Williams, Wendy

From: Timothy Stephenson <tim@oakhillliving.com>
Sent: Tuesday, April 26, 2022 3:28 PM
To: Williams, Wendy
Subject: [External] Fwd: Message from "RNP5838791C60B5"
Attachments: 20220426145751134.pdf

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Thanks for all of your help!
Tim Stephenson

---------- Forwarded message ---------
From: <tim@oakhillliving.com>
Date: Tue, Apr 26, 2022 at 3:15 PM
Subject: Message from "RNP5838791C60B5"
To: Tim <tim@oakhillliving.com>

This E-mail was sent from "RNP5838791C60B5" (MP 305+).

Scan Date: 04.26.2022 14:57:50 (-0400)
Queries to: tim@oakhillliving.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	R 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 02/02/22 - 02/04/22 and 02/07/22.	{D 000}		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed	D 188	3-24-22 We have contacted additional staffing agencies for availability. We have discussed with all staff about picking up additional hours and shifts. Current schedule now reflects the required number of staff to meed State guidelines and even extra staff. The RCD and HR Director will work together to make the schedule and monitor it on a weekly basis. The schedules will be made for a two week but may have to be adjusted as needed.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Stephenson — TITLE: Administrator — (X6) DATE: 3-30-2022

STATE FORM 6899 IPPU12 If continuation sheet 1 of 77

Reviewed and acknowledged.
MW 4/27/22

Division of Health Service Regulation

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D 188	Continued From page 1 by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure aide hours met the minimum staffing requirements for 9 of 24 shifts sampled from 01/28/22 - 02/04/22. The findings are: Review of the facility's current 2022 license revealed the facility had a capacity of 122 residents. Review of a resident census report dated 01/28/22 (Friday) revealed the facility's in-house census was 69, which required at least 32 hours of staff duty on second shift and at least 24 hours of staff duty on third shift. Review of the punch time detail report dated 01/28/22 (Friday) revealed: -There were 30 hours and 57 minutes of staff duty provided on second shift, leaving the shift short staffed by 1 hour and 3 minutes. -There were 17 hours and 53 minutes of staff duty provided on third shift, leaving the shift short staffed by 9 hours and 7 minutes. -There was 1 medication aide (MA) and 1 personal care aide (PCA) on duty from 11:13pm - 5:57am.	D 188	All callouts will be directed to the RCD unless she is out of town. 3-14-22	

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D 188	Continued From page 2 Review of a resident census report dated 01/29/22 (Saturday) revealed the facility's in-house census was 69, which required at least 32 hours of staff duty on second shift and at least 24 hours of staff duty on third shift. Review of the punch time detail report dated 01/29/22 (Saturday) revealed: -There were 26 hours and 25 minutes of staff duty provided on second shift, leaving the shift short staffed by 5 hours and 35 minutes. -There were 17 hours and 6 minutes of staff duty provided on the third shift, leaving the shift short staffed by 6 hours and 54 minutes. -There was 1 MA and 1 licensed practical nurse (LPN) on duty from 11:07pm - 6:13am. Review of a resident census report dated 01/30/22 (Sunday) revealed the facility's in-house census was 69, which required at least at least 32 hours of staff duty on first shift and second shift and at least 24 hours of staff duty on third shift. Review of the punch time detail report dated 01/30/22 revealed: -There were 31 hours and 13 minutes of staff duty on first shift, leaving the shift short staffed by 47 minutes. -There was 1 MA and 1 PCA on duty from 7:45pm - 11:00pm on second shift. -There were 18 hours and 29 minutes of staff on duty for third shift, leaving the shift short staffed by 4 hours and 31 minutes. -There was 1 MA and 1 LPN on duty from 11:44pm - 5:56am. Review of a resident census report dated 02/03/22 (Thursday) revealed the facility's in-house census was 69, which required at least 32 hours of staff duty on second shift and at least	D 188		

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D 188	Continued From page 3 24 hours of staff duty on third shift. Review of the punch time detail report dated 02/03/22 (Thursday) revealed: -There were 28 hours and 41 minutes of staff duty provided on second shift, leaving the shift short staffed by 3 hours and 19 minutes. -There were 17 hours and 33 minutes of staff duty provided on third shift, leaving the shift short staffed by 6 hours and 27 minutes. Observation on 02/03/22 revealed the Resident Care Manager (RCM) finished the morning medication pass (medications scheduled for 7:00am, 8:00am, and 10:00am) on the 100 hall at 12:02pm. Interview with the RCM on 02/03/22 at 1:30pm revealed: -She had been helping with the administration of medications because the facility had been short-staffed with MAs. -She was working as one of 2 MAs the morning of 02/03/22 in addition to performing RCM duties. -She had to stop administering medications several times that morning to provide resident care, take phone calls, and deal with families. -She thought the facility being short-staffed contributed to resident's medications being administered late. Review of a resident census report dated 02/04/22 (Friday) revealed the facility's in-house census was 69, which required at least 32 hours of staff duty on second shift and at least 24 hours of staff duty on third shift. Review of the punch time detail report dated 02/04/22 (Friday) revealed: -There were 30 hours and 25 minutes of staff	D 188		

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D 188	Continued From page 4 duty provided on second shift, leaving the shift short staffed by 1 hour and 35 minutes. -There were 16 hours of staff duty provided on third shift, leaving the shift short staffed by 8 hours. Interview with the MA on 02/04/22 at 8:51am revealed: -She was the only MA working on first shift today, 02/04/22. -There were usually 2 MAs for first shift. -She was responsible for administering morning medications to all 69 residents in the facility. A second interview with the MA on 02/04/22 at 10:58am revealed: -She was starting the morning medication pass (7:00am, 8:00am, 9:00am, and 10:00am) for the residents residing on the 100 hall. -There were 23 residents residing on the 100 hall that had not received their morning medications yet. Observation on 02/04/22 revealed the MA finished the morning medication pass (medications scheduled for 7:00am, 7:30am, 8:00am, and 10:00am) on the 100 hall at 2:06pm. Interview with the Administrator on 02/04/22 at 11:12am revealed: -He was not aware there was only 1 MA administering medications for first shift on 02/04/22. -The RCM was sent home on the day prior, 02/03/22, because she refused to wear the recommended personal protective equipment (PPE) and he was not sure if she planned to work on 02/04/22. -He did not have a plan in place to cover the RCM's shift on 02/04/22 if she did not work.	D 188		

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D 188	Continued From page 5 -He was not sure if anyone else attempted to seek coverage for the RCM's shift on 02/04/22. -He had not seen or talked with the RCM so he was not sure if she was currently in the facility. Interview with the facility's General Manager (GM) on 02/07/22 on 02/07/22 at 6:11pm revealed: -It was the responsibility of the RCM to complete the clinical staffing schedule with the assistance of the transporter. -It was the responsibility of the Administrator, the Human Resource Director and the GM to assist with the schedule as needed. -It was the responsibility of the MA shift supervisors to monitor the staffing for each shift and notify the RCM as needed if there was additional coverage needed. Interview with the RCM on 02/07/22 at 3:18pm revealed: -She made the facility staffing schedule every 2 weeks and the facility's transporter posted the schedule. -She usually tried to schedule 2 to 3 MAs and 5 to 6 PCAs on first and second shifts. -She usually tried to schedule 3 staff for third shift, 1 MA and 2 PCAs. -The facility had problems with being short-staffed and seemed to have more problems this week than in the past. -Staff were supposed to give a 2 hour notice if they could not make their shift but that did not always happen. -Staff were responsible for finding their own coverage if they called out but that did not always happen either. -She helped to find coverage when staff called out or did not show up. -If there was a "no show" for a shift, the other staff on duty were supposed to notify	D 188		

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D 188	Continued From page 6 management so they could help find coverage. -She stated she could not comment as to why the facility was short staffed. Attempted telephone interview with a third shift MA on 02/02/22 at 12:31pm was unsuccessful.	D 188		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were served hot for 4 of 4 residents observed that were being quarantined for COVID-19. The findings are: Observation of the lunch meal on 02/04/22 at 12:30pm - 1:51pm revealed: -There were two personal care aides (PCA) and one medication aide (MA) working during the lunch meal. -The two PCAs were in the dining room assisting residents with meal and the MA was administering medications. -At 12:30pm, the dietary aide started delivering lunch trays to the resident's rooms. -At 12:53pm, the PCA delivered a lunch tray to the resident residing in room #324 from the top of the isolation cart outside room #324. -The PCA did not re-heat the lunch tray prior to	D 288	3-24-22 At this time we are feeding no one in their rooms because everyone is out of quarantine. Our kitchen has changed the way they prepair meals to be delivered to rooms and we will desinate one staff to deliver these meals in a timely manner when needed. The Chef and Kitchen Manager will monitor to make sure that foods are served at proper temperature and checked at every meal.	

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D 288	Continued From page 7 delivering it to room #324. -At 1:05pm, a second PCA delivered a lunch tray to the resident residing in room #202 from the top of the isolation cart outside room #202. -The PCA did not re-heat the lunch tray prior to delivering it to room #202. -At 1:08pm, the second PCA delivered a lunch tray to the resident residing in room #200 from the top of the isolation cart outside room #200. -The PCA did not re-heat the lunch tray prior to delivering it to room #200. -At 1:51pm, the Resident Care Manager (RCM) delivered a lunch tray to the resident residing in room #401 from the top of the isolation cart outside of room #401. -The RCM did not re-heat the lunch tray prior to delivering it to room #401. Interview with a PCA on 02/04/22 at 12:50pm revealed: -Residents who were positive for COVID-19 were quarantined in their rooms and ate all meals in their rooms. -It was the responsibility of the dietary staff to deliver meal trays to residents in quarantine and place the trays on the resident's isolation carts outside of their room doors. -It was the responsibility of the PCAs and the medication aides (MA) to retrieve the meal trays from the isolation carts and deliver them inside of the rooms to the residents. Interview with a resident on 02/04/22 at 1:40pm revealed: -She had been quarantined due to positive COVID-19 test results. -The staff had been delivering all meals to her room during meal times. -The staff had brought breakfast to her room earlier that morning (02/04/22), but she had not	D 288		

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D 288	Continued From page 8 seen anyone since then. -She usually ate lunch at 1:00pm and supper at 6:00pm. -She had not eaten since breakfast and was hungry. -At 1:43pm, she pressed the call light so that she could ask the staff how much longer she had to wait before lunch was served. Interview with a second resident on 02/04/22 at 1:45pm revealed: -She had been eating meals in her room for the past few days because she tested positive for COVID-19. -She was not sure what times the meals were served. -She had not seen a staff member since they served her breakfast earlier that morning (02/04/22). A second interview with the second resident on 02/07/22 at 11:05am revealed: -Sometimes the staff were late bringing her meals to her room and the food would be cold. -She had not asked the staff to re-warm the food because she was hungry and she did not like to complain. Interview with a dietary aide on 02/07/22 at 11:32am revealed: -It was the responsibility of the dietary staff to deliver the meals to residents' rooms who were quarantined. -The meals were placed outside of these resident's rooms, on the isolation carts. -It was the responsibility of the PCAs and the MAs to take the meals inside of the rooms for the residents being quarantined. -The meals were delivered to the rooms at approximately 7:30am, 12:30pm and 5:30pm.	D 288		

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D 288	Continued From page 9 Interview with the Administrator on 02/04/22 at 4:45pm revealed: -Residents who were positive for COVID-19 were quarantined and consumed all meals in their rooms. -The dietary staff prepared the meals and the PCAs would take the meals to the quarantined rooms. -It was the responsibility of the dietary staff to ensure that the resident's meals were delivered in a timely manner. -It was the responsibility of the dietary staff to alert the PCAs and the MAs prior to or immediately after delivering the meal trays on the hall to ensure the meals were served in a timely manner and at the correct temperatures.	D 288		
{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 ensure medications were administered as ordered for 1 of 5 residents (#3) sampled for record review for a medication used to treat overactive bladder and urinary incontinence.	{D 358}	3-14-22 We have two employees ready to take State Med Tech exams. We have three administrative staff taking the Med Tech courses and have already worked with the RN from pharmacy and getting ready for their check off and exam. The RN from pharmacy did an additional training to make sure all Med Techs were aware of timing of med passes. The RCD will monitor all Med Pass on a weekly basis and the Pharmacist will also audit every quarter.	

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{D 358}	Continued From page 10 The findings are: Review of Resident #3's current FL-2 dated 07/12/21 revealed diagnoses included urge incontinence, type 2 diabetes mellitus with hyperglycemia, hypothyroidism, and dementia. Review of Resident #3's urology provider visit report dated 12/13/21 revealed: -The resident was seen for evaluation of overactive bladder. -The resident had intermittent urge incontinence and urinated every 30 minutes in the daytime. -There was an order for Myrbetriq 50mg 1 tablet daily. (Myrbetriq is used to treat overactive bladder.) Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed there was no entry for Myrbetriq 50mg 1 tablet daily and none was documented as administered. Review of Resident #3's January 2022 eMAR revealed there was no entry for Myrbetriq 50mg 1 tablet daily and none was documented as administered. Review of Resident #3's February 2022 eMAR revealed there was no entry for Myrbetriq 50mg 1 tablet daily and none was documented as administered. Observation of Resident #3's medications on hand on 02/07/22 at 2:50pm revealed there was no Myrbetriq available for the resident. Interview with the medication aide (MA) on 02/07/22 at 2:50pm revealed: -She did not know Resident #3 had an order to	{D 358}	All orders written by [redacted] are sent to the Pharmacy are added to the MARS. The RCD will monitor all MARS to make sure that all orders are current & correct. The Pharmacy delivers six days a week to make sure we always have proper Meds available. 3-24-22	

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{D 358}	Continued From page 11 receive Myrbetriq. -She did recall the resident having any Myrbetriq on hand and she had not administered any to the resident. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/22 at 3:51pm revealed: -The facility usually faxed medication orders to the pharmacy and pharmacy staff would enter the order into the eMAR system. -The pharmacy did not receive the order dated 12/13/21 for Resident #3's Myrbetriq so the medication was not entered into the eMAR and none was dispensed. Interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm revealed: -The MAs and RCM were responsible for faxing medication orders to the pharmacy. -There was no system in place to check the eMARs for accuracy. Interview with Resident #3 on 02/07/22 at 5:12pm revealed: -She was seen by a urology provider but she was not sure if she was receiving any medication for overactive bladder. -She could not control her bladder and had incontinence episodes when she would wet her clothing. -She felt the urge to urinate "all the time". -She needed something to help with her overactive bladder. Telephone interview with a licensed practical nurse (LPN) at the urology provider's office on 02/07/22 at 4:47pm revealed: -Resident #3 was seen by a urology provider in their office on 12/13/21 because she was having	{D 358}		

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{D 358}	Continued From page 12 problems with overactive bladder and urinary incontinence. -The urology provider ordered the Myrbetriq to help with the resident's overactive bladder and urinary incontinence. -The urology provider wanted to follow-up with the resident in 1 year to see how the medication was working for her. -Not receiving the Myrbetriq could increase the resident's incontinence and overactive bladder problems.	{D 358}		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for eight residents on the 100 hall on 02/03/22 including 6 of 6 residents sampled (#4, #11, #15, 18, 22, 23) with medications ordered 2 or 3 times a day and for twenty-two residents on the 100 hall on 02/04/22 including 8 of 8 residents sampled (#8, #9, #12, #17, #20, #21, #23, #24) with medications ordered before meals or multiple times a day resulting in medications being administered after residents ate or too close to the next scheduled administration time resulting in missed doses of medications. The findings are:	D 364	3-24-22 We have had additional training to make sure Med Techs are following all doctor's orders concerning timing and instructions with doctors orders. We are also working with PAs to reevaluate RXs and orders. The RCD will monitor MARs weekly to make sure Meds are given at proper times and within the proper time period. The RN from the pharmacy is here every other Wednesday to do assessments and training. She was last here on 3-23-22 and 4-06-22.	

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D 364	Continued From page 13 Review of the facility's Medication Administration Policies and Procedures (undated) revealed: -Medications were administered within 60 minutes of the scheduled time, except before or after meal orders, which are administered based on meals. -Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. Review of the facility's census report dated 02/02/22 revealed the facility's current in-house census was 69 residents. 1. Observation of the 100 hall on 02/03/22 from 11:06am to 12:02pm revealed the Resident Care Manager (RCM) was on the 100 hall administering medications. Interview with the RCM on 02/03/22 at 11:06am revealed: -She was still administering the "8:00am 9:00am, and 10:00am" medications to the residents on the 100 hall. -She could not say how long it usually took her to administer morning medications. -It depended on how many times she had to stop to do other tasks. -She did not know how many more residents she had left; she just "keeps on going". Observation on 02/03/22 revealed the RCM finished the morning medication pass (medications scheduled for 7:00am, 8:00am, and 10:00am) on the 100 hall at 12:02pm. A second interview with the RCM on 02/03/22 at 1:30pm revealed:	D 364		

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D 364	Continued From page 14 -She had been helping with the administration of medications because the facility had been short-staffed with medication aides (MAs). -She was working as one of 2 MAs that morning (02/03/22) in addition to performing RCM duties. -She had to stop administering medications several times that morning to provide resident care, take phone calls, and deal with families. -It was unusual for the morning medication pass to be as late as it was that morning on 02/03/22. -If MAs were running late with their medication pass, they were supposed to let each other know and report it to her so she could get some help for them. -She did not ask the other MA on duty on first shift that morning (02/03/22) for help because she did not know if the MA had finished administering medications to her assigned halls and she did not know where the MA was located. -Some of the residents who received late medications that morning (02/03/22) were due to receive some medications again at 2:00pm. -Those medications would be administered again at 2:00pm because she did not think it would be too close to the morning dose even though the morning doses were late. Interview with the Administrator on 02/03/22 at 2:29pm revealed: -The MAs had a 2-hour window to administer scheduled medications. -He was aware of the medications being administered late a couple of times over the last 6 months. -He would expect the MAs to ask another MA to assist them if they were running late with their medication pass. -He was concerned about the medications being late because certain medications such as blood pressure medications needed to be administered	D 364		

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D 364	Continued From page 15 at a certain time about the same time every day. Review of the February 2022 electronic medication administration records (eMARs) for 8 residents on the 100 hall observed to receive late medications on 02/03/22 revealed: -All eight residents had morning medications scheduled for 7:00am and/or 8:00am. -Six of the 8 residents had medications ordered twice a day and/or 3 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] a. Review of Resident #23's current FL-2 dated 07/08/21 revealed diagnoses included dementia, essential hypertension, constipation, osteoarthritis, and edema. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed: -The RCM administered Resident #23's medications scheduled for 8:00am at 12:01pm, 3 hours and 1 minute beyond the allowed time frame. -The RCM administered Resident #23's medication scheduled for 10:00am at 12:01pm, 1 hour and 1 minute beyond the allowed time frame. Review of Resident #23's February 2022 electronic medication administration record (eMAR) revealed: -There were 2 medications, Furosemide (for swelling and excess fluid) and Milk of Magnesia (for constipation), scheduled once a day at 8:00am. - Diclofenac Sodium 1% Gel (topical for pain and inflammation) was scheduled at 10:00am and	D 364		

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D 364	Continued From page 16 7:00pm and Senna Plus (for constipation) was scheduled at 8:00am and 8:00pm. -Tylenol (mild pain reliever) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Tylenol was documented as administered at 2:00pm on 02/03/22, less than two hours from administration of the 8:00am dose at 12:01pm. -Diclofenac Gel was documented as administered on 02/03/22 at 7:00pm and Senna Plus at 8:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed medications used to treat pain could cause breakthrough pain if administered late. Attempted telephone interview with Resident #23's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #23 was not interviewable. b. Review of Resident #22's current FL-2 dated 07/12/21 revealed diagnoses included dementia, major depressive disorder, anxiety disorder, Alzheimer's disease, chronic pain, essential hypertension, peripheral vascular disease, and arterial fibromuscular dysplasia. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed: -The RCM administered Resident #22's medications scheduled for 8:00am at 12:02pm, 3 hours and 2 minutes beyond the allowed time frame. -Calcium Antacid was scheduled to be	D 364		

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D 364	Continued From page 17 administered at 2:00pm on 02/03/22, in less than 2 hours. Review of Resident #22's February 2022 electronic medication administration record (eMAR) revealed: -There were 7 medications scheduled once a day at 8:00am including Aspirin (prevents heart disease), Escitalopram (for depression), Furosemide (for swelling and excess fluid), Omeprazole (reduces stomach acid), Psyllium Powder (for constipation), Vitamin B12 (vitamin supplement), and Vitamin D3 (for low Vitamin D levels). -Risperidone (antipsychotic) was scheduled twice a day at 8:00am and 8:00pm. -Calcium Antacid (for indigestion) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Calcium Antacid was documented as administered on 02/03/22 at 2:00pm, less than 2 hours after the 8:00am dose was administered at 12:02pm. -Risperidone was documented as administered on 02/03/22 at 8:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed antipsychotics and antidepressants should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #22's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Interview with Resident #22 on 02/07/22 at 10:16am revealed: -She sometimes received her morning	D 364		

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D 364	Continued From page 18 medications late. -Her medications were late "a few times a week". -She did not recall having any symptoms when receiving her medications late. -She would like for her medications to be administered on time. c. Review of Resident #4's current FL-2 dated 07/29/21 revealed diagnoses included hyperthyroidism, dementia, delusional disorders, major depressive disorder, anxiety disorder, benign paroxysmal vertigo, essential hypertension, and gastroesophageal reflux disease. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed the RCM administered Resident #4's medications scheduled for 8:00am at 11:13am, 2 hours and 13 minutes beyond the allowed time frame. Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed: -There were 6 medications scheduled once a day at 8:00am including Amlodipine (lowers blood pressure), Citalopram (for depression), Docusate Sodium (for constipation), Famotidine (reduces stomach acid), Lisinopril (lowers blood pressure), and Vitamin B12 (vitamin supplement). -Risperidone (antipsychotic) was scheduled at 8:00am and 7:00pm and Calcium with Vitamin D (a calcium supplement) was scheduled at 8:00am and 4:30pm. -Calcium with Vitamin D was documented as administered on 02/03/22 at 4:30pm. -Risperidone was documented as administered on 02/03/22 at 7:00pm.	D 364		

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D 364	Continued From page 19 Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed antipsychotics, antidepressants, and medications used to lower blood pressure should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #4's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. d. Review of Resident #18's current FL-2 dated 07/12/21 revealed diagnoses included hypothyroidism, major depressive disorder, mild cognitive impairment, seizures, essential hypertension, venous insufficiency, osteoarthritis, and chronic kidney disease. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed: -The RCM administered Resident #18's Omeprazole (reduces stomach acid) scheduled for 7:00am, 30 minutes before meals at 11:27am, after the resident had eaten breakfast and just prior to the lunch meal at 12:00pm. -The RCM administered Resident #18's medications scheduled for 8:00am at 11:27am, 2 hours and 27 minutes beyond the allowed time frame. Review of Resident #18's February 2022 electronic medication administration record (eMAR) revealed:	D 364		

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D 364	Continued From page 20 -Omeprazole was scheduled 30 minutes before meals at 7:00am. -There were 6 medications scheduled once a day at 8:00am including Tylenol (mild pain reliever), Acidophilus (a probiotic), Citalopram (for depression), Magnesium Oxide (magnesium supplement), Vitamin B12 (vitamin supplement), and Vitamin D3 (for low Vitamin D levels). -Senna Plus (for constipation) was scheduled twice a day at 8:00am and 8:00pm. -Senna Plus was documented as administered on 02/03/22 at 8:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Omeprazole was ordered before a meal to help reduce stomach acid before a resident started eating. -Not receiving Omeprazole before the meal could cause the resident to have symptoms of acid reflux. -Antidepressants should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #18's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Interview with Resident #18 on 02/07/22 at 10:10am revealed: -She sometimes received her morning medications late. -She had received her morning medications as late as lunch time. -She did not recall any side effects from her medications.	D 364		

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D 364	Continued From page 21 e. Review of Resident #15's current FL-2 dated 07/12/21 revealed diagnoses included dementia, major depressive disorder, essential hypertension, and osteoarthritis. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed the RCM administered Resident #15's medications scheduled for 8:00am at 11:13am, 2 hours and 13 minutes beyond the allowed time frame. Review of Resident #15's February 2022 electronic medication administration record (eMAR) revealed: -There were 5 medications scheduled once a day at 8:00am including Amlodipine (lowers blood pressure), Aspirin (prevents heart disease), Escitalopram (for depression), Losartan (lowers blood pressure), and Vitamin B-Complex (vitamin supplement). -Memantine (for Alzheimer's disease) was scheduled twice a day at 8:00am and 8:00pm. -Memantine was documented as administered on 02/03/22 at 8:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed antidepressants, medication used to lower blood pressure, and medication used to treat Alzheimer's disease should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #15's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful.	D 364		

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D 364	Continued From page 22 Based on observations, interviews, and record reviews, it was determined Resident #15 was not interviewable. f. Review of Resident #11's current FL-2 dated 07/26/21 revealed diagnoses included major depressive disorder and Alzheimer's disease. Observation of the Resident Care Manager (RCM) administering morning medications on 02/03/22 revealed the RCM administered Resident #11's medications scheduled for 8:00am at 11:07am, 2 hours and 7 minutes beyond the allowed time frame. Review of Resident #11's February 2022 electronic medication administration record (eMAR) revealed: -Citalopram (for depression) was scheduled once a day at 8:00am. -Tylenol (mild pain reliever), scheduled twice a day at 8:00am and 8:00pm. -Tylenol was documented as administered on 02/03/22 at 8:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Medications used to treat pain could cause breakthrough pain if administered late. -Antidepressants should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #11's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record	D 364		

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D 364	Continued From page 23 reviews, it was determined Resident #11 was not interviewable. 2. Interview with the medication aide (MA) on 02/04/22 at 8:51am revealed: -She was the only MA working on first shift today (02/04/22). -There were usually 2 MAs for first shift. -She was responsible for administering morning medications to all 69 residents in the facility. -There were 4 medications carts, one each for 100 hall, 200 hall, 300 hall, and 400 hall. -She started administered medications around 6:45am - 7:00am. -She had finished administering medications to residents residing on the 400 hall. -She had completed half of 200 hall and half of 300 hall. -She had not started any medication administration for 100 hall. A second interview with the MA on 02/04/22 at 10:51am revealed: -She just finished administering morning medications to the residents residing on the 200 hall. -She still had to administer medications to all residents residing on 100 hall. Observation of the MA on 02/04/22 at 10:57am revealed the MA came out of the medication room pushing the 100 hall medication cart. A third interview with the MA on 02/04/22 at 10:58am revealed: -She was starting the morning medication pass (7:00am, 8:00am, 9:00am, and 10:00am) for the residents residing on the 100 hall. -There were 23 residents residing on the 100 hall that had not received their morning medications	D 364		

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D 364	Continued From page 24 yet. -She had not reported she was running late to facility management because she figured they already knew since she was the only MA that morning on first shift. Interview with the Administrator on 02/04/22 at 11:12am revealed: -He was not aware the MA was still administering morning medications and the residents residing on 100 hall had not received their morning medications. -The Resident Care Manager (RCM) was not working at the facility today (02/04/22). -He was not sure if the RCM would feel like working today but no one had been scheduled to work in her place. -He did not know if anyone had asked a third shift MA to stay after their shift to help with the morning medications. -Nothing had been put in place to make sure 2 MAs were administering medications on first shift on 02/04/22. -He would see if he could find some help for the MA. Observation of the MA on 02/04/22 at 12:07pm revealed the Human Resources Director (HRD) told the MA that the RCM would be coming into the facility to work. Observation on 02/04/22 from 12:27pm - 12:43pm revealed: -At 12:27pm, the RCM came walking down the hall past the dining room. -At 12:34pm, the RCM walked to the 100 hall medication cart and talked with the MA. -At 12:35pm the RCM walked away from the 100 hall medication cart. -At 12:43pm, the RCM pushed the 200 hall	D 364		

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D 364	Continued From page 25 medication cart to the 200 hall. A fourth interview with the MA on 02/04/22 at 12:45pm revealed: -The RCM was administering the lunch time medications to the residents on the 200 hall. -She was going to finish administering the morning medications to residents on the 100 hall. Observation of the MA on 02/04/22 at 2:06pm revealed the MA finished the morning medication pass (medications scheduled for 7:00am, 7:30am, 8:00am, and 10:00am) on the 100 hall at 2:06pm. Review of the February 2022 electronic medication administration records (eMARs) for 22 residents on the 100 hall observed to receive late medications on 02/04/22 revealed: -Six of the 22 residents had a morning medication scheduled for either 7:00am or 7:30am before a meal or on an empty stomach and received them late and after they had eaten breakfast. -All 22 residents had morning medications scheduled once daily for 8:00am. -Eighteen of the 22 residents had medications scheduled twice a day. -Ten of the 22 residents had medications ordered 3 times a day. -Two of the 22 residents had medications ordered 4 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] a. Review of Resident #24's current FL-2 dated 06/21/21 revealed diagnoses included Alzheimer's disease, Vitamin D deficiency, hyperlipidemia, glaucoma, and anxiety disorder.	D 364		

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D 364	Continued From page 26 Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #24's Levothyroxine (for hypothyroidism) scheduled for 7:30am before food at 12:18pm, after the resident had eaten breakfast and while the resident was eating lunch. -The MA administered Resident #24's medications scheduled for 8:00am at 12:18pm, 3 hours and 18 minutes beyond the allowed time frame. -The MA administered Resident #24's medication scheduled for 10:00am at 12:18pm, 1 hour and 18 minutes beyond the allowed time frame. Review of Resident #24's February 2022 electronic medication administration record (eMAR) revealed: -Levothyroxine was scheduled once a day 30 minutes before food at 7:30am. -There were 4 medications scheduled once a day at 8:00am including Aspirin (prevents heart disease), Escitalopram (for depression), Vitamin B12 (a vitamin supplement), and Vitamin D3 (for low Vitamin D levels). -Dorzolamide HCL 2% Eye Drops (for glaucoma), scheduled twice a day at 10:00am and 7:00pm. -Lorazepam (for anxiety) and Tramadol (for moderate to severe pain) were scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Lorazepam and Tramadol were scheduled to be administered again at 2:00pm, in less than 2 hours from receiving the 8:00am doses at 12:18pm. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #24 just received her morning doses of Lorazepam and Tramadol so she would not	D 364		

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D 364	Continued From page 27 administer the 2:00pm doses. -The 2:00pm doses were missed doses on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Levothyroxine was ordered once a day before breakfast because it was better absorbed on an empty stomach and provided a consistent level of medication in the bloodstream. -Medications used to treat pain could cause breakthrough pain if administered late and doses were missed. -Antidepressants should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #24's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #24 was not interviewable. b. Review of Resident #21's current FL-2 dated 12/13/21 revealed diagnoses included cerebral infarction, fibromyalgia, aphasia, depressive episodes, hyperlipidemia, insomnia, and blindness in left eye. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #21's medications scheduled for 8:00am at 12:04pm, 3 hours and 4 minutes beyond the allowed time frame.	D 364		

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D 364	Continued From page 28 -The MA administered Resident #21's medications scheduled for 10:00am at 12:04pm, 1 hour and 4 minutes beyond the allowed time frame. Review of Resident #21's February 2022 electronic medication administration record (eMAR) revealed: -There were 9 medications scheduled once a day at 8:00am including Amlodipine (lowers blood pressure), Aspirin (prevents heart disease), Duloxetine (for depression), Losartan (lowers blood pressure), Miralax (for constipation), Potassium Chloride ER (for low potassium levels), Senna Plus (for constipation), Vitamin B12 (vitamin supplement), and Vitamin D3 (for low Vitamin D levels). -There were 3 medications scheduled for twice a day including Eliquis (a blood thinner) at 8:00am and 8:00pm; Hydrocortisone 1% Ointment was scheduled at 10:00am and 7:00pm; and Timolol Maleate Eye Drops was scheduled at 10:00am and 9:00pm. -Brimonidine Eye Drops (for glaucoma), scheduled 3 times a day at 10:00am, 2:00pm, and 7:00pm. -Refresh Lacri-Lube Ointment (for dry eyes), scheduled 4 times a day at 10:00am, 2:00pm, 6:00pm; and 9:00pm. -Brimonidine Eye Drops and Refresh Lacri-Lube Ointment were scheduled to be administered again at 2:00pm, in less than 2 hours from receiving the morning doses at 12:04pm. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #21 just received her eye medications so she would not receive them again at 2:00pm. -The 2:00pm doses were missed doses on 02/04/22.	D 364		

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D 364	Continued From page 29 Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed antidepressants, medications used to lower blood pressure, and medications for glaucoma should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #21's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #21 was not interviewable. c. Review of Resident #12's current FL-2 dated 07/12/21 revealed diagnoses included anemia, hypothyroidism, major depressive disorder, anxiety disorder, insomnia, polyneuropathy, gastroesophageal reflux disease, constipation, and osteoarthritis. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #12's Vitamin B12 (for Vitamin B12 deficiency) scheduled at 7:00am before breakfast at 1:00pm, 5 hours after breakfast at 8:00am. -The MA administered Resident #12's medications scheduled for 8:00am at 1:00pm, 4 hours beyond the allowed time frame. Review of Resident #12's February 2022 electronic medication administration record (eMAR) revealed: -Vitamin B12 (a vitamin supplement) was	D 364		

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D 364	Continued From page 30 scheduled before breakfast at 7:00am. -There were 3 medications scheduled once a day at 8:00am including Citalopram (for depression), Docusate Sodium (for constipation), and Miralax (for constipation). -There were 3 medications scheduled twice a day including Diclofenac 1% Gel was scheduled at 10:00am and 7:00pm; Omeprazole (reduces stomach acid) and Senna Plus (for constipation) were scheduled at 8:00am and 8:00pm. -Tylenol (mild pain reliever) and Simethicone (for indigestion) were scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Maxitrol Eye Ointment (for eye infections) was scheduled 4 times a day at 10:00am, 2:00pm, 6:00pm, and 9:00pm. -Tylenol, Simethicone, and Maxitrol were scheduled to be administered again at 2:00pm, 1 hour after the morning doses were administered late at 1:00pm. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #12 just received her Tylenol, Simethicone, and eye ointment so she would not receive them again at 2:00pm. -The 2:00pm doses were missed doses on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Medications used to treat pain could cause breakthrough pain if administered late. -Medications, such as Vitamin B12, were ordered once a day before breakfast because they were better absorbed on an empty stomach. -Antidepressants and antibiotics should be administered about the same time each day for a consistent and steady amount of medication in	D 364		

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D 364	Continued From page 31 the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #12's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Attempted interview with Resident #12 on 02/07/22 at 10:06am was unsuccessful. d. Review of Resident #9's current FL-2 dated 07/22/21 revealed diagnoses included dementia, major depressive disorder severe with psychosis, generalized anxiety disorder, Huntington's disease, chronic migraines, essential hypertension, and gastroesophageal reflux disease. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed the MA administered Resident #9's medications scheduled for 8:00am at 11:32am, 2 hours and 32 minutes beyond the allowed time frame. Review of Resident #9's February 2022 electronic medication administration record (eMAR) revealed: -There were 3 medications scheduled once a day at 8:00am including Desvenlafaxine (for depression), Pantoprazole (reduces stomach acid), and Vitamin D3 (for low Vitamin D levels). -Tylenol (mild pain reliever) was scheduled twice a day at 8:00am and 8:00pm. -Gabapentin (for nerve pain or seizures) and Topamax (for mood disorders, migraines, or seizures) were scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Gabapentin and Topamax were scheduled to be administered again at 2:00pm, in less than 3	D 364		

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D 364	Continued From page 32 hours from the 8:00am doses administered at 11:32am. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #9 just received her Gabapentin and Topamax so she would not receive them again at 2:00pm. -The 2:00pm doses were missed doses on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Medications used to treat pain could cause breakthrough pain if administered late. -Antidepressants and medications used to treat mood disorders should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #9's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Interview with Resident #9 on 02/04/22 at 1:57pm revealed her medications were sometimes administered late and they were late that morning on 02/04/22. e. Review of Resident #20's current FL-2 dated 07/12/21 revealed diagnoses included major depressive disorder, motor neuron disease, amyotrophic lateral sclerosis, and cervical disc disorder with radiculopathy. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed the MA administered Resident #20's	D 364		

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D 364	Continued From page 33 medications scheduled for 8:00am at 11:58am, 2 hours and 58 minutes beyond the allowed time frame. Review of Resident #20's February 2022 electronic medication administration record (eMAR) revealed: -There were 4 medications scheduled once a day at 8:00am including Duloxetine (for depression), Loratadine (for allergies), Vitamin B12 (vitamin supplement), and Vitamin D3 (for low Vitamin D levels). -Baclofen (muscle relaxer) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Baclofen was scheduled to be administered again at 2:00pm, in 2 hours and 2 minutes from the morning dose administered late at 11:58am. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #20 just received her Baclofen so she would not receive it again at 2:00pm. -The 2:00pm dose was missed dose on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed medications used to treat muscle spasms and muscle pain could cause breakthrough muscle spasms and muscle pain if doses were late or missed. Attempted telephone interview with Resident #20's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Interview with Resident #20 on 02/07/22 at 10:13am revealed: -The facility was short-staffed and needed more help. -She had received her medications as late as	D 364		

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D 364	Continued From page 34 11:00am. -She did not recall having any side effects from receiving her medications late. f. Review of Resident #17's current FL-2 dated 07/26/21 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, dementia without behavioral disturbance, essential hypertension, atherosclerotic heart disease, bilateral primary osteoarthritis of the knee, and chronic kidney disease. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #17's medications scheduled for 8:00am at 12:32pm, 3 hours and 32 minutes beyond the allowed time frame. -The MA administered Resident #17's medications scheduled for 10:00am at 12:32pm, 1 hour and 32 minutes beyond the allowed time frame. Review of Resident #17's February 2022 electronic medication administration record (eMAR) revealed: -Amlodipine (lowers blood pressure) was scheduled once a day at 8:00am. -Clear Eyes Itchy Relief Drops (for eye allergy symptoms) were scheduled at 10:00am and 2:00pm; Nystatin Cream (antifungal cream) was scheduled at 10:00am and 7:00pm; and Tramadol (for moderate to severe pain) was scheduled at 8:00am and 8:00pm. -Diclofenac Sodium 1% Gel (topical for pain and inflammation) was scheduled 3 times a day at 10:00am, 2:00pm, and 7:00pm. -Diclofenac Sodium 1% Gel was scheduled to be administered again at 2:00pm, less than 2.5	D 364		

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D 364	Continued From page 35 hours from the dose administered at 12:32pm. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #17 just received her Diclofenac topical gel so she would not receive it again at 2:00pm. -The 2:00pm dose was a missed dose on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed: -Medications used to treat pain could cause breakthrough pain if doses were late or missed. -Medications used to lower blood pressure should be administered about the same time each day for a consistent and steady amount of medication in the bloodstream to ensure the medication was most effective. Attempted telephone interview with Resident #17's primary care provider (PCP) on 02/07/22 at 4:34pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable. g. Review of Resident #23's current FL-2 dated 07/08/21 revealed diagnoses included dementia, essential hypertension, venous insufficiency, constipation, osteoarthritis, and edema. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #23's medications scheduled for 8:00am at 1:55pm, 4 hours and 55 minutes beyond the allowed time frame.	D 364		

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D 364	Continued From page 36 -The MA administered Resident #23's medication scheduled for 10:00am at 1:55pm, 2 hours and 55 minutes beyond the allowed time frame. Review of Resident #23's February 2022 electronic medication administration record (eMAR) revealed: -Furosemide (for swelling and excess fluid) and Milk of Magnesia (for constipation) were scheduled once a day at 8:00am. -Diclofenac Sodium 1% Gel (topical for pain and inflammation) was scheduled at 10:00am and 7:00pm and Senna Plus (for constipation) was scheduled at 8:00am and 8:00pm. -Tylenol (mild pain reliever) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Tylenol was scheduled to be administered again at 2:00pm, in 5 minutes of receiving the late 8:00am scheduled dose on 02/04/22. Interview with the MA on 02/04/22 at 2:00pm revealed: -Resident #23 just received her morning dose Tylenol so she would not administer the 2:00pm dose. -The 2:00pm dose was a missed dose on 02/04/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed medications used to treat pain could cause breakthrough pain if doses were late or missed. Based on observations, interviews, and record reviews, it was determined Resident #23 was not interviewable. h. Review of Resident #8's current FL-2 dated 12/20/21 revealed diagnoses included bipolar	D 364		

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D 364	Continued From page 37 disorder, insomnia, hypertension, asthma, depression, chronic kidney disease - stage 3, osteoarthritis, and hypothyroidism. Observation of the medication aide (MA) administering morning medications on 02/04/22 revealed: -The MA administered Resident #8's Levothyroxine (for hypothyroidism) scheduled for 7:00am on an empty stomach at 11:24am, over 3 hours late and after the resident had already eaten breakfast at 8:00am. -The MA administered Resident #8's medications scheduled for 8:00am at 11:24am, 2 hours and 24 minutes beyond the allowed time frame. Review of Resident #8's February 2022 electronic medication administration record (eMAR) revealed: -Levothyroxine was scheduled at 7:00am on an empty stomach. -There were 8 medications scheduled once a day at 8:00am including Amlodipine (lowers blood pressure), Aspirin (used to prevent heart disease), Depakote (for mood disorders or seizures), Fish Oil, (a supplement to lower triglycerides), Lisinopril (lowers blood pressure), Loratadine (for allergies), Miralax (for constipation), Vitamin D3 (for low Vitamin D levels). -There were 5 medications scheduled twice a day at 8:00am and 8:00pm including Tylenol (mild pain reliever), Benztropine (used to treat Parkinson-like symptoms), Metoprolol Tartrate (lowers blood pressure and heart rate), Seroquel (antipsychotic), and Senna Plus (for constipation). -Tylenol, Benztropine, Metoprolol, Seroquel, and Senna Plus were scheduled to be administered again at 8:00pm.	D 364		

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D 364	Continued From page 38 Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/07/22 at 5:20pm revealed Levothyroxine was ordered once a day before breakfast because it was better absorbed on an empty stomach and needed consistent levels to be most effective. Interview with Resident #8 on 02/04/22 at 12:00pm revealed: -She had just received her morning medications a few minutes ago. -That was the latest she had ever received her medications.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	3-24-2022 The pharmacist from our pharmacy has been here to audit all MARs and charts. The pharmacist and the RN from pharmacy have done a couple of inservice training to make sure all Med Techs are doing better with documentation. The RCC and RCD will monitor MARs weekly to make sure all Meds were given as ordered and orders followed.	

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D 367	Continued From page 39 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 5 of 5 residents sampled (#1, #2, #3, #4, #5) related to multiple omissions for multiple medications for each resident with no reasons for the omissions documented. The findings are: Review of the facility's Medication Omission Policies and Procedures (undated) revealed: -When documenting omissions on the medication administration record (MAR), medication aides (MAs) should write their initials and circle. -This circle indicates the medication has not been given to the resident. -The MA should document on the back of the MAR, the reason for omission (i.e. refusal, hospital, leave of absence, out of stock, etc.). -For facilities with electronic MARs, omissions must also be documented appropriately with the reason for omission. -If a MA circles an omission on the MAR for more than 0 consecutive day(s) due to out of stock, the MA must report this to their supervisor and contact the facility's contracted pharmacy. -Provider should be contacted for the following: more than 0 consecutive/cumulative refusals, extended out of stock situation (more than 3 doses), or missed dose. 1. Review of Resident #3's current FL-2 dated 07/12/21 revealed: -Diagnoses included urge incontinence, type 2 diabetes mellitus with hyperglycemia, hypothyroidism, dementia, bipolar disorder, and anxiety disorder.	D 367		

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D 367	Continued From page 40 -There was an order for Flonase Nasal Spray use 2 sprays in each nostril daily. (Flonase is used to treat seasonal allergy symptoms such as sneezing and runny nose.) -There was an order for Duoneb use 1 vial in nebulizer 4 times a day. (Duoneb is used to treat chronic obstructive pulmonary disease.) -There was an order for Pulmicort 180mcg Flexhaler inhale 1 puff once daily. (Pulmicort is used to treat chronic obstructive pulmonary disease.) -There was an order for Refresh Tears 0.5% place 2 drops in each eye 3 times daily. (Artificial Tears is used to treat dry eyes.) Review of Resident #3's physician's orders dated 12/20/21 revealed: -There was an order for Duoneb use 1 vial in nebulizer 3 times a day -There was an order for Pulmicort 180mcg Flexhaler inhale 1 puff twice daily. Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase Nasal Spray use 2 sprays in each nostril daily scheduled for 10:00am. -Documentation for administration of Flonase was blank on 12/13/21 and 12/18/21 with no reason for the omissions. -There was an entry for Duoneb use 1 vial in nebulizer 3 times a day scheduled for 10:00am, 2:00pm, and 7:00pm. -There was an entry for Pulmicort 180mcg Flexhaler inhale 1 puff twice daily scheduled for 10:00am and 7:00pm. -There was an entry for Refresh Tears 0.5% place 2 drops in each eye 3 times daily scheduled for 10:00am, 2:00pm and 7:00pm.	D 367		

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D 367	Continued From page 41 -Documentation for administration of Duoneb, Pulmicort, and Refresh Tears was blank at 10:00am on 12/13/21 and 12/18/21 and at 7:00pm on 12/25/21 with no reason for the omissions. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for Flonase Nasal Spray use 2 sprays in each nostril daily scheduled for 7:00pm. -Documentation for administration of Flonase was blank on 01/29/22 with no reason for the omission. -There was an entry for Duoneb use 1 vial in nebulizer 3 times a day scheduled for 10:00am, 2:00pm, and 7:00pm. -Documentation for administration of Duoneb was blank at 7:00pm on 01/29/22 and 10:00am and 2:00pm on 01/30/22 with no reason for the omissions. -There was an entry for Pulmicort 180mcg Flexhaler inhale 1 puff twice daily scheduled for 10:00am and 7:00pm. -Documentation for administration of Pulmicort was blank at 7:00pm on 01/29/22 and 10:00am on 01/30/22 with no reason for the omissions. -There was an entry for Refresh Tears 0.5% place 2 drops in each eye 3 times daily scheduled for 10:00am, 2:00pm and 7:00pm. -Documentation for administration of Refresh Tears was blank at 2:00pm on 01/14/22, 7:00pm on 01/29/22, and 10:00am and 2:00pm on 01/30/22 with no reason for the omissions. Interview with the medication aide (MA) on 02/07/22 at 2:50pm revealed: -She did not know why there were omissions on Resident #3's eMARs. -Resident #3 usually took her medications and	D 367		

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D 367	Continued From page 42 did not refuse any. Interview with Resident #3 on 02/07/22 at 5:12pm revealed: -She received medications everyday, but she was not sure what medications she received. -She did not know if she had missed any doses of any medications. Refer to interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm. Refer to interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm. 2. Review of Resident #1's current FL-2 dated 08/19/21 revealed: -Diagnoses included essential primary hypertension, chronic atrial fibrillation, heart failure, sick sinus syndrome, dementia without behavioral disturbance, and malignant neoplasm of bronchus, testes, and bladder. -There was an order for Ferrex 150 take 1 capsule twice a day. (Ferrex 150 is an iron supplement used to treat low iron levels.) -There was an order for Metoprolol Tartrate 25mg 1 tablet twice daily. (Metoprolol lowers blood pressure and heart rate.) -There was an order for Senna Plus 8.6mg/50mg 2 tablets at bedtime. (Senna Plus is a laxative used for constipation.) -There was an order for Simvastatin 20mg 1 tablet at bedtime. (Simvastatin is used to lower cholesterol.) -There was an order for Warfarin 4mg 1 tablet once a day. (Warfarin is a blood thinner used to prevent blood clots.) Review of Resident #1's December 2021 electronic medication administration record	D 367		

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D 367	Continued From page 43 (eMAR) revealed: -There was an entry for Ferrex 150 take 1 capsule twice a day scheduled for 7:00am and 7:00pm. -There was an entry for Metoprolol Tartrate 25mg 1 tablet twice daily scheduled for 7:00am and 7:00pm. -There was an entry for Senna Plus 8.6mg/50mg 2 tablets at bedtime scheduled for 7:00pm. -There was an entry for Simvastatin 20mg 1 tablet at bedtime scheduled for 7:00pm. -There was an entry for Warfarin 4mg 1 tablet once a day scheduled for 7:00pm. -Documentation for administration of Ferrex 150, Metoprolol, Senna Plus, Simvastatin, and Warfarin was blank at 7:00pm on 12/12/21 with no reason for the omission. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for Ferrex 150 take 1 capsule twice a day scheduled for 7:00am and 7:00pm. -There was an entry for Metoprolol Tartrate 25mg 1 tablet twice daily scheduled for 7:00am and 7:00pm. -There was an entry for Senna Plus 8.6mg/50mg 2 tablets at bedtime scheduled for 7:00pm. -There was an entry for Simvastatin 20mg 1 tablet at bedtime scheduled for 7:00pm. -There was an entry for Warfarin 4mg 1 tablet once a day scheduled for 7:00pm. -Documentation for administration of Ferrex 150, Metoprolol, Senna Plus, Simvastatin and Warfarin was blank at 7:00pm on 01/12/22, 01/14/22, 01/19/22, 01/26/22, and 01/29/22 with no reason for the omissions. Interview with the Resident Care Manager (RCM) on 02/07/22 at 3:10pm revealed:	D 367		

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D 367	Continued From page 44 -She was not aware there were any omissions on Resident #1's eMARs. -Resident #1 usually took his medications without refusals. Interview with Resident #1 on 02/02/22 at 9:48am revealed: -She usually received his medications about the same time every day. -He was not aware of any recent missed doses of any medications. Refer to interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm. Refer to interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm. 3. Review of Resident #2's current FL-2 dated 07/12/21 revealed: -Diagnoses included hypothyroidism, hyperlipidemia, dementia, depression, hearing loss, hypertension (HTN), peripheral vascular disease (PVD) and seborrheic dermatitis. -There was an order for Acetaminophen 500mg 2 tablets twice a day. (Acetaminophen is used to treat minor aches and pains and reduce fevers.) -There was an order for Chlorhexidine 0.12% Rinse swish and spit 15ml by mouth 3 times a day. (Chlorhexidine 0.12% Rinse is used to reduce bacteria in the mouth.) -There was an order for Dermacloud Ointment to be applied to the buttocks four times a day. (Dermacloud Ointment is a skin protectant used to treat dermatological inflammations.) -There was an order for Escitalopram 20mg once a day. (Escitalopram is used to treat depression.) -There was an order for Fiber-Lax 625mg once a day. (Fiber-Lax is used to treat constipation.) -There was an order for Levothyroxine 100mcg	D 367		

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D 367	Continued From page 45 once a day. (Levothyroxine is used to treat hypothyroidism.) Review of a signed physician's order for Resident #2 dated 11/18/21 revealed there was an order for Risperidone 0.5mg 3 times a day. (Risperidone is used to treat certain mental/mood disorders.) Review of a second signed physician's order for Resident #2 dated 11/22/21 revealed there was an order for Trazodone 50mg ½ tablet twice a day. (Trazodone is used to treat depression.) Review of a third signed physician's order for Resident #2 dated 01/24/22 revealed there was an order for Bactrim DS twice a day for 10 days. (Bactrim DS is an antibiotic used to treat or prevent infections.) Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 500mg 2 tablets twice a day scheduled for 8:00am and 8:00pm. -Documentation for administration of Acetaminophen was blank at 8:00pm on 12/16/21, 8:00am on 12/21/21 and 8:00pm on 12/25/21 with no reason for the omissions. -There was an entry for Chlorhexidine 0.12% Rinse swish and spit 15ml by mouth 3 times a day scheduled for 10:00am, 2:00pm and 7:00pm. -Documentation for administration of Chlorhexidine was blank at 2:00pm on 12/01/21, 12/02/21, and 12/05/21; at 7:00pm on 12/16/21 and 12/25/21; and 10:00am on 12/21/21 with no reason for the omissions. -There was an entry for Dermacloud Ointment to be applied to the buttocks four times a day	D 367		

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D 367	Continued From page 46 scheduled for 10:00am, 2:00pm, 6:00pm and 9:00pm. -Documentation for administration of Dermacloud Ointment was blank at 10:00am on 12/21/21, at 2:00pm on 12/01/21, 12/02/21 and 12/05/21, at 6:00pm on 12/08/21, 12/09/21, 12/16/21, 12/18,21, 12/19/21, 12/24/21, 12/27/21 and 12/28/21, at 9:00pm on 12/15/21, 12/16/21, 12/21/21 and 12/25/21 with no reason for the omissions. -There was an entry for Escitalopram 20mg once a day scheduled for 8:00am. -There was an entry for Fiber-Lax 625mg once a day scheduled for 8:00am. -There was an entry for Levothyroxine 100mcg once a day scheduled for 7:00am. -Documentation for administration of Escitalopram, Fiber-Lax, and Levothyroxine was blank on 12/21/21 with no reason for the omissions. -There was an entry for Risperidone 0.5mg 3 times a day scheduled for 8:00am, 2:00pm and 8:00pm. -Documentation for administration of Risperidone was blank at 8:00am on 12/21/21, at 2:00pm on 12/05/21 and at 8:00pm on 12/16/21 and 12/25/21 with no reason for the omissions. -There was an entry for Trazodone 50mg ½ tablet twice a day scheduled for 12:00pm and 5:00pm. -Documentation for administration of Trazodone was blank at 12:00pm on 12/05/21 and at 5:00pm on 12/08/21, 12/09/21 and 12/28/21 with no reason for the omissions. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for Acetaminophen 500mg 2 tablets twice a day scheduled for 8:00am and 8:00pm. -Documentation for administration of	D 367		

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D 367	Continued From page 47 Acetaminophen was blank at 8:00pm on 01/12/22, 01/23/22 and 01/29/22 with no reason for the omissions. -There was an entry for Chlorhexidine 0.12% Rinse swish and spit 15ml by mouth 3 times a day scheduled for 10:00am, 2:00pm and 7:00pm. -Documentation for administration of Chlorhexidine was blank at 7:00pm on 01/12/22 and 01/23/22 with no reason for the omissions. -There was an entry for Dermacloud Ointment to be applied to the buttocks four times a day scheduled for 10:00am, 2:00pm, 6:00pm and 9:00pm. -Documentation for administration of Dermacloud Ointment was blank at 10:00am on 01/31/22, at 6:00pm on 01/06/22, 01/12/22, 01/19/22, 01/27/22 - 01/31/22, at 9:00pm on 01/05/22, 01/12/22, 01/23/22, 01/25/22, 01/29/22 and 01/30/22 with no reason for the omissions. -There was an entry for Risperidone 0.5mg 3 times a day scheduled for 8:00am, 2:00pm and 8:00pm. -Documentation for administration of Risperidone was blank at 8:00pm on 01/12/22, 01/23/22 and 01/29/22 with no reason for the omissions. -There was an order for Bactrim DS twice a day scheduled for 8:00am and 9:00pm. -Documentation for administration of Bactrim DS was blank at 9:00pm on 01/29/22 and 01/30/22 with no reason for the omissions. -There was an entry for Trazodone 50mg ½ tablet twice a day scheduled for 12:00pm and 5:00pm. -Documentation for administration of Trazodone was blank at 5:00pm on 01/06/22, 01/12/22, 01/27/22 and 01/29/22 with no reason for the omissions. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.	D 367		

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D 367	Continued From page 48 Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/07/22 at 4:35pm was unsuccessful. Refer to interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm. Refer to interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm. 4. Review of Resident #4's current FL-2 dated 07/29/21 revealed: -Diagnoses included hyperthyroidism, dementia, delusional disorder, major depression, anxiety, vertigo, hypertension (HTN) and gastroesophageal reflux disease (GERD). -There was an order for Amlodipine 2.5mg once a day. (Amlodipine is used to treat HTN.) -There was an order for Calcium 600mg with Vitamin D3 twice a day. (Calcium 600mg with Vitamin D3 is a vitamin supplement.) -There was an order for Citalopram 20mg once a day. (Citalopram is used to treat depression.) -There was an order for Docusate Sodium 100mg once a day. (Docusate Sodium is used to treat constipation.) -There was an order for Famotidine 20mg once a day. (Famotidine is used to treat GERD.) -There was an order for Levothyroxine 25mcg once a day. (Levothyroxine is used to treat hypothyroidism.) -There was an order for Risperidone 0.5mg ½ tablet in the morning and 2 tablets in the evening. (Risperidone is used to treat certain mental/mood disorders.) -There was an order for Systane Ultra 0.3-0.4% eye drops 2 drops to each eye once a day. (Systane eye drops are used to treat dry eyes.) -There was an order for Vitamin B-12 500mcg	D 367		

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D 367	Continued From page 49 once a day. (Vitamin B-12 is used to treat B-12 deficiencies.) -There was an order for Zinc Oxide 20% Ointment to be applied to the buttocks 3 times a day. (Zinc Oxide is used to treat and prevent diaper rashes.) Review of Resident #4's signed physician's orders dated 12/20/21 revealed: -There was an order for Lisinopril 30mg once a day. (Lisinopril is used to treat HTN.) -There was an order for Geri-Sleeves to be applied to both arms in the morning and removed at bedtime. (Geri-Sleeves are used to prevent skin tears.) -There was an order for Mighty Shakes three times a day. (Mighty Shake is a nutritional supplement used to increase caloric intake.) Review of Resident #4's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Calcium 600mg with Vitamin D3 twice a day scheduled for 7:30am and 5:00pm. -Documentation for administration of Calcium with Vitamin D3 was blank at 7:30am on 12/29/21 and 5:00pm on 12/02/21, 12/04/21, 12/12/21, 12/16/21, 12/23/21 with no reason for omissions. -There was an entry for Levothyroxine 25mcg once a day scheduled for 6:00am. -Documentation for administration of Levothyroxine was blank on 12/11/21 and 12/12/21 with no reason for omissions. -There was an entry for Risperidone 0.5mg ½ tablet in the morning scheduled for 8:00am and 2 tablets in the evening scheduled for 7:00pm. -Documentation for administration of Risperidone was blank at 7:00pm on 12/01/21, 12/02/21, 12/05/21 and 12/28/21 with no reason for	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 50 omissions. -There was an entry for Systane Ultra 0.3-0.4% eye drops 2 drops to each eye once a day scheduled for 7:00pm. -Documentation for administration of Systane eye drops was blank on 12/01/21, 12/02/21, 12/05/21 and 12/28/21 with no reason for omissions. -There was an entry for Zinc Oxide 20% Ointment to be applied to the buttocks 3 times a day scheduled for 7:00am - 3:00pm, 3:00pm - 11:00pm and 11:00pm - 7:00am. -Documentation for administration of Zinc Oxide was blank for 3:00pm - 11:00pm on 12/02/21 and 11:00pm - 7:00am on 12/10/21 with no reason for the omissions. -There was an entry for Geri-Sleeves to be applied to both arms in the morning scheduled for 6:00am - 11:00am and to be removed at bedtime scheduled for 7:30pm. -Documentation for administration of Geri-Sleeves was blank on 12/01/21, 12/02/21, 12/05/21 and 12/28/21 with no reason for omissions. -There was an entry for administration of Mighty Shakes three times a day scheduled for 7:30am, 12:00pm and 5:00pm. -Documentation for Mighty Shakes was blank at 7:30am on 12/29/21 and 5:00pm on 12/02/21, 12/04/21, 12/12/21, 12/16/21 and 12/23/21 with no reason for omissions. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Amlodipine 2.5mg once a day scheduled for 8:00am. -Documentation for administration of Amlodipine was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Calcium 600mg with Vitamin D3 twice a day scheduled for 7:30am and	D 367		

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D 367	Continued From page 51 5:00pm. -Documentation for administration of Calcium with Vitamin D3 was blank at 7:30am on 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 and blank at 5:00pm on 01/13/22, 01/14/22, 01/17/22, 01/19/22, 01/20/22, 01/22/22, 01/24/22, 01/26/22, 01/28/22, 01/29/22 and 01/31/22 with no reason for omissions. -There was an entry for Citalopram 20mg once a day scheduled for 8:00am. -Documentation for administration of Citalopram was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Docusate Sodium 100mg once a day scheduled for 8:00am. -Documentation for administration of Docusate Sodium was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Famotidine 20mg once a day scheduled for 8:00am. -Documentation for administration of Famotidine was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Lisinopril 30mg once a day scheduled for 8:00am. -Documentation for administration of Lisinopril was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Geri-Sleeves to be applied to both arms in the morning scheduled for 6:00am - 11:00am and to be removed at bedtime scheduled for 7:30pm. -Documentation for administration of Geri-Sleeves was blank on 01/22/22, 01/24/22, 01/28/22 and 01/31/22 with no reason for omissions. -There was an entry for Levothyroxine 25mcg once a day scheduled for 6:00am. -Documentation for administration of	D 367		

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D 367	Continued From page 52 Levothyroxine was blank on 01/14/22, 01/19/22, 01/22/22, 01/24/22, 01/28/22 and 01/31/22 with no reason for omissions. -There was an entry for Mighty Shakes three times a day scheduled for 7:30am, 12:00pm and 5:00pm. -Documentation for administration of Mighty Shakes was blank at 7:30am from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22, blank at 12:00pm from 01/21/22 - 01/24/22 and 01/26/22 - 01/31/22, and blank at 5:00pm on 01/13/22, 01/14/22, 01/17/22, 01/19/22, 01/20/22, 01/22/22, 01/24/22, 01/26/22, 01/28/22, 01/29/22 and 01/31/22 with no reason for omissions. -There was an entry for Risperidone 0.5mg ½ tablet in the morning scheduled for 8:00am and 2 tablets in the evening scheduled for 7:00pm. -Documentation for administration of Risperidone was blank at 8:00am from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 and blank at 7:00pm on 01/12/22, 01/14/22, 01/19/22, 01/20/22, 01/22/22, 01/24/22, 01/28/22, 01/29/22 and 01/31/22 with no reason for omissions. -There was an entry for Systane Ultra 0.3-0.4% eye drops 2 drops to each eye once a day scheduled for 7:00pm. -Documentation for administration of Systane eye drops was blank on 01/12/22, 01/14/22, 01/19/22, 01/20/22, 01/22/22, 01/24/22, 01/28/22, 01/29/22 and 01/31/22 with no reason for omissions. -There was an entry for Vitamin B-12 500mcg once a day scheduled for 8:00am. -Documentation for administration of Vitamin B-12 was blank from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 with no reason for omissions. -There was an entry for Zinc Oxide 20% Ointment to be applied to the buttocks 3 times a day scheduled for 7:00am - 3:00pm, 3:00pm - 11:00pm and 11:00pm - 7:00am.	D 367		

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D 367	Continued From page 53 -Documentation for administration of Zinc Oxide was blank for 7:00am - 3:00pm from 01/20/22 - 01/28/22, 01/30/22 and 01/31/22 and blank for 3:00pm - 11:00pm on 01/14/22, 01/19/22, 01/20/22, 01/22/22, 01/24/22, 01/28/22, 01/29/22 and 01/31/22 with no reason for the omissions. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Attempted telephone interview with Resident #4's primary care provider (PCP) on 02/07/22 at 4:35pm was unsuccessful. Refer to interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm. Refer to interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm. 5. Review of Resident #5's current FL-2 dated 08/19/21 revealed: -Diagnoses included dementia, major depression, insomnia, hypertension and heart disease. -There was an order for Docusate Sodium 100mg twice a day. (Docusate Sodium is used to treat constipation.) -There was an order for Healthy Eyes Super Vision 1 capsule twice a day. (Healthy Eyes Super Vision is a supplement used to support eye health.) -There was an order for Melatonin 5mg at bedtime. (Melatonin is used to treat insomnia.) -There was an order for Nystatin 100,000 unit/gm cream to be applied to affected skin twice a day. (Nystatin is used to treat fungal infections.) -There was an order for Sertraline 50mg at bedtime. (Sertraline is used to treat depression.)	D 367		

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D 367	Continued From page 54 Review of Resident #5's January 2022 electronic medication record (eMAR) revealed: -There was an entry for Docusate Sodium 100mg twice a day scheduled for 9:00am and 9:00pm. -There was an entry for Healthy Eyes Supervision 1 capsule twice a day scheduled for 9:00am and 9:00pm. -There was an entry for Melatonin 5mg at bedtime scheduled for 9:00pm. -Documentation for administration of Docusate Sodium, Healthy Eyes Super Vision, and Melatonin was blank at 9:00pm on 01/12/22, 01/17/22, 01/19/22, 01/25/22, 01/29/22 and 01/30/22 with no reason for omissions. -There was an entry for Nystatin 100,000 unit/gm cream to be applied to affected skin twice a day scheduled for 10:00am and 7:00pm. -Documentation for administration of Nystatin was blank on 01/12/22, 01/17/22, 01/19/22, 01/29/22 and 01/30/22 with no reason for omissions. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Attempted telephone interview with Resident #5's primary care provider (PCP) on 02/07/22 at 4:35pm was unsuccessful. Refer to interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm. Refer to interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm. Interview with the Resident Care Manager (RCM) on 02/07/22 at 3:18pm revealed: -If there was a blank on the eMAR, it may have been caused by the computer system going offline.	D 367		

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D 367	Continued From page 55 -If the computer system was down, the eMARs could be printed and the MAs could use paper copies of the eMARs to document. -If a medication was omitted, there should be a reason documented. -She did not check the eMARs for accuracy and there was no system in place to check the eMARs for accuracy. Interview with the facility's General Manager (GM) on 02/07/22 at 6:11pm revealed: -It was the responsibility of the RCM and the Resident Care Director (RCD) to review the electronic medication administration records (eMAR) at least weekly for accuracy and omissions. -It was the responsibility of the RCM and the RCD to notify the resident's primary care provider (PCP) and the Administrator for eMAR inaccuracies and omissions. -The RCD position was currently vacant so the RCM was solely responsible for monitoring the eMARs at this time.	D 367	Continued from page 55 3-24-22 Supervisors and administrative staff are constantly observing to make sure all meds and carts are kept secure. Pharmacist has been in to audit all carts and meds. We had to have locks replaced on one of the carts and the 400 Hall Med Room. All Med Techs, the RCC, the RCD and Administrative staff will be checking carts and storage daily. 3-24-22	
(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 review, the facility failed to ensure the medication	(D 378)		

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{D 378}	Continued From page 56 storage room was locked on the 400 hall with two medication carts when not under the direct physical supervision of staff in charge of medication administration. The findings are: Review of the facility's Medication Storage Policies and Procedures (undated) revealed: -Only licensed nurses, pharmacy personnel, medication aides (MAs), and those lawfully authorized to administer medications were allowed to access medications. -Medication rooms, carts, and medication supplies were locked or attended by persons with authorized access. -Potentially harmful substances were clearly identified and stored in a locked area separately from medications. Observation of the medication room on the 400 hall on 02/02/22 at 10:11am revealed: -The medication room was across the hall from resident room #401. -There was a door handle with a keyhole lock and a key pad above the handle. -The door was unlocked and opened when the handle was pulled. -There was no staff in the medication room or in the hallway in sight of the medication room. -There was one medication cart inside the unlocked medication room. -The medication cart was locked and there was a bottle of drug buster disposal system (activated charcoal) on top of the cart. -There was open shelving in the medication room with 3 bottles of Calcium Antacid Extra Strength tablets, hand sanitizer, drug buster disposal solution, and a plastic container with diabetic supplies.	{D 378}		

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{D 378}	Continued From page 57 -There was a small medication refrigerator with a latch and padlock that was unlocked. -The refrigerator contained two insulin pens and two bottles of Miracle Mouthwash (medication used to treat oral thrush). Observation of the medication room on the 400 hall on 02/02/22 at 10:16am revealed a resident walked down the hall and by the unlocked medication room. Second observation of the medication room on the 400 hall on 02/02/22 at 11:02am revealed: -The door was unlocked and opened when the handle was pulled. -There was no staff in the medication room or in the hallway in sight of the medication room. -There were two medication carts inside the unlocked medication room. -Both medication carts were locked and there was a bottle of drug buster disposal system on top of each cart. -There was open shelving in the medication room with 3 bottles of Calcium Antacid Extra Strength tablets, hand sanitizer, drug buster disposal solution, and a plastic container with diabetic supplies. -There was a small medication refrigerator with a latch and padlock that was unlocked. -The refrigerator contained two insulin pens and two bottles of Miracle Mouthwash (medication used to treat oral thrush). Interview with the Resident Care Manager (RCM) on 02/02/22 at 11:03am revealed: -The door to the medication room on 400 hall was usually locked. -There was usually a clicking sound when the door locked. -The MAs were responsible for making sure the	{D 378}		

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{D 378}	Continued From page 58 door was locked. -She was not aware of any problems with the door not locking. Interviews with a MA on 02/02/22 at 11:09am and 2:12pm revealed: -All medication rooms should be locked at all times. -She was not aware the medication room on the 400 hall was not locked that morning on 02/02/22. -The MAs used a code with the key pad to unlock the medication room door. -The door usually locked when it was shut and a clicking noise was heard. -She did not usually pull on the handle to make sure the door was locked because she thought when heard the click the door was locked. Interview with the Maintenance Director on 02/02/22 at 2:35pm revealed: -No one had reported any problems with locking the medication room door on the 400 hall prior to today, 02/02/22. -The RCM reported to him that the door was not locking today, 02/02/22. -He checked the door and the strike plate was not catching so the door could be pulled open even with the handle locked. -He repaired the strike plate and the door was now locked. Interview with the Administrator on 02/02/22 at 4:15pm revealed: -All medication rooms should be locked if there were no MAs in the medication rooms. -Only MAs and their supervisor had access to the medication rooms and they were responsible to make sure the medication room doors were locked. -The MAs should physically pull on the	{D 378}		

Division of Health Service Regulation

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(D 378)	Continued From page 59 medication room door to make sure it was locked when they closed the door. -The door to the medication refrigerator should be locked after each use unless medication staff were in the medication room. -There were residents in the facility who were confused and had wandering behaviors. -He was concerned a resident could take medications if the medications were left unlocked and unattended by staff.	(D 378)		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and	D 611	3-24-22 We had the RN from our pharmacy to come in and do an in-service on infection control, Covid guidelines and proper use of PPE. We did an inventory and organized storage of PPE to make sure that we maintain a proper supply. The RN was here on 2-09-22 to do a training on the proper use of PPE and was attended by ten staff. Our new RN (an LPN) will help monitor and train staff on proper infection prevention and control on a daily basis. We will also have classes quarterly!	

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D 611	Continued From page 60 (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and	D 611		

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D 611	Continued From page 61 procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection for residents during the global coronavirus (COVID-19) pandemic as related to staff wearing personal protective equipment (PPE) when caring for residents who were diagnosed with COVID-19. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Long-Term Care Facilities dated 09/10/21 revealed: -The guidance referred to Interim Infection Control Recommendations for Healthcare Personnel during the COVID-19 Pandemic. -Healthcare personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N-95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).	D 611		

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D 611	Continued From page 62 Review of the NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/21 revealed DHHS continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. a. Review of an email dated 02/03/22 from the local health department (LHD) public health nurse/preparedness coordinator revealed healthcare personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N-95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Observation of the 100 hall on 02/02/22 from 10:19am to 10:21am revealed: -There was an isolation cart outside of resident room #107. -On the door of resident room #107 was a paper in a plastic sleeve, "Caution enter with personal protective gear only" and a stop sign on the paper. -There was also a paper in a plastic sleeve labeled Airborne Infection Isolation Precautions. -The medication aide (MA) was wearing an N-95 face mask and applied a gown from the isolation cart. -At 10:19am, the MA entered resident room #107 wearing the gown and N-95 face mask. -At 10:21am, the MA exited resident room #107 wearing the N-95 face mask. -The MA sanitized her hands with hand sanitizer located on the isolation cart outside the room. -The MA did not wear a face shield or goggles	D 611		

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D 611	Continued From page 63 when entering resident room #107. -The MA did not change the N-95 face mask after she exited resident room #107. -The MA pushed the medication cart down 100 hall towards the nurses' station wearing the same N-95 face mask. Interview with the MA on 02/02/22 at 1:00pm revealed: -She wore gloves, a gown, N-95, and face mask when providing care for residents with COVID-19. -She did not wear a face shield or goggles when caring for residents with COVID-19 because she was diagnosed with COVID-19 two weeks ago. -She removed the gown and gloves and disposed of them in a biohazard box located in the resident room. -She was supposed to change her N-95 face mask after exiting the room of a COVID-19 positive resident. -She did not change her N-95 face mask after exiting a COVID-19 positive resident in room #107 this morning, 02/02/22, because she forgot. -There was no trash can outside of room #107 to dispose of her N-95 face mask. Interview with the Administrator on 02/02/22 at 8:45am revealed: -There were two residents in the facility who tested positive for COVID-19 on 02/01/22. -The residents who had tested positive for COVID-19 were isolated in their rooms. -There was an isolation cart outside the room of the residents who had tested positive for COVID-19. -The isolation carts contained face masks (type of face masks not specified), gowns, and gloves. -Staff were required to wear a face mask, gown, and gloves when entering the room of a resident who had been diagnosed with COVID-19.	D 611		

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D 611	Continued From page 64 -It was the responsibility of the Human Resources Director (HRD) to contact the LHD for COVID-19 guidance. Interview with a personal care aide (PCA) on 02/02/22 at 9:40am revealed: -Staff were expected to wear a gown, gloves, foot coverings, face shield, and face mask when providing personal care to residents who were diagnosed with COVID-19. -Staff were expected to wear a gown and gloves if they were in the same room with the resident and not providing personal care, such as when delivering a food tray. -Before exiting the room, staff were expected to remove their gown, gloves, and face shield and throw in the garbage located in the resident room. -Staff were expected to remove their face mask after exiting the room and apply a new one and sanitize their hands. Interview with the Resident Care Manager (RCM) on 02/02/22 at 3:19pm revealed: -Isolation carts and trash cans were outside the room of every resident who tested positive for COVID-19. -In the isolation carts were N-95s, face masks, face shields, shoe coverings, gowns, gloves, hand sanitizer, and disinfectant spray. -Staff were to wear an N-95 face mask, gown, and gloves when entering the room of a resident who was on isolation because they tested positive for COVID-19. -She did not know staff were to wear a face shield or goggles when entering the room of a resident who was on isolation because they tested positive for COVID-19. -The facility had face shields available for use if staff preferred but it was not mandatory. -The facility had face shields and she had	D 611		

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D 611	Continued From page 65 restocked face shields in the isolation carts today, 02/02/22. -Staff were expected to throw away their N-95 face masks in the trashcan located outside the room and apply a new one after exiting a room of a resident who was on isolation because they tested positive for COVID-19 to prevent cross contamination. -She observed staff entering and exiting the room of a resident who was on isolation on 01/31/22 and she had no concerns with their process. A second interview with the Administrator on 02/02/22 at 4:45pm revealed: -He expected staff to wear gowns, gloves, and a facemask when entering the room of a resident who was on isolation to protect from contracting COVID-19. -Staff were not required to wear face shields or goggles when caring for residents who were on isolation because of COVID-19. -Face shields were available if staff wanted to use them. -He expected staff to remove their face mask, place it in the trash, and apply a new face mask after exiting the room of a resident who was on isolation to prevent cross contamination of COVID-19. -He knew the process for staff caring for residents diagnosed with COVID-19 because he received the emails from the state and county regarding the proper procedures when caring for residents with COVID-19. -He would share those same emails with the HRD. -The facility nurse had provided staff training on the proper use of PPE when caring for residents who had COVID-19 however, he did not remember when. -He thought the last COVID-19 training for staff	D 611		

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D 611	Continued From page 66 was about three - four months ago provided by a nurse from the facility's contracted pharmacy. Interview with the HRD on 02/02/22 at 4:50pm revealed: -The LHD emailed her guidelines for a COVID-19 outbreak. -She last reviewed the guidelines on 01/27/22 and 01/28/22. -She only reviewed the guidelines regarding COVID-19 testing. -She did not review guidelines regarding PPE when caring for COVID-19 residents. b. Observation of the 300 hall on 02/03/22 from 4:38pm to 4:41pm revealed: -There was an isolation cart outside of resident room #304. -On the door of resident room #304 was a paper in a plastic sleeve, "Caution enter with personal protective gear only" and a stop sign on the paper. -There was also a paper in a plastic sleeve labeled Airborne Infection Isolation Precautions. -At 4:38pm, the MA was wearing an N-95 face mask and put on a gown, gloves and a face shield from the isolation cart and went inside room #304 to administer medications. -At 4:39pm, the MA exited resident room #304 wearing all of her PPE including the N-95 face mask, gown, gloves and face shield. -The MA removed her gown and gloves in the hallway and placed them in a trash can beside the isolation cart. -The MA removed the face shield (without cleaning or sanitizing it) and placed it on the hand rail above the isolation cart. -The face shield was not labeled with anyone's name. -The MA did not change her N-95 mask.	D 611		

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D 611	Continued From page 67 -The MA sanitized her hands. -At 4:41pm, the MA pushed medication cart down the hall, then went inside the small dining room and began assisting residents with dinner while wearing the same N-95 face mask. Interview with the MA on 02/03/22 at 4:50pm revealed: -She did not recall having training on when to take off PPE when working with COVID-19 positive residents. -She usually put the gown and gloves in a box with a red biohazard bag inside the resident's room just prior to exiting the room. -There was no box or biohazard bag in resident room #304 that morning, 02/03/22, so she did not remove the PPE until she came back out into the hallway. -She did not know if the face shields could be re-used or if they needed to be sanitized. -She did not change her N-95 face mask when she came out of resident room #304 because she did not like the style of N-95 face masks stored in the isolation cart. Observation of the same MA on 02/03/22 at 4:52pm revealed: -The MA removed her N-95 face mask while standing outside resident room #3. -The MA walked all the way down the 300 to the middle hallway and past both dining rooms to the front hall nurses' station. -She walked past two staff members and one resident without a face mask. -She retrieved an N-95 face mask from the front hall nurses' station and put it on. Interview with the Administrator on 02/03/22 at 5:12pm revealed: -A nurse from the facility's contracted pharmacy	D 611		

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D 611	Continued From page 68 did an in-service for facility staff on infection control, including PPE " a couple of months" ago. -The MA might not have been working at the facility at the time and may not have attended the in-service. Interview with the Administrator on 02/04/22 at 9:06am revealed: -He was going to require all staff to do online infection control training for COVID-19 by Monday, 02/07/22. -The nurse from the facility's contracted pharmacy would have a class on infection control for COVID-19 for all staff on 02/09/22. or she would have to quarantine for the required time period.	D 611	3-24-22 We have had additional training and the supervisor and now the new RCD will continue to observe and supervise the Med Tech staff about proper procedures. The RN was here on March 4th and February 23 to check off new Med Techs and do training. The HR Director will maintain all personal files and make sure that all required training and testing are complete. RCD will make sure that only qualified Med Techs administer Meds. 3-24-22	
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	D935		

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D935	Continued From page 69 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff A) who administered medications had completed the state approved 5, 10, or 15 hour Medication Aide Training Courses and the Medication Administration Clinical Skills Validation Checklist prior to administering medications. The findings are: Review of Staff A's personnel record revealed: -She was hired as a personal care aide (PCA) on 01/24/22. -There was no documentation of Staff A completing the 5, 10, or 15 hour Medication Aide (MA) Training Courses.	D935		

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D935	Continued From page 70 -There was no documentation of Staff A completing the Medication Administration Clinical Skills Validation Checklist. Observation of the 100 hall on 02/02/22 at 10:11am revealed: -There was a medication aide (MA) and a personal care aide (PCA) standing at a medication cart in the hallway. -The PCA walked away from the medication cart carrying a pill cup with medications. -The MA remained at the medication cart. -At 10:12am, the PCA entered resident room #115 with the medications and administered them to a female resident. -The PCA exited the room and walked toward the medication cart. Interview with the PCA on 02/02/22 at 10:15am revealed: -She was a PCA who had been working at the facility for about one week. -Yesterday, 02/01/21, was her first day of shadowing on the medication cart. -Today, 02/02/22, the MA was training her on the medication cart as a MA. -She had just administered medications to the resident in room #115. -She did not know the names of the medications she administered to the resident in room #115. -The MA training her prepared the medications and gave the medications to her to administer to the residents. -The MA told her the resident's name and room # she administered the medications to. -The MA did not observe her administer the medications to the residents. -She had administered medications to about ten different residents so far today, 02/02/22.	D935		

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D935	Continued From page 71 Interview with the MA on 02/02/22 at 1:00pm revealed: -The PCA observed her prepare resident medications. -Sometimes she would let the PCA administer the medications prepared by her to the residents. -The MA accompanied the PCA when she had to administer medications to residents who were difficult. -She did not observe the PCA administer medications to residents who easily took their medications. A second interview with the PCA on 02/02/22 at 2:00pm revealed: -She did not document on the eMAR when administering medications. -The MA documented on the eMAR all medications administered by the PCA. A second interview with the MA on 02/02/22 at 2:02pm revealed: -She documented on the eMAR all medications administered by the PCA. -The PCA would not document on the eMAR medications administered by her because the PCA had not been entered in the eMAR system. Observation of the 400 hall on 02/02/22 from 2:10pm - 2:15pm revealed: -At 2:10pm, the same MA and PCA were standing at a medication cart in the hallway. -The MA prepared medications in a medication cup and handed the medication cup to the PCA. -The PCA walked away from the medication cart carrying the medication cup with medications down the hall. -At 2:12pm, the MA pushed the medication cart into the medication room on the 400 hall and closed the door.	D935		

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D935	Continued From page 72 -The PCA went into resident room #330 alone and administered the medications to the resident while the MA was in the medication room. -At 2:15pm, the MA came out of the medication room with a medication cart and the PCA returned to the medication cart. -The MA did not ask the PCA if the resident took the medication. Interview with the MA on 02/02/22 at 2:17pm revealed: -The PCA was in training to become a MA. -The PCA was to "shadow" the MA only. -The PCA administered the medications to the resident in room #330 on her own during the 2:00pm medication pass because the PCA knew the resident from training during the morning medication pass on 02/02/22. -The MA documented she administered the medications on the electronic medication administration record (eMAR) but she did not actually administer the medications or observe the resident take the medications. Interview with the PCA on 02/02/22 at 2:21pm revealed: -She just started shadowing the MAs yesterday, 02/01/22. -The MA prepared the medications for the residents and sometimes the MA would hand her the medication cups to administer to the residents. -She had completed some online medication courses but she did not know if it was the required state approved medication training courses. -The RCM was supposed to do a "check off" with her (not sure when) and a nurse was supposed to do a "check off" with her on next Wednesday (02/09/22)..	D935		

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D935	Continued From page 73 -After the "check offs" were completed, then she would take the state medication exam. Interview with the Resident Care Manager (RCM) on 02/02/22 at 3:19pm revealed: -The MA was to review the eMAR with the PCA and the PCA observe the MA on the first day of training on the medication cart. -The second day of training the PCA was to observe the MA and prepare and administer medications to the residents with the MA observing to ensure no errors were made. -The third day of training would be the same as the second day. -Once the MA was comfortable with the way the PCA performed the medication pass, the MA would report to the RCM. -The RCM would then observe the PCA administer medications to ensure she was competent with medication administration. -The RCM contacted the facility's contracted nurse after the RCM was comfortable with the PCAs progress on the medication cart. -The nurse then checked off the PCA for the medication administration clinical skills validation checklist. -The PCA was supposed to complete the 5/10- or 15-hour state medication aide training before shadowing or training on the medication cart. -There was no reason why a MA would not observe the PCA administer medications. -She did not know who was responsible for organizing the 5/10- or 15-hour state medication aide training course. -The Human Resources Director (HRD was responsible for keeping up with staff qualifications. -There was one PCA training on the medication cart and today, 02/02/22, was her second day of training.	D935		

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D935	Continued From page 74 -She was training the PCA today but had to place her with another MA because of the survey. -She told the PCA to observe the MA during the medication pass. -About three - four months ago she told the MA her expectations for the second day of medication pass were to observe MA trainees administer medications when performing medication cart training. -The PCA should have been able to perform the medication pass today, 02/02/22, with the MA observing her. -She expected the MA to observe the PCA perform the medication pass. -She had not been able to observe the PCA on the medication pass today. -A MA was not independent with the medication pass until completing the state mandated 5, 10, or 15-hour MA class, shadowing on the medication cart, and signed off by the facility's nurse; in those steps. Interview with the Administrator on 02/02/22 at 4:05pm revealed: -Staff must have their MA certification prior to working on the medication cart. -The HRD was responsible for hiring staff. -He did not know the process for MA training. Interview with the HRD on 02/02/22 at 4:08pm revealed: -Staff were expected to have completed the 15 hour state medication aide training and pass the MA state exam before working on the medication cart. -The MA was required to be validated by the facility nurse on the medication administration clinical skills validation check list before working on the medication cart. -The PCA may observe the MA working the	D935		

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D935	Continued From page 75 medication cart. -The PCA was not expected to prepare or administer medications while shadowing on the medication cart. -The PCA must have completed the state mandated 15 hour medication aide class before shadowing on the medication cart. -Once the 15 hour state mandated medication aide training class was completed, she verified completion and informed the RCM. -The RCM would then scheduled a date for the facility nurse to perform the medication administration clinical skills validation check off. -The RCM was responsible for coordinating the shadowing. -The RCM was responsible for performing training on the medication cart because the facility wanted MA's trained properly. -There was no one currently training on the medication cart. -She would know and expected to have been told if there was staff training on the medication cart because she would need to verify the 15 hour state mandated training had been completed and schedule the medication clinical skills check off. -It was the responsibility of the RCM to tell her before anyone shadowed on the medication cart. -There were proper steps regarding the medication cart shadowing process and she expected the RCM to follow her expectations. -She had previously told the RCM no one was to shadow on the medication cart without her knowledge. She did not remember when. -She did not know Staff A was shadowing on the medication cart yesterday and today. -Without following the steps of medication cart training "a million things could go wrong". -Not following the expected process of medication cart training, there could be medication errors.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	R 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D935	Continued From page 76 Second interview with the HRD on 02/02/22 at 4:32pm revealed she did not know if Staff A had completed the required state 15-hour training.	D935		