

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____

TITLE

(X6) DATE

STATE FORM

Executive Director

12/9/22
Continuation sheet 1 of 1

STATE FORM

6899

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If continuation sheet 1 of 24

Reviewed and Acknowledged SCM 12/09/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/01/2022
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
(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 270	Continued From page 1 -When a fall occurs, staff checks and assists the resident according to protocol; provides first aide care, obtains outside medical care and/or calling 911 as needed. -All staff members who respond to a fall complete an Incident and Accident (I/A) Report and implement the initial interventions as indicated on the document. -Staff will notify the family, the primary care provider (PCP), the Health and Wellness Director (HWD) and contact the local emergency department (ED) if needed. -Staff will document in the residents chart the incident, outcome and that notification has been completed to all appropriate parties. -Staff will chart daily for three days following the fall, documenting any complaints and follow up that is needed. Staff will notify the PCP if any new complaints or abnormalities arise. Review of the facility's Resident Supervision Policy dated 08/15/22 revealed: -The facility reasonably ensures that residents receive the supervision and assistance to help with activities consistent with daily living requirements and needs. These services monitored by healthcare assistance and staff contribute to ensure a resident's health, safety, and well-being. The facility staff provide personal care services 24-hour supervision and assistance, activities and health related services which promotes independence and dignity. -General supervision ensures staff provide a general level of oversight to assist the resident with activities of daily living as outlined in the resident's service plan. The resident is provided at a minimum 2-hour safety check to ensure residents needs are being met. Only documentation required is noted in the service plan.	D 270	The facility resident care coordinator, licensed practical nurse or designee will implement 15-minute checks for 72 hours or as needed for residents involved in adverse changes resulting in incidents. 3. On 11/22/2022, 12/14/2022 and ongoing, facility staff were educated by facility Administrator on the facilities policy for increased supervision when required for resident incidents or significant changes. 4. The facility Administrator or facility designee will complete weekly audits for 12 weeks and quarterly thereafter to ensure the residents experiencing significant changes or incidents have had increased supervision, proper notifications, and referrals when needed. Results from weekly audits will be submitted to the QA committee to review for compliance. 5. Compliance with regard to increased supervision was completed on 12/5/2022.	11/22/2022 12/5/2022 12/5/2022

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D 270	Continued From page 2 -Increased supervision ensures facility staff provide a general level of oversight to assist the resident with activities of daily living as outlined in the resident's service plan. The resident is provided at a minimum 1-hour safety check to ensure resident's needs are being met. Only documentation required is noted in the service plan. -15-minute checks are an advanced level of supervision and require documentation. Facility staff provide a safety check approximately every 15 minutes to ensure the resident's overall safety and well-being. Typically, 15-minute checks are conducted for a 72-hour period or once the team has reassessed the resident's behaviors or interventions modifying the resident service plan and it has been established the resident no longer requires this advanced level of supervision. -One on one supervision is the highest level of supervision and is initiated when it has been determined the resident is at greatest risk. This should be considered prior to an incident when a resident may be exhibiting aggressive statements and behaviors, or a resident is actively exit seeking or making comments about wanting to leave. Facility staff are to always remain with the resident for their or others safety. One on one supervision should continue until it can be determined by the team the resident's behaviors are extinguished or interventions have been implemented modifying the resident behavior and the resident no longer poses a safety risk for themselves or others. The service plan should be revised to include the appropriate level of supervision and revised to include new and effective interventions. -All staff may increase a resident's level of supervision, then contact the Executive Director (ED) or Health and Wellness Director (HWD) with	D 270			

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D 270	Continued From page 3 consultation of the care plan team can lower the resident's level of supervision. -The ED, HWD, PCP and family need to be notified immediately with a change in level of supervision, the resident should be placed on 24-hour report and the incident documented in the resident's medical record. 1. Review of Resident #1's current FL-2 dated 02/16/22 revealed: -Diagnosis included dementia and anxiety. -The resident was intermittently disoriented, ambulatory, and walked independently. -The resident's level of care was Special Care Unit (SCU). Review of Resident #1's current care plan dated 03/24/22 revealed: -The resident required supervision with eating, toileting, ambulation, and transfers. -The resident required limited assistance with bathing, dressing, and grooming. -The resident wandered. Observation of Resident #1 on 10/31/22 at 8:46am revealed: -She had a light brown bruise approximately ½ an inch under both eyes near her nose. -She had a brown bruise to the left side of her nose approximately ½ an inch. -A personal care aide (PCA) was walking beside her to escort her to the activity room. a. Review of Resident #1's incident and accident (I/A) report dated 10/17/22 at 1:30pm revealed: -Resident #1 had an unwitnessed fall and was found on the floor in the hallway near the beauty shop. -Resident #1 tripped over the facility weight scale near the beauty shop.	D 270			

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D 270	Continued From page 4 -The resident had a nosebleed and a bruise on her nose. -Emergency Medical Services (EMS) was notified and the resident was transported to the local emergency department (ED) Review of Resident #1's progress note dated 10/17/22 at 6:13pm revealed: -Resident #1 had an unwitnessed fall on 10/17/22 at 1:30pm in the common area of the hallway. -The resident tripped over a weight scale in the hallway and hit her nose which caused a nosebleed. -Staff reported that they heard the resident fall onto the scale. -EMS was notified and the resident was transported to the local ED. Review of Resident #1's discharge summary from the local ED dated 10/17/22 revealed: -The resident was seen for a fall and was diagnosed with a nose fracture, facial fracture, and closed head injury. -The resident was prescribed an antibiotic for 10 days. Review of Resident #1's 72 Hour Report dated 10/17/22 revealed the resident returned from the hospital on 3rd shift. Review of Resident #1's progress note dated 10/18/22 at 2:03am revealed vital signs were taken and 72 hour report was started. Review of Resident #1's 72 Hour Report dated 10/18/22 through 10/19/22 revealed the resident's vitals were taken on 1st shift, 2nd shift, and 3rd shift. Review of Resident #1's 72 Hour Report dated	D 270		

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D 270	Continued From page 5 10/20/22 revealed the resident's vitals were taken on 1st shift. Review of Resident #1's facility record revealed there was no documentation of increased supervision or interventions following the 10/18/22 fall. Review of the facility's 15 Minute Check Sheet binder at the nurse's station revealed there was no documentation of 15 minute checks for Resident #1 from 10/17/22 to 10/20/22. Interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm revealed she was unable to locate the 15 Minute Check sheets for Resident #1. b. Review of Resident #1's incident and accident (I/A) report dated 10/18/22 at 10:39 am revealed: -Resident #1 had an unwitnessed fall and was found on the floor in her bathroom. -Staff was assisting a resident in the room next door and staff heard a "bang," and then overheard Resident #1 say "help, help!" -Staff observed the resident on the floor on her left side and a "dislocation" to her finger. -The resident stated, "it hurts" and pointed to her finger. -The resident had a dislocation of her fourth finger on her left hand. -Staff redirected the resident onto her bed, vital signs were checked, and the Health and Wellness Director (HWD) was notified of the "dislocated" finger. -The resident's primary care provider (PCP) was notified. Review of Resident #1's progress note dated 10/18/22 at 11:00am revealed:	D 270		

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D 270	Continued From page 6 -Resident #1 had an unwitnessed fall on 10/18/22 at 10:39am in her bathroom. -There were injuries from the fall, the resident had a dislocated finger. -Staff was in the room next to Resident #1, heard a bang onto the bathroom door and heard the resident yell "help, help." -Staff found the resident on the floor on her left side. -Staff checked for injuries and identified a "dislocation" of the resident's finger; the HWD was called to assist with her injury. -The resident pointed to her finger and stated it hurt. Review of Resident #1's resident record revealed there no documentation that the resident was taken to the local emergency department (ED). Review of Resident #1's progress note dated 10/18/22 at 8:20pm revealed her vital signs were taken, the resident had been walking around and she had no complaints of pain or discomfort. Review of Resident #1's progress note dated 10/19/22 at 6:53am revealed her vital signs were taken, the resident slept through the night and had no complaints. Review of Resident #1's progress note dated 10/20/22 at 7:59pm revealed the residents left hand had a purple tint to her hand, she had no complaints and vital signs were taken. Review of Resident #1's 72 Hour Report dated 10/18/22 revealed the 72 Hour Report started on 10/18/22 and would end 10/20/22. Review of Resident #1's 72 Hour Report dated 10/18/22 through 10/19/22 revealed her vital	D 270		

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D 270	Continued From page 7 signs were taken on the 1st shift, 2nd shift, and 3rd shift. Review of Resident #1's 72 Hour Report dated 10/20/22 revealed her vital signs were taken on 1st shift, 2nd shift, and 3rd shift. Review of Resident #1's 72 Hour Report revealed there was no documentation for 10/19/22 on 3rd shift. Review of Resident #1's resident record revealed there was no documentation of increased supervision or interventions following the 10/17/22 fall. Observation of a binder at the nurse's station on 11/01/22 revealed: -The binder had a 15 Minute Check Sheet form that listed the resident's name, date, location and time observed. -Times were typed on the form in 15 minute increments with a blank space for staff to document the location of the resident and their initial. -Staff placed the location of the resident on the 15 Minute Check Sheet and the time. Review of the facility's 15 Minute Check Sheet binder at the nurse's station revealed there was no documentation of 15 minute checks for Resident #1 from 10/18/22 to 10/20/22. Interview with a personal care aide (PCA) on 11/01/22 at 3:30pm revealed: -PCAs checked on resident's at least every hour. -If a resident needed increased supervision the medication aide (MA) or the PCA from the previous shift would let her know. -There was a binder at the nurse's station where	D 270			

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D 270	Continued From page 8 PCAs documented 15 minute checks. -She did not know how long a resident stayed on 15 minute checks. -She did not remember if Resident #1 had to be checked on more frequently than one hour. Interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm revealed she was unable to locate the 15 Minute Check sheets for Resident #1. Telephone interview with Resident #1's primary care provider (PCP) on 11/01/22 at 3:17pm revealed: -She expected that after a resident had a fall with an injury that staff would check on the residents more frequently than every one to two hours. -It was important for staff to increase the frequency of supervision to help prevent additional falls and to protect the resident. -Resident #1's finger was bruised from her fall on 10/18/22. -Resident #1 walked around the facility frequently and she expected staff to monitor her for falls to prevent additional falls. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Refer to the interview with the medication aide (MA) on 11/01/22 at 3:51pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 11/01/22 at 4:13pm. Refer to the telephone interview with the	D 270		

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D 270	Continued From page 9 Executive Director (ED) on 11/01/22 at 4:20pm. 2. Review of Resident #2's current FL-2 dated 07/11/22 revealed: -Diagnosis included dementia. -The resident was intermittently disoriented, ambulatory, and a wanderer. -The resident's level of care was Special Care Unit (SCU). Review of Resident #2's current care plan dated 04/25/22 revealed: -The resident wandered and needed fall preventions. -She required extensive assistance with bathing and limited assistance with toileting, dressing and grooming. Observation of Resident #2 on 10/31/22 at 8:55am revealed she was walking independently around the activity room talking to residents and staff. a. Review of Resident #2's incident and accident (I/A) report dated 08/29/22 at 12:50pm revealed: -Resident #2 had an unwitnessed fall in the facility hallway. -Staff heard the resident fall onto the floor. -Staff saw blood coming from the resident's nose and she had two teeth missing. -Staff provided first aide to the resident until emergency medical services (EMS) arrived and the resident was transported to the local emergency department (ED). Review of Resident #2's progress note dated 08/29/22 at 1:39pm revealed: -Resident #2 had an unwitnessed fall in the hallway 08/29/22 at 8:37am. -Staff reported that the resident tripped over her	D 270		

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D 270	Continued From page 10 own feet, fell on the floor, and hit her head on a chair in the hallway. -The resident had blood coming from her nose and was missing 2 teeth. -Staff provided first aide until EMS arrived. Review of Resident #2's discharge summary from the local ED dated 08/29/22 revealed: -The resident was seen for a fall and was diagnosed with a contusion across the face, an abrasion on her nasal bridge, and two chipped teeth. -The resident was discharged to the facility on 08/29/22. Review of Resident #2's resident record on revealed there was not a 72 Hour Report initiated after the resident returned to the facility. Review of Resident #2's resident record revealed there was no documentation of increased supervision or interventions following the 08/29/22 fall. Observation of a binder at the nurse's station on 11/01/22 revealed: -The binder had a 15 Minute Check Sheet form that listed the resident's name, date, location and time observed. -Times were typed on the form in 15 minute increments with a blank space for staff to document the location of the resident and their initial. -Staff placed the location of the resident on the 15 Minute Check Sheet and the time. Review of the facility's 15 Minute Check Sheet binder at the nurse's station revealed there was no documentation of 15 minute checks for Resident #2 from 08/29/22 to 08/31/22.	D 270		

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D 270	Continued From page 11 Interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm revealed she was unable to locate the 15 Minute Check sheets for Resident #2. Interview with a personal care aide (PCA) on 11/01/22 at 3:30pm revealed: -PCAs checked on resident's at least every hour. -If a resident needed increased supervision the medication aide (MA) or the PCA from the previous shift would let her know. -There was a binder at the nurse's station where PCAs documented 15 minute checks. -She did not know how long a resident stayed on 15 minute checks. -She checked on Resident #2 usually every 30 minutes because she wandered through the facility every day. Telephone interview with Resident #2's Primary Care Provider (PCP) on 11/01/22 at 3:17pm revealed: -Resident #2 was fidgety and walked around the facility frequently. -Resident #2 had to be redirected frequently from going into other resident's rooms. -She was not aware that Resident #2 had not been placed on 15 minute checks after she fell on 08/29/22. -She expected staff to increase supervision and monitoring of residents that had an injury from a fall to ensure their safety and prevent additional falls. -When a resident had a fall with an injury, she assumed the facility staff would check on the resident more frequently than every hour to prevent additional falls and injury. Based on observations, interviews, and record	D 270			

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D 270	Continued From page 12 reviews, it was determined that Resident #2 was not interviewable. Refer to the interview with the medication aide (MA) on 11/01/22 at 3:51pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 11/01/22 at 4:13pm. Refer to the telephone interview with the Executive Director (ED) on 11/01/22 at 4:20pm. Interview with a medication aide (MA) on 11/01/22 at 3:51pm revealed: -When a resident had to go to the hospital for an injury, once they returned the resident should be placed on 72 Hour Monitoring. -Each shift provided an update to the oncoming shift and reviews the 72 Hour Monitoring form with the next shift. -MAs document increased supervision checks in their progress notes. -She was not sure why there was not documentation of increased supervision for Resident #1 and Resident #2 after they were discharged from the hospital. Interview with the Resident Care Coordinator (RCC) on 11/01/22 at 4:00pm revealed: -When a resident returned from the hospital after an injury, they were placed on a 72 Hour Monitoring program to ensure their safety. -When a resident fell and had an injury, they were placed on increased supervision with 15 minute checks. -Personal care aides (PCAs) and medication aides (MAs) were expected to document 15	D 270		

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D 270	Continued From page 13 minute checks in the increased supervision binder located at the nurse's station. -She did not know why there were not 15 minute check forms completed for Resident #1 and Resident #2. -Staff were expected to complete the 15 minute checks to prevent the resident from having additional falls that could cause further injury. -She was unable to provide documentation of the 15 minute checks that had been completed for Resident #1 and Resident #2. -MAs also documented 15 minute checks in progress notes and did not know why staff had not documented 15 minute checks in the progress notes for Resident #1's falls on 10/17/22 and 10/18/22 and for Resident #2's fall on 10/29/22. Interview with the Health and Wellness Director (HWD) on 11/01/22 at 4:13pm revealed: -PCAs and MAs were expected to document 15 minute checks to ensure increased supervision for residents that went to the hospital with an injury. -The facility had an increased supervision binder at the nurse's station for PCAs and MAs to document increased supervision for residents. -MAs were expected to document each shift on the 72 Hour Monitoring report to provide an update on the resident. -Increased supervision should have been documented for Resident #1 and Resident #2 after they returned from the hospital by the MAs and the PCAs. -She did not know why 15 minute checks were not implemented for Resident #1 and Resident #2. Interview with the Executive Director (ED) on 11/01/22 at 4:20pm revealed:	D 270		

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
(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 270	Continued From page 14 -She expected staff to follow the facility's Fall Management Policy and Resident Supervision Policy. -Staff were expected to document 72 Hour Monitoring and increased supervision checks to ensure resident safety. -MAs and PCAs should have documented 15 minutes checks for Resident #1 and Resident #2. The facility failed to provide supervision to 2 of 5 sampled residents (#1, #2) in accordance with their current diagnoses, assessed needs, and facility policy resulting in Resident #1 having 2 unwitnessed falls within 24 hours resulting in a nose fracture, facial fracture and closed head injury, and a bruised finger and Resident #2 having an unwitnessed fall resulting in a contusion across her face, an abrasion on her nasal bridge and two chipped teeth. This failure resulted in substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/22/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 11/30/22.	D 270		
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:	D 358		

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D 358	Continued From page 16 pass on 11/01/22 revealed the Solifenacin 5mg, 1 tablet was crushed with her other medications, mixed in vanilla pudding, and administered at 7:41am. Review of Resident #3's November 2022 electronic medication record (eMAR) revealed: -There was an entry for Solifenacin 5mg, 1 tablet with the instructions to swallow whole, do not crush or chew, to be administered at 8:00am on 11/01/22. -There was documentation that Solifenacin 5mg, 1 tablet was administered at the 8:00am medication pass on 11/01/22. Interview with the medication aide (MA) on 11/01/22 at 2:00pm revealed: -She was the Resident Care Coordinator (RCC) and usually worked on the medication cart about two times a week. -She did not notice the instructions on the eMAR to not crush the Solifenacin. -She was aware there were some medications that should not be crushed. -She needed to pay more attention to instructions on the eMAR regarding the administration of medications. Interview with the Health and Wellness Director (HWD) on 11/01/22 at 3:49pm revealed: -Some medications were not supposed to be crushed for a reason. -Some medications were extended release and could have an adverse effect on the resident if they were crushed. -She expected Resident 3's medication to be administered as ordered and instructions on the eMAR to be followed. Interview with the Administrator on 11/01/22 at	D 358	The facility reviewed their policy on missing or incorrect medication to ensure all medication aides follow procedure to ensure medications are available to administer per physician order. 3. On 11/22/2022, 12/14/2022, facility and ongoing facility staff were re-educated by facility administrator on proper procedures for identifying missing meds, proper re-ordering of medication and the review of 5 medication rights to ensure that medications are available per physician order. 4. The facility resident care coordinator, licensed practical nurse, administrator, or facility designee will complete weekly cart audits for 12 weeks and quarterly thereafter to ensure resident medications are available for administration as prescribed the physician as well as the medication aides understanding of the 5 rights of medication administration. The results will be submitted to the QA committee to review for compliance. 5. The facility alleges compliance with regard to proper medication administration on 12/14/2022.	12/14/2022	12/12/2022	12/14/2022

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D 358	Continued From page 17 3:57pm revealed: -She did not think about reaching out to the primary care provider (PCP) for an alternative form of the Solifenacin prescribed for Resident #3. -She expected medications to be administered as ordered and to follow instructions on the eMAR. Interview with Resident #3's Primary Care Provider (PCP) on 11/01/22 at 3:06pm revealed: -She was not aware that Resident #3 could not swallow pills whole. -She could have prescribed an alternative form of the Solifenacin. -There were reasons some medications were not to be crushed. -She expected medications to be administered as ordered. b. Review of Resident #4's FL-2 dated 07/05/22 revealed: - Diagnoses included dementia, post traumatic syndrome disorder (PTSD), and hypertension. -The resident was intermittently disoriented. Review of Resident #4's Resident Register dated 06/30/22 revealed an admission date of 06/13/22. Review of Resident #4's physician order sheet dated 09/11/22 revealed an order for Senna plus, 8.6-50mg, 2 tabs two times a day to be administered at 9:00am and 9:00pm. (Senna plus is a medication used to treat constipation). Observation of the Resident #4's 9:00am medication pass revealed Senna plus, 8.6-50mg was not administered on 11/01/22 because it was not on the medication cart. Review of Resident #4's November 2022 eMAR	D 358	D358 Countrysi	

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COUNTRYSIDE VILLAGE

**5383 US 117 NORTH
PIKEVILLE, NC 27863**

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D 358	Continued From page 18 revealed: -There was an entry for Senna plus, 8.6-50mg, 2 tabs two times a day to be administered at 9:00am and 9:00pm on 11/01/22. -There was documentation that Senna-Plus was not administered at the 9:00am medication pass on 11/01/22. Interview with the medication aide (MA) on 11/01/22 at 2:00pm revealed: -Senna plus was not on the medication cart that contained Resident #4's medications. -She should have looked in the overstock drawer on one of the other medication carts to see if the Senna plus was available to be administered to Resident #4. -She understood medications should be administered as ordered. Interview with the Health and Wellness Director (HWD) on 11/01/22 at 3:49pm revealed: -Senna plus was a stock item and should have been available in the facility. -She expected medications to be administered as ordered. Interview with the Administrator on 11/01/22 at 3:57pm revealed: -There was an overstock drawer at the bottom of one of the other medication carts that may have had the Senna plus. -She expected medications to be administered as ordered and for the MA to check the overstock drawer. Interview with Resident #4's the Primary Care Provider (PCP) on 11/01/22 at 3:06pm revealed she expected medications to be administered as ordered.	D 358		

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D 358	Continued From page 19 c. Review of Resident #5's current FL-2 dated 11/04/21 revealed diagnoses included dementia, type 2 diabetes mellitus, hypothyroidism, hypertension, chronic obstructive pulmonary disease (COPD), and cognitive communication deficit. Review of Resident #5 physician order report dated 09/11/22 revealed an order for metoprolol succinate 100mg ER, 1 tablet daily with instructions do not crush. (Metoprolol is a medication used to treat high blood pressure, chest pain, and heart failure). Observation of Resident #5's 8:00am medication pass on 11/01/22 revealed metoprolol succinate 100mg ER was crushed with her other medications, mixed in vanilla pudding, and administered at 7:35am. Review of Resident #5's November 2022 electronic administration record (eMAR) revealed: -There was an entry for metoprolol succinate 100mg ER, 1 tablet with instructions do not crush to be administered at 8:00am. -There was documentation that metoprolol succinate 100mg ER was administered at the 8:00am medication pass. Interview with the medication aide (MA) on 11/01/22 at 2:00pm revealed: -She did not notice the instructions on the eMAR to not crush the metoprolol succinate 100mg ER. -She was aware there were some medications that should not be crushed. -She needed to pay more attention to instructions on the eMAR regarding the administration of medications. Interview with the Health and Wellness Director	D 358		

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D 358	Continued From page 20 (HWD) on 11/01/22 at 3:49pm revealed she expected Resident 5's medication to be administered as ordered. Interview with the Administrator on 11/01/22 at 3:57pm revealed: -She did not think about reaching out to the PCP for an alternative form of the metoprolol succinate ER tablet prescribed for Resident #5. -She expected medications to be administered as ordered and to follow instructions on the eMAR to avoid any adverse effects of the medication. Interview with Resident #5's Primary Care Provider (PCP) on 11/01/22 at 3:06pm revealed: -She was not aware that Resident #5 could not swallow pills whole. -She could have prescribed an alternative form of the metoprolol succinate ER. -There were reasons some medications were not to be crushed for the safety of the resident. -She expected medications to be administered as ordered and instructions to be followed. d. Review of Resident #6's current FL-2 dated 03/23/22 revealed diagnoses included dementia with behavioral disturbances, anxiety disorder, hyperlipidemia, hypertension, and white matter disease. Review of Resident #6's physician order report dated 09/11/22 revealed an order for Resource 2.0 liquid vanilla, 120ml two times a day with medications to be administered at 9:00am and 9:00pm. (Resource 2.0 liquid is used for a nutritional supplement). Observation of Resident #6's 9:00am medication pass on 11/01/22 revealed Resource 2.0 liquid was not administered.	D 358			

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D 358	Continued From page 21 Review of Resident #6's November 2022 eMAR revealed: -There was an entry for Resource 2.0 liquid, 120ml to be administered at 9:00am on 11/01/22. -There was documentation that Resource 2.0 liquid, 120ml was not administered at the 9:00am medication pass on 11/01/22. Interview with the medication aide (MA) on 11/01/22 at 2:00pm revealed: -The Resource 2.0 liquid was available in the kitchen. -She forgot to administer the Resource 2.0 liquid to Resident #6 at the 9:00am medication pass. Interview with the Health and Wellness Director (HWD) on 11/01/22 at 3:49pm revealed she expected the nutritional supplement to be administered as ordered. Interview with the Administrator on 11/01/22 at 3:57pm revealed: -The Resource 2.0 liquid was available in the kitchen. -She expected nutritional supplements to be available and administered as ordered. Interview with Resident #6's Primary Care Provider (PCP) on 11/01/22 at 3:06pm revealed she expected nutritional supplements to be administered as ordered. e. Review of Resident #7's current FL-2 dated 07/18/22 revealed diagnoses included dementia, agitation with behavior disturbance, and Parkinson's disease. Review of Resident #7's physician order report dated 09/11/22 revealed there was an order for	D 358		

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D 358	Continued From page 22 Escitalopram 10mg , 1 tablet daily to be administered at 8:00am. (Escitalopram is a medication used to treat depression and anxiety). Observation of Resident #7's medication pass revealed Escitalopram 10mg was not administered at the 8:00am medication pass on 11/01/22. Review of Resident #7's November 2022 electronic medication record (eMAR) revealed: -There was an entry for Escitalopram 10mg, 1 tablet to be administered at 8:00am. -There was documentation the Escitalopram 10mg, 1 tablet was administered at the 8:00am medication pass on 11/01/22. Interview with the medication aide (MA) on 11/01/22 at 2:00pm revealed: -The Escitalopram was available on the medication cart. -She thought she had administered the medication to Resident #7 at the 8:00am medication pass on 11/01/22. Interview with the Health and Wellness Director (HWD) on 11/01/22 at 3:49pm revealed she expected medications to be administered as ordered. Interview with the Administrator on 11/01/22 at 3:57pm revealed: -The Escitalopram was available on the medication cart. -She expected medications to be administered as ordered. Interview with Resident #7 Primary Care Provider (PCP) on 11/01/22 at 3:06pm revealed: -There were no concerns regarding Resident #7	D 358			

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D 358	Continued From page 23 not being administered the Escitalopram one time. -She expected medications to be administered as ordered for the benefit and safety of the resident.	D 358			