Received via electronic mail 01/05/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029001	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE RETIREMENT CENTER	2968 OLD SALISBURY ROAD LEXINGTON, NC 27295

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 11/30/22 through 12/02/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 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: Based on observations, record review and interviews, the facility failed to ensure follow-up for for 1 of 5 sampled residents (#1) related to portable oxygen. The findings are: Review of Resident #1's current FL2 dated 06/27/22 revealed: -Diagnoses included chronic respiratory failure with hypoxia. -There was an order for continuous oxygen at 3 liters (L). Review of Resident #1's physician's order dated 08/03/22 revealed: -An order for 3 L of oxygen with exertion. -There was documentation Resident #1's oxygen saturation on room air was 94%. -There was documentation Resident #1's oxygen saturation on room air with exertion was 89%. Review of Resident #1's physician's orders dated 08/24/22 revealed an order for 3 L of oxygen continuously. Observation of Resident #1's room on 11/30/22 at 9:51am revealed:	D 273	**D273: Starting 12/06/22, prior to admission of a resident requiring O2, all paperwork will be completed and O2 equipment will be in the facility when the resident is admitted.** **All future orders for O2 will be monitored by the SCU RCC to ensure Med-techs have faxed/called and followed up on all required orders,documents and documentation needed by the DME provider. SCU RCC will do monthly monitoring to make sure any/all existing O2 orders are correct & equipment is working properly.**	**12/06/22**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/4/23

Reviewed and acknowledged 01/06/23. SG.

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D 273	Continued From page 1 -Resident #1 was seated in a recliner chair in his room and he was not wearing oxygen. -Resident #1's oxygen concentrator was running, and his oxygen tubing was laying on his bed. -There were no portable oxygen tanks available for Resident #1. Interview with Resident #1 on 11/30/22 at 9:52am revealed: -He was supposed to have his oxygen all the time, but he did not always need it. -He did not have portable oxygen available. -He pushed his family member in her wheelchair and "it got to him a little (He became short of breath)." -When he was outside of his room and became short of breath, he got to a table to sit down and huffed and puffed for a while. Interview with Resident #1's Primary Care Provider (PCP) on 12/01/22 at 10:54am revealed: -She wrote an order for oxygen 2L with exertion on 08/03/22. -She did not remember an order after 08/03/22 for oxygen 3 L continuous dated 08/24/22. -She would expect Resident #1 to have portable oxygen available to use with exertion. -She did not know if the facility requested portable oxygen for Resident #1. -She was aware Resident #1 did not like to wear oxygen and referred him to see a pulmonologist because of his refusals and because he was hypoxic. -Possible outcomes of Resident #1 not having portable oxygen were Resident #1 could become more hypoxic and he may have to rest more frequently during exertion. Observation of Resident #1 on 12/01/22 at 11:26am revealed:	D 273		

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D 273	Continued From page 2 -Resident #1 pushed a family member in her wheelchair to the dining area for lunch. -Resident #1 did was not using any oxygen, but he did not seem to be short of breath. Interview with Resident #1 on 12/01/22 at 11:28am revealed: -Sometimes he wore his oxygen and sometimes he did not. -Staff did not encourage him to wear his oxygen. Interview with the Special Care Unit Coordinator (SCUC) on 12/01/22 at 3:54pm revealed: -Resident #1 refused to use his oxygen a lot. -Resident #1 said he did not need his oxygen and she had never seen him use it. -Resident #1 was admitted to the facility without an oxygen concentrator or portable oxygen. -She thought Resident #1 told his PCP, when she visited the facility, that he did not need his oxygen. -Resident #1's PCP conducted room air testing and told Resident #1 he did need oxygen. -Resident #1's PCP wrote an order for oxygen on 08/03/22 and the order was sent to the oxygen provider. -Usually, when the oxygen provider received orders for oxygen, they sent portable oxygen to the facility in additional to the oxygen concentrator. -The facility was trying to get an oxygen concentrator and portable oxygen for Resident #1, but the oxygen provider was requesting additional testing and notes. -Resident #1 had an appointment with a pulmonologist on 01/13/23 to get additional testing and notes to submit to the oxygen provider. Interview with the SCU Manager 12/01/22 at	D 273		

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D 273	Continued From page 3 4:03pm revealed: -Resident #1 was admitted to the facility in July 2022 with an order for continuous oxygen, but he did have an oxygen concentrator or portable oxygen with him when he was admitted. -There was an extra oxygen concentrator at the facility and the facility provided the concentrator for him to use. -She did not think any staff reached out to Resident #1's PCP regarding the portable oxygen for his continuous use between the time he was admitted in July 2022 and when he was first seen by the PCP on 08/03/22, because it took so long for residents to be established as patients with the facility's provider due to verifications of insurance. -An order had been sent to the oxygen provider and the oxygen provider indicated they needed more notes and documentation in order to provide an oxygen concentrator and portable oxygen for Resident #1. -Resident #1 told staff when he was admitted that he had been to a pulmonologist in the past and he told the pulmonologist he did not need oxygen and he would not take oxygen with him everywhere he went. -Resident #1 stated he could breath just fine and she had never observed him to be short of breath. Telephone interview with a representative at the facility's oxygen provider's office on 12/01/22 at 4:36pm revealed: -The office received an order dated 07/15/22 for 3 L of continuous oxygen; there was documentation the facility needed the oxygen by 07/18/22. -The oxygen provider's office called the facility multiple times to request testing because the order they received on 07/15/22 was not sufficient.	D 273		

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D 273	Continued From page 4 -The oxygen provider's office called the facility on 07/15/22 after receiving the order, the morning of 07/18/22, the afternoon of 07/18/22, and on 07/19/22 to advised they were still waiting on an order with appropriate testing information. -The oxygen provider needed a new order with testing results within 30 days in order to provide oxygen for Resident #1. -When the oxygen provider sent out an oxygen concentrator for continuous oxygen, they also sent out portable oxygen for residents. Second telephone interview with a representative at the facility's oxygen provider's office on 12/02/22 at 12:52pm revealed: -The facility was aware of what information was needed regarding testing, but the oxygen provider's office never received any testing information from the facility in order to provide an oxygen concentrator and portable oxygen. -Any provider could have performed the required testing for oxygen, and the resident was not required to see a pulmonologist. -The provider's office was required to follow up three times and did so on 07/15/22, 07/18/22, and on 07/19/22. -The original order for oxygen dated 07/15/22 was canceled due to no response from the facility regarding required testing. -Staff from the facility contacted her today, 12/01/22, and stated they faxed an order for oxygen on 08/03/22, but it was not received by the oxygen provider's office; staff faxed a confirmation sheet on 12/01/22 for the order faxed on 08/03/22 and a copy of the order dated 08/03/22. -No one from the facility called to ask if the oxygen order dated 08/03/22 had been received or why oxygen had not been provided. -There had been no communication from or to	D 273		

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D 273	Continued From page 5 the facility documented in Resident #1's chart beyond 07/19/22. -The order dated 08/03/22 that was received on 12/01/22, contained incomplete testing. -If the 08/03/22 order had been received by the oxygen provider, someone would have informed the facility that the testing information was incomplete. -The oxygen order needed to document oxygen saturation resting on room air, oxygen saturation with exertion, and oxygen saturation with recovery. Interview with a medication aide (MA) on 12/01/22 at 5:08pm revealed: -She usually worked in the SCU and was responsible for faxing physician's orders to outside providers. -She did not think she faxed the order for oxygen to the oxygen provider, but she knew they needed a lot of notes in order to provide the oxygen. -"They probably called back to the facility to advise they can not provide the oxygen without further documentation." -Resident #1 could not get any notes regarding his oxygen needs until he was seen by a pulmonologist and he had an appointment to see a pulmonologist in January 2023. -She had seen Resident #1 use oxygen in his room, but he did not have portable oxygen to use when he was not in his room. -She had not seen him short of breath when he was out of his room. Interview with Resident #1's family member on 12/01/22 at 5:20pm revealed: -Resident #1 was using oxygen as needed. -When she visited Resident #1 at the facility, he was usually in his reclining chair in his room and she had not observed him outside of his room in	D 273		

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D 273	Continued From page 6 the facility. -She had Resident #1 out of the facility at a medical appointment recently and he did not have any problems with his breathing. -She noticed Resident #1 did not have portable oxygen, but she had not said anything because he seemed to be doing fine. Interview with a personal care aide (PCA) on 12/01/22 at 5:27pm revealed she had not seen portable oxygen for Resident #1 and had not observed him to have shortness of breath. Interview with a second MA on 12/01/22 at 5:34pm revealed: -One of the MAs or the SCUC was responsible for sending orders to outside providers and for following up with the outside provider or the resident's PCP. -Resident #1 was on continuous oxygen, but he refused to wear oxygen a lot. -Sometimes Resident #1 stated he could not breathe. -If he felt short of breath, he would let staff know and he sometimes put the oxygen on himself. -Resident #1 did not have portable oxygen for when he was outside of his room. -She noticed Resident #1 to have shortness of breath at times when he was out of his room. -She had not seen Resident #1 stop during ambulation, but she had seen him take deep breaths once he got to his seat in the dining room like he was trying to catch his breath. Interview with a second PCA on 12/01/22 at 5:58pm revealed: -She had seen Resident #1 using oxygen in his room, but she had not seen him with portable oxygen outside his room. -She did not know if Resident #1 had portable	D 273		

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D 273	Continued From page 7 oxygen. -Resident #1 had never complained to her of being short of breath. Interview with the facility's Registered Nurse (RN) on 12/01/22 at 6:40pm revealed: -Staff tried to get the oxygen provider to provide an oxygen concentrator and portable oxygen, but they needed more information. -Resident #1 did not have an oxygen concentrator when he was admitted to the facility and the facility provided one for him. -The facility had been unable to get portable oxygen. -Resident #1's oxygen concentrator was on wheels and could have been rolled to the dining area for Resident #1 if he had difficulty breathing. Telephone interview with the SCUC on 12/02/22 at 1:15pm revealed: -MAs were responsible for following up with outside provider regarding treatment orders. -If additional information was needed from an outside provider, she would get involved with the follow-up. -She faxed Resident #1's oxygen order dated 08/03/22 to the pharmacy on 08/03/22. -She did not think anyone from the facility followed up with the oxygen provider after she sent the oxygen order on 08/03/22. Telephone interview with the facility's RN on 12/02/22 at 1:24pm revealed: -The SCUC would have been responsible for following up with the facility's oxygen provider regarding the oxygen order dated 08/03/22. -He thought the SCUC faxed Resident #1's oxygen order dated 08/03/22 to the oxygen provider, but he did not know why the order was not received by the oxygen provider or entered	D 273		

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D 273	Continued From page 8 into their system. Telephone interview with the Administrator on 12/02/22 at 3:38pm revealed: -MAs were responsible for sending orders and following up with the oxygen providers. -If the MAs could not get the order fulfilled, the MA should have discussed with the SCUC or the SCU Manager. -She expected staff to work on Resident #1's oxygen order until he received the oxygen concentrator and portable oxygen. -The facility provided Resident #1 with an oxygen concentrator when he was admitted in July 2022. -The oxygen concentrator could have been rolled to Resident #1 if he needed it when he was outside of his room. -Resident #1 not having portable oxygen was not as important as him not having an oxygen concentrator. -If Resident #1 left the facility, he would have to take the oxygen concentrator with him.	D 273		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents in the Special Care Unit (SCU) who required feeding assistance were	D 312	**D312: SCU Manager and/or SCU RCC will show or retrain PCAs on how to properly feed residents. While a resident who needs assistance eating a meal, is eating in the dinning room or room, the PCA will sit in front of resident/residents. The staff will focus solely on the resident that she/he is assisting with feeding. PCA will not leave resident until he/she has finished eating.** **SCU RCC or SCU Manager will monitor/ assist in dinning room for at least 2 meals daily to ensure assistance with feeding is being done correctly. Retraining will take place as needed to ensure that assistance with feeding continues to be done correctly.**	**12/06/22**

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D 312	Continued From page 9 assisted upon receipt of their meal and continuously throughout the meal and in an unhurried manner that maintains the residents' dignity and respect. The findings are: Observation of the lunch meal service in the SCU on 11/30/22 between 11:50 and 12:30pm revealed: -There were 3 half-moon shaped tables in close proximity in the SCU dining area. -There were 3 residents at the first table, 4 residents at the second table, and 3 residents at the third table. -There was 1 staff standing in the hollow of the first table in front of the residents, 1 staff standing in the hollow of the second table in front of the residents, and 1 staff seated in front of the residents in the hollow of the third table. -At 12:01pm, a staff bent down beside a resident, fed the resident 4 to 5 bites and then left the resident. -At 12:07pm, a staff stood over a resident's right should and fed the resident. -At 12:18pm, staff was standing feeding 1 resident at the second table, 1 resident was feeding herself, and 2 residents were seated with their plates in front of them receiving no assistance. -Staff stood in the hollows of the first and second tables in front of the residents throughout the lunch meal. Observation of the breakfast meal service in the SCU on 12/01/22 between 7:45am and 8:36pm revealed: -There were 3 half-moon shaped tables in close proximity in the SCU dining area. -There were 3 residents at the first table, 4	D 312		

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D 312	Continued From page 10 residents at the second table, and 3 residents at the third table. -There was 1 staff seated in the hollow of the first table in front of the residents, 2 staff standing in the hollow of the second table in front of the residents, and 1 staff standing in the hollow of the third table in front of the residents. -At 7:58am, a staff stood over a resident's right should to feed the resident and then went to stand in the hollow of the table in front of the resident. -At 8:02am, a resident who was served a pureed plated, lifted the plate from the table into her lap, and then lifted the plate to her face to take a bite of the pureed food. -Another resident was not prompted or offered a bite of food from 8:01am to 8:04am. -The same resident was fed a bite of food and went without another bite of food from 8:04am to 8:08am. -At 8:07am, the staff who was standing at the third table walked away from the table leaving the 3 residents without any feeding assistance. -The 3 residents did not attempt to feed them themselves between 8:07am and 8:14am and at 8:14am, 1 of the residents took a bite of eggs. -At 8:16am, a staff stood in front of 1 of the residents at the third table and fed the resident a few bites of food; the staff did not offer any food to the other two residents at the third table before walking away from the table at 8:17am. -At 8:19am, 1 resident propelled himself away from the third table after not being offered any feeding assistance from 8:07am to 8:19am; staff pushed the resident back to the table. -At 8:20am, 1 resident at the third table was offered feeding assistance and had 95% of the breakfast meal remaining on the plate. -At 8:22am, another resident at the third table was offered feeding assistance and had 95% of	D 312		

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D 312	Continued From page 11 the breakfast meal remaining on the plate. -At 8:25am, a staff who was standing at the second table started to feed a resident from another resident's plate, but realized it was the wrong resident before putting the spoonful of food in the wrong resident's mouth. -At 8:34am, staff were removing plates from the first, second, and third tables; staff asked a resident at the second table if he wanted another bite and stood over his left shoulder to offer the bite to him. Interview with the Special Care Unit Coordinator (SCUC) on 12/01/22 at 3:30pm revealed: -There were 10 residents in the SCU who needed assistance with feeding, and they all sat at the half-moon shaped tables. -Seven of the residents needed to be fed by staff and the other 3 residents required prompting. -There were usually 3 staff assisting at the three tables of the residents who needed assistance with feeding. -Staff were usually seated at the hollow of the half-moon shaped tables in front of the residents. -She did not know why they had been standing. Interview with the SCU Manager on 12/01/22 at 3:44pm revealed: -There were 10 residents who sat at the half-moon shaped tables during meals and needed to be fed, supervised, or prompted during meals. -There were usually 3 staff assisting with the 10 residents. -Staff had been instructed to give 3 bites of food and then allow the resident to drink. -Staff were to encourage the residents to drink and to eat as much as they would eat. -Staff were to sit in front of the residents to assist with feeding and prompting residents during	D 312		

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D 312	Continued From page 12 meals. -She would need to do some additional training. Interview with a personal care aide (PCA) on 12/01/22 at 4:14pm revealed: -All the residents who sat at the half-moon shaped tables needed feeding assistance. -There were usually 3 staff providing assistance to the residents, 1 staff at each table. -Staff were told to get in front of residents and feed them at eye level. -She usually sat while providing feeding assistance. -Staff sometimes moved from table to table to assist with feeding residents. Interview with a second PCA on 12/01/22 at 5:27pm revealed: -Most all the residents who sat at the half-moon shaped tables needed to be fed. -Staff should have been seated in front of the residents to provide feeding assistance. -She stood in front of residents to feed them because she just liked to stand up. -She tried to sit down, but someone at a different tabled needed to be fed, she would have to get up to go them. Interview with a medication aide (MA) on 12/01/22 at 5:34pm revealed: -Staff usually stood to feed the residents who needed assistance with feeding and went from table to table to assist with feeding. -Staff had not been told they needed to be seated when providing feeding assistance. Interview with a third PCA on 12/01/22 at 5:58pm revealed: -When she provided feeding assistance to residents she tried to stand in front of the	D 312		

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	HAL029001	A. BUILDING: _____ B. WING _____	12/02/2022

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D 312	Continued From page 13 resident. -Sometimes she sat beside one of the residents because he tried to get up and walk off during meals. -She stood to provide feeding assistance because she usually did not sit down unless she was taking a break and standing made it easier for her to step away if she needed to grab something quickly. -Most of the staff stood in front of the residents to provide feeding assistance. -She sometimes had to leave the residents she was assisting to go to assist at another table or to provide care for a resident who was not seated in the dining room. -If she had to leave residents, she asked the PCA at another table to cover for her with the residents. Telephone interview with the Administrator on 12/02/22 at 3:38pm revealed: -There were 10 residents in the SCU who required feeding assistance; seven of the residents needed to be fed and three residents needed to be prompted. -She expected staff to sit down to feed the residents. -She did not agree with staff standing and hovering over residents while providing feeding assistance. -She was not aware staff was standing to feed the residents who needed assistance or leaving the residents during meals. -Staff should not have left the residents needing feeding assistance during meals. Based on observations and interviews, it was determined the 10 residents who needed assistance with feeding were not interviewable.	D 312		

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D 358	Continued From page 14	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 5 sampled residents (#4) including an error related to an oral diabetic medication. The findings are: Review of Resident #4's current FL2 dated 11/02/22 revealed: -Diagnoses included type 2 diabetes and hypertension. -There was an order to check fingerstick blood sugar (FSBS) once weekly and as needed. Review of Resident #4's physician's orders dated 06/15/22 revealed an order for metformin (an oral medication used to treat high blood sugar levels) 500mg daily. Review of Resident #4's laboratory results dated 09/12/22 revealed: -His glomerular filtration rate (GFR, a blood laboratory test that shows how well the kidneys	D 358	**D358: To Prevent Medication Errors AL Admin Assistant and AL RCC will be auditing the medication cart every two weeks. Every two weeks, the AL Admin Assistant and/or AL RCC will take a sample from the residents that are seeing the doctor that week and audit those residents (MAR to Cart). AL Admin Assistant and/or AL RCC will review all new orders when they come in.**	**12/07/22**

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D 358	Continued From page 15 are functioning) was 51mL/min/1.73m2, (normal reference range included values greater than 60mL/min/1.73m2). -There was an order written on the lab result and signed by the primary care provider (PCP) on 09/22/22 to stop metformin and start Farxiga (an oral medication used to treat diabetes by controlling blood sugar levels) 5mg daily. Review of Resident #4's fax from the pharmacy dated 09/22/22 revealed: -The fax was an insurance non-formulary alert. -The fax was written attention to the Resident Care Coordinator (RCC) or Director of Nursing (DON). -There was documentation that Farxiga was not covered by Resident #4's insurance. -There was documentation that due to the high cost of the medication and inability to send a partial amount, the pharmacy would not be able to send Farxiga to the facility; the primary care provider (PCP) must complete the medication change request at the bottom of the fax to prevent a delay in therapy for the resident and fax the form back to the pharmacy. -There was an order written by the PCP to start Jardiance (an oral medication used to treat diabetes by controlling blood sugar levels) 10mg daily. Review of Resident #4's signed physician's order dated 09/23/22 revealed an order to discontinue Farxiga and start Jardiance 10mg daily. Review of Resident #4's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Farxiga 5mg daily scheduled at 8:00am, with a start date of 09/23/22.	D 358		

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D 358	Continued From page 16 -There was documentation Farxiga was administered 09/24/22, and 09/26/22 through 09/30/22. -There was a second entry for Farxiga 5mg daily scheduled at 8:00am, with a start date of 09/22/22 and a discontinue date of 09/23/22 with no doses administered. -There was an entry for Jardiance 10mg daily scheduled at 8:00am, with a start date of 09/23/22. -There was documentation Jardiance was administered daily from 09/24/22 through 09/30/22. -There was an entry to check FSBS once weekly on Tuesdays. -FSBS values for September 2022 ranged from 145 to 164. Review of Resident #4's October 2022 eMAR revealed: -There was an entry for Farxiga 5mg daily scheduled at 8:00am. -There was documentation Farxiga was administered daily from 10/01/22 through 10/31/22. -There was an entry for Jardiance 10mg daily scheduled at 8:00am. -There was documentation Jardiance was administered daily from 10/01/22 through 10/31/22. -There was an entry to check FSBS once weekly on Tuesdays. -FSBS values for October 2022 ranged from 125 to 194. Review of Resident #4's November 2022 eMAR revealed: -There was an entry for Farxiga 5mg daily scheduled at 8:00am. -There was documentation Farxiga was	D 358		

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D 358	Continued From page 17 administered daily from 11/01/22 through 11/30/22. -There was an entry for Jardiance 10mg daily scheduled at 8:00am. -There was documentation Jardiance was administered daily from 11/01/22 through 11/30/22. -There was an entry to check FSBS once weekly on Tuesdays. -FSBS values for November 2022 ranged from 128 to 175. Observation of medications on hand for Resident #4 on 12/01/22 at 9:50am revealed: -There was one medication card for Farxiga 5mg tablets with a dispensed date of 11/02/22. -There were 30 tablets of Farxiga dispensed and 8 tablets remaining in the medication card. -There was one medication card for Jardiance 10mg tablets with a dispensed date of 11/14/22. -There were 14 tablets of Jardiance dispensed and 4 tablets remaining in the medication card. Telephone interview with a representative from the facility's contracted pharmacy on 12/01/22 at 9:30am revealed: -On 09/22/22, the pharmacy received an order to discontinue Resident #4's metformin and start Farxiga. -On 09/24/22, the pharmacy received the order to discontinue Resident #4's order for Farxiga and start Jardiance. -The Farxiga order had been discontinued, but on 10/09/22 the facility requested a refill of the Farxiga, and the medication was mistakenly reactivated and dispensed to the facility. -The Farxiga refill request included the medication barcode, prescription number and resident identification number. -The pharmacy was receiving paid claims from	D 358		

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D 358	Continued From page 18 Resident #4's insurance for both the Farxiga and Jardiance, so a prior authorization to have Farxiga covered by insurance must have been processed. -The pharmacy dispensed Farxiga on 10/10/22, 11/02/22, and 11/30/22 for a quantity of 30 tablets each time. -The pharmacy also dispensed Jardiance on 09/23/22 for 30 tablets, and on 10/21/22, 11/01/22, 11/13/22 and 11/28/22 with 14 tablets each time. Interview with a medication aide (MA) on 12/01/22 at 10:00am revealed: -The night shift MAs usually completed medication cart audits and reordered medications that were running low. -The MAs were supposed to reorder medications once they reached a quantity of 5 day supply remaining. -To request a refill from the pharmacy, the MA would take the barcode sticker off the medication card, stick the barcode to the blue pharmacy form and fax it to the pharmacy. -The pharmacy entered medication orders on the eMARs, then the RCC reviewed and approved the medication entries on the eMARs. -Both Farxiga and Jardiance displayed as medications that were due for Resident #4 daily at 8:00am, so she had been administering both medications. Interview with the RCC on 12/01/22 at 10:21am revealed: -She was responsible for processing new medication orders for the residents. -She was responsible for accepting order entries on the eMARs that were entered by the pharmacy. -When the PCP wrote a new medication order,	D 358		

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D 358	Continued From page 19 the order was given to her, and she faxed it to the pharmacy. -The pharmacy entered new order entries on the eMARs, and they showed up on her computer screen as pending orders for her to review. -She would compare the new entry on the eMAR with the original order written by the PCP, then approve it if it was entered accurately. -She did audits of the eMARs and medication orders for all residents every 6 months, and December 2022 was the month the audits were due next. -The last time she had audited Resident #4's medication orders was around June 2022. -On 09/23/22, the pharmacy entered Resident #4's order for Farxiga on the eMAR, and the eMAR system showed that she accepted the order at midnight on 09/24/22. -She was not working at midnight on 09/24/22 so she did not know how the entry had been approved. -There was a second entry for Resident #4's Farxiga order with a discontinued date of 09/25/22. -She did not know how two entries for Farxiga ended up on Resident #4's eMAR but only one entry had been discontinued. -She was not aware that Resident #4 had been receiving Farxiga daily since it had been discontinued on 09/23/22. Telephone interview with Resident #4's PCP on 12/01/22 at 10:50am revealed: -Resident #4's metformin had been discontinued since his GFR value was low, and metformin could effect kidney function. -Both Farxiga and Jardiance protected kidney function while also controlling diabetes. -She was not aware that Resident #4 had been receiving Farxiga daily since she had	D 358		

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D 358	Continued From page 20 discontinued it on 09/23/22, and that he had also been receiving Jardiance daily. -The possible adverse effect for taking both Farxiga and Jardiance was low blood sugar. -She expected the facility staff to administer medication to Resident #4 how she ordered it, so that he would not receive duplicate antidiabetic therapy. Interview with a second MA on 12/01/22 at 11:30am revealed: -She had documented that she administered Farxiga to Resident #4 on 10/06/22. -If she documented the medication as administered, she was sure that she administered it and it was not an error in documentation. -If one of the MAs had sent a refill request for Farxiga to the pharmacy, the medication would have had to be in the facility to pull the barcode off of. -She thought the pharmacy probably sent a 14-day supply of Farxiga at the end of September 2022 to get him by until a new medication could be ordered for him or a prior authorization could be completed to get the Farxiga approved. Interview with Resident #4 on 12/01/22 at 3:00pm revealed: -He was not very familiar with the names of the medications he took. -He had not felt symptoms of low blood sugar in the last three months. -Staff checked his blood sugar once a week and he thought it was always good. Interview with the Administrative Assistant on 12/01/22 at 3:50pm revealed: -She spoke with the pharmacy regarding Resident #4's Farxiga and was told that someone at the PCP's office had completed a prior	D 358		

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D 358	Continued From page 21 authorization to have Farxiga covered through his insurance company. -The pharmacy received a copy of the approved prior authorization and re-activated Resident #4's Farxiga order and dispensed the medication to the facility. -The night shift MAs usually unpacked the totes of medication that were delivered from the pharmacy and put the medication cards in the medication cart. -The night shift MAs did not have a process in a place where they were supposed to check medications received with the medication orders. -Usually if there was a new order change, a copy of the new order was posted in the medication room for the night shift MAs to see while they were unpacking the new medication cards from the pharmacy. -Since the Farxiga had been discontinued right away and was not supposed to be dispensed to the facility, she had not posted the discontinue order in the medication room for the MAs to see. Telephone interview with the Administrator on 12/02/22 at 3:40pm revealed: -She was not aware that Resident #4 had been receiving Farxiga since the order was discontinued. -The RCC and the Administrative Assistant were responsible for managing new prescription orders and order changes. -When a medication was discontinued, the RCC or Administrative Assistant would be responsible for removing the medication from the medication cart, but the Farxiga had been discontinued prior to when it was dispensed so there should not have been a medication card to remove. -The RCC and Administrative Assistant completed audits of the medication cart with medication orders every six months, and the	D 358		

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D 358	Continued From page 22 pharmacy did mediation reviews quarterly. -She expected the RCC and Administrative Assistant to ensure medications were administered as ordered by the PCP by verifying that orders were correct in the eMAR for the MAs who administer the medication.	D 358		