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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted an annual survey, a follow-up survey and complaint investigation from May 17, 2023 to May 18, 2023. The complaint investigation was initiated by the New Hanover County Department of Social Services on April 27, 2023.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 medication aides (Staff E) who administered medications independently had completed the medication aide clinical skills checklist prior to administering medications. Observation of Staff E, Medication Aide (MA) on 05/17/23 at 8:45am upon entering the facility	D 125		

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revealed:
-She was standing at the medication cart in the hallway next to a resident room.
-There was a resident seated next to the medication cart.
-There was a resident who approached Staff E while she was standing at the medication cart.

Interview with Staff E on 05/17/23 at 9:20am revealed:
-She was the medication aide administering resident medications on 05/17/23 in the assisted living section of the facility.
-She was "running behind" and still administering medications because there had been an issue the morning of 05/17/23. She did not provide any information on the issue that occurred.

Interview with Staff E on 05/17/23 at 10:10am revealed:
-She had one resident remaining to administer morning medications.
-She had been employed at the facility since November 2022 after relocating from another state.

Observation of Staff E on 05/17/23 at 10:16am revealed:
-She prepared and administered 14 pills, one 30cc cup of liquid medication, and an inhaler medication to a resident.
-She locked the medication cart with keys in her possession before leaving the medication cart with the medications for the resident.

Review of Staff E, medication aide (MA) personnel record revealed:
-Staff E was hired on 11/01/22 as a personal care aide/medication aide.
-She passed the medication aide written

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examination on 02/23/23.
-She completed the 5/10-hour medication aide training on 03/25/23.
-There was no documentation Staff E completed the medication aide clinical skills competency validation checklist.

Review of resident March 2023 electronic medication administration records (EMARs) revealed Staff E documented administration of medications on 03/21/23, 03/24/23, 03/25/23, 03/26/23, 03/27/23, and 03/31/23.

Review of resident April 2023 EMARs revealed Staff E documented administration of medications on 04/01/23, 04/03/23, 04/04/23, 04/05/23, 04/10/23, 04/13/23, 04/14/23, 04/19/23, 04/21/23, 04/23/23, 04/24/23, 04/26/23, 04/27/23, and 04/28/23.

Review of resident May 2023 EMARs revealed Staff E documented administration of medications on 05/02/23, 05/03/23, 05/05/23, 05/06/23, 05/07/23, 05/08/23, 05/10/23, 05/11/23, 05/12/23, 05/16/23, and 05/17/23.

Second interview with Staff E on 05/17/23 at 3:00pm revealed:
-She had not completed the medication aide clinical skills validation checklist.
-The nurse was supposed to come to the facility on 05/18/23 to complete her medication aide clinical skills validation checklist.
-The Executive Director (ED), Memory Care Manager (MCM), or Resident Care Coordinator (RCC) "usually" came to assist her with medication administration.
-There had not been any assistance or supervision for her today (05/17/23).
-The ED was the only manager present earlier

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D 125	Continued From page 3 the morning of 05/17/23 and was busy with other things. -The ED, MCM, or RCC were "always here in the mornings and come down the hall". Interview with the Administrator on 05/17/23 at 3:07pm revealed: -He expected all staff to meet credentialing and training requirements. -There had been a communication and scheduling issue between the Executive Director and nurse with getting Staff E's medication clinical skills validation checklist completed. Interview with the Executive Director on 05/18/23 at 8:43am revealed: -Staff E was not supposed to administer medications without supervision from her, RCC, or MCM. -She could not answer regarding Staff E being scheduled to work as the MA without having the medication clinical skills competency validation checklist completed by the nurse. -She was aware Staff E was administering medications on 05/17/23 when she (ED) arrived at work around 9:00am. -The RCC assigned Staff E to work as the MA on 05/17/23. -The RCC was not working at the facility today (05/17/23). Second interview with the Executive Director on 05/18/23 at 4:30pm revealed she was responsible for ensuring staff trainings, including medication aide clinical skills validations, were completed and in the staff record. Refer to Tag D 358, 10A NCAC 13F .1004(a) Medication Administration.	D 125		

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D 276	Continued From page 4	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders for a bed alarm, chair alarm and fall mat were implemented for 1 of 5 sampled residents (#2), who had a history of falls. The findings are: Review of Resident #2's current FL-2 dated 11/16/22 revealed: -Diagnoses included dementia, depression, anemia, displaced intertrochanteric fracture of right femur, elevated white blood cells, generalized anxiety disorder and mild cognitive impairment. -The resident was constantly disoriented. -The resident needed assistance with bathing, feeding, and dressing. Review of Resident#2's Resident Register revealed she was admitted to the facility on 11/14/2022. Review of Resident #2's medical record revealed a signed physician's order request dated 11/16/22 for a chair alarm, bed alarm and a fall mat.	D 276		

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D 276	Continued From page 5 -The same signed physician's order request noted "Resident is a fall risk, family is concerned." Observation of Resident #2's room on 05/17/2023 at 2:27pm revealed: -Resident #2 was lying in bed with her eyes closed. -There was no fall mat in Resident #2's room. -There was no bed alarm attached to Resident's #2's bed. -There was no wheelchair in Resident #2's room. -There was a walker on the opposite side of the room. Interview with a PCA on 05/17/22 at 2:47pm revealed: -Resident #2 can walk but required "a lot of assistance". -Resident #2 was a fall risk. -Resident #2 was kept at the Nurse's station when she was out of bed so she could be watched. -She checked on Resident #2 at least every 2 hours. Observation of Resident #2's room on 05/17/2023 at 2:48pm revealed: -2 Personal Care Aides (PCAs) entered her room with a wheelchair and got her out of bed and placed her in the wheelchair and took her to the shower. -There was no chair alarm attached to the wheelchair. -There was no fall mat present. Observation of Resident #2's room on 05/18/22 at 7:25am revealed: -Resident #2 was lying in bed. - The MA and a PCA entered her room and tried to assist her to the side of the bed.	D 276		

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D 276	Continued From page 6 -Resident #2 did not want to get up. -The PCA propped Resident #2 up in the bed and the MA administered her morning medications. -Resident #2 was allowed to lay back down after her medications were administered. -There was no fall mat in her room. -There was no bed alarm attached to her bed. Interview with a 2nd PCA on 05/18/22 at 7:34am revealed: -Resident #2 never had a chair alarm, bed alarm or fall mat. Observation of Resident #2 on 05/18/2023 at 11:20am revealed: -Resident #2 was sitting in a recliner in the common area by the Nurse's station. -2 PCAs were placing a chair alarm on the recliner being used by Resident #2. Interview with the Memory Care Manager on 05/18/23 at 11:42am revealed: -She had obtained an order from the Primary Care Provider for a combination chair/bed alarm and fall mat for Resident #2 on 05/16/23 after she had a recent fall on 05/13/23. -A combination chair/bed alarm was delivered this morning. -The fall mat was to be delivered pending prior authorization. -She was not aware of the order for the chair alarm, bed alarm and fall mat from 11/16/22. -She, the Resident Care Coordinator (RCC), or the Executive Director (ED) were responsible for processing and faxing Durable Medical Equipment (DME) orders to their DME supplier. -She reviewed the order and said it appeared that the previous 11/16/22 order for the chair alarm, bed alarm and fall mat were faxed to the facility's contracted pharmacy instead of the DME	D 276		

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D 276	Continued From page 7 supplier. -She did not know why the 11/16/22 order was not faxed to the DME supplier. -She said if DME was ordered by the PCP, the orders should be faxed to the DME provider, and she would follow up with the DME supplier in 2-3 days for delivery because the items most likely would require prior authorization with by Resident's #2's insurance company. -She did not know why the DME order dated 11/16/22 was faxed to the pharmacy and not the DME supplier. -She did not know why there was no follow up when the chair alarm, bed alarm and fall mat were not delivered in November 2022. -She expected DME ordered the PCP to be faxed to the DME supplier and if not delivered in 2 to 3 days then to contact to inquire about delivery. Interview with the Executive Director (ED) on 05/18/23 at 3:13Ppm revealed: -She expected all DME orders to be faxed to their DME provider and there should have been follow up when the items were not delivered. -The MCM was responsible for faxing DME orders and to follow up on delivery 2-3 days after order faxed if the items were not received. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	D 276		
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	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#2, #6) observed during the 8:00am medication passes on 05/17/23 and 05/18/23 including errors with a thyroid hormone, iron supplement, heart medication, and anti-fungal medication (#6), and a medication used to treat constipation (#2).

The findings are:

A. The medication error rate was 17% as evidenced by 5 errors out of 29 opportunities during the 8:00am medication passes on 05/17/23 and 05/18/23.

Interview with the medication aide (MA) on 05/17/23 at 9:20am revealed she was "running behind" and still administering medications because there had been an issue the morning of 05/17/23.

Interview with the MA on 05/17/23 at 10:10am revealed she had one resident remaining to administer morning medications.

1. Review of Resident #6's current FL-2 dated 03/01/23 revealed diagnoses included sequelae of other infections and parasitic diseases, acute respiratory failure with hypoxia, candidal stomatitis, and hypothyroidism.

a. Review of Resident #6's prescription from a

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local hospital physician dated 05/15/23 revealed the physician prescribed Nystatin 100,000 unit/ml oral Suspension (used to treat infections caused by fungus such as thrush) take 5mls by mouth 4 times daily for 12 days.

Observation of the MA during the medication pass on 05/17/23 at 10:10am revealed:
-The MA prepared 30ml of Nystatin Suspension in a graduated medicine cup.
-The MA took the 30ml cup of Nystatin Suspension to Resident #6 who was in her room.
-The MA handed the 30ml cup of Nystatin Suspension to Resident #6 and instructed her to "swish and spit".

Observations of Resident #6 at 10:10am on 05/17/23 revealed:
-Resident #6 retrieved the Nystatin Suspension from the MA while the MA observed.
-Resident #6 swished the Nystatin Suspension in her mouth and swallowed the Nystatin Suspension.
-The MA asked Resident #6 if she had swallowed the Nystatin Suspension.
-Resident #6 replied she had thrush in her mouth and was supposed to swish and swallow the Nystatin Suspension.

Interview with the MA on 05/17/23 at 10:20am revealed:
-She did not know the instructions for Nystatin Suspension was "swish and swallow".
-She thought the resident was supposed to swish and spit out the Nystatin Suspension.

Review of Resident #6's May 2023 electronic medication administration records (eMAR) revealed:
-There was a printed entry for Nystatin

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Suspension 100,000 give 5mls by mouth four times a day scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation for administration of the Nystatin Suspension beginning at 8:00pm on 05/16/23 and 8:00am on 05/17/23.

Second interview with the MA on 05/17/23 at 2:46pm revealed:
-She only administered one dose of the Nystatin Suspension on 05/17/23.
-Resident #6 refused the 12:00pm dose of Nystatin Suspension.

Interview with the Pharmacist at the contracted provider pharmacy on 05/18/23 at 11:59am revealed:
-The recommended dosing amount for the Nystatin Suspension was 4-6ml four times a day.
-There was no recommended maximum dose.
-There may not be enough of the Nystatin Suspension to last the prescribed treatment time if the medication was administered inaccurately.

Refer to the interview with the Medication Aide on 05/17/23 at 2:40pm.

Refer to the interview with the Administrator dated 05/17/23 at 3:07pm.

Refer to the interview with the Executive Director dated 05/18/23 at 8:35am.

b. Review of a physician's order for Resident #6 revealed there was a physician's order dated 03/01/23 for Diltiazem capsule (used to treat heart disease) 180mg ER take one capsule every day.

Review of Resident #6's prescription from a local

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D 358	Continued From page 11 hospital physician dated 05/15/23 revealed the physician prescribed Diltiazem 240mg 24-hr capsule daily. Observation of the medication pass on 05/17/23 at 10:10am revealed the MA prepared and administered 14 pills with water to Resident #6, including Diltiazem 180mg ER capsule. Review of Resident #6's May 2023 electronic medication administration records (eMAR) revealed: -There was a printed entry for Diltiazem 180mg ER capsule every day scheduled for administration at 8:00am. -There was documentation for administration of the Diltiazem 180mg ER capsule every day on 05/01/23 through 05/06/23. -There was a printed entry discontinuing the Diltiazem 180mg capsule on 05/15/23 at 3:14pm. -There was a second printed entry for Diltiazem 240mg ER capsule every day dated 05/16/23 scheduled for administration at 8:00am. -There was documentation for administration of the Diltiazem 240mg ER capsule every day dated 05/17/23 scheduled for administration at 8:00am. Observation of Resident #6's medication on hand on 05/17/23 at 2:29pm revealed: -There was a pharmacy labeled blister pack of Diltiazem 180mg ER capsules with instructions to take one tablet every day stored in the medication cart with other medications being administered to Resident #6. -The MA removed a second pharmacy labeled blister pack of Diltiazem 240mg ER capsules with a dispense date of 05/15/23 and instructions to take one tablet every day stored in the bottom drawer of the medication cart with other overflow medications. There were 10 capsules dispensed	D 358		

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and 10 capsules on hand.

Interview with the medication aide (MA) on 05/17/23 at 2:29pm revealed:
-The resident was supposed to have been administered Diltiazem 240mg ER capsule on 05/17/23.
-The resident returned to the facility on the evening of 05/16/23 and should have been administered the first dose of Diltiazem 240mg on 05/17/23.
-Resident #6 was sent back to the hospital earlier today (05/17/23) after the primary care Provider saw her.

Interview with the Primary Care Provider (PCP) on 05/17/23 at 2:50pm revealed:
-He was okay with Resident #6 being administered the Diltiazem 180mg ER capsule on 05/17/23 instead of the Diltiazem 240mg capsule prescribed from the hospital physician.
-His planned visit day at the facility was 05/17/23 and Resident #6's post hospital orders would be reviewed.
-He was sending Resident #6 back to the hospital.

Refer to the interview with the medication aide on 05/17/23 at 2:40pm.

Refer to the interview with the Administrator dated 05/17/23 at 3:07pm.

Refer to the interview with the Executive Director dated 05/18/23 at 8:35am.

c. Review of a physician's order for Resident #6 revealed there was a physician's order dated 03/01/23 for Levothyroxin tablet (used to treat underactive thyroid disease) 25mcg tablet

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 everyday *do not take within 4 hours of calcium or iron containing products or bile acid sequestrants*. Observation of the medication pass on 05/17/23 at 10:10am revealed the MA prepared and administered 14 pills with water to Resident #6, including Levothyroxin 25mcg tablet and Ferrous Sulfate 325mg tablet (used to treat low iron levels). Review of Resident #6's May 2023 electronic medication administration records (eMARs) revealed: -There was a printed entry for Levothyroxin 25mcg tablet every day *do not take within 4 hours of calcium or iron containing products or bile sequestrants* scheduled for administration at 8:00am. -There was documentation for administration of the Levothyroxin 25mcg and Ferrous Sulfate 325mg tablet at 8:00am on 05/01/23 through 05/06/23 and 05/17/23. -There was documentation the resident was in the hospital 05/08/23 through 05/16/23. Observation of Resident #6's medication on hand on 05/17/23 at 2:40pm revealed: -There was a pharmacy labeled blister pack of Levothyroxin 25mcg tablets with instructions to take one tablet every day. -Additional instructions printed on the blister pack of Levothyroxin included the medication was not to be taken within 4 hours of calcium or iron. Interview with the MA on 05/17/23 at 2:40pm revealed: -She administered the Levothyroxin at the same time she administered the Ferrous Sulfate (iron) tablet.	D 358		

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	HAL065035	A. BUILDING: _____ B. WING _____	05/18/2023

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D 358	Continued From page 14 -She noticed the instructions for the Levothyroxin indicated the medication was not to be administered within 4 hours of iron but did not question or say anything to anyone about the instructions. Telephone interview with a pharmacist at the contracted pharmacy provider on 05/18/23 at 11:53am revealed: -Levothyroxin was not supposed to be administered with calcium or iron. -The calcium or iron would prevent the entire dose from being absorbed. -Taking the iron within 4 hours of the Levothyroxin would lower the thyroid level and could cause heartburn, goiters, and a higher risk of heart disease and heart failure over a long period of time. Review of Resident #6's laboratory reports available in the resident's record revealed the last TSH (thyroid stimulating hormone) result was 2.44 (reference range for TSH is 0.46 - 4.66) collected on 03/01/22. Refer to the interview with the medication aide on 05/17/23 at 2:40pm. Refer to the interview with the Administrator dated 05/17/23 at 3:07pm. Refer to the interview with the Executive Director dated 05/18/23 at 8:35am. d. Review of a physician's order for Resident #6 revealed there was a physician's order dated 03/01/23 for Ferrous Sulfate (used to treat low iron levels) 325mg tablet every morning with breakfast.	D 358		

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D 358	Continued From page 15 Observations of the MA on 05/17/23 at 10:10am revealed: -The MA prepared and administered 14 pills with water to Resident #6, including Ferrous Sulfate 325mg tablet. -There was no food offered with the administration of the Ferrous Sulfate at 10:10am. Review of Resident #6's May 2023 eMAR revealed: -There was a printed entry for Ferrous Sulfate 325mg (65mg) take one tablet with breakfast scheduled for administration at 8:00am. -There was documentation for administration of the Ferrous Sulfate 325mg tablet at 8:00am on 05/01/23 through 05/06/23 and 05/17/23. -There was documentation the resident was in the hospital 05/08/23 through 05/16/23. Interview with the MA on 05/17/23 at 2:46pm revealed: -The printed instructions on the EMAR was Ferrous Sulfate 325mg tablet every day with breakfast. -Resident #6 ate breakfast in her room just before her medication was administered. -The resident "usually" ate breakfast around 8:30am. -She could not administer the Ferrous Sulfate before breakfast but could administer the Ferrous Sulfate if the resident had something on her stomach. -The resident kept food in her room. Refer to the interview with the medication aide on 05/17/23 at 2:40pm. Refer to the interview with the Administrator dated 05/17/23 at 3:07pm.	D 358		

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D 358	Continued From page 16 Refer to the interview with the Executive Director dated 05/18/23 at 8:35am. 2. Review of Resident #2's current FL-2 dated 11/16/22 revealed diagnoses included unspecified dementia, depression unspecified, anemia unspecified, displaced intertrochanteric fracture of right femur, elevated white blood cell, generalized anxiety disorder, and mild cognitive impairment. Review of signed physician's orders for Resident #2 dated 11/17/22 and 12/29/22 revealed physician's orders for Senna Plus (used to treat constipation) 8.6-50mg tablet twice daily. Observation of the medication pass on 05/18/23 at 7:34am in the Special Care Unit (SCU) revealed: -The MA prepared and administered 4 oral medication tablets to Resident #2 with water in the resident's room. -There was no Senna Plus 8.6-50mg tablet prepared or administered to Resident #2. Review of Resident #2's May 2023 electronic medication administration records (eMARs) revealed: -There was a printed entry for Senna Plus 8.6-50mg tablet twice daily scheduled for 8:00am and 8:00pm. -The MA documented and initialed in the eMAR medication notes "medication on hold". Interview with the MA on 05/18/23 at 9:46am revealed: -There were no Senna Plus 8.6-50mg tablets on hand. -The pharmacy had not delivered any Senna Plus tablets to the facility for Resident #2.	D 358		

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D 358	Continued From page 17 Interview with a personal care aide (PCA) working on the SCU on 05/18/23 at 9:49am revealed: -Resident #2 was in her assignment on 05/17/23 and 05/18/23. -She did not know or remember when Resident #2 last had a bowel movement. -Resident #2 had not had a bowel movement on 05/17/23 or 05/18/23 while the PCA was assigned to the resident's care. Telephone interview with a Pharmacist from the contracted pharmacy on 05/18/23 at 10:10am revealed: -There was an active order dated 11/14/22 on Resident #2's pharmacy profile for Senna Plus tablet twice daily. -According to review of the dispensing record, it did not look like the Senna Plus had ever been dispensed to the facility for Resident #2. -There was a notation at the pharmacy indicating Resident #2's family would provide the medication. Second interview with the MA on 05/18/23 at 10:50am revealed she found out that Resident #2 had a bowel movement on last night (05/17/23). Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the medication aide on 05/17/23 at 2:40pm. Refer to the interview with the Administrator dated 05/17/23 at 3:07pm. Refer to the interview with the Executive Director dated 05/18/23 at 8:35am.	D 358		

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D 358	Continued From page 18 _____ Interview with the MA on 05/17/23 at 2:40pm revealed: -She administered medications according to the assigned time on the EMARs. -The contracted pharmacy provider input orders to the EMAR and released the orders to the facility Resident Care Director (RCD) for approval prior to the MA being able to access the instructions to administer the medications. Interview with the Administrator on 05/17/23 at 3:07pm revealed: -He expected medications to be administered properly. -The Executive Director was responsible to ensure staff were credentialed and trained to administer medications as ordered according to regulations. Interview with the Executive Director on 05/18/23 at 8:35am revealed she expected medications to be administered as ordered. Refer to Tag D 0125 10A NCAC 13F .0403(a) Qualifications of Medication Staff B. Review of Resident #2's current FL-2 dated 11/16/22 revealed: -Diagnoses included dementia, depression, anemia, displaced intertrochanteric fracture of right femur, elevated white blood cells, generalized anxiety disorder and mild cognitive impairment. -The resident was constantly disoriented. -The resident needed assistance with bathing, feeding, and dressing. Review of Resident#2's Resident Register	D 358		

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D 358	Continued From page 19 revealed she was admitted to the facility on 11/14/2022. Review of Resident#2's Physicians order sheet dated 12/29/22 revealed there was an order for Senna Plus 8.6-50mg 5mg take 1 tablet by mouth twice per day. (Senna Plus is a medication used for constipation). Review of March 2023 electronic medication administration (eMAR) revealed: -There was an entry for Senna Plus 8.6-50mg, 1 tablet twice a day for constipation scheduled to be administered at 8:00am and 8:00pm, -There was documentation that Senna Plus 8.6-50mg was not administered on 03/01/23 at 8:00am, on 03/04/23 at 8:00pm, on 03/07/23 at 8:00pm, on 03/08/23 at 8:00am, on 03/14/23 at 8:00am, on 03/15/23 at 8:00pm, on 03/17/23 at 8:00am, on 03/19/23 at 8:00pm, on 03/21/23 at 8:00pm, on 03/23 at 8:00pm, and on 03/28/23 at 8:00am with the notation of "waiting". -There was documentation Senna Plus was not administered 03/02/2023 at 8:00pm, on 03/03/23 at 8:00am, on 03/05/23 at 8:00am, on 03/06/23 at 8:00am, on 03/13/23 at 8:00am and 8:00pm, on 03/16/23 at 8:00am and 8:00pm, on 03/18/23 at 8:00am , on 03/19/23 at 8:00am, on 03/21/23 at 8:00am, on 03/22/23 at 8:00am, on 03/22/23 at 8:00pm, on 03/23/23 at 8:00am, on 03/25/23 at 8:00am, and on 03/30/23 at 8:pm with the notation of "Medication on hold". -There was documentation Senna Plus was not administered on 03/11/23 at 8:00pm and on 03/20/23 at 8:00pm with the exception noted as 'refill". -There was documentation Senna Plus was not administered on 03/24/23 at 8:00pm,on 03/26/23 at 8:00pm, and on 03/27/23 at 8:00pm with the exception documented as "Patient refused	D 358		

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D 358	Continued From page 20 medication". Review of Resident #2's April 2023 eMAR revealed: -There was an entry for Senna Plus 8.6-50mg, 1 tablet twice a day for constipation scheduled to be administered at 8:00am and 8:00pm. -There was documentation Senna Plus was not administered on 04/01/23 at 8:00am, and on 04/26/23 at 8:00am with the exception noted as "waiting". -There was documentation Senna plus was not administered on 04/01/23 at 8:00pm, 04/02/23 at 8:00pm, on 04/03/23 at 8:00pm, on 04/04/23 at 8:00am and 8:00pm, on 04/05/23 at 8:00am and 8:00pm, on 04/13/23 at 8:00am, on 04/15/23 at 8:00pm, on 04/21/23 at 8:00pm, on 04/23/23 at 8:00am, on 04/25/23 at 8:00pm, on 04/28/23 at 8:00pm, and on 04/30/23 at 8:00pm with the exception noted as "Medication on hold". -There was documentation Senna Plus was not administered on 04/10/23 at 8:00pm, on 04/16/23 at 8:00pm, and on 04/17/23 at 8:00pm with the exception noted as "don't need". -There was documentation Senna Plus was not administered on 04/1023 at 8:00pm, on 04/16/23 at 8:00pm and 04/17/23 at 8:00pm with the exception noted as "don't need". -There was documentation Senna Plus was not administered on 04/12/23 at 8:00pm, on 04/19/23 at 8:00pm, and on 04/29/23 at 8:00pm with the exception noted as "Patient refused medication". -There was documentation Senna Plus was not administered on 04/26/23 at 8:00pm with the exception noted as "meds out". Review of May 2023 eMAR revealed: -There was an entry for Senna Plus 8.6-50mg, 1 tablet twice a day for constipation scheduled to be administered at 8:00am and 8:00pm	D 358		

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D 358	Continued From page 21 -There was documentation Senna Plus was not administered on 05/01/23 at 8:00pm, and on 05/09/23 at 8:00pm with the exception noted as "Patient refused medication". -There was documentation Senna Plus was not administered on 05/03/23 at 8:00am and 8:00pm, on 05/08/23 at 8:00pm, on 05/10/23 at 8:00am and 8:00pm, on 05/12/23 at 8:00pm, on 05/16/23 at 8:00am and 8:00pm, and on 05/17/23 at 8:00am with the exception noted as "Medication on hold". -There was documentation Senna Plus was not administered on 05/11/23 at 8:pm with the exception noted as "refill". -There was documentation Senna Plus was not administered on 05/13/23 at 8:00pm, on 05/14/23 at 8:pm, and on 05/15/23 at 8:00pm with the exception noted as "Patient unable to take medication". Observation of Resident #2's medication on hand on 05/18/22 at 11:00am revealed there was no Senna Plus on the medication cart. Interview with the medication aide (MA) on 05/18/23 at 11:00am revealed: -She said Senna Plus was an over the counter medication and she was unsure if this was provided by the contracted pharmacy or if Resident #2's family provided it. -She was unsure how long the Senna Plus had been out. -She planned to discuss with the Memory Care Manager who was on her way to the facility this morning.. -Resident #2 often refused her medications. -Resident #2 frequently had loose stools and Senna Plus was not administered when this occurred.	D 358		

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D 358	Continued From page 22 Interview with the memory care manager (MCM) on 05/18/23 at 11:34am revealed: -Resident #2 had frequent stools and the Senna Plus was often held. -She had discussed the frequent stools with Resident #2's daughter and suggested requesting Senna Plus as an "as needed" medication but Resident #2's daughter wanted Senna Plus continued as a scheduled medication due to concerns for fecal impaction. -Resident #2's daughter provided the Senna Plus. -She was responsible for contacting Resident #2's daughter for refills of the Senna Plus. -She did weekly medication cart audits on Fridays and forgot to notify Resident#2's daughter that she was out of Senna Plus. -She usually notified Resident #2's daughter by phone or text when Senna Plus refills were needed. -She did not have written documentation of notifying Resident #2's daughter of need for refills. -She had purchased a bottle of Senna Plus for Resident #2 on her way to the facility on 05/18/23 and placed it on the cart when she arrived. -She expected the MAs to document accurately to reflect why a medication was not administered. -She should have notified Resident #2's daughter of the need for a Senna Plus refill before she was out of her medication. -She expected medications to be available and administered to Resident #2 as ordered. Interview with the Executive Director on 05/18/23 at 3:13pm revealed: -The MCM was responsible for making sure medications were available on the medication cart. -The MCM should have notified Resident #2's daughter of the need for the Senna Plus 5 to 7	D 358		

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D 358	Continued From page 23 days prior to being out. -She expected MCM to document on the Nurse's Note when family is contacted about the need for a medication refill. -She expected medications to be available and administered to the residents as ordered.	D 358		