STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090036	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF INDIAN TRAIL	5306 SECREST SHORT CUT ROAD MONROE, NC 28110

(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 000	Initial Comments The Adult Care Licensure Section and the Union County Department of Social Services conducted an annual and complaint investigation from 05/23/23 to 05/24/23.	D 000	Facility will contact residents hospice and primary care providers about any accidents or incidents occured to residents including falls, seizures and abnormal vital signs and seek further instructions from there. Education to Med Techs, HWD, RCC, and Memory Care Director. Responsible Person: HWD, RCC, MCC and ED. Due Date: 7/7 and ongoing.	7/7 and ongoing
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, interviews and record reviews, the facility failed to notify the primary care provider (PCP) for a significantly high blood pressure result, and a seizure accompanied by a fall for 1 of 5 sampled residents (#4) who had a history of recent seizure activity and falls. The findings are: Review of Resident #4's current FL-2 dated 07/18/23 revealed diagnoses included early onset dementia with behaviors, seizures, insomnia, and delusions. Review of Resident #4's physician's order dated 02/24/23 revealed an order to admit to hospice on 02/24/23 with a diagnosis of Alzheimer's dementia. Review of Resident #4's health and service evaluation dated 04/04/23 revealed: -There was documentation the resident's active diagnoses were reviewed. -She was ambulatory without assistance or any devices. -She did not have any skin breakdown or wounds.	D 273		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: Administrator (X6) DATE: 7/5/2023

Reviewed and Acknowledged CAS 07/07/23

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D 273	Continued From page 1 -She did not have a current (within 90 days) or history of falls. -She had a diagnosis of seizures and medications included antiseizure medications. -There was no documentation of a seizure precautions or recent (within 90 days) seizure activity. a. Review of Resident #4's electronic progress note dated 04/09/23 at 8:47pm revealed: -At 3:30pm the medication aide (MA) saw Resident #4's face as the first shift MA was walking out of the door on the special care unit (SCU). -Resident #4 looked as if she had fallen and had a bruise above her left eye. Interview with the MA on 05/24/23 at 3:33pm revealed: -When she saw a large swollen area over Resident #4's left eye that was not reported to her, she documented it in the resident's electronic progress note. -She first saw the swollen area over the resident's left eye at 3:00pm with the shift change on 04/09/23. -The first shift MA reported not seeing it before she asked about it on 04/09/23. -There was no fall or seizure reported to her at shift change on 04/09/23. -There was no note documented before her note at 8:47pm on 04/09/23 for the knot identified at 3:30pm. -She reported the swollen area over Resident #4's left eye to the Resident Care Coordinator (RCC), the Memory Care Coordinator (MCC), and the Health and Wellness Director (HWD). Review of Resident #4's electronic progress notes dated 04/10/23 revealed:	D 273	Facility will document any contacts or visits from hospice and primary care providers and recieved orders from them in progress notes. 7/7 and ongoing Education will be provided to all Medtechs, HWD, RCC, and Memory Care Directors. Responsible Person: HWD, RCC, MCD and ED. Facility will reinforce the 24 hours communication book and during this book to standup meeting every morning to follow up any clinical issues including falls, seizures, abnormal vital signs, or other condition changes of residents. Responsible Person: HWD, RCC, MCD, ED. 7/7 and ongoing	

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D 273	Continued From page 2 -At 10:13am, the HWD documented Resident #4 had a virtual visit with the primary care provider (PCP) at 9:25am. -The resident was seen for impaired skin and discoloration of the left eye area. -The PCP ordered the resident to be sent to the emergency room (ER). -The resident was sent to the ER via emergency medical service (EMS). -At 10:21am, the facility nurse documented a late entry for 04/09/23 that the resident was observed having seizure activity on 04/09/23. -There was no documentation of what care was provided or what intervention was implemented. Interview with the HWD on 05/24/23 at 4:09pm revealed: -She was told by the MA about the swollen area over Resident #4's left eye. -She asked everyone on that shift if the resident fell and no one knew anything. -Someone eventually told her staff observed Resident #4 having a seizure and a fall around 5:30am the morning of 04/09/23. -She did not remember who told her and when or who was working at the time the resident had the seizure and fall. -The MA on duty should have called hospice about the seizure and fall on 04/09/23 and followed direction given by hospice. -She did not have a response to why that was not done. -Resident #4 had a virtual visit with the PCP the morning of 04/10/23 (9:25am) because the swelling and bruising had spread to around her left eye and face. -She did not recall the exact timeline between the fall and seizure, when she became aware, and when the resident was seen by the PCP. -The PCP instructed her to send the resident to	D 273	Facility will ensure HWD, or her designees checks on residents with any falls in the last 24 hours, arrange appropriate clinical follow-ups for resident and document them in progress notes. Responsible Person: HWD, RCC, MCD, ED. 7/7 and ongoing Facility will have HWDs on call member posted in all nursing stations and for clinical suggestions and consultation to Med Tech team per SLC policy. Responsible person: ED 7/7 ongoing	

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D 273	Continued From page 3 the ER for further evaluation immediately following the virtual visit with the PCP on 04/10/23. Review of Resident #4's physician's phone order dated 04/10/23 revealed: -Resident #4 had a seizure with head trauma. -There was a telephone order to send the resident to the ER for evaluation and treatment signed by the PCP. Review of Resident #4's ER discharge instructions dated 04/10/23: -Resident #4 was seen for a fall and diagnoses included a left orbital contusion and head injury. -Urine and blood tests were completed. -Face, head, and spine computed tomography (CT) scans were completed. -There was no documentation Resident #4 was seen for a seizure. Review of Resident #4's handwritten hospice visit notes revealed: -There were no entries for 04/09/23 or 04/10/23. -There was no documentation of a large swollen area over Resident #4's left eye. -There was no documentation of a fall on 04/09/23. -There was no documentation of a seizure on 04/09/23. Review of Resident #4's PCP visit notes dated 04/09/23 and 04/10/23 revealed: -On 04/09/23, she had a virtual visit for a knot over her left eye of unknown origin and no change in consciousness. -There were no new orders and no documentation of seizure activity on 04/09/23. -On 04/10/23, she had a virtual visit for a change in behavior and bruising of her left eye.	D 273	Facility will ensure all falls are reported in our community; incident reports have been completed within 24-48 hours and appropriate nursing intervention or measures are in place to ensure resident's safety and wellbeing. Disciplinary actions will be followed for not-reporting incidents or accidents including falls in incident reports. Responsible Persons: HWD and ED.	7/7 and ongoing

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D 273	Continued From page 4 -The PCP directed staff to send the resident to the ER. Telephone interview with a third shift MA on 05/24/23 at 6:16pm revealed: -Resident #4 had a few seizures that she knew of within the last month or two. -The resident sustained swelling and bruising on her head every time she had a seizure because she rolled out of her bed and hit the floor. Interview with Resident #4's PCP on 05/24/23 at 11:30am revealed she did not have documentation in her notes that she was notified that Resident #4 had a seizure on 04/09/23 with a fall and head injury. Telephone interview with the Hospice Manager on 05/24/23 at 2:26pm revealed: -Staff were expected to notify hospice of any changes in condition and incidents such as falls and seizures for Resident #4. -Hospice was notified on 04/10/23 that Resident #4 was sent to the ER after a seizure and a fall. -Hospice was not notified on 04/09/23 that the resident had a seizure. -Hospice was not notified on 04/09/23 that the resident had a large area of swelling above her left eye. Interview with the Administrator on 05/24/23 at 4:37pm revealed: -Someone should have contacted Resident #4's PCP or hospice about the seizure, fall and head injury on 04/09/23. -The MCC, RCC and facility nurse should have been made aware of Resident #4's seizure the morning of 04/09/23. -An accident and incident report should have been completed by the MA on duty for the MCC,	D 273	Education of Fall Response and Post-Fall and Investigation Tool will be provided to MedTechs, PCAs, HWD, RCC and MCD before 7/24/2023 ongoing 7/24 in-service log will be available to be reviewed by survey team. Responsible Persons: HWD, RCC, MCD, ED.	

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D 273	Continued From page 5 RCC and facility nurse to review and follow up. -She did not know a large area over Resident #4's left eye was found without any reported fall or seizure. Upon request on 05/23/23 and 05/24/23, Resident #4's incident and accident report dated 04/09/23, was not available for review. Attempted interview on 05/24/23 at 6:15pm with a second third shift medication aide (MA) was unsuccessful. b. Review of Resident #4's electronic progress notes dated 05/07/23 revealed: -At 3:14pm, a medication aide (MA) documented the resident's blood pressure result was 184/145. -There was no documentation a Care Coordinator, the Health and Wellness Director (HWD), hospice, or the primary care provider (PCP) was notified. Interview with the MA on 05/24/23 at 2:53pm revealed: -She did not remember what she did for Resident #4's blood pressure result of 184/145 on 05/07/23. -She started working as the MA on the medication cart approximately 6 months ago but only every other weekend. -She was not experienced in handling everything as the MA and basically completed tasks and then documented what she had done. -She forgot to document what she had done about the blood pressure result. -She did not know if she notified anyone of Resident #4's blood pressure result. -She was supposed to notify the HWD and the HWD followed up.	D 273	Managers will round in the community at least twice a day to identify resi-dents condition changes and take actions to address residents acute or routine needs. AL Responsible Persons: RCC and HWD or designee MC: Responsible Persons: MCD or designee. ED will supervise and ensure the rounding has been completed daily.	7/7 and ongoing

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Interview with the Health and Wellness Director (HWD) on 05/24/23 at 4:01pm revealed:
-She was not notified of Resident #4's blood pressure result of 184/145 on 05/07/23.
-She and the PCP should have been notified and the notification documented in the resident's electronic progress notes.
-The MA should have checked for any as needed medications for elevated blood pressures also.

Telephone interview with Resident #4's primary care provider (PCP) on 05/24/23 at 11:30am revealed:
-Resident #4 was receiving hospice services.
-She continued to see residents receiving hospice services.
-She did not have notation in her record that she was notified of Resident #4 having a blood pressure result of 184/145 on 05/07/23.
-The documented blood pressure result was very high and was probably a typographical error.
-Sometimes she did not write down staff notifying her of specific vital signs.
-It looked like Resident #4's blood pressure was rechecked by staff and the result was 118/74 at 8:47pm on 05/07/23.
-She did not know if she had instructed staff to recheck the blood pressure and when or if the documentation was part of acute charting each shift during antibiotic therapy.

Telephone interview with the Hospice Manager on 05/24/23 at 2:26pm revealed:
-Staff were expected to notify hospice about anything abnormal they see about Resident #4.
-There was no documentation in Resident #4's hospice records that hospice was notified of a blood pressure result of 184/145 on 05/07/23.

Interview with the Administrator on 05/24/23 at

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D 273	Continued From page 7 4:37pm revealed: -She was not aware Resident #4 had a blood pressure result of 184/145 on 05/07/23. -The MA should have let the HWD know if she was in the building. -If the HWD was in the building, she would have followed up with the PCP. -In the absence of the HWD, MAs were responsible to contact the PCP and document in the resident's electronic progress note. Attempted telephone interview on 05/24/23 at 2:26pm with Resident #4's hospice provider was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367	Community Wide MAR audits to identify and delete any duplicate orders, non D/C'ed orders or PRN orders without appropriate indications. 7/14 and ongoing will be the immediate actions to correct the situation. Responsible persons: HWD, RCC, MCD.	

Division of Health Service Regulation

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D 367	Continued From page 8 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the accurate documentation of antiseizure medications on the electronic medication administration record (eMAR) for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL-2 dated 07/18/23 revealed diagnoses included early onset dementia with behaviors, seizures, insomnia, and delusions. Review of Resident #4's physician's order dated 02/17/23 revealed an order to increase the 3:00pm and 9:00pm doses of divalproex to 250mg. Review of Resident #4's prescription order dated 03/23/23 revealed: -There was an order to discontinue the order for divalproex sprinkles. -There was an order for valproic acid 250mg/5ml give 2.5ml every morning and 5ml twice daily at 3:00pm and 9:00pm. (Divalproex and valproic acid are both valproate medications used to treat seizures) Review of Resident #4's prescription orders dated 04/25/23 revealed: -There was an order for valproic acid 250mg/5ml give 2.5ml every morning.	D 367	MAR audit and Chart Audits weekly per SLC policy to ensure we have correct medications, correct dosage, pulling, D/C'ed or expired medications from the med carts and reordering ongoing medications in time at least weekly and as needed. Responsible persons: HWD, RCC, and MCD. ED to ensure this has been implemented in community weekly and review the report after each audit. 7/14	

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D 367	Continued From page 9 -There was an order for valproic acid 250mg/5ml give 5 twice daily at 3:00pm and 9:00pm. Review of Resident #4's prescription orders dated 05/19/23 and 05/23/23 revealed: -There was an order to discontinue all current orders for valproic acid. -There was an order to start valproic acid 300mg (6ml) three times daily at 9:00am, 3:00pm, and 9:00pm. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for divalproex sodium 125mg every morning at 9:00am and 250mg twice daily at 3:00pm and 9:00pm. -There was documentation divalproex sodium 125mg every morning and 250mg twice daily was administered 03/01/23 through 03/30/23 except at 3:00pm and 9:00pm on 03/27/23. -There was documentation divalproex was not administered at 3:00pm and 9:00pm on 03/27/23 because the MA was awaiting doses from the pharmacy. -There was an entry for valproic acid 250mg/5ml take 5ml twice daily at 3:00pm and 9:00pm. -There was documentation valproic acid 250mg/5ml twice daily was administered 03/23/23 through 03/30/23. -There was documentation that both divalproex and valproic acid were administered 03/23/23 through 03/30/23 except at 3:00 and 9:00pm on 03/27/23. Review of Resident #4's April 2023 eMAR revealed: -There was an entry for valproic acid 250mg/5ml take 2.5ml daily at 9:00am. -There was documentation valproic acid 2.5ml was administered 04/26/23 through 04/30/23.	D 367	Orders Verification: Reinforce the orders verification process in community and ensure the orders verification completed in AL and MC daily. Responsible persons: HWD, RCC and MCD. Missed meds report: Pull and print missed meds report every morning before standup meetings and bring the report to standup to discuss follow-up steps. Responsible Persons: HWD, RCC, and MCD	7/7 and ongoing. 7/7 and ongoing.

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-There was an entry for divalproex sodium 125mg every morning and 250mg twice daily at 3:00pm and 9:00pm.
-There was documentation divalproex sodium 125mg every morning and 250mg twice daily was administered 04/01/23 through 04/25/23 except at 9:00am on 04/10/23 due to the resident was not awake to take.
-There was documentation divalproex sodium 125mg every morning and 250mg twice daily was discontinued on 04/25/23 at 9:00pm.
-There was an entry for valproic acid 250mg/5ml take 5ml twice daily at 3:00pm and 9:00pm.
-There was documentation valproic acid 5ml twice daily was administered 04/01/23 through 04/26/23 except at 3:00pm on 04/25/23 due to the resident was not awake to take.
-There was documentation valproic acid 5ml twice daily was discontinued on 04/26/23 at 9:00pm.
-There was documentation that both divalproex and valproic acid were administered at 3:00pm and 9:00pm from 04/01/23 through 04/24/23.
-There was documentation that both divalproex and valproic acid at 3:00pm and 9:00pm were discontinued and not administered from 04/26/23 through 04/30/23.

Review of Resident #4's May 2023 eMAR revealed:
-There was an entry for valproic acid 250mg/5ml take 2.5ml daily at 9:00am.
-There was documentation valproic acid 2.5ml was administered 05/01/23 through 05/22/23 except on 05/02/23 (out of facility), 05/06/23 (other unspecified reason), and 05/22/23 (duplicate entry).
-There was an entry for valproic acid 250mg/5ml take 5ml twice daily at 3:00pm and 9:00pm.
-There was documentation valproic acid 5ml

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twice daily was administered 05/01/23 through 05/22/23 except on 05/19/23 at 9:00pm (new order) and 05/22/23 at 3:00pm (duplicate entry).
-There was an entry for valproic acid 250mg/5ml take 6ml three times daily at 9:00am, 3:00pm and 9:00pm.
-There was documentation valproic acid 6ml three times daily was administered 05/19/23 at 9:00pm through 9:00pm on 05/22/23 except at 3:00pm on 05/21/23 (out of facility).
-There was documentation the 3:00pm doses of valproic acid 6ml on 05/20/23 and 05/21/23 were duplicate entries.
-There was documentation valproic acid 2.5ml at 9:00am and valproic acid 5ml at 3:00pm and 9:00pm, and valproic acid 6ml three times daily were both administered from 05/20/23 through 05/23/23 except at 3:00pm on 05/21/23 and 05/22/23.

Observation of Resident #4's medications on hand on 05/24/23 at 10:10am revealed:
-There was a prescription bottle approximately 2/3 full of liquid with a pharmacy label.
-The pharmacy label had Resident #4's name and instructions for valproic acid 250mg/5ml take 6ml three times daily.
-The pharmacy label indicated 160ml was dispensed on 05/19/23.
-There was a second prescription bottle with approximately 30ml of liquid and a pharmacy label.
-The pharmacy label had Resident #4's name and instructions for valproic acid 250mg/5ml take 2.5ml every morning and 5ml twice daily.
-The pharmacy label indicated 473ml was dispensed on 03/23/23.

Interview with a medication aide (MA) on 05/24/23 at 5:47pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090035	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF INDIAN TRAIL	5306 SECREST SHORT CUT ROAD MONROE, NC 28110

(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
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-There were duplicate entries on the eMAR for valproic acid.
-She did not give the medication twice.
-It was documented that way because you had to enter something on the eMAR to complete documentation.
-When she saw duplicate entries on the eMAR she told the RCC or the Health and Wellness Director (HWD) and then it was usually fixed.
-There had been many duplicate entries on all the eMARs because of the new pharmacy.
-She reported the duplicates to the RCC and HWD and they said they were working on it.
-She could not remember when she last told them about duplicate entries.

Interview with the HWD on 05/24/23 at 4:01pm revealed:
-It looked like the Depakote capsules were not discontinued on the eMAR.
-She did not think Resident #4 received multiple doses.
-MAs had a habit of click and go through the eMAR to complete the medication pass timely.
-All residents eMARs were a mess due to switching pharmacy services in March 2023.
-She and the Resident Care Coordinator (RCC) worked through the transition to review all residents' eMARs and fix duplicate order entries.
-She talked with the facility's pharmacy consultant regularly and it was an ongoing process to correct.
-The RCC was responsible for checking the eMAR against the Physician Order sheets.
-Orders were normally sent to the pharmacy electronically.
-She faxed the few written orders to the pharmacy.
-Pharmacy staff entered the orders on the eMAR.
-She, the RCC and Memory Care Coordinator

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	HAL090035	A. BUILDING: _____ B. WING _____	05/24/2023

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D 367	Continued From page 13	D 367		

(MCC) were responsible for approving orders on the eMAR.
-She learned recently that she had to enter the stop date for discontinued orders which was why some discontinued orders remained on the eMARs.
-She thought the valproic acid entries for Resident #4 might have been overlooked due to how it was entered on the eMAR.

Telephone interview with the facility's contracted pharmacy on 05/24/23 at 3:00pm revealed:
-The pharmacy had started providing services to the facility on 03/21/23.
-Orders were faxed or sent electronically to the pharmacy, the pharmacy entered orders onto the eMAR and facility staff approved orders on the eMAR.
-Resident #4's current order for valproic acid was 6ml (250mg/5ml) three times daily dated 05/19/23.
-The previous order dated 04/27/23 was for valproic acid (250mg/5ml) 2.5ml every morning and 5ml twice daily at 3:00pm and 9:00pm which was discontinued on 05/19/23.
-The pharmacy was not able to see the facility's eMAR to determine duplicate entries.
-Divalproex capsules were never dispensed from the pharmacy.
-The pharmacy dispensed 473ml of valproic acid on 03/23/23 which was a 30 day supply and 260ml on 05/19/23 which was a 14 day supply.

Telephone interview with Resident #4's primary care provider (PCP) on 05/24/23 at 11:30am revealed:
-Resident #4 was receiving hospice services.
-She continued to see residents receiving hospice services.
-Valproic acid was initially prescribed for Resident

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	HAL090035	A. BUILDING: _____ B. WING _____	05/24/2023

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D 367	Continued From page 14	D 367		

#4 to help manage behaviors related to dementia.
-Valproic acid doses were increased due to seizure activity.
-The resident was also having difficulty swallowing capsules so the valproic acid was changed to a liquid form.
-She did not think multiple doses of valproic acid were administered to Resident #4 because there were orders to discontinue previous orders.
-There was a recent switch in the facility's contracted pharmacy provider which resulted problems with refills and entries on residents' eMARs.
-She had spoken directly with the new contracted pharmacy provider regarding duplicate entries and signed new refill orders for all residents.
-Resident #4 last had serum valproic acid levels done in February 2023 which were normal.
-It was too soon after the dosage increase to check serum valproic acid level.

Telephone interview with the Hospice Manager on 05/24/23 at 2:26pm revealed:
-Hospice was responsible for Resident #4's medication orders.
-Valproic acid was recently increased to 6ml (250mg/5ml) three times daily due to seizure activity.
-Prior to that the order was for valproic acid 125mg every morning and 250mg twice daily at 3:00pm and 9:00pm dated 03/23/23.
-Depakote sprinkles, originally ordered 02/24/23 on admission to hospice, were switched to liquid due to swallowing issues.

Interview with the Administrator on 05/24/23 at 4:37pm revealed:
-She did not know there were multiple entries for valproic acid on Resident #4's March, April, and May 2023 eMARs.

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	HAL090035	A. BUILDING: _____ B. WING _____	05/24/2023

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D 367	Continued From page 15 -She, the HWD, and the RCC worked with the pharmacy and reviewed eMARs. -MAs were responsible for documenting medications that were administered accurately. Attempted telephone interview on 05/24/23 at 2:26pm with Resident #4's Hospice provider was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 367		