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D 000	Initial Comments The Adult Care Licensure Section and the Carteret County Department of Social Services conducted an Annual Survey on 08/24/22 to 08/26/22.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews, and interviews the	D 254		

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facility failed to ensure a care plan was completed for 1 of 5 sampled residents (#1) within 30 days of admission.

The findings are:

Review of Resident #1's current FL-2 dated 05/27/22 revealed:
-Diagnoses included heart failure, mild intermittent asthma, Type 2 diabetes, muscle weakness, unsteady on her feet, and abnormalities of gait and mobility.
-She was ambulatory.
-She required minimal assistance with dressing and bathing.

Review of Resident #1's Resident Register revealed an admission date of 06/02/22.

Review of Resident #1's records revealed there was no care plan.

Interview with the Administrator in charge (AIC) on 08/26/22 at 2:13pm revealed:
-She performed the role of the Resident Care Coordinator (RCC).
-She was aware a care plan was to be completed within 30 days of admission of a resident.
-A care plan was not completed for Resident #1.
-The RCC was responsible for completing Resident #1's care plan.
-She did not know why a care plan was not completed.
-A care plan should have been completed for Resident #1.
-The care plan was important because it provided information for staff regarding how to care for the resident.

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D 273	10A NCAC 13F .0902(b) Health Care	D 273		

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

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

Based on observations, record reviews, and interviews the facility failed to ensure immediate referral to meet the routine and acute health care needs of 1 of 5 sampled residents (#5) related to a resident who had arm pain.

The findings are:

Review of Resident #5's current FL-2 dated 06/07/22 revealed:
-Diagnoses included hypertension, coronary artery disease, and abnormalities of gait and mobility.
-He was ambulatory and used a rollator.

Review of Resident #5's Resident Register revealed an admission date of 01/12/19.

Review of Resident #5's Accident/Incident Report dated 08/16/22 revealed:
-The resident had an unwitnessed fall with injury on 08/13/22 at 2:00pm.
-The resident was sent to the emergency room (ER) on 08/16/22 at 5:30am.
-There was injury to the lower back and right arm.

Review of Resident #5's ER visit summary dated 08/16/22.
-The resident's complaint was a fall and right arm pain.

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-The resident fell three days ago on 08/13/22.
-The resident was diagnosed with a right arm fracture and effusion (swollen) right arm joint.
-A posterior splint and sling were placed on the resident's right arm.
-The resident was discharged back to the facility the same day on 08/16/22.

Interview with Resident #5 on 08/24/22 at 10:30am revealed:
-On 08/13/22, the resident was sitting on his bed in his room.
-He reached for his rollator and it moved because it was not locked, causing him to lose his balance and fall on the floor landing on his right arm.
-The fall was unwitnessed.
-It was the first time he had fallen since being at the facility.
-He did not tell staff at the time the fall occurred.
-The next day on 08/14/22, his right arm felt different.
-The arm stung a little and it was difficult to move.
-He informed staff on 08/14/22 that he had fallen on the day before (08/13/22).
-He could not remember who he had told about the fall.
-He requested pain medication because his right arm was hurting.
-Several staff were in the room and looked at his right arm and noticed it was swollen.
-The medication aide (MA) administered pain medication and placed an ice pack on his right arm.
-On 08/15/22 he was still in pain and the right arm was red, swollen, and difficult to move.
-He requested pain medication.
-The MA administered pain medication and placed an ice pack on his right arm.
-He requested to go to the emergency room early in the morning of 08/16/22 due to redness,

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swelling, and right arm pain that he could no longer tolerate.

Observation of Resident #5 on 08/24/22 at 10:30am revealed resident was sitting in a recliner in his room with his right arm in a splint and a sling.

Review of a Resident #5's physician medication standing order dated 09/08/21 revealed there was an order for acetaminophen 500 mg 1 tablet every 6 hours as needed for minor headache, and minor discomfort; for severe discomfort call primary care provider (PCP), if symptoms persist for longer than 24 hours contact PCP.

Review of Resident #5's August 2022 electronic medication administration record eMAR revealed:
-There was an entry for acetaminophen 500mg 1 tablet as needed every six hours for headache and minor discomfort, for severe discomfort call PCP, if symptoms persist for longer than 24 hours contact PCP.
-There was documentation acetaminophen 500 mg 1 tablet was administered on 08/14/22 at 11:40am for a headache.
-There was documentation acetaminophen 500mg 1 tablet was administered on 08/14/22 at 5:02pm for right arm pain.
-There was documentation acetaminophen 500mg 1 tablet was administered on 08/15/22 at 1:42pm for right arm pain.

Review of Resident #5's physician medication order dated 08/15/22 revealed there was an order for tramadol 50mg 1 tablet three times a day as needed for pain.

Review of Resident #5's August 2022 eMAR revealed:

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-There was an entry for tramadol 50mg 1 tablet three times day as needed for pain.
-There was documentation tramadol 50mg 1 tablet was administered on 08/16/22 at 4:39am for right arm pain.

Interview with a personal care aide (PCA) on 08/26/22 at 9:54 revealed:
-She worked on 08/14/22 from 7:00am to 3:00pm.
-She was aware Resident #5 had fallen.
-She could not recall the date she became aware of Resident #5's fall and injury.
-She did not notice any problems with Resident #5 performing his activities of daily living during her shift on 08/14/22..

Interview with the medication aide (MA) on 08/25/22 at 11:00am revealed
-She worked on Resident #5's hall on 08/14/22 from 7:00am to 7:00pm.
-Resident #5 complained of right arm pain.
-She did not notice any redness or swelling of the right arm.
-She did not notice if the resident had any problems with performing his activities of daily living.
-She did not recall any staff reporting to her that the resident had problems with performing his activities of daily living.
-She administered pain medication once during the shift.
-She did not notify anyone regarding the pain because the pain medication was effective.
-Resident # 5 did not inform her that he had fallen.
-She worked on another hall on 08/15/22 and was off on 08/16/22.
-She did not know he had fallen and suffered a fracture to his right arm until he returned from the

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hospital visit on 08/16/22.

Interview with a second MA on 08/25/22 at 11:45am revealed:
-She worked on Resident #5's hall on 08/15/22 from 7:00am to 7:00pm.
-Resident #5 complained of pain of his right arm.
-She took vitals, placed an ice pack on the right arm, and administered pain medication which was somewhat effective.
-She did not notice any redness or swelling of Resident#5's right arm.
-A PCA had to assist Resident #5 with putting his shirt on because his arm was hurting and he was unable to do so.
-She was not aware if any other staff looked at Resident #5's arm on 08/15/22.
-She could not recall if she notified the PCP or the Resident Care Coordinator (RCC) regarding Resident #5's right arm on 08/15/22.
-She could not recall if other staff had notified the PCP or the RCC regarding Resident #5's right arm on 08/15/22.

Interview with a third MA on 08/26/22 at 7:14am revealed:
-She worked on 08/15/22 on the 7:00pm to 7:00am shift.
-Resident #5 notified her around 4:00am on 08/16/22 that his right arm was hurting.
-She administered pain medication.
-His right arm was red and swollen and difficult for him to move.
-The resident told her he had fallen on 08/13/22.
-Resident #5 requested to go to the ER because he could not tolerate the pain anymore.
-She called the Emergency Management Services (EMS) who transported Resident #5 to the ER around 5:00am on 08/16/22.
-She notified the power of attorney (POA), the

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D 273	Continued From page 7 PCP, and the RCC that she was sending Resident #5 to the ER. Interview with the Lead MA on 08/25/22 at 3:54pm revealed: -She learned of Resident #5's fall from a MA on 08/15/22. -She did not recall if the PCP was notified on 08/15/22. -She did not recall if the RCC was notified on 08/15/22. -She did not inspect the resident's right arm on 08/15/22. -The RCC should have been notified of Resident 5's right arm pain. Interview with the Administrator in charge (AIC) on 08/26/22 at 2:13pm revealed: -She was not aware of any problems with Resident #5's right arm until Monday (08/15/22). -When she arrived at the facility on that Monday morning, the resident was sitting in the front lobby. -His hair was uncombed which was not normal for him. -She inquired as to why his hair was not combed and what was wrong. -He said his right hand and arm hurt. -She noticed his right arm was red, swollen, and warm to touch and difficult to move. -She took a picture of the right arm and sent it to the PCP. -The PCP prescribed tramadol for pain and an antibiotic. -She was not aware that Resident #5 had fallen that resulted in a broken arm until he returned from the ER on 08/16/22. Telephone interview with the PCP on 08/25/22 at 9:35am revealed:	D 273		

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D 273	Continued From page 8 -Resident #5 had a fall on 08/13/22 and did not notify staff when the fall occurred. -She was notified on 08/15/22 that Resident #5's right arm was red, swollen and he was in pain. -She prescribed tramadol for pain and an antibiotic for a possible infection on 08/15/22. -She was not aware that Resident #5 had fallen until she was notified that he was being sent to the ER on 08/16/22. -She did not know Resident #5 had suffered a broken right arm as a result of the fall until he returned from the ER on 08/16/22. -She did not know when Resident #5 notified staff that he had fallen on 08/13/22. -She expected staff to inform her immediately if Resident #5 had fallen. _____ The facility failed to ensure referral to meet the acute healthcare needs of 1 of 5 sampled residents (#5) who had unresolved right arm pain for 48 hours, whose right arm was red, swollen, and warm to touch and was not sent to the emergency room for evaluation for 24 hours after being informed the resident had fallen, which resulted in a right arm fracture and swollen joint that was untreated from 08/13/22-08/16/22. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 10/10/22.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 9 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure a therapeutic diet was served as ordered for 1 of 7 sampled residents (Residents #6) with an order for chopped meats . The findings are: Review of Resident #6's current FL-2 dated 09/29/21 diagnoses revealed: -Diagnosis included vascular dementia with behaviors, low back pain, panic disorder, muscle weakness, bilateral osteoarthritis of hips and knees, disorientation unspecified and other specified myoneutral disorder. -Diet order was regular chopped meats. Review of Resident #6's Physician's diet order form dated 08/13/22 revealed the diet type regular with entire meal chopped. Review of the diet order spreadsheet dated 08/24/22 revealed Resident #6's diet type was a regular diet mechanical soft with chopped meats only. Review of the diet binder in the kitchen on 08/24/22 at 10:20am revealed:	D 310		

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-There was a diet order list with all residents' names and diet order type.
-There was a cycle menu for breakfast, lunch and dinner.
-There was a therapeutic diet menu.

Review of the Residents' diet order posted at the serving counter in the dining room on 08/24/22 at 10:24 am revealed Resident #6 was listed as a ground (meat) as chopped.

Review of Resident #6's Licensed Health Professional Support (LHPS) dated 05/25/22 revealed feeding techniques to be used with residents who had swallowing problems.

Review of the breakfast menu posted at the serving station in the dining hall on 08/25/22 at 7:25am revealed the meal was scrambled eggs, bacon, pancakes, juice of choice, coffee and milk.

Review of the therapeutic diet menu posted outside of the dining hall on 08/25/22 at 7:28am revealed banana oak meal, egg of choice, assorted fruit, 100% juices, grain toast and milk.

Observation of the Resident #6's breakfast meal on 08/25/22 at 8:04am revealed:
-Resident #6 was served two pancakes with syrup, 4 slices of bacon, scrambled eggs and 8oz of milk.
-The bacon was not chopped, and pancakes were cut up into sections.
-The Personal Care Aide (PCA) broke off a piece of bacon and served it to Resident #6.
-Resident #6 ate the piece of bacon that was served to her.

Observation of the Resident #6's lunch meal on

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08/25/22 at 12:20pm revealed:
-Resident #6 was served parmesan crusted chicken, rosemary potatoes, carrots, lemon pudding, roll, tea, and water.
-The chicken, potatoes and carrots were chopped into fine small pieces.
-The PCA feed Resident #6 some of the chicken, potatoes and carrots.
-Resident #6 ate 1/4 of her lunch meal.

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

Interview with a PCA on 08/25/22 at 8:10am revealed:
-Resident #6's meats were sometimes chopped.
-When the meats were not chopped, she would usually break off a small piece of the meat and feed it to Resident #6.
-Resident #6 meals were mostly prepared as mechanical soft so that she could eat her food.

Interview with the Cook on 08/25/22 at 8:13am revealed:
-She prepared the meals for residents who had a special therapeutic diet.
-There were residents who had a chopped meat diet.
-She knew Resident #6 had a mechanical soft diet.
-She had prepared Resident #6's breakfast meal on 08/25/22.
-She had not known of Resident #6 having a chopped meat diet.
-She knew the residents' diet orders were posted and were placed in the dietary binder for review.
-The PCAs had received training on therapeutic diets.
-Dietary Aides and PCAs were to ensure they had

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the correct meal before serving the residents.
-The Dietary Manager reviewed the residents diet orders with her as residents' diet orders changed.
-The Dietary Manager was responsible for posting the updated residents diet orders.

Interview with the Dietary Manager on 08/25/22 at 8:19am revealed:
-The residents' diet orders were posted and recorded in the dietary binder.
-The Cook was responsible for preparing all of the residents' meals according their diet order.
-The Dietary Aides and PCAs had received training on therapeutic diets.
-The Dietary Aides and PCAs were to check the meal before serving to the residents to ensure they were serving the correct meal to the residents.
-Residents' therapeutic diets lists were posted to ensure the residents' meals were served correctly and for all who help serve meals to see.
-She knew Resident #6 had a therapeutic diet order for chopped meats only and mechanical soft.
-She was responsible for updating the residents' therapeutic diet list and posting.

Telephone interview with Resident #6's Primary Care Physician (PCP) on 08/25/22 at 9:41am revealed:
-Resident #6's diet order was regular with chopped meats only and mechanical soft.
-She did not know if Resident #6 had a history of aspiration.
-There was a concern of Resident #6 not receiving the correct diet meal as ordered because if not properly chopped it could cause choking issues.

Interview with the Lead Medication Aide on

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D 310	Continued From page 13 08/25/22 at 3:55pm revealed: -PCAs were trained for certain dietary tasks such as the residents' dietary orders. -The Medication Aides (MA) and PCAs completed training on different diet orders. -When a resident received an incorrect meal, the Dietary Aides, MAs and PCAs were to inform the Cook and not served the meal. -The Resident Care Coordinator was responsible for ensuring all resident diet orders were updated and given to the Dietary Manager. Interview with the Administrator in Training (AIT) on 08/26/22 at 2:14pm revealed: -The Dietary Manager, Cook and Dietary Aides were to prepare and serve all meals according to residents' diet orders. -The Cook was responsible for plating all of the meals served. -The Dietary Aides and PCAs were to convey with the Cook if a resident's meal was not prepared according the diet order. -The expectation was that all Dietary Staff, MAs and PCAs knew the diet orders for all residents and not serve an incorrect meal. -If the meal was not plated correctly the staff serving the meal were to give it back to the Cook and not serve the meal. -The residents' diet orders posted was the most current diet. -She was responsible for updating all residents' diet orders and giving the information to the Dietary Manager.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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	HAL016018	A. BUILDING: _____ B. WING _____	08/26/2022

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(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, record reviews, and interviews the facility failed to administer medications as ordered for 2 of 4 residents (#8, #9) observed during the medication passes including errors with medications used to treat shortness of breath, to control blood sugar, to treat schizophrenia and bipolar disorder (#8), and a vitamin supplement (#9).

The findings are:

The medication error rate was 14% as evidenced by the observation of 4 errors out of 28 opportunities during the 8:00am and 9:00am medication passes on 08/25/22.

1. Review of Resident #8's current FL-2 dated 07/13/22 revealed diagnoses included psychosis, anxiety, Type 2 diabetes mellitus, schizophrenia, atrial fibrillation, and chronic obstructive pulmonary disease.

Review of Resident #8's Resident Register revealed an admission date of 11/08/19.

a. Review of Resident #8's physician medication order dated 08/24/22 revealed there was an order for Ventolin HFA 90 mcg inhale 2 puffs every 4 hours to be administered at 4:00am, 8:00am, 12:00pm, 4:00pm, and 11:59pm. (Ventolin is an

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aerosol inhaled medication used to treat or prevent bronchospasm).

Observation of the 8:00am medication pass on 08/25/22 for Resident #8 revealed the resident did not receive Ventolin HFA 90 mcg 2 puffs because it was not available on the medication cart.

Review of Resident #8's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Ventolin HFA 90 mcg inhale 2 puffs every 4 hours to be administered at 4:00am, 8:00am, 12:00pm, 4:00pm, 8:00pm and 11:59pm.
-There was documentation Ventolin HFA 90 mcg inhale 2 puffs was not administered at the 8:00am medication pass because it was not available on the medication cart.

Interview with Resident #8 on 08/25/22 at 10:00am revealed she did not have shortness of breath.

Interview with the medication aide (MA) on 08225/22 at 3:26pm revealed:
-The Ventolin medication was not on the medication cart.
-The MA was responsible for auditing the medication cart and ensuring medications were on the medication cart.
-She needed to notify the facility's contracted pharmacy to request a refill of the medication.
-The Ventolin medication should have been on the medication cart.
-It was important Resident #8 received her medications as ordered.

Interview with the Lead MA on 08//25/22 at

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3:54pm revealed the MA was responsible for auditing the medication cart and ensuring medications were on the medication cart.

Interview with the administrator in charge (AIC) on 08/26/22 at 2:13pm revealed:
-The MAs were responsible for auditing the medication cart and ensuring medications were on the medication cart.
-The MAs should request a refill from the family (if provided by the family), the facility's contracted pharmacy or an order from the PCP 7 to 14 days before the medication runs out.

Attempted telephone interview with the primary care provider (PCP) on 08/26/22 at 3:15pm was unsuccessful.

b. Review of Resident #8's physician medication order dated 08/24/22 revealed there was an order for metformin 500 mg 2 tablets (1000mg) with breakfast to be administered at 8:00am. (Metformin is a medication used to control blood sugar)

Observation of Resident #8's medication pass on 08/25/22 revealed metformin 500mg 2 tablets (1000mg) was administered at 7:30am.

Observation of Resident #8 on 08/25/22 from 7:30am to 9:30am intermittently revealed she did not eat breakfast or a snack.

Interview with Resident #8 on 08/25/22 at 10:00am revealed:
-She did not eat breakfast or a snack on the morning of 08/25/22.
-She was not experiencing any stomach upset.

Review of Resident #8's August 2022 eMAR

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revealed:
-There was an entry for metformin 500mg 2 tablets (1000mg) with breakfast at 8:00am.
-There was documentation that the metformin 500mg 2 tablets was administered at the 8:00am medication pass.

Interview with the MA on 08/25/22 at 11:06am revealed:
-Resident #8 was administered her medication after she ate the majority of the time.
-Resident #8 usually did not like to eat breakfast.
-She should have offered the resident a snack with the medication.
-It was important Resident #8's medications were administered as ordered.

Interview with the Lead MA on 08//25/22 at 3:54pm revealed:
-The MA should have had snacks on the medication cart to provide to residents who needed to take their medications with meals as ordered.
-It was important for Resident #8 to receive her medications as ordered for the full benefit of the medication.

Interview with the AIC on 08/26/22 at 2:13pm revealed:
-Resident #8 usually did not eat breakfast and sometimes did not eat lunch.
-The medication for Resident #8 should have been administered as ordered with food for the health and safety of the resident.

Attempted telephone interview with the PCP on 08/26/22 at 3:15pm was unsuccessful

c. Review of Resident #8's physician medication order dated 08/24/22 revealed there was an order

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for ziprasidone HCl 60 mg 1 capsule twice a day with meals to be administered at 8:00am and 5:00pm. (Ziprasidone is a medication used to treat schizophrenia and bipolar disorder).

Observation of Resident #8's medication pass on 08/25/22 revealed the resident received ziprasidone HFI 60mg 1 capsule at 7:30am.

Review of Resident #8's August 2022 eMAR revealed:
-There was an entry for ziprasidone HCl 60mg 1 capsule twice daily with meals at 8:00am and 5:00pm.
-There was documentation that ziprasidone HCl 60mg 1 capsule was administered to Resident #8 at the 8:00am medication pass.

Observation of Resident #8 on 08/25/22 from 7:30am to 9:30am intermittently revealed she did not eat breakfast or a snack.

Interview with Resident #8 on 08/25/22 at 10:00am revealed:
-She did not eat breakfast or a snack on the morning of 08/25/22.
-She felt fine.

Interview with the MA on 08/25/22 at 11:06am revealed:
-Resident #8 was administered her medication after she ate the majority of the time.
-Resident #8 usually did not like to eat breakfast.
-She should have offered the resident a snack with the medication.
-It was important Resident #8's medications were administered as ordered.

Interview with the Lead MA on 08//25/22 at 3:54pm revealed:

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-The MA should have had snacks on the medication cart to provide to residents who needed to take their medications with meals as ordered.
-It was important for Resident #8 to receive her medications as ordered for the full benefit of the medication.

Interview with the AIC on 08/26/22 at 2:13pm revealed:
-Resident #8 usually did not eat breakfast and sometimes did not eat lunch.
-The medication for Resident #8 should have been administered as ordered with food for the health and safety of the resident.

Attempted telephone interview with the PCP on 08/26/22 at 3:15pm was unsuccessful.

2. Review of Resident #9's current FL-2 dated 02/17/22 revealed diagnoses included chronic heart failure, vitamin D deficiency, hypertension osteoarthritis, and prosthetic aortic valve.

Review of Resident #9's Resident Register revealed an admission date of 02/11/22.

Review of Resident #9's physician medication order dated 08/24/22 revealed there was an order for centrum adult gummies, 2 tablets to be administered every day at 9:00am. (Centrum adult gummies was used as a vitamin supplement).

Observation of Resident #9's medication pass on 08/25/22 at 8:00am revealed centrum adult gummies 2 tablets were not administered at the 9:00am medications pass because the vitamin supplement was not on the medication cart.

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D 358	Continued From page 20 Review of Resident #9's August 2022 eMAR revealed: -There was an entry for centrum adult gummies take 2 tablets every day at 9:00am. -There was documentation the centrum adult gummies were not administered at the 9:00am medication pass because the vitamin supplement was not available on the cart. Interview with the medication aide (MA) at 08/25/22 at 11:06am revealed: -Resident #9's family member provided the centrum adult gummies. -The centrum adult gummies should have been available on the cart for Resident #9. -She needed to notify the family member the facility was out of the centrum adult gummies for the resident. -The MA was responsible for auditing the medication cart and ensuring medications were on the medication cart. Interview with the Lead MA on 08//25/22 at 3:54pm revealed the MA was responsible for auditing the medication cart and ensuring medications were on the medication cart. Interview with the AIC on 08/26/22 at 2:13pm revealed: -The MAs were responsible for auditing the medication cart and ensuring medications were on the medication cart. -The MAs should request a refill from the family (if provided by the family), the facility's contracted pharmacy or an order from the PCP 7 to 14 days before the medication runs out. Attempted telephone interview with the PCP on 08/26/22 at 3:15pm was unsuccessful	D 358		