days of the month and documented on the eMAR. -Resident #2's vital signs were not obtained because she and the other MAs were unaware of an order to do so. -There was no order on the residents eMAR to notify them of the task. Interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm revealed: -She was unsure if Resident #2's FL-2 with the order for monthly blood pressures had been faxed to the pharmacy. -She was unsure why the order for Resident #2's vital signs were not showing up on his eMAR. Interview with the Administrator on 07/14/21 at 2:24pm revealed: -Resident #2 was not receiving monthly blood pressures/vital signs as ordered because the orders had not been faxed to the pharmacy yet. -She was not aware Resident #2 had orders for monthly blood pressures/vital signs until it had been brought to her attention today, 07/14/21. Interview with Resident #2's PCP on 07/14/21 at 1:46pm revealed: -She was not aware Resident #2's orders for monthly blood pressures/vital signs had not been implemented and carried out. -She ordered monthly blood pressures/vital signs to monitor the resident due to his past medical history. -She was worried about Resident #2's edema and his risk for being in fluid overload.	D 276		

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-If the resident had ended up with fluid overload, he would have been at risk for respiratory issues and shortness of breath.
-The resident was also at risk of elevated blood pressures which could have led to kidney disease or stroke in severe cases; the resident also had a history of kidney issues which concerned her.
-She expected the facility to implement and carry out her orders as written and notify her of the results.

A request for monthly vital sign documentation to include blood pressure monitoring during May, June, and July 2021 for Resident #2 on 07/13/21 and 07/14/21 but was not provided prior to exit.

Refer to interview with a MA on 07/14/21 at 12:41pm.

Refer to interview with the RCC on 07/14/21 at 3:11pm.

Refer to interview with the Administration on 07/14/21 at 2:24pm.

2. Review of Resident #5's current FL-2 dated 01/26/21 revealed:
-Diagnoses included memory loss, diabetes mellitus, osteoarthritis, diverticulosis, and spleen artery aneurysm (a bulging weak spot in the blood vessel that could burst causing internal bleeding).
-She was ambulatory and was incontinent of bladder and bowel.

Review of Resident #5's current assessment and care plan dated 07/13/21 revealed:
-The resident required Licensed Health Professional Support (LHPS) tasks for collecting and test of fingerstick blood sugar (FSBS) samples.

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D 276	Continued From page 9 -The resident required LHPS tasks for administration of medication through injection. Review of Resident #5's physician orders dated 01/26/21 revealed: -There was an order to obtain a FSBS on the resident every day at 7:00am. -There were no parameters attached to the order regarding the results of the FSBS. Review of Resident #5's physician orders dated 06/30/21 revealed: -There was an order to obtain a FSBS on the resident every day at 7:00am. -There were no parameters attached to the order regarding the results of the FSBS. Review of Resident #5's pharmacy consultation report dated 04/06/21 revealed: -It was documented that the resident had an order for FSBS without parameters to notify the prescriber of abnormally high or low blood glucose occurred. -It was recommended to contact the prescriber to clarify FSBS parameters. -There was a handwritten order from the primary care provider (PCP) on the pharmacy consultation report dated 05/26/21 to call the PCP for a FSBS less than 60 or greater than 400. Review of Resident #5's June 2021 electronic medication administration record (eMAR) revealed: -There was an order to obtain the residents FSBS daily at 7:00am with no parameters. -There was an entry on 06/27/21 with a FSBS documented of 413. -There was an entry on 06/28/21 with a FSBS documented of 447. -There was an entry on 06/30/21 with a FSBS	D 276		

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documented of 447.
-There was no documentation that Resident #5's PCP was notified of the FSBS great than 400 on 06/27/21, 06/28/21, or 06/30/21 on the eMAR.

Review of Resident #5's July 2021 eMAR revealed:
-There was an order to obtain the residents FSBS daily at 7:00am with no parameters.
-There was an entry on 07/06/21 with a FSBS documented of 505.
-There was an entry on 07/07/21 with a FSBS documented of 511.
-There was no documentation that Resident #5's PCP was notified of the FSBS great than 400mg/dl on 07/07/21 eMAR.

Review of a physician communication sheet dated 07/07/21 revealed:
-Resident #5's PCP was notified of a FSBS that day of 511.
-There was a handwritten order asking if Resident #5's Lantus had been increased as ordered.

Review of Resident #5's laboratory results dated 04/15/21 revealed:
-The resident had a blood sugar of 465 which was documented as out of range and had to be repeated to confirm the value because it was high.
-The resident had a Hemoglobin A1C (a blood test that measures average blood sugars over a three-month period to evaluate treatment and management of blood sugars in people with diabetes) result of 11.7.
-It was documented that the normal range for Resident #5's Hemoglobin A1C should have been between 4 and 6.

Review of a PCP visit note dated 06/30/21

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revealed Resident #5's labs dated 04/15/21 were reviewed by the PCP and it was documented Resident #5's Hemoglobin A1C goal should be less than 7.

Interview with a medication aide (MA) on 07/14/21 at 12:41pm revealed:
-There was an order to obtain FSBS on Resident #5 every morning because the resident was a diabetic.
-There were no special instructions or parameters attached to Resident #5's FSBS order.
-She did not know Resident #5 had a parameter order for her daily FSBS.

Interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm revealed:
-She was aware that Resident #5 had FSBS parameter orders and assumed they had been faxed to the pharmacy.
-She did not have a way to confirm Resident #5's FSBS parameter orders had been faxed to the pharmacy and did not realized they were not showing up on the eMAR.
-It was her responsibility to ensure the orders had been faxed and verify they were on the eMAR.
-She did not realize she had overlooked Resident #5's FSBS parameter orders.

Interview with the Administrator on 07/14/21 at 2:24pm revealed:
-She was acting as the MA on 06/27/21, 06/28/21, and 06/30/21 when Resident #5 had FSBS greater than 400 and did not notify the resident's PCP of the increased FSBS because she did not stop what she was doing to fax the information to the PCP.
-She was also the acting MA on 07/06/21 and 07/07/21 when the PCP had been notified by her that Resident #5 had FSBS over 500.

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D 276	Continued From page 12 -She only notified the PCP on 07/06/21 because she felt it was good practice, not because she knew about the FSBS parameter order. -She did not know Resident #5 had a parameter order that was supposed to be attached to the daily FSBS order. -Resident #5 did not have any FSBS parameter orders on her eMAR and staff would not know to notify the PCP of FSBS parameters unless they were able to see the order. -She was not sure if Resident #5's FSBS order had been faxed to the pharmacy or why it was not on the eMAR. Interview with Residents #5's PCP on 07/14/21 at 1:46pm revealed: -She had been monitoring Resident #5's FSBS and was trying to get them under control for the last six months. -She was not aware that the order to add parameters to Resident #5's daily FSBS order had not been implemented. -She had not been notified that Resident #5 had increased blood sugars on 06/27/21, 06/28/21, or 06/30/21. -She expected the facility to implement and carry out her orders as written and for the FSBS parameter order to show up on Resident #5's eMAR so staff knew when to do when the resident's FSBS were out of range. -She expected to be notified of Resident #5's FSBS results that were out of range because she needed to be able to increase the resident's insulin appropriately in response. -Resident #5 was at increased risk of kidney and ophthalmic complications due to prolonged increase of her FSBS which was why she was trying to manage them and get them under control.	D 276		

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D 276	Continued From page 13 A request was made for physician communication sheets to notify the PCP of Resident #5's increased FSBS on 06/27/21, 06/28/21, and 06/30/21 but were not provided prior to exit. Refer to interview with a MA on 07/14/21 at 12:41pm. Refer to interview with the RCC on 07/14/21 at 3:11pm. Refer to interview with the Administrator on 07/14/21 at 2:24pm. _____ Interview with a MA on 07/14/21 at 12:41pm revealed: -The RCC was responsible for reading resident PCP visit notes, reviewing all orders, and ensuring implementation of new orders for residents. -When a resident received a new order, it was the responsibility of the MAs, the Resident Care Coordinator (RCC), the facility nurse, the business office manager (BOM), or the Administrator (whomever saw the order first) to fax the order to the pharmacy so that it would be placed on the resident's eMAR. -The pharmacy fax line was available 24/7 and would process all new orders on the same day if received by 11:00am. -After every fax, facility staff would call the pharmacy to ensure the fax had been received but there was no system in place to verify or track this practice. -It was important to implement and carry out PCP orders to ensure the resident received proper care. Interview with the RCC on 07/14/21 at 3:11pm	D 276		

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D 276	Continued From page 14 revealed: -It was her responsibility to process orders from PCP visit notes, FL-2s, and verbal orders. -It was her responsibility to read Resident #2's PCP visit notes and fax his orders to the pharmacy. -She began her position on 05/17/21. -She was working on a process to ensure orders did not go overlooked and ensure implementation of orders were followed through. -It was concerning that residents had not received ordered treatments as prescribed by their PCP because if it was not important to their health, the PCP would not have written the order. -She was unsure why resident orders had been overlooked but they should have been implemented. Interview with the Administrator on 07/14/21 at 2:24pm revealed: -The RCC was expected to read, process, and implement resident notes and orders. -When an order was received, she expected the RCC to fax the order to the pharmacy immediately, or within 24 hours of receiving the order. -The RCC was responsible to ensure orders had been faxed to the pharmacy and verify that they had been placed on the eMAR. -She was unsure why orders had not been processed and implemented as expected. -It was a major concern for residents to not receive care as ordered by their PCP. -They were still working on a process and audit system to ensure all orders were processed and implemented without being missed.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 15 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 11 residents (#6, #7) observed during the medication pass including errors with a heart medication (#6) and a blood pressure medication with parameters (#7), and record review for 1 of 5 sampled residents' with missed medications (#2) prescribed to the resident to control blood pressure and edema, insomnia medication, and vitamin supplementation, as well as the administration of discontinued medications (#2) for insomnia. The findings are: 1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am/9:00am medication passes on 07/13/21 and 07/14/21. a. Review of Resident #6's current FL-2 dated 01/20/21 revealed diagnoses included hypertension, coronary artery disease, chronic kidney disease, reflux, tremors, hypothyroidism, and major depressive disorder.	D 358		

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D 358	Continued From page 16 Review of a physician's order for Resident #6 dated 07/01/21 revealed a physician's order for Imdur ER (used to treat pain associated with heart disorders) 30mg tablet daily. Observation of the 9:00am medication pass on 07/13/21 at 9:08am revealed: -The Executive Director (ED) was the medication aide (MA). -She prepared to administer six medications to Resident #6. -The MA entered Resident #6's room and administered the cup of six medications to Resident #6. -There was no Imdur 30mg tablet prepared or administered to Resident #6, which would have been a total of seven tablets administered. Review of Resident #6's July 2021 electronic medication administration records (eMARS) revealed: -There was a printed entry for isosorbide mononitrate (generic for Imdur) tablet extended release 24-hour 30mg tablet every day scheduled for administration at 8:00am with a start date of 07/01/21 and end date of 07/07/21. -There was a second printed entry for isosorbide mononitrate tablet extended release 24-hour 30mg tablet every day scheduled for administration at 9:00am with a start date of 07/08/21 and no end date. -There was no documentation of administration for the isosorbide mononitrate 30mg tablet from 07/02/21 through 07/13/21. -The MAs initialed the eMAR and documented the isosorbide mononitrate was "not administered: drug/item unavailable" beginning 07/03/21 through 07/13/21.	D 358		

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D 358	Continued From page 17 Interview with the Executive Director (ED) on 07/13/21 at 11:15am revealed: -If the MAs initials were in parenthesis, it meant the medication was not administered. -The isosorbide mononitrate was not available in the facility for administration. -She and facility staff had been communicating with Resident #6's physician and pharmacy provider trying to obtain the isosorbide mononitrate for administration to Resident #6. -The Resident Care Coordinator (RCC) was "working on the order". -The RCC was responsible for scanning physician orders into the eMAR system. Interview with a second MA on 07/13/21 at 2:05pm revealed: -Resident #6 had a physician's appointment at the cardiologist office on 07/01/21. -The resident returned with a new order for isosorbide. -The staff transporting the resident to the appointment told her the physician's office was going to send the order for the isosorbide to Resident #6's provider pharmacy. -When the facility realized the isosorbide was not in the facility to administer to Resident #6, the RCC was contacted and instructed the MA to call the pharmacy for follow up. -The pharmacy told the MA the medication was not in the pharmacy. -The MA contacted the cardiologist office on 07/07/21 and was told by the physician's office staff the prescription would be faxed to the pharmacy. -She documented her contact with the cardiologist in Resident #6's notes. -The RCC or any MA that was aware a resident's medication was not in the facility, was responsible for contacting the pharmacy to follow up on the	D 358		

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D 358	Continued From page 18 medication needed. Interview with the RCC on 07/13/21 at 2:30pm revealed: -She received the cardiologist office visit report which documented the order for isosorbide for Resident #6 on 07/01/21. -She saw the physician's order documented on the office visit report. -She did not send the visit report order to the resident's pharmacy because she thought the physician had electronically sent the medication order to the pharmacy. -She faxed the cardiologist visit report order to the contracted provider pharmacy so the order could be transcribed to Resident #6's eMARs. -Resident #6's medications were not provided by the facility contracted pharmacy because the resident had selected another pharmacy to provide her medications. -She contacted the cardiologist office on 07/07/21 about the order for Resident #6's isosorbide. Second interview with the RCC on 07/13/21 at 2:51pm revealed: -She received the physician visit reports when a resident returned from a physician visit. -If she was not in the facility, the transportation person or the MA faxed the physician visit report to the contracted provider pharmacy so new orders could be added to the eMARs. -The transportation person or MA was supposed to put the original document in her (RCC) mailbox located in the medication room. -She retrieved the office visit report from her mailbox and took them to her office until the documents were filed after she or the ED approved any new orders that were entered to the eMAR by the contracted provider pharmacy from the office visit reports.	D 358		

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-She and the ED were the only staff who approved new orders in the eMAR computer system.

Interview with the ED on 07/13/21 at 3:00pm revealed she did not know why the facility copy of the physician's order for Resident #6's Imdur (brand name for isosorbide mononitrate) dated 07/01/21 was not sent to the resident's pharmacy.

Second interview with the ED on 07/13/21 at 4:30pm revealed:
-She was concerned the 07/01/21 copy of the isosorbide mononitrate order was not sent to Resident #6's pharmacy.
-The facility copy of the order was sent to the pharmacy today (07/13/21) and the medication should be in the facility on 07/13/21.

Interview with Resident #6 on 07/13/21 at 3:20pm revealed:
-She went to an appointment with the Cardiologist on 07/01/21 for a check-up.
-She still did not have the "new medicine" that was ordered on 07/01/21.
-She talked to the RCC about the medicine on Saturday (07/10/21), and the RCC was trying to contact the physician about the medicine.
-She was supposed to return to the cardiologist office on 07/16/21 for a "stress test".
-She had been feeling sick to her stomach in the morning, but after she ate, she felt better.

Interview with Resident #6 on 07/14/21 at 8:12am revealed:
-She was feeling sick to her stomach.
-She had a pain on her left side under her breast last night that "just hurt, then it went away".

Interview with the Transporter on 07/14/21 at

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D 358	Continued From page 20 9:05am revealed: -She transported Resident #6 to an appointment with the cardiologist on 07/01/21 which the resident told her about. -She went to Resident #6's contracted pharmacy on 07/13/21 with the facility 07/01/21 paper copy of the isosorbide mononitrate (Imdur) order and was told by the pharmacy that the medication could not be filled from the paper copy order. When she returned to the facility, Resident #6's contracted pharmacy called and informed the facility that the medication was ready for pickup. -She thought the ED picked up the medication [isosorbide mononitrate] from Resident #6's contracted pharmacy. Observation of the isosorbide mononitrate on hand for Resident #6 on 07/14/21 at 11:15am revealed: -There was a pharmacy printed label for isosorbide mononitrate ER 30mg tablet once daily, quantity 90. -The original prescription date on the pharmacy printed label was 07/07/21. -There were 89 tablets remaining. Interview with the ED on 07/15/21 at 8:51am revealed: -When Resident #6 returned from the cardiologist visit on 07/01/21, the resident mentioned to her that the physician was adding a medication. -She told the resident that the "paperwork" would be checked for that. -The Transporter told the ED the physician said the prescription would be called to Resident #6's provider pharmacy. -She remembered talking to Resident #6's provider pharmacy on 07/13/21 about the isosorbide mononitrate and was informed the prescription was there and had been there for	D 358		

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seven days waiting for pick up.
-She went to the pharmacy and picked up the isosorbide mononitrate prescribed for Resident #6.
-If a medication was listed on a resident's eMAR and not in the facility, she expected the facility to call the pharmacy to try and locate the medication and to contact the physician for assistance.
-She was not aware of a backup pharmacy process for obtaining resident medications.
-The facility was responsible to make sure resident medications were available in the facility for administration.
-She expected resident medications to be in the facility within 24 hours of receiving knowledge of a medication ordered.
-The MAs were responsible for tracking medications to ensure medications were in the facility.
-The MAs were to involve the RCC if there were delays in getting resident medications in the facility.

Telephone interview with the nurse at the cardiologist office on 07/15/21 at 9:25am revealed:
-Resident #6 was seen by the cardiologist on 07/01/21.
-She sent the prescription for Imdur (isosorbide mononitrate) to Resident #6's contracted pharmacy on 07/07/21.
-The physician "normally" sent the prescription to the pharmacy electronically.
-She was not sure why there was a 6-day delay in transmitting the prescription to the pharmacy.
-The physician wanted Resident #6's target blood pressure to be less than 130/80.
-Resident #6's office blood pressure reading was 132/84.

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D 358	Continued From page 22 b. Review of Resident #7's current FL-2 dated 08/20/20 revealed a diagnosis of hypertension (high blood pressure). Review of the physician's orders for Resident #7 listed on the 08/20/20 FL-2 revealed a physician's order for amlodipine (used to treat high blood pressure) 5mg tablet daily. Review of a physician's order for Resident #7 dated 06/30/21 revealed there was a printed order for amlodipine 5mg tablet every day hold if blood pressure less than 120. Observation of the medication pass on 07/14/21 8:17am revealed: -The Executive Director (ED) was the medication aide (MA). -She prepared to administer four medications to Resident #7, including amlodipine besylate 10mg tablet. -The MA entered Resident #7's room and administered the cup of four medications to Resident #7. -The MA did not check Resident #7's blood pressure before administering the amlodipine 10mg tablet. Review of the July 2021 electronic medication administration records (eMARs) for Resident #7 revealed: -There was an entry for amlodipine 5mg tablet every day with special instructions to take one tablet every day and hold if blood pressure less than 120. -There were no blood pressure readings documented on the eMARs. Interview with Resident #7 on 07/14/21 at 9:30am revealed:	D 358		

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D 358	Continued From page 23 -Staff checked her blood pressure "every once in a while" (she could not define "every once in a while"). -She did not remember the last time staff had checked her blood pressure. -Her blood pressure was not checked on the morning of 07/14/21. Interview with the ED on 07/14/21 at 9:35am revealed: -Resident #7's blood pressure was checked monthly. -She was not aware of the printed instructions on the eMARs requiring a blood pressure check daily for Resident #7 and to hold the amlodipine if the blood pressure was less than 120. Interview with the ED on 07/14/21 at 9:45am revealed: -Resident #7's blood pressure reading was 108/56 with a wrist blood pressure cuff. -She (ED) was going to call the PCP. Interview with a second MA on 07/15/21 at 11:10am revealed: -She checked Resident #7's blood pressure monthly. -She had never checked Resident #7's blood pressure prior to administering the amlodipine. Interview with Resident #7's Primary Care Provider (PCP) on 07/14/21 at 2:03pm revealed: -Resident #7's blood pressure should have been checked before staff administered amlodipine. -She was not aware the facility was not checking Resident #7's blood pressure before administering amlodipine. -Resident #7 had been prescribed amlodipine for at least a year and she (PCP) had not received any reports of the resident having a drop in her	D 358		

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blood pressure.
-She (PCP) checked the resident's blood pressure when she visited on 06/30/21 and Resident #7's blood pressure was 138/79.
-She did not review resident eMARs every time she came to see the residents.

Telephone interview with a representative from the facility's contracted pharmacy on 07/15/21 at 11:00am revealed:
-There was a physician's order in the pharmacy profile dated 01/21/21 for amlodipine 5mg tablet daily and hold if systolic blood pressure was less than 120.
-There had not been any change in the amlodipine physician's order for Resident #7 since 01/21/21.
-He would be concerned if the resident was being administered the blood pressure medication and the blood pressure was not being checked.
2. Review of Resident #2's current FL-2 dated 04/15/21 revealed:
-Diagnoses included gastrointestinal reflux disorder (GERD), constipation, insomnia, hypertension, and vitamin D deficiency.
-The resident was intermittently disoriented, required assistance with dressing, and was ambulatory.

Review of Resident #2's previous FL-2 dated 06/23/20 revealed diagnoses that included a history of acute hypoxemic respiratory failure (03/10/20)(respiratory failure with low oxygen to the brain), history of acute on chronic systolic heart failure (03/10/20)(inadequate heart function), history of pleural effusion (03/10/20) (collapsed lungs), and a history of encephalopathy (03/10/20)(swelling of the brain).

Review of Resident #2's most recent PCP visit

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notes dated 05/19/21 and 05/26/21 revealed:
-The resident had an active problem list of acute on chronic systolic (congestive) heart failure and unspecified edema.
-The resident had a past medical history that included acute respiratory failure with hypoxia, alcoholic cirrhosis of the liver with ascites, and gastric ulcers with surgical treatment.
-The resident was seen on these visits for edema, neck pain, and difficulty sleeping.

a. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for Nadolol 20mg once daily. (Nadolol is commonly used to treat high blood pressure.)

Review of Resident #2's physician order form dated 06/30/21 revealed there was an order for Nadolol 20mg once daily at 8:00am.

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Nadolol 20mg daily at 8:00am.
-Nadolol was documented as administered once daily at 8:00am, except on 05/11/21 and 05/13/21-05/22/21.
-There was documentation that the dose on 05/11/21 was not administered due to not being available.
-There was documentation that the doses on 05/13/21-05/22/21 were not administered due to waiting on verification/clarification/being discontinued.
-Resident #2 did not receive his Nadolol 20mg daily as ordered for 11 out of 31 opportunities in May 2021.

Review of Resident #2's June 2021 eMAR

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D 358	Continued From page 26 revealed: -There was an entry for Nadolol 20mg daily at 8:00am. -Nadolol was documented as administered once daily at 8:00am, except on 06/07/21-06/09/21 and 06/11/21-06/17/21. -There was documentation that the doses on 06/07/21-06/09/21 and 06/11/21-06/17/21 were not administered due to not being available/being discontinued. -Resident #2 did not receive his Nadolol 20mg daily as ordered for 11 out of 30 opportunities in June 2021. Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there were 29 of 30 nadolol 20mg tablets remaining that were filled by the pharmacy on 07/10/21. Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed: -She was not sure how Resident #2 received any nadolol in May 2021 because there were payment issues with insurance, and they had not filled the medication during that month for the resident. -A prior authorization for the medication on behalf of Resident #2 was sent to his PCP on 04/30/21, 05/11/21, and again 05/27/21 to get the medication approved for payment to fill it. -The pharmacy was able to approve and fill the nadolol medication on 06/09/21 for a supply of 6 doses and again on 06/15/21 for a supply of 30 doses. -There should be no reason Resident #2 did not receive his Nadolol after 06/08/21. Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed:	D 358		

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D 358	Continued From page 27 -Resident #2 was receiving nadolol for the treatment of high blood pressure and prophylaxis of varices (abnormal veins in the lower part of the stomach running from the throat to the stomach in people with advanced liver disease). -The risk of not receiving nadolol as ordered for blood pressure could lead to higher blood pressures which could cause a stroke or heart attack. -The risk of not receiving nadolol for prophylaxis of varices as ordered could lead to increased internal bleeding of the stomach, esophagus, or liver. Refer to interview with Resident #2 on 07/14/21 at 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am.	D 358		

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D 358	Continued From page 28 Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. b. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for Protonix 40mg every 12 hours. (Protonix is used to treat gastroesophageal reflux disorder (GERD) and damaged stomach/esophagus lining.) Review of Resident #2's physician's order form dated 06/30/21 revealed there was an order for Protonix 40mg every 12 hours. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Protonix 40mg every 12 hours at 8:00am and 8:00pm. -Protonix was documented as administered daily at 8:00am, except on 05/15/21, 05/19/21, 05/20/21, 05/26/21, 05/29/21, and 05/30/21. -Protonix was documented as administered daily at 8:00pm, except on 05/14/21, 05/15/21, 05/17/21-05/20/21, 05/22/21, 05/23/21, and 05/25/21-05/31/21. -There was documentation the doses of Protonix not administered were due to being discontinued. -Resident #2 did not receive Protonix as ordered for 21 out of 62 opportunities in May 2021. Review of Resident #2's June 2021 eMAR revealed: -There was an entry for Protonix 40mg every 12 hours at 8:00am and 8:00pm. -Protonix was documented as administered once	D 358		

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daily at 8:00am, except on 06/01/21, 06/03/21, 06/06/21-06/19/21, 06/21/21, and 06/22/21.
-Protonix was documented at administered once daily at 8:00pm, except on 06/01/21-06/03/21, 06/05/21-06/18/21, 06/20/21, and 06/21/21.
-There was documentation the doses of Protonix not administered were due to either being on hold or discontinued.
-Resident #2 did not receive Protonix as ordered for 37 out of 60 opportunities in June 2021.

Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there were 17 of 30 Protonix 40mg tablets remaining that were filled by the pharmacy on 03/23/21.

Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed:
-Resident #2's Protonix had been requested to be filled by the pharmacy every month in 2021 except May.
-She was not sure why the facility did not request a refill for Resident #2's Protonix in May 2021 as there were no issues with filling the medication for the resident when needed and the order remained active.
-Each month the facility was provided with a 1-month supply of 60 doses of Protonix when requested for Resident #2.
-The facility last requested refills of Resident #2's Protonix on 04/26/21 and 06/18/21.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed that Resident #2 not receiving his Protonix as ordered would have increased his symptoms of GERD, heartburn, and esophageal reflux.

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D 358	Continued From page 30 Refer to interview with Resident #2 on 07/14/21 at 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. c. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for Seroquel 50mg every evening. (Seroquel is commonly used to treat insomnia.) Review of Resident #2's physician order form	D 358		

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dated 06/30/21 reveled there was an order for Seroquel 50mg every evening at 5:00pm.

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 50mg every evening at 5:00pm.
-Seroquel was documented as administered daily at 5:00pm, except on 05/07/21 and 05/11/21-05/17/21.
-There was documentation the doses of Seroquel not administered were due to being discontinued.
-Resident #2 did not receive Seroquel as ordered for 8 out of 30 opportunities for May 2021.

Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there were 6 of 7 doses Seroquel 50mg tablets remaining that were filled by the pharmacy on 07/13/21.

Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed:
-Resident #2's Seroquel was automatically filled by the pharmacy every week in May 2021 as a 7-day supply on 05/08/21, 05/15/21, 05/22/21, and 05/29/21.
-She was not sure why Resident #2 missed any doses of his Seroquel in May 2021 because the facility had the medication for him on hand.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed:
-Resident #2 was receiving Seroquel to help with insomnia.
-Not receiving the Seroquel as ordered would lead to increased insomnia and trouble sleeping.

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D 358	Continued From page 32 Refer to interview with Resident #2 on 07/14/21 at 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. d. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for magnesium oxide 400mg every night before bed. (Magnesium oxide is commonly used as a vitamin replacement or to help treat insomnia.)	D 358		

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D 358	Continued From page 33 Review of Resident #2's physician order form dated 06/30/21 reveled there was an order for magnesium oxide 400mg every night before bed at 8:00pm. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for magnesium oxide 400mg daily at 8:00pm. -Magnesium oxide was documented as administered daily at 8:00pm, except on 05/06/21, 05/07/21, 05/10/21, 05/12/21-05/14/21, 05/17/21-05/20/21, and 05/22/21-05/31/21. -There was documentation the doses of magnesium oxide not administered were due to being discontinued. -Resident #2 did not receive magnesium oxide as ordered for 20 out of 31 opportunities for May 2021. Review of Resident #2's June 2021 eMAR revealed: -There was an entry for magnesium oxide 400mg daily at 8:00pm. -Magnesium oxide was documented as administered once daily at 8:00pm, except on 06/01/21-06/03/21, 06/05/21 and 06/06/21. -There was documentation the doses of magnesium oxide not administered were due to being discontinued. -Resident #2 did not receive magnesium oxide as ordered for 5 out of 30 opportunities in June 2021. Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was a bottle of over the counter magnesium oxide 400mg tablets available for administration.	D 358		

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D 358	Continued From page 34 Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed: -There was no reason Resident #2 did not receive his magnesium oxide at any time during 05/01/21-05/26/21. -The magnesium oxide was included in a multi-dose package that was provided to the facility for Resident #2 on a weekly basis with a seven-day supply throughout the month of May 2021 with the last fill date being 05/19/21. -The pharmacy had received a note to stop filling the magnesium oxide for Resident #2 beginning 05/28/21 because his family member was going to begin providing it to the facility on his behalf thereafter. Interview with Resident #2's family member on 07/15/21 at 8:15pm revealed: -She began buying and sending all of Resident #2's over the counter vitamins and supplements sometime in May 2021, but she could not remember the exact date. -She mailed the package to Resident #2 at the facility, but they did not give it to him right away. -She had to tell Resident #2 to request the package so the facility would give it to him to open and he could give the medications to the MA. Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed that not receiving vitamin supplements as ordered could cause vitamin deficiency and symptoms such as fatigue, brittle bones, and feeling weaker than normal. Refer to interview with Resident #2 on 07/14/21 at 11:27am.	D 358		

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D 358	Continued From page 35 Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. e. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for vitamin D3 10mcg daily. (Vitamin D3 is a vitamin replacement commonly used to help strengthen bones, muscles, and immunity.) Review of Resident #2's physician's order form dated 06/30/21 reveled there was an order for vitamin D3 10mcg daily at 8:00am.	D 358		

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D 358	Continued From page 36 Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 10mcg daily at 8:00am. -Vitamin D3 was documented as administered daily at 8:00am, except on 05/13/21-05/16/21, 05/19/21-05/22/21, 05/25/21-05/27/21, and 05/30/21. -There was documentation the doses of vitamin D3 not administered were due to being discontinued. -Resident #2 did not receive vitamin D3 as ordered for 12 out of 31 opportunities for May 2021. Review of Resident #2's June 2021 eMAR revealed: -There was an entry for vitamin D3 10mcg daily at 8:00am. -Vitamin D3 was documented as administered once daily at 8:00am, except on 06/03/21 and 06/05/21-06/09/21. -There was documentation the doses of vitamin D3 not administered were due to being discontinued. -Resident #2 did not receive vitamin D3 as ordered for 6 out of 30 opportunities in June 2021. Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was a bottle of over the counter vitamin D3 10mcg tablets available for administration. Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed: -There was no reason Resident #2 did not	D 358		

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receive his Vitamin D3 at any time during 05/01/21-05/26/21.
-The vitamin D3 was included in a multi-dose package that was provided to the facility for Resident #2 on a weekly basis with a seven-day supply throughout the month of May 2021 with the last fill date being 05/19/21.
-The pharmacy had received a note to stop filling the vitamin D3 for Resident #2 beginning on 05/28/21 because the medication was going to be provided to the facility on his behalf via his family member thereafter.

Interview with Resident #2's family member on 07/15/21 at 8:15pm revealed:
-She began buying and sending all of Resident #2's over the counter vitamins and supplements sometime in May 2021, but she couldn't remember the exact date.
-She mailed the package to Resident #2 at the facility, but they did not give it to him right away.
-She had to tell Resident #2 to request the package so the facility would give it to him to open and he could give the medications to the MA.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed that not receiving vitamin supplements as ordered could cause vitamin deficiency and symptoms such as fatigue, brittle bones, and feeling weaker than normal.

Refer to interview with Resident #2 on 07/14/21 at 11:27am.

Refer to interview with Resident #2's family member on 07/15/21 at 8:15am.

Refer to interview with the county ombudsman on

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D 358	Continued From page 38 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. f. Review of Resident #2's physician order form dated 06/30/21 revealed there was an order for vitamin B1 100mg daily at 8:00am. (Vitamin B1 is commonly used to treat vitamin B1 deficiency which can result in fatigue, irritability, and physical ailments.) Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin B1 100mg daily at 8:00am. -Vitamin B1 was documented as administered	D 358		

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daily at 8:00am, except on 05/13/21-05/16/21, 05/19/21-05/22/21, 05/25/21-05/27/21, and 05/30/21.
-There was documentation the doses of vitamin B1 not administered were due to being discontinued.
-Resident #2 did not receive vitamin B1 as ordered for 12 out of 31 opportunities for May 2021.

Review of Resident #2's June 2021 eMAR revealed:
-There was an entry for vitamin B1 100mg daily at 8:00am.
-Vitamin B1 was documented as administered once daily at 8:00am, except on 06/05/21-06/09/21.
-There was documentation the doses of vitamin B1 not administered were due to being discontinued.
-Resident #2 did not receive vitamin B1 as ordered of 5 out of 30 opportunities in June 2021.

Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was a bottle of over the counter vitamin B1 tablets available for administration.

Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed:
-There was no reason Resident #2 did not receive his Vitamin B1 at any time during 05/01/21-05/26/21.
-The vitamin B1 was included in a multi-dose package that was provided to the facility for Resident #2 on a weekly basis with a seven-day supply throughout the month of May 2021 with the last fill date being 05/19/21.
-The pharmacy had received a note to stop filling

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the vitamin B1 for Resident #2 beginning on 05/28/21 because the medication was going to be provided to the facility on his behalf via his family member thereafter.

Interview with Resident #2's family member on 07/15/21 at 8:15pm revealed:
-She began buying and sending all of Resident #2's over the counter vitamins and supplements sometime in May 2021, but she could not remember the exact date.
-She mailed the package to Resident #2 at the facility, but they did not give it to him right away.
-She had to tell Resident #2 to request the package so the facility would give it to him to open and he could give the medications to the MA.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed that not receiving vitamin supplements as ordered could cause vitamin deficiency and symptoms such as fatigue, brittle bones, and feeling weaker than normal.

Refer to interview with Resident #2 on 07/14/21 at 11:27am.

Refer to interview with Resident #2's family member on 07/15/21 at 8:15am.

Refer to interview with the county ombudsman on 07/14/21 at 10:59am.

Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm.

Refer to interview with another MA on 07/15/21 at 10:40am.

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D 358	Continued From page 41 Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. g. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for thera-m tab 9mg iron-400mcg daily. (Thera-m is a multivitamin commonly used to replace vitamin deficiencies in the body.) Review of a handwritten physician's order for Resident #2 dated 05/28/21 revealed the PCP discontinued the thera-m and wrote a new order for centrum silver multivitamin 1 tablet daily. Review of Resident #2's physician's order form dated 06/30/21 reveled there was an order for thera-m tab 9mg iron-400mcg daily had been changed to centrum silver multivitamin 1 tablet every day at 8:00am. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for thera-m tab 9mg	D 358		

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iron-400mcg daily at 5:00pm.
-Thera-m was documented as administered daily at 5:00pm, except on 05/07/21, 05/10/21-05/16/21, 05/18/21-05/23/21, and 05/25/21-05/28/21.
-There was no entry to administer centrum silver multivitamin 1 tablet daily on the eMAR beginning 05/28/21 as ordered.
-There was documentation the doses of thera-m not administered were due to being discontinued.
-Resident #2 did not receive thera-m as ordered for 17 out of 27 opportunities for May 2021.
-Resident #2 did not receive centrum silver multivitamin at ordered for 4 out of 4 opportunities.

Review of Resident #2's June 2021 eMAR revealed:
-There was an entry for centrum silver multivitamin 1 tablet daily at 8:00am.
-Centrum silver multivitamin was documented as administered once daily at 8:00am, except on 06/01/21-06/17/21.
-There was no documentation why the doses of centrum silver multivitamin were not administered on the eMAR.
-Resident #2 did not receive centrum silver multivitamin as ordered for 17 out of 30 opportunities in June 2021.

Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was a bottle of over the counter centrum silver multivitamin tablets available for administration.

Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed:
-There were issues with the thera-m medication availability and the pharmacy was unable to fill

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the medication during May 2021.
-The pharmacy notified the facility of the issue via email at the beginning of May 2021 to get a different order for Resident #2 from his PCP, but they never received any communication back to fill his vitamin differently.
-The pharmacy received an order to discontinue the medication on 05/28/21 because the order was being changed to centrum silver multivitamin and Resident #2's family member would be providing the medication to the facility on his behalf thereafter.

Interview with Resident #2's family member on 07/15/21 at 8:15pm revealed:
-She began buying and sending all of Resident #2's over the counter vitamins and supplements sometime in May 2021, but she could not remember the exact date.
-She mailed the package to Resident #2 at the facility, but they did not give it to him right away.
-She had to tell Resident #2 to request the package so the facility would give it to him to open and give the medications to the MA.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed that not receiving vitamin supplements as ordered could cause vitamin deficiency and symptoms such as fatigue, brittle bones, and feeling weaker than normal.

Refer to interview with Resident #2 on 07/14/21 at 11:27am.

Refer to interview with Resident #2's family member on 07/15/21 at 8:15am.

Refer to interview with the county ombudsman on 07/14/21 at 10:59am.

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D 358	Continued From page 44 Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. h. Review of Resident #2's current FL-2 dated 04/15/21 revealed an order for melatonin 1mg every night at bedtime.(Melatonin is commonly used as a sleep aid for insomnia.) Review of a handwritten physician's order for Resident #2 dated 05/18/21 revealed the PCP discontinued the melatonin 1mg and wrote a new order for melatonin 5mg every night at bedtime. Review of Resident #2's physician's order form dated 06/30/21 reveled there was an order for melatonin 5mg every night at 8:00pm.	D 358		

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D 358	Continued From page 45 Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for melatonin 1mg daily at 8:00pm. -Melatonin 1mg was documented as administered daily at 8:00pm, even after the discontinuation order date on 05/21/21 and 05/22/21. -There was an entry for melatonin 5mg daily at 8:00pm. -Melatonin 5mg was not documented as administered on the May 2021 eMAR. -There was no documentation why the melatonin 1mg was given after the discontinuation date. -There was no documentation why the melatonin 5mg was not administered in May 2021. -Resident #2 received melatonin 1mg incorrectly after a discontinuation date of 05/18/21 twice in May 2021. -Resident #2 did not receive melatonin 5mg as ordered for 11 out of 11 opportunities. Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was a bottle of over the counter melatonin 5mg tablets available for administration. Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed: -Resident #2's melatonin order had been changed from 1mg to 5mg on 05/18/21. -Resident #2's melatonin 5mg was filled and sent to the facility on 05/19/21 for 13 doses. -There was no reason Resident #2 did not get his 5mg of melatonin as ordered starting 05/19/21. -There was no reason Resident #2 received the melatonin 1mg after being discontinued on 05/18/21.	D 358		

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D 358	Continued From page 46 Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed: -Resident #2 was receiving melatonin to aid with insomnia. -Not receiving the melatonin as ordered would lead to increased insomnia and trouble sleeping. Refer to interview with Resident #2 on 07/14/21 at 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am.	D 358		

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D 358	Continued From page 47 Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. i. Review of Resident #2's medication order dated 05/06/21 revealed there was an order for acetaminophen 500mg three times per day. (Acetaminophen is commonly used to treat mild pain.) Review of a physician's order for Resident #2 dated 05/28/21 revealed the PCP discontinued the acetaminophen 500mg three times per day. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen 500mg three times per day at 8:00am, 2:00pm, and 8:00pm. -Acetaminophen was documented as administered daily at 8:00am, except from 05/06/21-05/14/21. -Acetaminophen was documented as administered daily at 2:00pm, except from 05/06/21-05/16/21. -Acetaminophen was documented as administered daily at 8:00pm, except from 05/06/21-05/14/21. -There was no documentation why the doses of acetaminophen were not administered on 05/06/21-05/14/21. -There was documentation the doses of acetaminophen not administered on 05/15/21 were due to "other" reasons and on 05/16/21 due to drug not available/waiting to hear from doctor. -Resident #2 did not receive acetaminophen as ordered for 29 out of 63 opportunities for May 2021. Observation of medications on hand for Resident	D 358		

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D 358	Continued From page 48 #2 on 07/14/21 at 2:57pm revealed there was no acetaminophen 500mg tablets available for administration. Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed: -Resident #2's acetaminophen had payment and insurance issues on 05/06/21. -The pharmacy was able to resolve the payment and insurance issues for Resident #2's acetaminophen and fill the prescriptions for a 7-day supply that was delivered to the facility on 05/13/21, 05/20/21, and 05/27/21. -There was no reason for Resident #2 to miss doses of acetaminophen from 05/14/21-05/16/21. Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed: -Resident #2 was receiving acetaminophen for pain. -Not receiving the acetaminophen as ordered would have led to increased pain for the resident. Refer to interview with Resident #2 on 07/14/21 at 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am.	D 358		

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D 358	Continued From page 49 Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. j. Review of Resident #2's medication order dated 05/06/21 revealed there was an order for ibuprofen 800mg three times per day. (Ibuprofen is commonly used to treat pain.) Review of a handwritten physician's order for Resident #2 dated 05/28/21 revealed the PCP discontinued the ibuprofen 800mg three times per day. Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Ibuprofen 800mg three times per day at 8:00am, 2:00pm, and 8:00pm. -Ibuprofen was documented as administered daily at 8:00am, except from 05/06/21-05/14/21. -Ibuprofen was documented as administered daily at 2:00pm, except from 05/06/21-05/16/21. -Ibuprofen was documented as administered daily at 8:00pm, except from 05/06/21-05/13/21 and	D 358		

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05/15/21.
-There was no documentation why the doses of ibuprofen were not administered from 05/06/21-05/13/21.
-There was documentation the doses of ibuprofen not administered on 05/14/21 were due to being a new order, on 05/15/21 due to being "other" reasons, and on 05/16/21 due to the drug not available/waiting to hear from doctor.
-Resident #2 did not receive ibuprofen as ordered for 28 out of 63 opportunities for May 2021.

Observation of medications on hand for Resident #2 on 07/14/21 at 2:57pm revealed there was no ibuprofen 800mg tablets available for administration.

Interview with a pharmacy technician at the facility's contracted pharmacy on 07/15/21 at 9:26am revealed:
-Resident #2's ibuprofen was filled for a 7-day supply each week that was delivered to the facility on 05/06/21, 05/13/21, 05/20/21, and 05/27/21.
-There was no reason for Resident #2 to miss his doses of ibuprofen from 05/06/21-05/28/21.

Interview with a pharmacist from the facility's contracted pharmacy on 07/15/21 at 10:13am revealed:
-Resident #2 was receiving ibuprofen for pain.
-Not receiving the ibuprofen as ordered would have led to increased pain for the resident.
-Additionally, Resident #2 had been receiving naproxen (another medication used for pain similar to ibuprofen) scheduled for pain at the same time as the ibuprofen; receiving both medications could have led to increased blood pressure and gastric bleeding.

Refer to interview with Resident #2 on 07/14/21 at

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D 358	Continued From page 51 11:27am. Refer to interview with Resident #2's family member on 07/15/21 at 8:15am. Refer to interview with the county ombudsman on 07/14/21 at 10:59am. Refer to interview with a medication aide (MA) on 07/14/21 at 12:41pm. Refer to interview with another MA on 07/15/21 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/21 at 3:11pm. Refer to second interview with the RCC on 07/15/21 at 10:58am. Refer to interview with the Administrator on 07/14/21 at 2:24pm. Refer to second interview with the Administrator on 07/15/21 at 11:08am. Refer to interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am. Refer to interview with Resident #2's PCP on 07/14/21 at 1:46pm. _____ Interview with Resident #2 on 07/14/21 at 11:27am revealed: -There was a point in time that he was not receiving his medications as ordered and he had trouble sleeping and had been in pain. -Facility staff told him that he was not receiving	D 358		

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his medications as ordered because the pharmacy had not been sending his medications.
-He asked his family member for help with the issue and she contacted a "woman" (ombudsman) who helped resolve the issue with his medications.

Interview with Resident #2's family member on 07/15/21 at 8:15am revealed:
-She lived out of town but spoke with Resident #2 almost every day.
-Resident #2 complained of pain. All his pain medication had been taken away and she had to work with his primary care provider (PCP) to get something prescribed for him because no one at the facility did that for him.
-The facility was not giving Resident #2 his medications as ordered, and duplicated several pain medications due to him having two different doctors.
-She had a very difficult time communicating with the facility because none of the staff had any answers to her questions and would not return her phone calls regarding Resident #2.
-She had ultimately had to involve the county ombudsman regarding Resident #2's medications most recently to get a resolution to the issue.

Interview with county ombudsman on 07/14/21 at 10:59am revealed:
-She was aware that Resident #2 was not receiving his medications as ordered.
-Resident #2 told his family member that he had been in pain and knew he was not receiving all of his medications but did not know which ones he was not getting.
-Resident #2 had several medications that had not been administered and were documented as being not given, but none of the facility staff had followed up as to why the issue was happening

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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with a current order to administer the medications.
-She brought Resident #2's medication issues to the facility's attention in May 2021.
-The facility had not been aware of Resident #2's medication issues prior to her bringing it to their attention.

Interview with a medication aide (MA) on 07/14/21 at 12:41pm revealed:
-Her duties included passing medications, faxing pharmacy orders and checking pharmacy medication changes on the eMAR, writing progress notes on important resident information, documented in the resident record, and contacting the residents primary care provider (PCP) as needed.
-Resident #2 did not receive his medications as ordered due to miscommunication and review of previous documentation that had been incorrect.
-She was not sure why she or any other MAs did not verify Resident #2's orders prior to holding medications he had an active order for.
-She brought Resident #2's medication issues to the RCC's attention when the resident questioned whether he was getting all of his medications to her.
-Resident #2's medication orders were showing up correctly on his eMAR, but when staff tried to use the scanning device attached to the facility's computer system and eMAR to administer the medication, there was an error message stating that the medication had been discontinued, preventing the staff from administering and documententing the medication in the eMAR.
-Staff had been told to use the scanner in May 2020 which was when issues with Resident #2's mediation administration began.
-If staff did not use the scanners, they were able to administer Resident #2's medications correctly

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as ordered.
-Staff were no longer using the scanners in the facility currently due to the ongoing issue with them.
-She had been concerned about Resident #2's medication issues because he could have been overdosed or not gotten a medication he needed for his health issues.

Interview with another MA on 07/15/21 at 10:40am revealed:
-The facility had gotten behind on medication cart audits around the middle of May 2021.
-There was no formal process to ensure medications were stocked on the medication carts for residents as ordered.
-Beginning in the middle of May 2021, staff would just request refills daily when they realized a resident's medication was beginning to run low to ensure medications did not run out.
-To re-order a medication, staff would fax a reorder sticker for the medication to the pharmacy or call the pharmacy, then write a note in the resident's eMAR for the RCC to follow up on.
-Resident #2's medications were stocked and on the medication cart during the months of May 2021 and June 2021.
-Resident #2 did not receive his medications as order in May 2021 and June 2021 because there was confusion that the medications had mistakenly been discontinued when trying to use the scanner to administer medications.
-She was unaware that facility MAs were following previous staff's documentation and assuming the medications had been discontinued instead of investigating the accuracy of the order and resolving the issue, but it had been corrected in July 2021.
-The issue had to do with the orders not being

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D 358	Continued From page 55 accepted by the facility from the pharmacy correctly in the resident's eMAR which caused the scanner to become confused. -Facility staff had to stop using the scanners because of this issue because new orders had been rejected and old orders had remained causing the barcodes on the medications to not match the orders that appeared on the residents eMAR. -Staff reported the scanning issues to the supervisor in charge (SIC) and the previous RCC at the time. -When the new RCC came, the issue with scanners and medication administration began to get resolved. -By the time Resident #2 questioned whether he was receiving all of his medications accurately, she had reported the issue to the new RCC who was actively working on the problem with the resident's family member. -When a resident's family called, the MAs would try to assist the family member with any questions or concerns, then leave a message for the Administrator to call them back if she was unavailable at that time. -She had spoken to Resident #2's family member about his medication issues and left a message for the Administrator to call the family member back, but she could not remember when that had been. -There was no reason for Resident #2 to miss any of his medication doses in May and June 2021 because his medications had been in stock on the medication cart; the facility eMAR computer system was simply confusing. Interview with the RCC on 07/14/21 at 3:11pm revealed: -None of the MAs had reported issues with Resident #2's medications to her.	D 358		

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D 358	Continued From page 56 -She identified issues with Resident #2's medications when she noticed they had been documented as not administered and investigated what was going on. -She expected staff to report any issues about medications to her immediately. -She had been concerned that Resident #2 had not received his medications as ordered because he could have had high blood pressures or negative outcomes. -Resident #2's issues with his medications and orders should not have gone overlooked as long as they did during May 2021 and June 2021. Second interview with the RCC on 07/15/21 at 10:58am revealed: -She first noticed Resident #2 had not been receiving his medications as ordered from a facility activity report that she had run on 06/07/21. -None of the facility staff, Resident #2, or Resident #2's family member had brought Resident #2's medication issues from May 2021 or June 2021 to her attention prior to that date. -She had never spoken to Resident #2's family member prior to that morning on 07/15/21. -She had notified Resident #2's PCP of insurance and payment issues for Resident #2's medication on 05/11/21, but had not thought to notify the PCP of Resident #2's multiple missed doses of several medications from May or June 2021; she did not know why except she did not think about it. -There were medication scanner issues due to the previous RCC not accepting new and discontinuation pharmacy orders in the eMAR causing the barcode on the medication to not match the order showing in Resident #2's eMAR. -She was not sure why staff did not report the scanning issue to her or the Administrator sooner, but if they had it would have prevented Resident	D 358		

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D 358	Continued From page 57 #2 from missing his medication doses as ordered. Interview with the Administrator on 07/14/21 at 2:24pm revealed: -She was not sure why Resident #2 had not received his medications as ordered in May and June 2021. -She had been acting as an MA and passing medications since 06/07/21 and had been unaware of the issue until that time. -The facility had a different RCC who left in May 2021; she thought the RCC had been doing her job but found out later that she had not been following up with her on issues. -She was not sure why the MAs did not report the issues with Resident #2's medications to her if it had not been resolved in a timely manner with the previous RCC. -She expected staff to notify the her and the RCC immediately when there were issues with resident medications or orders. -She was not sure if Resident #2's medication issues had even been reported to the previous RCC. -It was a major concern than Resident #2 did not receive his medications as ordered because it was a lack of care, unfair, and neglectful. Second interview with the Administrator on 07/15/21 at 11:08am revealed: -She was recently told that staff reported medication scanning issues prior to her beginning her position at the facility in March 2021. -The staff had stopped using the medication scanners prior to March 2021 but began using them again sometime in May 2021. -The previous RCC had not been accepting new and discontinued orders properly from the pharmacy which caused confusion with eMAR	D 358		

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D 358	Continued From page 58 orders for Resident #2. -Resident #2 had been receiving his medication correctly as ordered until staff began using the medication scanners again in May 2021. -She was not sure why staff had not reported an issue with the use of the scanners prior to early June 2021, but she expected them to report the issue immediately to the RCC or to her so they could have corrected it. -Staff had never given her a message to contact Resident #2's family member regarding his medication issues and she had never spoken to his family member about anything except Resident #2's packages that came in the mail. -There was no excuse for why Resident #2 did not receive his medications as ordered for such a long period of time during May 2021 and June of 2021. -After being made aware of Resident #2's medication issues in May 2021 and June of 2021, she corrected the issue but did not think to report the issue to Resident #2's PCP. Interview with a pharmacist at the facility's contracted pharmacy on 07/15/21 at 10:13am revealed: -Resident #2's PCP had sent in several discontinue orders for medication on 05/28/21 in an attempt to "clean up" his eMAR because a family member was going to begin providing several of the vitamin supplements to the facility on his behalf to try and save him some money. -There was no reason for Resident #2 missed so many medication doses in May 2021 or June 2021. -The pharmacy was unable to see the facility's eMARs, but all new orders and discontinuation orders crossed over from the pharmacy's computer system to the facility's computer system.	D 358		

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D 358	Continued From page 59 -Once the pharmacy updated eMAR orders, it was up to the facility to accept the new or discontinued orders to ensure that their eMARs remained updated and accurate for resident safety and accurate medication administration. Interview with Resident #2's PCP on 07/14/21 at 1:46pm revealed: -She was unaware Resident #2 had gone any length of time without receiving his medications as needed and ordered. -She expected facility staff to implement and carry out her orders as written, and to notify her if there was a problem. -There was no reason or explanation for why Resident #2 had not received his medications as ordered. -Resident #2 had several medications prescribed to him for prophylactic purposes such as preventing esophageal varices, cirrhosis issues, and keeping his blood pressure regulated due to his past medication history because she had been worried about edema and fluid overload. _____ The facility failed to administer medications as ordered including to a resident (#2) used to treat hypertension, edema, stomach disorders, sleep disturbance, vitamin deficiency, and pain resulting in the resident having trouble sleeping and experiencing pain; and failed to obtain a medication for a resident (#6) for thirteen days prescribed to treat heart problems. This 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 in accordance with G.S. 131D-34 on 07/13/21 for	D 358		

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D 358	Continued From page 60 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2021.	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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication aide training and competency. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 11 residents (#6, #7) observed during the medication pass including errors with a heart medication (#6) and a blood pressure medication with parameters (#7), and record review for 1 of 5 sampled residents' with missed medications (#2) prescribed to the resident to control blood pressure and edema, insomnia medication, and vitamin supplementation, as well as the administration of discontinued medications (#2) for insomnia.	D912		

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D912	Continued From page 61 [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		