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BROOKDALE MONROE SQUARE 1	918 FITZGERALD STREET MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 02/16/22 - 02/18/22.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#2, #4, #6) observed during the medication pass including errors with a diuretic for swelling (#2, #6), and a rapid acting insulin (#4); and for 1 of 5 residents sampled (#1) for record review including errors with medications for low potassium levels, low Vitamin D levels, and dry, irritated eyes. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am and 11:00am/12:00pm medication passes on 02/17/22. a. Review of Resident #6's current FL-2 dated 01/20/22 revealed: -Diagnoses included atrial-fibrillation, congestive	D 358		

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heart failure, hypertension, and diabetes mellitus type 2.
-There was an order for Furosemide 40mg 1 tablet every day. (Furosemide is a diuretic used to treat swelling and fluid retention.)

Observation of the 8:00am medication pass on 02/17/22 revealed:
-The medication aide (MA) prepared and administered 8 medications to Resident #6 at 8:05am.
-Furosemide was not administered or offered to Resident #6 when he received his other morning medications at 8:05am.

Interview with the MA on 02/17/22 at 8:13am revealed Resident #6 was not scheduled to receive any other morning medications.

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Furosemide 40mg 1 tablet by mouth one time a day related to chronic congestive heart failure scheduled for 8:00am.
-Furosemide was documented as administered on 02/17/22 at 8:00am.

Observation of Resident #6's medications on hand on 02/17/22 at 1:40pm revealed there was no Furosemide available for administration.

A second interview with the MA on 02/17/22 at 1:40pm revealed:
-Resident #6's Furosemide was not administered during the 8:00am medication pass because there was none available on the medication cart.
-The MAs were responsible for faxing refill requests to the pharmacy when the supply got down to the color strip on the medication card.

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-She gave the last tablet of Furosemide to the resident on 02/16/22.
-The medication label was used to fax a refill request to the facility's contracted pharmacy provider.
-She did not remember if a refill request for Resident #6's Furosemide had been sent to the pharmacy.

Interview with the Health and Wellness Director (HWD) on 02/17/22 at 2:15pm revealed:
-She expected the MAs to check the medications carts daily for medications that needed refilling.
-The MAs were expected to reorder a medication when the supply was in the blue color strip area on the medication card or down to a 7-day supply.

Interview with Resident #6's primary care provider (PCP) on 02/17/22 at 3:45pm revealed:
-Resident #6 was prescribed Furosemide because of his chronic heart failure and edema.
-Failing to receive Furosemide as ordered could cause the resident to have increased edema, especially if multiple doses were missed.
-She expected to be notified if the medication was not available for the resident so she could monitor for increased edema.

Interview with the Administrator on 02/17/22 at 4:39pm revealed:
-The MAs, Supervisors, or the Resident Care Coordinator (RCC) were responsible for reordering medications.
-Medication refills were expected to be requested when the resident's medication was down to a 7-day supply on hand.

Observation of Resident #6's medications on hand on 02/18/22 at 10:10am revealed:
-A 30-day supply of Furosemide 40mg tablets

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dated 02/17/22 was available on the medication cart.
-There were 29 of 30 tablets remaining on the medication card.

Interview with a MA on 02/18/22 at 10:10am revealed she administered one tablet of Furosemide to Resident #6 on 02/18/22 during the 8:00am medication pass.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy provider on 02/18/22 at 2:15pm revealed:
-Furosemide was a diuretic used to reduce fluid retention and edema associated with congestive heart failure.
-A 30-day supply of Resident #6's Furosemide was ordered, filled and delivered to the facility on 01/21/22.
-The 30-day supply dispensed on 01/21/22 should have still been available for administration on 02/17/22.
-A 30-day supply of Resident #6's Furosemide was requested and filled on 02/17/22 and was delivered to the facility on 02/18/22 at 2:00am.

A second interview with the HWD on 02/18/22 at 2:35pm revealed Resident #6's Furosemide 40mg medication card filled on 01/21/22 was found located on the medication cart filed behind another resident's name.

Observation of Resident #6's misplaced supply of Furosemide on 02/18/22 at 2:35pm revealed there were 4 tablets remaining on the medication card.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

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D 358	Continued From page 4 b. Review of Resident #2's FL-2 dated 08/01/21 revealed diagnoses included acute kidney failure, hydronephrosis, urinary retention, unspecified heart failure, diabetes mellitus type 2 and atrial fibrillation. Review of Resident #2's primary care provider (PCP) order dated 09/30/21 revealed an order for Furosemide 40mg 1 tablet every day for edema, give 30 minutes after Bumetanide. (Furosemide is a diuretic used to treat swelling and fluid retention.) (Bumetanide is a diuretic used to treat swelling and fluid retention.) Observation of the 8:00am medication pass on 02/17/22 revealed: -The medication aide (MA) administered Furosemide and Bumetanide to Resident #2 at 8:56am. -The Furosemide tablets were labeled to give 30 minutes after Bumetanide. -Furosemide was not administered 30 minutes after Bumetanide as ordered. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 40mg 1 tablet one time a day for swelling, give 30 minutes after Bumetanide, and scheduled for 8:30am. -Bumetanide was scheduled for 8:00am. Interview with the MA on 02/17/22 at 2:03pm revealed: -She administered Resident #2's 8:00am and 8:30am medications at the same time because they both popped up on the eMAR to be given. -Resident #2 liked to take all her morning medications at the same time.	D 358		

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-She had not noticed the instructions on the eMAR and medication label to administer the Furosemide 30 minutes after the Bumetanide.

Interview with the Health and Wellness Director (HWD) on 02/17/22 at 2:51pm revealed:
-She expected all MAs to read and follow the instructions on the medication label and eMAR.
-Resident #2's Furosemide should have been administered 30 minutes after the Bumetanide.

Interview with Resident #2's PCP on 02/17/22 at 3:45pm revealed:
-Resident #2 was prescribed Furosemide because of her edema associated with heart failure and kidney failure.
-Furosemide was to be given 30 minutes after Bumetanide because Bumetanide opened the kidneys and made Furosemide more effective.
-She was not aware the resident was administered the Furosemide at the same time as the Bumetanide.
-The resident's edema was well controlled and she had no concerns at this point.

Interview with the Administrator on 02/17/22 at 4:39pm revealed:
-The MAs were expected to follow the administration instructions printed on the medication pharmacy label and the eMAR.
-Furosemide should have been administered 30 minutes after Bumetanide.

Interview with Resident #2 on 02/18/22 at 11:07am revealed:
-She was not aware the Furosemide was ordered to be taken 30 minutes after Bumetanide was administered.
-She was administered all her morning medications at the same since coming to the

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facility in April or May 2021.
-She did not recall telling the MAs she wanted all her morning medications given to her at the same time, she assumed they were supposed to be administered together.
-She had swelling in her legs most days, some days it was worse than others.

Observation of Resident #2 on 02/18/22 at 11:07am revealed visible swelling of both legs below the knee, red shiny skin with patchy areas of flaking skin, and pitting edema on both feet.

c. Review of Resident #4's current FL-2 dated 10/21/21 revealed diagnoses included diabetes mellitus.

Review of Resident #4's order review report dated 12/30/21 revealed an order for Humalog insulin inject 3 units subcutaneously before meals and at bedtime, hold for blood sugar less than 150. (Humalog is a rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog to be taken within 15 minutes before eating or right after eating a meal.)

Observation of the 11:00am medication pass on 02/17/22 revealed:
-The medication aide (MA) checked the resident's blood sugar at 11:06am with a result of 152.
-The MA administered 3 units of Humalog insulin into Resident #4's posterior upper right arm at 11:07am.

Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog insulin inject 3 units subcutaneously before meals and at

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bedtime.
-Humalog insulin was scheduled for 7:45am, 12:00pm, 5:45pm, and 8:00pm.

Interview with the MA on 02/17/22 at 11:10am revealed she usually administered Resident #4's Humalog insulin at the time she checked the resident's blood sugar, scheduled at 11:00am.

A second interview with the MA on 02/17/22 at 11:26am revealed serving of the lunch meal usually started at 12:00pm.

Observation of Resident #4 on 02/17/22 revealed the resident was served lunch at 12:28pm and began eating at 12:32pm, 1 hour and 25 minutes after being administered Humalog insulin.

A third interview with the MA on 02/17/22 at 1:40pm revealed:
-She was aware the insulin was ordered to be given before meals.
-The facility's policy was to administer insulin 30 minutes before meals when ordered to be given with or before meals.
-She usually gave the resident her insulin around the same time each day.
-The resident did not have any problems with her insulin or low blood sugar in the past.

Interview with the Health and Wellness Director (HWD) on 02/17/22 at 2:51pm revealed:
-Insulin ordered with meals was expected to be administered right before the resident ate a meal.
-Insulin ordered before meals was expected to be administered no more than 30 minutes before a resident ate a meal.
-The insulin administered to Resident #4 at 11:07am on 02/17/22 was administered too early and put the resident at risk for low blood sugar.

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D 358	Continued From page 8 Interview with Resident #4's primary care provider (PCP) on 02/17/22 at 3:45pm revealed: -Insulin should be administered within 30 minutes of a resident's meal when the instructions were to give before or with meals. -Rapid-acting insulin should be administered right before a meal or right after the meal. -There was a risk for Resident #4's blood sugar dropping too low when the Humalog was administered 1 hour and 25 minutes before her meal. Interview with the Administrator on 02/17/22 at 4:39pm revealed it was the facility's policy to give insulin within 30 minutes of the resident's scheduled mealtime. Review of the facility's policy for insulin management last revised September 2018 revealed: -Insulin was typically administered 30 minutes prior to a meal or snack to allow the insulin to work as glucose was being absorbed into the body. -Delayed consumption of food following insulin administration can cause serious or harmful low blood sugar. -Staff were expected to notify the HWD if mealtime was delayed or if the resident refused to eat the meal. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #1's current FL-2 dated 07/26/21 revealed diagnoses included congestive heart failure, hypertension, osteoarthritis, gout, and insomnia.	D 358		

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D 358	Continued From page 9 a. Review of Resident #1's physician's order dated 02/10/22 revealed: -There was an order for Lasix once a day and at noon as needed for edema (swelling) and weight gain greater than 3 pounds. -There was an order for Potassium Chloride 10mEq 1 tablet daily as needed (prn) if taking prn Lasix. (Lasix is a diuretic used for excess fluid and swelling and can cause the body to lose potassium. Potassium Chloride is a potassium supplement used to treat or prevent low potassium levels.) Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lasix 20mg to be administered prn edema and weight gain of 3 pounds. -Lasix was documented as administered prn on 3 occasions: 02/11/22, 02/12/22, and 02/14/22. -There was an entry for Potassium Chloride 10mEq 1 tablet prn to take when taking prn Lasix. -No Potassium Chloride was documented as administered including the 3 occasions when prn Lasix was documented as administered. Observation of Resident #1's medications on hand on 02/18/22 at 10:40am revealed there was no Potassium Chloride 10mEq tablets available for the resident. Interview with a medication aide (MA) on 02/18/22 at 10:40am revealed: -Resident #1 received her medications from a mail order pharmacy. -She was not sure why the resident's Potassium Chloride had not been received or when it would be received.	D 358		

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D 358	Continued From page 10 Interview with the Health and Wellness Director (HWD) on 02/18/21 at 11:20am revealed: -Resident #1 received her medications from a mail order pharmacy. -Resident #1's providers electronically sent her medication orders to the mail order pharmacy. -The facility had no system to check to see if the mail order pharmacy received the orders. -The facility had made no attempts to get the Potassium Chloride from the back up pharmacy because they were waiting for it to come from the mail order pharmacy. -She would check with the resident's primary care provider (PCP) to see if the PCP had received confirmation of the mail order pharmacy receiving the order for Potassium Chloride. Interview with Resident #1 on 02/18/22 at 3:57pm revealed: -She had swelling in both feet and ankles. -She had received a few doses of prn Lasix but not prn Potassium Chloride because she did not have any on hand. -Her medications came from a mail order pharmacy and she used her computer to check to see when her medications would be delivered. -She received an email from the mail order pharmacy indicating the Potassium Chloride would be delivered on 02/20/22. Interview with Resident #1's PCP on 02/17/22 at 3:48pm revealed: -Resident #1 used a mail order pharmacy and there was sometimes a delay in the resident receiving her medications. -She was not aware Resident #1's Potassium Chloride had not been available since ordered on 02/10/22. -Resident #1 needed to receive prn Potassium	D 358		

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Chloride each time she received a prn dose of Lasix.
-The resident already received scheduled Lasix so the prn Lasix made the resident more likely to lose more potassium from her body so the prn Potassium Chloride would help prevent low potassium levels.

Review of Resident #1's labwork dated 02/17/22 revealed the resident's potassium level was within normal levels at 3.8 (reference range 3.7 - 5.5).

b. Review of Resident #1's current FL-2 dated 07/26/21 revealed an order for Vitamin D2 2,000 units 1 tablet daily. (Vitamin D2 is ergocalciferol, a supplement used to treat and prevent Vitamin D deficiency.)

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D2 (ergocalciferol) 2,000 units 1 capsule one time a day scheduled for 8:00am.
-Vitamin D2 2,000 units was documented as administered from 02/01/22 - 02/16/22.

Observation of Resident #1's medications on hand on 02/18/22 at 10:40am revealed:
-There was an over-the-counter (OTC) bottle of Vitamin D3 5,000 units on hand for the resident. (Vitamin D3 is cholecalciferol, a supplement used to treat and prevent Vitamin D deficiency. Vitamin D2 and Vitamin D3 are two different forms of Vitamin D and are not the same.)
-There was no supply of Vitamin D2 2,000 units capsules available for the resident.

Interview with a medication aide (MA) on 02/18/22 at 10:40am revealed:

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-The bottle of Vitamin D3 5,000 units capsules in the medication cart was the Vitamin D that was administered to the resident.
-She administered the Vitamin D3 5,000 units capsules to Resident #1 because that was what the family brought for the resident.
-She had not noticed the Vitamin D on hand did not match the Vitamin D order listed on the eMAR.

Interview with the Health and Wellness Director (HWD) on 02/18/21 at 11:20am revealed:
-Resident #1's family had brought in the supply of Vitamin D on hand.
-The MAs were responsible for checking any medications brought by families to make sure it matched the current order.
-The MAs were supposed to compare the medication label to the eMAR when administering medications and they should not administer the medication if it did not match.

Interview with Resident #1 on 02/18/22 at 3:57pm revealed:
-She was going to start getting her OTC medications from her mail order pharmacy.
-She thought she was going to be receiving Vitamin D 1,000 units from the mail order pharmacy.
-She was not sure what strength of Vitamin D she had an order to take.

Telephone interview with Resident #1's primary care provider (PCP) on 02/18/22 at 3:34pm revealed:
-She last checked Resident #1's Vitamin D level on 09/24/21 and it was 52.8 (reference range for normal was 30 to 100).
-The resident needed to be taking Vitamin D2 2,000 units as ordered because when she tested

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the resident's Vitamin D level, she made changes based on the resident receiving 2,000 units per day.
-She was not aware Resident #1 was receiving Vitamin D3 5,000 units so she would have the resident's Vitamin D level rechecked.

c. Review of Resident #1's eye care provider visit note dated 10/04/21 revealed:
-The resident was noted to have dry eye syndrome.
-There was an order for Artificial Tears 1 drop in each eye 4 times a day. (Artificial Tears is used to treat dry, irritated eyes.)

Review of Resident #1's December 2021 - February 2022 electronic medication administration records (eMARs) revealed there was no entry for Artificial Tears and none was documented as administered.

Observation of Resident #1's medications on hand on 02/18/22 at 10:40am revealed there was no Artificial Tears available for the resident.

Interview with a medication aide (MA) on 02/18/22 at 10:40am revealed:
-She was not aware Resident #1 had an order for Artificial Tears.
-Resident #1 did not have any Artificial Tears on hand and she had never administered any to the resident.

Interview with the Health and Wellness Director (HWD) on 02/18/21 at 11:20am revealed:
-Resident #1 received her medications from a mail order pharmacy.
-Resident #1's providers electronically sent her medication orders to the mail order pharmacy.
-The facility had no system to check to see if the

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D 358	Continued From page 14 mail order pharmacy received the orders. -She did not know if the eye care provider sent the order for Artificial Tears to the mail order pharmacy. -The MAs were responsible for entering medication orders into the eMAR system when the order was received. -The order for Artificial Tears must have been overlooked. -She would order the Artificial Tears through the facility's contracted pharmacy provider and the eye drops would come in tonight. Interview with Resident #1 on 02/18/22 at 3:57pm revealed: -She did not recall her eye care provider saying anything about using Artificial Tears during her last visit. -She had problems with her eyes itching at times. Attempted telephone interview with Resident #1's eye care provider on 02/18/22 at 2:05pm was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the	D 371		

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medication pass on 02/17/22 by 1 of 2 medication aides observed who failed to wash or sanitize her hands prior to preparing and after administering a nasal spray, eye drops, insulin, and multiple oral medications to residents, and after scratching her head and face with her ungloved hands.

The findings are:

Review of the facility's general guidelines for medication administration last revised in June 2020 revealed:
-Medication aides (MAs) were expected to wash their hands or use hand sanitizer prior to medication administration for each resident.
-Handwashing was expected to be performed with soap and water and not with the use of hand sanitizer when hands were visibly dirty.
-Tablets and capsules were not to be poured into the associates' hand or touched during the medication pass.

Observation of a MA administering medications from medication carts labeled Cart 2B and Cart 3 on 02/17/22 at 8:00am revealed she punched out oral medications in tablet or capsule form directly into her hand and then placed into a medication cup while not wearing gloves.

Observation of the same MA administering medications from medication carts labeled Cart 2B and Cart 3 on 02/27/22 from 11:00am to 11:27am revealed:
-There was a hand sanitizer dispenser attached to one end of Cart 2B and Cart 3.
-A bottle of hand sanitizer was setting on the top of Cart 3 near the computer.
-The MA checked the blood sugar and administered insulin to a resident at 11:07am while wearing gloves.

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-The MA returned to Cart 3 and removed her gloves but did not sanitize or wash her hands.
-The MA prepared and administered a nasal spray medication to a second resident at 11:10am from Cart 3.
-The MA touched her forehead and scratched her head with her ungloved hands.
-The MA documented information in a yellow binder on Cart 3.
-The MA did not sanitize or wash her hands prior to preparing the medication or after administering the medication and she was not wearing gloves.
-The MA prepared and administered an oral medication with a cup of water to a third resident at 11:13am from Cart 3.
-The MA then touched the computer keyboard and mouse.
-The MA did not sanitize or wash her hands prior to preparing the medication or after administering the medication and she was not wearing gloves.
-The MA prepared an oral medication with a cup of water for a fourth resident at 11:15am from Cart 2B and took the medication with a bottle of eye drops to the dining room.
-The MA returned to the medication cart with the oral medication and eye drops at 11:19am.
-The resident came from the dining room to the medication cart and the MA administered the oral medication and eye drops to the resident at 11:20am.
-The MA wore a glove on her right hand but not her left hand when administering the eye drops.
-The MA then went back to Cart 3 and touched the computer keyboard and mouse.
-The MA did not sanitize or wash her hands prior to preparing the medication and eye drops or after administering the medication or eye drops.
-The MA prepared an insulin pen for a fifth resident at 11:22am from Cart 3.
-The MA carried a pair of gloves with her to the

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resident's room but did not sanitize or wash her hands prior to preparing the insulin or after administering the insulin.
-The MA returned to Cart 3 and touched the computer keyboard and mouse at 11:24am.
-The MA positioned Cart 2B and Cart 3 facing each other in the hallway alcove and left the area at 11:27am.
-The MA did not sanitize or wash her hands.

Interview with the MA on 02/17/22 at 1:40pm revealed:
-The facility's procedure related to infection prevention during administering medications was to sanitize hands in between residents and wash hands with soap and water after every third resident or when visibly dirty.
-She did not recall omitting sanitizing her hands in between residents during the 11:00am medication pass this morning.
-She should have worn gloves during the 8:00am medication pass that morning instead of putting the medications in her ungloved hand.

Interview with the Health and Wellness Director (HWD) on 02/17/22 at 2:51pm revealed:
-The MAs were trained to put medications directly into the medication cups or use a gloved hand when touching the medication could not be avoided.
-All MAs were trained to sanitize or wash their hands with soap and water before and after administering medications to residents.
-Staff properly sanitizing their hands was essential in preventing cross-contamination and spreading of infection.

Interview with the facility's primary care provider (PCP) on 02/17/22 at 3:45pm revealed:
-The MAs were expected to wash or sanitize

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D 371	Continued From page 18 between residents when administering medications or providing care. -The MAs were expected to wear gloves when administering eye drops and sanitize their hands after removing the gloves. -She was concerned the lack of proper hand hygiene increased the risk of spreading infections. Interview with the Administrator on 02/17/22 at 4:39pm revealed: -The MAs were trained to punch pills directly into the medication cup and touch only if wearing gloves. -The MAs were trained to wash or sanitize their hands before and after administering medications to each resident. -She was concerned for spread of infection and cross-contamination if hand hygiene and standard precautions were not followed by the MAs.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were under locked security when a medication aide left a medication cart unlocked, without	D 378		

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direct physical supervision, for 32 minutes on 02/17/22, while 16 identified residents passed by or sat near the unlocked medication cart.

The findings are:

Review of the facility's medication storage policy last revised in October 2018 revealed medications were to be stored in a designated location that must be locked when not in use or when unattended.

Review of the facility's general guidelines for medication administration last revised in June 2020 revealed medication carts and medications should be locked when unattended and discreetly located when in public areas.

Observation on 02/17/22 from 8:10am to 8:44am revealed:
-At 8:10am, there was a medication cart labeled Cart 1 left unattended and unlocked in the hallway alcove in front of a sitting room located between resident rooms #9 and #10 and across from the beauty salon.
-The medication storage drawers opened when pulled, except the medication drawer with controlled substances was locked.
-There were no staff in the hallway near or around the medication cart.
-A housekeeping cart was in the adjacent hallway near resident room #20, the housekeeper was inside the room and not within sight of the unlocked medication cart.
-At 8:15am, two residents exited resident room #10 and walked pass the unlocked medication cart towards the front lobby.
-At 8:18am, the facility's hair stylist passed near the unlocked medication cart into the salon room and closed the door.

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D 378	Continued From page 20 -The unlocked medication cart was not in direct view of the stylist. -At 8:29am, a male resident walked past the unlocked medication cart towards the back hallway. -At 8:31am, a female resident passed by the unlocked medication cart and sat outside of the salon room. -At 8:32am, a female resident from resident room #28 passed by the unlocked medication cart towards her room. -At 8:34am, a male resident from resident room #30 passed by the unlocked medication cart towards his room. -At 8:36am, a female resident from resident room #23 passed the unlocked medication cart towards her room. -At 8:37am, a female resident from resident room #48 and a female resident from resident room #29 passed by the unlocked medication cart and sat outside the salon room. -At 8:38am, a female resident from resident room #28 passed by the unlocked medication cart and sat outside the salon room. -At 8:39am, a personal care aide (PCA) walked from the adjacent hall and passed by the unlocked medication cart towards the front lobby. -At 8:40am, a female resident from resident room #15 and a female resident from resident room #24 passed by the unlocked medication cart. -At 8:41am, both female residents from resident room #11 and two female residents from resident rooms #27 and #32 passed by the unlocked medication cart. -At 8:42am, a male resident from resident room #22 and a female resident from resident room #25 passed by the unlocked medication cart. -At 8:42am, the MA returned from the dining room and walked past the medication cart and went into the staff bathroom.	D 378		

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-At 8:44am, the MA assigned to the unlocked medication cart returned from the staff bathroom to the cart and changed the trash bag on the cart, but she did not lock the cart.
-The MA prepared medications for the resident in resident room #25 at 8:54am and locked medication Cart 1 before walking to the resident's room.
-From 8:10am to 8:42am, medication cart labeled Cart 1 was unlocked while 16 residents passed by or sat near the cart.

Observation of the medication aide (MA) assigned to cart 1 on 02/17/22 from 8:22am to 8:42am revealed she was in the dining room assisting residents with breakfast.

Interview with the MA assigned to Cart 1 on 02/17/22 at 9:10am revealed the medication cart should have been locked, but she forgot to lock it before going to the dining room.

Review of current FL-2 forms for the 16 residents who passed by or were near the unlocked medication cart unattended on 02/17/22 revealed 10 of the 16 residents' diagnoses included intermittently disoriented, dementia, memory loss, intermittently confused, Alzheimer's disease, and/or mild cognitive impairment.

Interview with the Health and Wellness Director (HWD) on 02/17/22 at 2:51pm revealed:
-The MAs were always trained and expected to keep all medications carts locked if the MA was not at or in sight of the cart.
-There were multiple residents with disorientation, confusion or dementia residing in rooms on the hallways near the medication cart that was left unlocked and unattended on 02/17/22.
-She was concerned that residents could gain

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D 378	Continued From page 22 access to medications that may cause harm or injury. Interview with the facility's contracted primary care provider (PCP) on 02/17/22 at 3:45pm revealed: -There were multiple confused and disoriented residents that could access medication in an unlocked medication cart. -She expected all medication carts to be locked and secure when not in the direct supervision of an MA. Interview with the Administrator on 02/17/22 at 4:39pm revealed: -The MAs were always expected to keep medication carts locked unless in direct supervision. -There were several confused, wandering, and/or disoriented residents in the facility. -She was concerned a resident could have been harmed if they accessed the unlocked medications.	D 378		