Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 05/17/23 to 05/18/23 with an exit via telephone on 05/19/23.	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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure the 5-hour medication aide training was completed for 5 of 6 medication aides prior to administering medications to the residents and an additional 10- hour medication training within 60 days of hire (Staff A, B, C, E and F). The findings are: 1. Review of Staff A's, medication aide (MA),	D 125	Med Techs were required to complete the 15 hour NC Med Tech training with a Registered Nurse. Med Techs completed a medication administration RN check off and satisfactorily completed the state exam. All MT files were audited to ensure compliance with all MT training and certification. The Business Office Manager or designee will be responsible to ensure this compliance. The Business Office Manager or designee will utilize a tracking tool to ensure continued compliance. Correction date per Executive Director 6/27/23 is 7/3/23. SG	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED — (X6) DATE: 6/21/23

Reviewed and acknowledged 6/27/23. SG

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D 125	Continued From page 1 personnel record revealed: -Staff A's date of hire was 03/15/23. -There was no documentation Staff A completed the state approved 5-10- or 15-hour MA training. -There was no documentation of employment verification for the previous 24 months at another facility as a MA. -There was documentation she passed the state approved MA written exam in 08/10/22. -There was documentation she completed the Competency Validation Skills Checklist on 03/15/23. Review of a resident's Medication Administration Record (MAR) revealed Staff A administered medication on 03/23/23 and on 05/11/23. Interview with Staff A on 05/18/23 at 3:35pm revealed: -She was hired in March 2023 as a MA. -She received MA training and passed the written test at another facility in 2022. -She worked as a MA at the facility and administered medications. -She completed some medication aide training with the facility's contracted nurse on 03/15/23. -She did not know if the training included the 5-10 or 15-hour training course. Refer to the interview with the Business Office Manager (BOM) on 05/18/23 at 3:25pm. Refer to the telephone interview with the facility's contract Nurse on 05/19/23 at 4:22pm. Refer to the telephone interview with the Director of Resident Care (DRC) on 04/19/23 at 4:25 pm. Refer to the interview with the Executive Director (ED) on 05/19/23 at 1:18pm.	D 125		

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D 125	Continued From page 2 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B's date of hire was 01/11/23. -There was documentation Staff B completed a 5-hour MA training course on 01/11/23. -There was no documentation Staff B had completed the state approved 10 or 15 hour MA training. -There was no documentation of verification of employment as a MA at another facility for the previous 24 months. -There was documentation she passed the state approved MA written exam in 07/24/02. -There was documentation she completed the Competency Validation Skills Checklist on 01/19/23. Review of a resident's Medication Administration Record (MAR) revealed Staff B administered medications on 4 opportunities from 03/24/23 through 03/31/23, on 16 opportunities from 04/01/23 through 04/20/23 and on 7 opportunities from 5/01/23 through 05/10/23. Attempted telephone interview with Staff B on 05/18/23 at 4:10pm was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 05/18/23 at 3:25pm. Refer to the telephone interview with the facility's contracted Nurse on 05/19/23 at 4:22pm. Refer to the telephone interview with the Director of Resident Care (DRC) on 04/19/23 at 4:25 pm. Refer to the interview with the Executive Director (ED) on 05/19/23 at 1:18pm.	D 125		

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D 125	Continued From page 3 3. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C's date of hire was 12/15/22 as a MA. -There was no documentation Staff C completed the state approved 5-10 or 15-hour MA training. -There was no documentation of verification of employment for the previous 24 months at another facility as a MA. -There was documentation she passed the state approved MA written exam on 03/21/17. -There was documentation she completed the Competency Validation Skills Checklist on 12/20/22. Review of a resident's Medication Administration Record (MAR) revealed Staff C administered medications on 03/07/23 and on 05/16/23. Telephone interview with Staff C on 05/18/23 at 4:48pm revealed: -She was hired in December 2022 as a MA. -She worked as a MA at the facility and administered medications. -She received MA training and passed the written test at another facility in 2017. -She completed some MA training with the facility's contracted nurse when she was hired. -She did not know if the training included the 5-10 or 15-hour training course. Refer to the interview with the Business Office Manager (BOM) on 05/18/23 at 3:25pm. Refer to the telephone interview with facility's contracted Nurse on 05/19/23 at 4:22pm. Refer to the telephone interview with the Director of Resident Care (DRC) on 04/19/23 at 4:25 pm. Refer to the interview with the Executive Director	D 125		

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D 125	Continued From page 4 (ED) on 05/19/23 at 1:18pm. 4. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E's date of hire was on 12/26/18. -There was no documentation Staff E completed the state approved 5-10 or 15-hour MA training. -There was no documentation of verification of employment for the previous 24 months at another facility as a MA. -There was documentation she passed the state approved MA written exam on 12/15/18. -There was documentation she completed the Competency Validation Skills Checklist on 01/14/19. Review of a resident's Medication Administration Record (MAR) revealed Staff E administered medications on 03/23/23 and on 05/16/23. Telephone interview with Staff E on 05/18/23 at 5:00pm revealed: -She was hired in December 2018 as a MA. -She worked as a MA at the facility and administered medications. -She received MA training and passed the written test in 2018. -She completed some medication training with the previous facility's contracted nurse when she was hired. -She thought the training included the 5-10- or 15-hour training, but she did not keep copies of any certificates. Refer to the interview with the Business Office Manager (BOM) on 05/18/23 at 3:25pm. Refer to the telephone interview with the facility's contracted Nurse on 05/19/23 at 4:22pm.	D 125		

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D 125	Continued From page 5 Refer to the telephone interview with the Director of Resident Care (DRC) on 04/19/23 at 4:25 pm. Refer to the interview with the Executive Director (ED) on 05/19/23 at 1:18pm. 5. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F's date of hire was on 05/24/22. -There was documentation Staff F completed the state approved 5-hour MA training. -There was no documentation Staff F completed the state approved 10 or 15-hour MA training. -There was no documentation of verification of employment for the previous 24 months at another facility as a MA. -There was documentation she passed the state approved medication aide written exam in 10/02/06. -There was documentation she completed the Competency Validation Skills Checklist on 06/03/22. Review of a resident's Medication Administration Record (MAR) revealed Staff F administered medication from 03/25/23 through 04/16/23. Interview with Staff F on 05/18/23 at 4:18pm revealed: -She was hired in May 2022 as a medication aide (MA). -She completed the MA competency validation skills checklist when she was hired, but not any training that read 5, 10 and 15 hour medication training. -She worked as a MA at the facility and administered medications. -She received MA training and passed the test in 2006. -She completed 5-10 and 15-hour MA training	D 125		

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D 125	Continued From page 6 with a previous facility, but not at this facility but did not keep any certificates. -There was documentation she completed the Competency Validation Skills Checklist on 01/14/19. Refer to the interview with the Business Office Manager (BOM) on 05/18/23 at 3:25pm. Refer to the telephone interview with the facility's contracted Nurse on 05/19/23 at 4:22pm. Refer to the telephone interview with the Director of Resident Care (DRC) on 04/19/23 at 4:25 pm. Refer to interview with the Executive Director (ED) on 05/19/23 at 1:18pm. --- Interview with the BOM on 05/18/23 at 3:25pm revealed: -She was responsible to keep track of and to have the contracted Nurse to schedule MA training for all new hires. -She knew Staff A, B, C, E and F had not completed all of their state required 5-10 and 15-hour MA training. -She provided the contracted Nurse with a list of MAs that needed training and what they were missing (no date given). -The contracted Nurse scheduled a training class and the BOM and managers would inform staff that they were due to take the training and when it was scheduled. -A 5-10 or 15-hour MA training class was not scheduled by the Contracted Nurse for these staff MAs. Telephone interview with the facility's contracted Nurse on 05/18/23 at 4:22pm revealed:	D 125		

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D 125	Continued From page 7 -She was contracted within the last 12 months to provide state required training for the facility, including MA 5-10 and 15-hour MA training. -The BOM would make a list of staff who needed training and text or call her to schedule training classes. -The BOM had requested a 5-10- or 15-hour MA training class, but the last one she taught at the facility was in January 2023 for the 5- hour only. -She did not keep a list of attendees and she did not keep copies of certificates. -She gave all signed certificates to the BOM to file in the staff records. Telephone interview with the DRC on 05/19/23 at 11:38am revealed: -The BOM was responsible to ensure all MAs had the required state medication training with the facility's contracted Nurse. -When an MA was hired, she assumed they had all the required training and could administer medications to residents. -Staff A, B, C, E and F had all administered medications at the facility since they were hired. Telephone interview with the ED on 05/19/23 at 1:18pm revealed: -The BOM was responsible for tracking and scheduling required MA training for new hires. -She had a grid on her computer to give to the facility's contracted Nurse when she scheduled a training class. -She knew the MAs had to have their 5-hour training when they were hired and the 10 or 15-hour MA training within 60 days. -She did not know that Staff A, B, C, E and F were behind in their 5-10- or 15-hour MA training. -She expected all MAs to have their required training in order to administer medications to residents.	D 125		

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D 125	Continued From page 8 [Refer to tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] The facility failed to ensure the 5-hour medication aide training was completed for 3 of 6 staff prior to administering medications to the residents and an additional 10- hour medication training for 5 of 6 staff within 60 days of hire, placing the residents at risk for medication administration errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/18/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, July 2, 2023.	D 125		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 234	All resident files were audited for appropriate TB test compliance. All residents will be monitored with a tracking tool for continued compliance. New move ins will not be admitted without at least the first step of the TB process complete. The Director of Resident Care or designee will ensure all resident TB tests are in continued compliance with the use of a tracking tool. Correction date per Executive Director 6/27/23 is 7/3/23. SG	

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D 234	Continued From page 9 facility failed to ensure 1 of 5 sampled residents (#3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL2 dated 11/23/22 revealed diagnoses included history of falls, osteoarthritis, high blood pressure, heart failure, atrial fibrillation and anemia. Review of Resident #3's Resident Register revealed an admission date of 11/25/22. Review of Resident #3's resident record on 05/17/23 revealed there were no documented TB skin tests for review. Telephone interview with the Director of Resident Care (DRC) on 05/19/23 at 11:45am revealed: -Resident #3 was admitted to the facility prior to her starting employment with the facility so she did not know who was responsible at that time for ensuring all new admissions had proof of negative TB skin tests. -The sales director was currently responsible for collecting a resident's admission information and forwarding the information to her. -She had noticed that Resident #3 was missing proof of TB testing in her record and had notified the facility's previous Executive Director (ED). -When she last did a record audit for Resident #3 at the end of April 2023, she noticed Resident #3 still did not have any documented TB testing so she faxed Resident #3's primary care provider (PCP) to request an order for a TB skin test. -She was still waiting for a response from Resident #3's PCP.	D 234		

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D 234	Continued From page 10 Telephone interview with the ED on 05/19/23 at 1:20pm revealed: -Resident #3 was admitted to the facility prior to she or the current DRC began working at the facility. -The DRC was aware of everything the residents needed in their records including documentation of TB testing. -She did not know if any resident record audits had been completed to ensure all residents had their TB skin tests. -She was not aware that Resident #3 did not have documentation of TB testing.	D 234		
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 reviews and interviews, the facility failed to ensure a primary care provider (PCP) follow-up was completed for 1 of 5 sampled residents (#1) who had been refusing to wear his compression stockings. The findings are: Review of Resident #1's current FL2 dated 02/09/23 revealed diagnoses included congestive heart failure, atrial fibrillation, coronary artery disease and high blood pressure. Review of Resident #1's physician's order dated 03/01/23 revealed an order for compression stockings, apply in the morning and remove in the	D 273	All medication orders audited. Any discrepancies are being clarified and/or corrected. The Director of Resident Care and/or the Assistant Director of Resident Care or designee is responsible to ensure compliance with following all physician orders. Medication Administration Records or Treatment Records should be reviewed monthly to ensure continued compliance to orders, as per regulation. Correction date per Executive Director 6/27/23 is 7/3/23. SG	

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D 273	Continued From page 11 evening. Review of Resident 1's March 2023 medication administration record (MAR) revealed: -There was an entry for compression stockings, apply in the morning and remove in the evening scheduled at 8:00am and 8:00pm. -There was documentation compression stockings were not applied 03/01/23 through 03/11/23, or on 03/13/23. -There was no documented reason why the compression stockings were not applied. Review of Resident #1's April 2023 MAR revealed: -There was an entry for compression stockings, apply in the morning and remove in the evening scheduled at 8:00am and 8:00pm. -There was no documentation compression stockings were applied on 04/14/23, 04/15/23, 04/19/23, 04/20/23, 04/21/23, 04/24/23-04/26/23, 04/28/23, 04/29/23, or 04/30/23. -There was no documented reason for the blank spaces on the MAR or why the compression stockings were not applied. Review of Resident #1's May 2023 MAR from 05/01/23 through 05/17/23 revealed: -There was an entry for compression stockings, apply in the morning and remove in the evening scheduled at 8:00am and 8:00pm. -There was documentation compression stockings were not applied on 05/12/23 through 05/16/23. -There was documentation on the back of the MAR on 05/01/23, 05/03/23, 05/04/23, 05/05/23, 05/07/23-05/10/23, 05/12/23, 05/13/23-05/15/23 and 05/17/23 that compression stockings were not applied due to resident refusing.	D 273		

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D 273	Continued From page 12 Observation of Resident #1's room on 05/17/23 at 9:15am and 4:05pm revealed: -There were three pairs of black compression stockings in Resident #1's room. -Resident #1 was sitting in his recliner chair with his legs elevated on the leg rest. -Resident #1 was not wearing compression stockings. -There was no swelling or skin breakdown observed to Resident #1's bilateral lower legs. Observations of Resident #1 on 05/17/23 at 12:41 and on 05/18/23 at 9:37am revealed: -He was not wearing compression stockings. -There was no swelling observed to his bilateral lower legs or ankles. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He had three pairs of compression stockings in his dresser drawer. -He wore his compression stockings if his legs were swollen, but since they were not currently swollen, he did not want to wear them. -The medication aides (MA) offered to put his compression stockings on him every day, but he refused most days due to his legs not being swollen. Interview with a MA on 05/18/23 at 10:50am revealed: -Resident #1 had compression stockings in his room but he refused to wear them most days. -She had documented on the MAR that Resident #1 refused to wear his compression stockings on 05/01/23, 05/03/23-05/05/23, 05/07/23-05/10/23, 05/12/23-05/15/23, and 05/17/23. -Resident #1 did not tell her why he did not want to wear his compression stockings and she had not asked him why.	D 273		

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	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 273	Continued From page 13 -Resident #1's primary care provider (PCP) was aware that he had been refusing to wear his compression stockings because she had told her in April 2023 and May 2023 during her visits to the facility. -She had not documented her notifications to Resident #1's PCP regarding his refusals to wear compression stockings. -Resident #1's PCP did not want to discontinue the order for his compression stockings, because he sometimes retained fluid and had swelling to hi slower legs. -She had not observed any swelling in Resident #1's lower legs recently. -Resident #1 agreed to wearing compression stockings if he had swelling to his lower legs. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She was not aware that Resident #1 had been refusing to wear his compression stockings daily as ordered. -She had ordered compression stockings for Resident #1 due to his diagnosis of congestive heart failure and to prevent swelling to his legs which could cause a venous stasis ulcer. -Resident #1 did not currently have any swelling or skin breakdown to his legs. -She saw Resident #1 at least once per month and would have wanted to be notified that Resident #1 was not wearing his compression stockings daily. Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed: -Resident #1 had three pairs of compression stockings and did not like to wear any of them. -Resident #1 occasionally had swelling to his right leg due to his history of having surgery on that leg.	D 273		

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D 273	Continued From page 14 -Resident #1 did not have any swelling to his legs in the previous four months. -Resident #1 wore his compression stockings if he felt like he needed them. Interview with a second MA on 05/18/23 at 2:45pm revealed: -Resident #1 did not usually wear his compression stockings, but the only reason was that he did not feel like it. -The MAs could notify the PCP about refusals in person if the PCP was in the facility, otherwise they could fill out a notification sheet and fax it to the PCP's office. -She had not notified Resident #1's PCP about his refusals to wear compression stockings, and she did not know why. -She had not observed any swelling to Resident #1's lower legs. Interview with a third MA on 05/18/23 at 3:40pm revealed: -She worked second shift and only occasionally had removed compression stockings from Resident #1's legs. -Resident #1 never had swelling to his lower legs. Interview with a fourth MA on 05/18/23 at 4:15pm revealed: -She worked second shift so was responsible for removing Resident #1's compression stockings. -Resident #1 usually did not have compression stockings on for her to remove. -She had never seen swelling to Resident #1's legs. Telephone interview with the Director of Resident Care (DRC) on 05/19/23 at 11:45am revealed: -She was aware that Resident #1 often refused to wear his compression stockings.	D 273		

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D 273	Continued From page 15 -She did not know why Resident #1 refused to wear his compression stockings. -She had not notified Resident #1's PCP about his refusals to wear compression stockings, but had no reason why. -She would normally notify the PCP about compression stocking refusals. -The MAs could notify Resident #1's PCP about his refusals to wear compression stockings either in person when they saw her, or by filling out a notification sheet and placing it in the PCP's folder for her to review. -She reviewed the sheets that the MAs filled out and put in the PCP folder, but did not remember ever seeing a sheet regarding Resident #1's compression stocking refusals. Telephone interview with the Executive Director (ED) on 05/19/23 at 1:20pm revealed: -She was not aware that Resident #1 had been refusing to wear compression stockings daily as ordered. -She expected the MAs to communicate with the resident about the importance of wearing the compression stockings, and also contacting the resident's POA for support and to encourage the resident's compliance as well. -She expected the MAs to work with the DRC to ensure the PCP was notified about the refusals.	D 273	Correction date per Executive Director 6/27/23 is 7/3/23. SG	
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	D 276	All medication orders audited. Any discrepancies are being clarified and/or corrected. The Director of Resident Care and/or the Assistant Director of Resident Care or designee is responsible to ensure compliance with following all physician orders. Medication Administration Records or Treatment Records should be reviewed monthly to ensure continued compliance to orders, as per regulation.	

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D 276	Continued From page 16 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure treatment orders were implemented for 1 of 5 sampled residents (#1) who had an order for weight monitoring. The findings are: Review of #1's current FL2 dated 02/09/23 revealed diagnoses included congestive heart failure, atrial fibrillation, coronary artery disease and high blood pressure. Review of Resident #1's physician's order dated 03/31/23 revealed an order for daily weights for 7 days, then every Monday, Wednesday and Friday afterward. Review of Resident #1's March 2023 medication administration record (MAR) revealed: -There was a handwritten entry for daily weights x7 days from 03/31/23 through 04/06/23, then weights every Monday, Wednesday and Friday starting on 04/07/23, scheduled at "morning." -There was no weight documented on 03/31/23. Review of Resident #1's April and May 2023 MARs revealed there was no entry for daily weights 04/01/23 through 04/06/23 or for weights every Monday, Wednesday and Friday starting 04/07/23. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He had congestive heart failure, so the staff sometimes weighed him.	D 276		

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D 276	Continued From page 17 -He thought the staff weighed him once per week. -He did not remember having any swelling or increased shortness of breath in the last month or two. Interview with the Director of Resident Care (DRC) on 05/18/23 at 9:30am revealed: -Resident #1 had congestive heart failure so his primary care provider (PCP) had ordered weight monitoring. -There were no acute symptoms that prompted the order for weight monitoring. -Resident #1 did not have any swelling or shortness of breath in the previous few months since the PCP wrote the order for weight monitoring. -The facility used paper MARs, so all new orders had to be faxed to the pharmacy for the pharmacy to print the orders on the MAR. -Since Resident #1's order for weight monitoring was written on 03/31/23, the pharmacy had already printed the April 2023 MAR. -The night shift medication aide (MA) would have been responsible for noticing that the March 2023 MAR included the order for weight monitoring, but the April 2023 MAR did not. -The MA would have been responsible for writing the order for weight monitoring on Resident #1's April MAR. -Whoever had received Resident #1's PCP's order for weight monitoring on 03/31/23, either herself or a MA, would have been responsible for faxing the order to the pharmacy so they could enter the order on Resident #1's MAR. -She had not noticed that Resident #1's order for weight monitoring was not entered on his April or May 2023 MARs. Interview with a MA on 05/18/23 at 10:50am revealed:	D 276		

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D 276	Continued From page 18 -She had not seen an order for weights for Resident #1. -The MAs had not been weighing Resident #1 because there was no order or entry on the MAR for weight monitoring. -The DRC had placed a weight monitoring sheet in the MAR book that morning on 05/18/23, so they were going to start monitoring Resident #1's weights daily for one week then every Monday, Wednesday and Friday after that. -She had not noticed any swelling or increased shortness of breath for Resident #1 in the previous few months. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She had ordered weight monitoring for Resident #1 because he had a diagnosis of congestive heart failure and she wanted to know if he gained weight. -There were no symptoms or illness to prompt her ordering weight monitoring, she just wanted to get baseline values so she would know if his weight increased. -She had recently reviewed Resident #1's MARs and noticed there were no weight values documented, and when she asked the MA where his weights were documented the MA told her she did not know. -Resident #1 did not have any current swelling or symptoms of fluid volume overload. -She expected the facility to implement the orders she wrote. Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed: -Resident #1 had a scale in his room and he thought the staff weighed him in the mornings. -Resident #1 had not reported to him whether the staff had been checking his weights or not.	D 276		

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D 276	Continued From page 19 -Resident #1 did not have symptoms of swelling or increased shortness of breath in the previous couple of months that he was aware of. Telephone interview with the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed they had not received the order dated 03/31/23 for daily weights x7 days then every Monday, Wednesday and Friday starting 04/07/23 or they would have entered it onto his MAR. Interview with a second MA on 05/18/23 at 2:45pm revealed: -Resident #1 did not have an order that she was aware of for weight monitoring. -The MAs checked on all the residents at the end of every month and got weights and vital signs for everyone and thought the DRC faxed those values to the facility's PCP. -She could not find the monthly weight documentation that included Resident #1's weights. Telephone interview with the Executive Director (ED) on 05/19/23 at 1:20pm revealed: -The DRC was responsible for checking each resident's MAR and ensure accuracy of the orders between months. -The DRC was responsible for faxing all new orders to the pharmacy or following up on the orders that the MAs received to ensure the pharmacy had received them. -She was not aware that Resident #1 had an order for weight monitoring that had not been implemented.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 344		

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D 344	Continued From page 20 (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#5) regarding an order for oxygen. The findings are: Review of Resident #5's current FL2 dated 02/01/23 revealed: -Diagnoses included acute and chronic respiratory failure with hypoxia, muscle weakness, difficulty walking, cognitive communication deficit, chronic diastolic congestive heart failure, chronic cor pulmonale, type 2 diabetes, chronic obstructive pulmonary disease, and hypertension. -There was an order for oxygen at 2 liters per minute continuously. Review of Resident #5's physician's orders dated 05/11/23 revealed: -There was an order for oxygen at 2 liters per minute (L/min) if Resident #5's oxygen saturation	D 344	All medication orders were audited. The Director of Resident Care and/or the Assistant Resident Care Director will be responsible to monitor all new resident orders, additional orders, order changes, and on a continuing basis with a Monthly MAR review before the start of each month to ensure continued compliance. Correction date per Executive Director 6/27/23 is 7/3/23. SG	

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D 344	Continued From page 21 was less than 88%. -The order did not specify how often Resident #5's oxygen saturation was to be checked. Review of Resident #5's MAR for May 2023 revealed there was not an entry for oxygen or oxygen saturation levels. Observation of Resident #5 on 05/17/23 at 12:05pm revealed: -Resident #5 was seated in the dining hall, eating, and was not using oxygen. -Resident #5 did not appear to have any difficulty breathing. Observation of Resident #5 on 05/18/23 at 3:47pm revealed: -She was laying in her bed and was using oxygen via a nasal cannula. -Her oxygen concentrator was set to 2 L/min.. Interview with Resident #5's primary care provider (PCP on 05/18/23 at 11:30am revealed: -Resident #5 was admitted to the facility in January 2023 with orders for continuous oxygen. -Resident #5 smoked and was not compliant at times with oxygen use. -The Director of Resident Care (DRC) requested that Resident #5's oxygen order be changed to oxygen use as needed. -She wrote the current order for oxygen at 2 L/min when her oxygen saturation was less than 88%. -She expected the facility check Resident #5's oxygen saturation daily. -She did not write an order for daily oxygen saturation checks on her oxygen order, but she expected the facility to contact her to clarify the order if there were questions or if they did not understand the order.	D 344		

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D 344	Continued From page 22 Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 2:08pm revealed the pharmacy had not received an order for oxygen dated 05/11/23. Interview with a medication aide (MA) on 05/18/23 at 2:46pm revealed: -Resident #5 received oxygen as needed. -She checked Resident #5's oxygen saturation when she stated she was out of breath, but she did not document Resident #5's oxygen saturation or oxygen use anywhere. -She dd not know about Resident #5's order dated 05/11/23 for Resident #5 to have 2 liters of oxygen if her oxygen saturation was less than 88%; the oxygen order dated 05/11/23 was not on Resident #5's MAR. -Resident #5's oxygen saturation was usually between 94% and 97% when she checked it. Interview with Resident #5 on 05/18/23 at 3:48pm revealed: -She was supposed to use her oxygen when she was asleep, but she used it all the time. -Staff sometimes checked her oxygen saturation, but she did not remember how often. -She had not had her oxygen saturation checked on 05/18/23. -She was sometimes out of breath when she walked and used an inhaler when she was out of breath. Interview with a second MA on 05/18/23 at 3:53pm revealed: -Resident #5 used 2 liters of oxygen at bedtime. -She did not know about Resident #5's physician's order dated 05/11/23 for oxygen at 2 liters when her oxygen saturation was less than 88%.	D 344		

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D 344	Continued From page 23 -She had not checked Resident #5's oxygen saturation. -She usually documented oxygen on the MAR, but Resident #5 did not have an entry for oxygen. -The DRC was responsible for reviewing physician's orders and adding new orders to the MAR, but sometimes she gave orders to MAs to add to the MAR and send to the pharmacy. Interview with the DRC on 05/19/23 at 11:36am revealed: -She believed she knew about the Resident #5's physician's order dated 05/11/23 for Resident #5 to be administered 2 liters of oxygen when her oxygen saturation was less than 88%. -MAs should have checked Resident #5's oxygen saturation when Resident #5 complained about being out of breath and documented her oxygen use and her oxygen saturation on the MAR. -She did not know there was not an entry for oxygen on the MAR or that the pharmacy did not have a copy any orders for oxygen, including the order for oxygen dated 05/11/23. -Whoever received the physician's order for oxygen dated 05/11/23 was responsible for ensuring the order was written on the MAR and a copy of the oxygen order was sent to the pharmacy to be entered on the MAR for the following month. -She did not know Resident #5's oxygen saturation was not being checked. -After looking back at the at the oxygen order dated 05/11/23, she found that the order should have been clarified. Interview with the ED on 05/19/23 at 1:16pm revealed: -The DRC was responsible for reviewing new physician's orders and following through with the orders.	D 344		

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D 344	Continued From page 24 -Physician's orders were to be entered on the MAR and sent to the pharmacy. -She expected that the order for Resident #5's oxygen at 2 liters when her oxygen saturations was below 88% to be clarified and documented on the MAR. -The DRC was responsible for clarifying orders that were unclear with Resident #5's PCP.	D 344		
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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 4 of 5 sampled residents (#1, #2, #4 and #5) who had orders for a gout medication, fiber supplement, cholesterol medication, acid reflux medication and diuretic (#1), cholesterol medication (#1 and #2), an anti-anxiety medication (#4), an antipsychotic medication, a medication used to control blood sugars, and a pain medication (#5). The findings are: 1. Review of Resident #4's current FL2 dated	D 358	Executive Director and RN conducted mandatory Med Tech trainings 5/19/23-6/2/23 to review North Carolina Medication Administration Policy. Trainings reviewed the new order tracking tool, shift change review of MARs, shift communication log and documentation requirements. Executive Director or designee will conduct daily audits of MARs for 4 weeks then weekly. Immediate training provided one on one if any issues identified. Executive Director or designee will audit shift communication log for 6 weeks then weekly. Immediate training provided one on one if any issues identified. Correction date per Executive Director 6/27/23 is 7/3/23. SG	

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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 25 08/31/22 revealed: -Diagnoses included dementia, total left hip replacement, and anxiety. -There was an order for alprazolam (used to treat anxiety) 0.25mg 1 tablet at bedtime. Review of Resident #4's Medication Administration Record (MAR) for January 2023 revealed: -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 10:00am. -There was documentation alprazolam was not administered for 28 of 31 opportunities on 01/02/23, 01/03/23, 01/04/23, 01/05/23, 01/06/23, 01/07/23, 01/09/23, 01/10/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/15/23, 01/16/23, 01/17/23, 01/18/23, 01/19/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 01/25/23, 01/26/23, 01/27/23, 01/28/23, 01/29/23, 01/30/23, 01/31/23. -There was documentation on the back of the MAR that alprazolam was not administered on 01/05/23, 01/10/23, 01/14/23, and 01/15/23 due to the medication was not in the facility. -There was a blank space with no documentation on 01/01/23, 01/08/23, and 01/20/23. -There was no documentation alprazolam was administered between 01/01/23 and 01/31/23 for a total of 31 times. Review of Resident #4's MAR for February 2023 revealed: -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 10:00pm. -There was documentation alprazolam was not administered for 22 of 28 opportunities on 02/01/23, 02/02/23, 02/03/23, 02/04/23, 02/05/23, 02/06/23, 02/07/23, 02/08/23, 02/10/23, 02/11/3, 02/12/23, 02/13/23, 02/17/23, 02/18/23, 02/19/23,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 26 02/20/23, 02/21/23, 02/22/23, 02/23/23, 02/24/23, 02/25/23, and 02/26/23. -There was documentation on the back of the MAR that alprazolam was not administered on 02/03/23 due to the medication was on order, on 02/04/23 due to there was no medication, on 02/05/23 due to medication "not here," on 02/11/23, 02/12/23, 02/13/23, 02/14/23, 02/15/23, 02/16/23, 02/17/23, 02/18/23, 02/019/23, 02/24/23, and on 02/26/23 due to medication not in the facility. -There was no documentation alprazolam was administered between 02/01/23 and 02/28/23 for a total of 28 times. Review of Resident #4's MAR for March 2023 revealed: -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 10:00am from 03/01/23 through 03/08/23. -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 8:00am from 03/09/23 through 03/31/23. -There was documentation alprazolam was not administered for 1 of 31 opportunities between on 03/13/23 and there was no documentation on the back of the MAR why alprazolam was not administered. -There was a blank space with no documentation on 03/06/23 and 03/17/23. -There was no documentation alprazolam was administered between 03/01/23 and 03/31/23 for a total of 3 times. Review of Resident #4's MAR for April 2023 revealed: -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 8:00am. -There was documentation alprazolam was not	D 358		

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D 358	Continued From page 27 administered for 2 of 31 opportunities on 04/01/23 and 04/02/23 and there was no documentation on the back of the MAR why alprazolam was not administered. -There was documentation on the back of the MAR on 04/02/23 alprazolam was not administered because the medication was not in the facility; a refill had been requested. -There was no documentation alprazolam was administered between 04/01/23 and 04/03/23 for a total of 3 times. Review of Resident #4's MAR for 05/01/23 through 05/17/23 revealed: -There was an entry for alprazolam 0.25mg 1 tablet at bedtime scheduled for administration at 8:00am. -There was documentation alprazolam was not administered for 7 of 17 opportunities on 05/03/23, 05/04/23, 05/05/23, 05/06/23, 05/07/23, 05/08/23, and 05/09/23 and there was no documentation on the back of the MAR why alprazolam was not administered. -There was documentation on the back of the MAR on 05/08/23 alprazolam was not administered because the medication was not available. -There was no documentation alprazolam was administered between 05/01/23 and 05/31/23 for a total of 7 times. Observation of Resident #4's medications available for administration on 05/17/23 at 2:45pm revealed: -There was a bubble pack of alprazolam 0.25mg 1 tablet at bedtime available. -Alprazolam was dispensed by the pharmacy 05/08/23 with a quantity of 30 tablets and 23 tablets were remaining.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 28 Interview with a medication aide (MA) on 05/17/23 at 2:51pm revealed: -If she did not see a medication in the facility, she called the pharmacy and let the Director of Resident Care (DRC) know. -If she contacted the pharmacy to refill medication and the resident needed a new prescription, she contacted the resident's physician for a new prescription and the physician usually faxed the new order to the pharmacy. -She knew Resident #4 was out of alprazolam in February 2023. -She contacted the pharmacy and the pharmacy responded Resident #4 needed a new prescription. -She contacted Resident #4's primary care provider (PCP) and requested a new refill and she also let the DRC know, but she did not remember when. Interview with a second MA on 05/17/23 at 3:09pm revealed: -She reordered medication when it was down to the fifth or sixth dose in the bubble pack. -Resident #4 had one dose in the bubble pack prior to medication administration on 05/02/23. -She contacted the pharmacy on 05/02/23 to let them know Resident #4 needed a refill of alprazolam because she only had 1 tablet in the facility. -She did not work on 05/03/23, but she returned to work on 05/04/23 and alprazolam was not available for administration; she also worked on 05/05/23 and 05/06/23 and alprazolam, was still not available in the facility. -She completed a medication request form and gave it to the DRC on 05/05/23, but she did not follow up with the DRC or the pharmacy after 05/05/23 when the medication continued to not be available.	D 358		

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D 358	Continued From page 29 Interview with Resident #4's PCP on 05/18/23 at 11:30am revealed: -The staff was able to send her request for a refill or a for a new medication order through the electronic communication system and the request came directly to her phone. -She was not aware Resident #4 went for so long without alprazolam in January and February 2023 and was out of alprazolam for 7 days in May. -Staff should have contacted her for a new prescription prior to Resident #4 running out of alprazolam. -Alprazolam was used for agitation and sleep. -Staff reported to her sometime in April 2023 that Resident #4 was wandering at night. -Outcome of not administering alprazolam to Resident #4 as ordered included not sleeping at night and increased agitation. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 2:08pm revealed: -Resident #4 had an order for alprazolam 0.25mg 1 tablet at bedtime and alprazolam was used to treat insomnia. -Alprazolam was dispensed on 02/14/23 with a quantity of 3 tablets, on 02/24/23 with a quantity of 30 tablets, and on 04/02/23 with a quantity of 30 tablets. -The order for alprazolam dated 02/24/23 was written with 6 refills. -Alprazolam was not dispensed to the facility in January or March 2023. Interview with a third MA on 05/18/23 at 4:26pm revealed: -Medications should have been reordered when they were down to the last row on the bubble pack, about 8 days prior to running out.	D 358		

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D 358	Continued From page 30 -There was no alprazolam available for Resident #4 on 05/08/23, so she sent a refill request for alprazolam to the pharmacy and there was 1 refill of alprazolam remaining. -She did not know why alprazolam had not been reordered and available in the facility prior to 05/08/23. -She did not remember Resident #4 being out of alprazolam, prior to May 2023. -Resident #4 had trouble sleeping in May 2023 when she was out of alprazolam; she was roaming around and worrying about other residents. Interview with the DRC on 05/19/23 at 11:36am revealed: -She expected the MAs to identify that Resident #4's alprazolam was not available on the medication cart and notify her if they were not able to get the alprazolam in the facility. -She became aware in February 2023 Resident #4 was not being administered alprazolam in January and February 2023. -Resident #4 was seeing an outside provider and when she switched to the facility provider, she began getting alprazolam regularly. -She was notified by a MA on 05/08/23 that Resident #4 was out of alprazolam. -She had not been notified at any other time in May 2023 that Resident #4 did not alprazolam available. -Alprazolam should have been reordered within 7 days of running out. -MAs had not reported any issues with Resident #4 not being able to sleep or any increased anxiety. Interview with the ED on 05/19/23 at 1:16pm revealed: -She did not know Resident #4 missed doses of	D 358		

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D 358	Continued From page 31 alprazolam from January through May 2023. -She expected MAs to reorder medication within 7 days of running out of the medication and to work with the DRC if they had trouble with getting the medication from the pharmacy. -Resident #4 missing doses of alprazolam, because the medication was not in the facility, should have been caught during medication cart and MAR audits. Based on interview, observation, and record review, it was determined Resident #4 was not interviewable. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. 2. Review of Resident #5's current FL2 dated 02/01/23 revealed diagnoses included acute and chronic respiratory failure with hypoxia, muscle weakness, difficulty walking, cognitive communication deficit, chronic diastolic congestive heart failure, chronic cor pulmonale, type 2 diabetes, chronic obstructive pulmonary disease, and hypertension. a. Review of Resident #5's current FL2 dated 02/01/23 revealed an order for olanzapine (used to treat symptoms of schizophrenia) 5mg 1 tablet at bedtime. Review of Resident #5's medication administration record (MAR) for March 2023 revealed: -There was an entry for olanzapine 5mg 1 tablet at bedtime scheduled for administration at 8:00pm.	D 358		

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D 358	Continued From page 32 -There was documentation olanzapine was not administered for 17 of 31 opportunities on 03/09/23, 03/10/23, 03/11/23, 03/13/23, 03/14/23, 03/15/23, 03/17/23, 03/18/23, 03/19/23, 03/20/23, 03/22/23, 03/23/23, 03/24/23, 03/26/23, 03/29/23, 03/30/23, and 03/31/23. -There was documentation on the back of the MAR on 03/09/23, 03/20/23, 03/24/23, 03/26/23, 03/29/23, 03/30/23 and on 03/31/23 that olanzapine was not administered because the medication was not available. -There was a blank space with no documentation on 03/06/23, 03/12/23, 03/16/23, 03/27/23, and 03/28/23. -There was no documentation olanzapine was administered between 03/01/23 and 03/31/23 for a total of 22 times. Review of Resident #5's MAR for April 2023 revealed: -There was an entry for olanzapine 5mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation olanzapine was not administered for 26 of 30 opportunities on 04/01/23, 04/02/23, 04/03/23, 04/04/23, 04/05/23, 04/06/23, 04/07/23, 04/08/23, 04/09/23, 04/11/23, 04/12/23, 04/13/23, 04/14/23, 04/15/23, 04/16/23, 04/17/23, 04/18/23, 04/19/23, 04/20/23, 04/22/23, 04/23/23, 04/24/23, 04/25/23, 04/26/23, 04/27/23, 04/28/23, and 04/29/23. -There was documentation on the back of the MAR on 04/04/23, 04/05/23, and 04/09/23 that alprazolam was not administered because the medication was not available. -There was a blank space with no documentation on 04/10/23, 04/12/23, 04/21/23, and 04/30/23. -There was no documentation olanzapine was administered between 04/01/23 and 04/30/23 for a total of 30 times.	D 358		

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D 358	Continued From page 33 Review of Resident #5's MAR for 05/01/23 through 05/16/23 revealed: -There was an entry for olanzapine 5mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation olanzapine was not administered for 4 of 16 opportunities on 05/01/23, 05/02/23, 05/07/23, and 05/14/23. -There was documentation on the back of the MAR on 05/02/23 that olanzapine was not administered because the medication was not available, and olanzapine was not administered on 05/07/23 and 05/14/23 because Resident #5 refused. -There was a blank space with no documentation on 05/15/23. -There was no documentation olanzapine was administered between 05/01/23 and 05/16/23 for a total of 5 times. Observation of Resident #5's medications available for administration on 05/17/23 at 2:58pm revealed: -There was a bubble card of olanzapine 5mg 1 tablet at bedtime dispensed by the pharmacy on 05/03/23 with a quantity of 30 tablets. -There were 15 tablets of olanzapine remaining. Interview with Resident #5's primary care provider (PCP) on 05/18/23 at 11:30am revealed: -Olanzapine was used to treat behaviors. -She did not know Resident #5 was out of olanzapine in March and April 2023. -She expected the facility to contact her for new prescriptions, if needed, prior to running out of a medication. -Possible outcomes of not being administered olanzapine as ordered were aggressive or bizarre behaviors and agitation.	D 358		

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D 358	Continued From page 34 -Staff had not reported Resident #5 had any behavior issues or agitation. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 2:08pm revealed: -Resident #5 had an order for olanzapine 5mg 1 tablet at bedtime and olanzapine was an antipsychotic medication. -Olanzapine was dispensed to the facility on 02/07/23 with a quantity of 30 tablets. -The facility requested a refill of olanzapine on 03/22/23, 04/03/23, and 04/08/23 and a pharmacy representative faxed the facility after each request to let them know Resident #5 needed an updated order for olanzapine. -The pharmacy did not receive an order for olanzapine until 05/03/23 and olanzapine was dispensed to the facility on 05/03/23 with a quantity of 30 tablets. Interview with a medication aide (MA) on 05/18/23 at 2:46pm revealed: -MA's conducted medication cart audits every Monday. -Medication cart audits included ensuring that the medications on the cart matched the medications on the MAR, checking for medications that needed to be refilled and for medications that were not available on the cart. -She reordered medication for residents when there were 7 days of medication remaining. -She knew Resident #5 as out of olanzapine, but she did not remember which month. -She faxed over a refill request to the pharmacy, called Resident #5's primary care provider (PCP) to request a new prescription, and gave medication request paperwork to the DRC. Interview with Resident #5 on 05/18/23 at 3:48pm	D 358		

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D 358	Continued From page 35 revealed she did not know about her medications or if she was ever out of olanzapine. Interview with a second MA on 05/18/23 at 3:53pm revealed: -Resident #5 was out of olanzapine in March and April 2023. -She faxed a request for a refill of olanzapine to the pharmacy (she did not remember when) and called to ensure they received the order, but the pharmacy was closed. -The fax machines on the third floor were not working in March and April 2023. -She went to the DRC at the end of April 2023 or the beginning of May 2023 to inform her that Resident #5 did not have olanzapine available. -She had not noticed Resident #5 had any agitation or behaviors. Interview with a third MA on 05/18/23 at 4:26pm revealed: -Olanzapine was not available on the medication cart when she first started working at the facility in March 2023. -She attempted to reorder olanzapine from the pharmacy 4 or 5 tines and then called the pharmacy, but she did not remember when. -The pharmacy told her Resident #5 needed a new prescription for olanzapine before it could be refilled. -She let the Director of Resident Care (DRC) know Resident #5 needed a new prescription for olanzapine. -Resident #5 had not had any behaviors or anxiety. Interview with the DRC on 05/19/23 at 11:36am revealed: -She did not know Resident #5 had been out of olanzapine for extended periods of time in March	D 358		

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D 358	Continued From page 36 and April 2023. -She was not notified by a MA until 04/26/23 that Resident #5 was out of olanzapine. -She reordered the olanzapine, but she did not remember if a new prescription was needed. -Staff had not reported Resident #5 had any increased behaviors or anxiety. Interview with the ED on 05/19/23 at 1:16pm revealed -She did not know Resident #4 missed doses of olanzapine from March through May 2023. -Resident #4 missing doses of olanzapine, because the medication was not in the facility, should have been caught during medication cart and MAR audits. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. b. Review of Resident #5's current FL2 dated 02/01/23 revealed an order for insulin lispro (used to control blood sugars)100 units/1ml insulin pen inject per sliding scale before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4 units. Review of Resident #5's medication administration record (MAR) for March 2023 revealed: -There was an entry for insulin lispro 100 units/1ml insulin pen inject per sliding scale before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4 units, scheduled for administration at 7:00am, 11:00, 5:00pm, and 8:00pm. -There was no space to document fingerstick	D 358		

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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 37 blood sugars (FSBS), number of units administered or site. -There were 26 blank spaces with no documentation insulin was or was not administered. Review of Resident #5's FSBS Log for March 2023 revealed: -There was a column to document the date, time, FSBS results, and the medication aides (MA) initials. -There was no space to document the number of units administered. -There was no documentation of Resident #5's FSBS for 33 of 124 opportunities. -Resident #5's FSBS ranged from 91 to 307. Based on review of Resident #5's MAR and FSBS Log for March 2023 revealed: -There was documentation lispro insulin was administered 11 times when Resident #5's FSBS was less than 201, but there was no documentation of the number of units administered. -There was documentation lispro insulin was not administered 2 times when Resident #5's FSBS was greater than 200. -There was no documentation of the how many units of insulin were administered 9 times when Resident #5's FSBS was greater than 200. Review of Resident #5's MAR for April 2023 revealed: -There was an entry for insulin lispro 100 units/1ml insulin pen inject per sliding scale before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4 units, scheduled for administration at 7:00am, 11:00, 5:00pm, and 8:00pm. -There was no entry to document FSBS, number	D 358		

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D 358	Continued From page 38 of units administered or site. -There were 37 blank spaces with no documentation insulin was or was not administered. Review of Resident #5's FSBS Log for April 2023 revealed: -There was a column to document the date, time, FSBS results, and the medication aides (MA) initials. -There was no space to document the number of units administered. -There was no documentation of Resident #5's FSBS for 43 of 120 opportunities. -Resident #5's FSBS ranged from 108 to 261. Based on review of Resident #5's MAR and FSBS Log for April 2023 revealed: -There was documentation lispro insulin was administered 21 times when Resident #5's FSBS was less than 201, but there was no documentation of the number of units of insulin administered. -There was documentation lispro insulin was not administered 1 time when Resident #5's FSBS was greater than 200. -There was documentation lispro insulin was administered 3 times when there was no documentation of a FSBS and no documentation of the number of units of insulin administered. -There was no documentation of the how many units of insulin were administered 10 times when Resident #5's FSBS was greater than 200. Review of Resident #5's MAR for 05/01/23 through 05/17/23 revealed: -There was an entry for insulin lispro 100 units/1ml insulin pen inject per sliding scale before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4	D 358		

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D 358	Continued From page 39 units, scheduled for administration at 7:00am, 11:00, 5:00pm, and 8:00pm. -There was no space to document FSBS, number of units administered or site. -There was a second entry for insulin lispro 100 units/1ml insulin pen inject per sliding scale before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4 units, contact the provider if FSBS greater than 400, scheduled for administration at 7:00am, 11:00, 5:00pm, and 8:00pm. -The second entry had a space to document the number of units of insulin administered, the FSBS, and the site. -There were 13 blank spaces with no documentation insulin was or was not administered. Review of Resident #5's FSBS Log for 05/01/23 through 05/17/23 revealed: -There was a column to document the date, time, FSBS results, and the medication aides (MA) initials. -There was no space to document the number of units administered. -There was no documentation of Resident #5's FSBS for 11 of 65 opportunities. -Resident #5's FSBS ranged from 112 to 248. Based on review of Resident #5's MAR and FSBS Log for 05/01/23 through 05/17/23 revealed: -There was documentation lispro insulin was administered 7 times when Resident #5's FSBS was less than 201, but there was no documentation of the number of units administered. -There was documentation lispro insulin was not administered 5 times when Resident #5's FSBS was greater than 200.	D 358		

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D 358	Continued From page 40 -There was no documentation of the how many units of insulin were administered 6 times when Resident #5's FSBS was greater than 200. Observation of Resident #5's medications available for administration on 05/17/23 at 2:58pm revealed there was one opened pen of insulin lispro and one unopened pen of insulin lispro. Interview with Resident #5's PCP on 05/18/23 at 11:30am revealed: -She noticed Resident #5's FSBS and units were not on the MAR and she was very concerned. -She did not know if Resident #5 was being administered according to her sliding scale or how much was being administered. -If Resident #5 was administered too much insulin, she could experience a diabetic coma. -If Resident #5 was not administered enough insulin, she could experience ketoacidosis and elevated FSBS. -Resident #5 has not, to her knowledge, had any issues with decreased or elevated FSBS and was clinically stable. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 2:08pm revealed: -Resident #5 had an order for lispro 100 units/ml sliding scale insulin (SSI) inject before meals and at bedtime: 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, 351-399= 4 units. -Lispro was dispensed to the facility on 02/01/23 and on 03/023/23 with an 18-day supply each time (based on 4 units per day). Interview with a medication aide (MA) on 05/18/23 at 2:46pm revealed: -She administered SSI to Resident #5 if her	D 358		

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D 358	Continued From page 41 FSBS was greater than 200. -If there were just MA initials on the MAR, it meant that insulin was administered. -If the MA's initials were circled, it meant that insulin was not administered. -There was a FSBS log where MAs were to document the FSBS reading, but there was no place to document how much insulin was administered. -She noticed on 05/07/23 that there was no place to document the number of units of insulin administered and she told the Director of Resident Care (DRC). -On 05/10/23, the DRC updated the MAR to add an entry box for the number of units administered. -The DRC was responsible for reviewing the MARs, but she did not know how often. -There was no way to tell if Resident #5's lispro was administered correctly if the number of units administered was not on the MAR. Interview with Resident #5 on 05/18/23 at 3:48pm revealed: -The MAs checked her FSBS before every meal and at bedtime. -Her dosage of insulin depended on what her FSBS was. -She did not what her FSBS results were. Interview with a second MA on 05/18/23 at 3:53pm revealed: -Resident #5 had lispro SSI before meals and at bedtime. -She knew that when she administered SSI, she should have documented the number of units administered, but she did not realize there was no place to document the number of units administered on the MAR or on the FSBS log. -If there were initials on the MAR for the lispro	D 358		

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D 358	Continued From page 42 SSI entry, it meant that lispro was administered; if the initials were circled, it meant that lispro was not administered. Interview with a third MA on 05/18/23 at 4:26pm revealed: -Resident #5 had an order for lispro SSI which was administered if her FSBS was greater than 200. -Most of the time Resident #5's FSBS was less than 200 and she was not administered lispro. -If a MA documented initials on the MAR for the lispro entry, it meant that insulin was administered; if the initials were circled, it meant that insulin was not administered. -If there was a blank space, it meant the at the medication was not administered. -She had not noticed there was no place to document the number of units of lispro administered for Resident #5 on the MAR or on the FSBS log. -She did not know she was supposed to document the number of units of lispro administered. -She thought that following the sliding scale and documenting her initials was sufficient documentation of the number of units of insulin administered. -The DRC was responsible for reviewing the MARs, but she did not know how often. -She noticed Resident #5's lispro entry changed o the MAR on 05/10/23 to include FSBS and the site where insulin was administered, but the DRC did not discuss the new entry with the MAs. Interview with the DRC on 05/19/23 at 11:36am revealed: -She had not noticed any issues with Resident #5's MARs or with her lispro SSI administration. -She had not noticed there was no documentation	D 358		

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D 358	Continued From page 43 of the number of units of insulin administered to Resident #5, but she did notice the omission in May 2023 and created a new entry on the MAR on 05/10/23 to include a place to document the number of units administered and the site where insulin was administered, the FSBS, as well as the MAs initials. -Prior to 05/10/23, MAs were to document on the MAR their initials to indicated insulin had been administered or circled initials to indicated insulin was not administered; MAs were to document FSBS 4 times daily on the FSBS log. -She knew the number of units should have been documented with each FSBS and insulin administration for lispro SSI; she just had not realized FSBS had been omitted from documentation. Interview with the ED on 05/19/23 at 1:16pm revealed: -There should have been documentation of lispro SSI insulin administration. -She did not know, prior to the survey, that there was no documentation of the number of units of insulin administered to Resident #5. -If a MAs initial was documented on the MAR, it indicated a medication was administered and if the MAs initial was circled on the MAR, it indicated a medication was not administered. -The omission of documentation of the number of units of insulin administered should have been caught by the DRC during MAR audits. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. c. Review of Resident #5's physician's orders	D 358		

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D 358	Continued From page 44 dated 03/20/23 revealed an order for Tylenol 1000mg twice daily for pain (used to treat pain). Review of Resident #5's medication administration record (MAR) for 03/05/23 through 03/31/23 revealed: -There was a handwritten entry for Tylenol 500mg 2 tablets (1000mg) twice daily for pain scheduled for 8:00am and 8:00pm. -There was documentation Tylenol 500mg (2 tablets totaling 1000mg) was administered for 44 of 51 opportunities between 03/05/23 and 03/31/23. Review of Resident #5's MAR for April 2023 revealed there was no entry for Tylenol. Review of Resident #5's MAR for May 2023 revealed there was no enter Tylenol. Observation of Resident #5's medications available for administration on 05/17/23 at 2:58pm revealed Tylenol 500mg was not available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 2:08pm revealed: -The pharmacy had not received the order dated 03/20/23 for Tylenol 1000mg twice daily for pain for Resident #5 and had not dispensed scheduled Tylenol to the facility. -If the pharmacy had received physician's orders for Tylenol for Resident #5, the pharmacy would haven entered Tylenol on Resident #5's MAR for documentation in the following month, April 2023, and ongoing. Interview with a medication aide (MA) on 05/18/23 at 2:46pm revealed:	D 358		

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D 358	Continued From page 45 -MA's conducted medication cart audits every Monday. -Medication cart audits included ensuring that the medications on the cart matched the medications on the MAR, checking for medications that needed to be refilled and for medications that were not available on the cart. -She did not realize Tylenol was not on the medication cart and was not on the MAR in April and May. Interview with Resident #5 on 05/18/23 at 3:48pm revealed: -She did not know about her medications or if she was ever out of Tylenol. -She sometimes had pain in her body, but she was not experiencing any pain currently. Interview with a second MA on 05/18/23 at 3:53pm revealed: -The Director of Resident Care (DRC) was responsible for reviewing physician's orders and adding new orders to the MAR, but sometimes she gave orders to MAS to add to the MAR and send to the pharmacy. -Resident #5 had Tylenol 325mg every 6 hours as needed on the medication, but she did not know Resident #5 had an order for Tylenol 1000mg twice daily. -Tylenol 1000mg twice daily was not on the MAR and was not available in the medication cart. Interview with a third MA on 05/18/23 at 4:26pm revealed: -She administered Tylenol 500mg 2 tablets (1000mg) twice daily to Resident #5 in March 2023. -She noticed Tylenol was not on the MAR in April and May 2023, but she thought it had been discontinued.	D 358		

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D 358	Continued From page 46 -She did not contact the pharmacy regarding Tylenol. Telephone interview with Resident #5's PCP on 05/19/23 at 9:35am revealed: -She prescribed Tylenol 1000mg twice daily for Resident #5 because she had complained about having back pain. -She did not know the pharmacy had not received the order for Tylenol and she had not discontinued the medication. -Resident #5 could have experienced increased pain due to Tylenol not being administered as ordered. -Resident #5 had complained to her about hurting when she moved, but she did not remember when. Interview with the DRC on 05/19/23 at 11:36am revealed: -She or the MAs were responsible for adding new medication orders to the MAR and sending the order to the pharmacy to be entered electronically to the MAR for the following month. -She did not know that Tylenol 500mg 2 tablet twice daily, which was written on the MAR in March 2023, was not carried over to the MAR for April and May 2023. -The MA who checked the April MAR at the end of March, should have written the medication on the April MAR if it there was not an entry from the pharmacy. -She also expected the MAs to follow up with her if the medications were not carried over on the MAR to the next month so she could follow up with the pharmacy. -Resident #5 complained of shoulder pain about a month ago and was given an as need pain medication, but Resident #5 had no other complaints of pain that she was aware of.	D 358		

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D 358	Continued From page 47 Interview with the ED on 05/19/23 at 1:16pm revealed: -She did not know there was no documentation in April and May 2023 that Tylenol had had been administered to Resident #5. -She did not know the pharmacy did not have documentation of the physician's order for Tylenol for Resident #5 and that Tylenol had not been dispensed to the facility. -The DRC was responsible for reviewing new physician's orders and following through with the orders. -Physician's orders were to be entered on the MAR and sent to the pharmacy. -The DRC was responsible for changing the MARs out from month to month. -It should have been identified that Tylenol was not on the April 2023 MAR. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. 3. Review of Resident #1's current FL2 dated 02/09/23 revealed diagnoses included congestive heart failure, atrial fibrillation, coronary artery disease, spinal stenosis, hypertension and gastroesophageal reflux disease (GERD). a. Review of Resident #1's current FL2 dated 02/09/23 revealed an order for allopurinol (a medication used to reduce uric acid levels and treat gout) 100mg every evening. Review of Resident #1's April 2023 medication administration record (MAR) revealed: -There was an entry for allopurinol 100mg every	D 358		

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D 358	Continued From page 48 evening scheduled at 8:00pm. -There was documentation that allopurinol was not administered on 04/03/23, 04/05/23, 04/06/23, 04/07/23, 04/08/23, and 04/09/23, and there was no documentation that allopurinol was administered on 04/21/23, 04/25/23, 04/28/23, or 04/20/23. -There was documentation on 04/03/23 and 04/08/23 that allopurinol was not administered due to the medication not being available. Observation of medications on hand for Resident #1 on 05/18/23 at 9:12am revealed: -There was one bottle of allopurinol 100mg tablets with a dispensed date of 08/08/22 and a dispensed quantity of 90 tablets that was ¼ full. -There was a second bottle of allopurinol 100mg tablets with a dispensed date of 04/27/23 and a dispensed quantity of 90 tablets that was full. -There was one medication card with allopurinol 100mg tablets with a dispensed date of 05/03/23 and had 11 out of 30 dispensed tablets remaining. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He remembered the days when he had not received allopurinol because the medication aide (MA) told him if a pill was missing and which one. -The MA told him they needed to reorder more allopurinol. -He did not experience symptoms of gout when he had not received allopurinol. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed: -Resident #1 had an active order for allopurinol 100mg every evening for gout. -The pharmacy dispensed allopurinol for Resident	D 358		

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D 358	Continued From page 49 #1 on 02/27/23 for 30 tablets, and on 05/03/23 for 30 tablets. -The prescription was not refilled automatically because it did not have refills available, and the prescription needed to be renewed by the primary care provider (PCP). -The facility had not requested a refill of allopurinol between the dates of 02/01/23 and 05/17/23. Interview with a MA on 05/18/23 at 10:50am revealed: -When a medication was not administered, the MAs documented it on the MAR by putting a circle around their initials. -If there was a blank space on the MAR and no initials, it indicated either the medication was not administered, or the MA forgot to document. -She did not remember Resident #1 running out of allopurinol. -On the MAR, she documented administering allopurinol to Resident #1 between the days that other MAs documented it as not administered. -The other MAs might not have known that he had a bottle of allopurinol and to check his medication bottles and not just his medication cards because he used two different pharmacies. -The MAs did MAR audits every Monday at the same time as doing the medication cart audits. -During the audits the MAs looked for any medications that needed to be reordered from the pharmacy, then the facility's Director of Resident Care (DRC) did medication cart and MAR audits too. -Resident #1 was able to make his needs known, and had never complained to her about having symptoms of gout. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed:	D 358		

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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 50 -She was not aware that Resident #1 was not administered 10 out of 30 doses of allopurinol for April 2023. -She expected the MAs to administer medications as ordered and to reorder medications prior to them running out. -The facility staff should notify her about any prescriptions that needed to be renewed two weeks prior to the medication running out so that she could send a prescription with refills to the pharmacy and the pharmacy could deliver the medication before it ran out. -Resident #1 had not complained of gout symptoms and staff had not reported any symptoms of gout to her on behalf of Resident #1. -She did not have concerns about Resident #1 experiencing adverse effects from missing 10 doses of allopurinol. Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed: -Resident #1 had told him that he ran out of a few of his medications in April 2023. -All of Resident #1's medications should be filled monthly by the facility's contracted pharmacy. -There were a couple medications that he was able to receive an additional supply of through a second pharmacy and allopurinol was one of those medications. -He only filled the allopurinol from the second pharmacy so the MAs would have a back-up supply of it if they ever needed it. -Resident #1 had not mentioned experiencing any symptoms of gout to him and he spoke to Resident #1 almost daily. -Resident #1 did not have a gout flare up since he was admitted to the facility in August of 2018. Interview with a second MA on 05/18/23 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 358	Continued From page 51 2:45pm revealed: -The MAs were supposed to do medication cart audits between the 1st and the 5th of each month and refill any medications that were either out or low. -If a medication quantity was down to 5 tablets, the MAs were supposed to take the sticker off the medication card, put it on a pharmacy reorder form, and fax it to the pharmacy. -She had not administered allopurinol to Resident #1 because she did not work second shift, but Resident #1 had never reported symptoms of gout to her. Interview with a third MA on 05/18/23 at 3:40pm revealed: -She remembered Resident #1 running out of allopurinol in April 2023. -She thought the allopurinol had run out of refills and the PCP had to send a new prescription to the pharmacy which sometimes took a while. -If a medication did not arrive from the pharmacy within a day of it being reordered, the MAs told the DRC and she would follow-up with the pharmacy or the PCP. -The MAs were expected to refill medications when the quantity of tablets remaining was down to 5 or 6 doses. -To request a refill of a medication from the pharmacy the MAs pulled the barcode sticker off the medication card and placed it on a pharmacy reorder sheet and faxed it to the pharmacy. -She could not remember if she had faxed a refill request for Resident #1's allopurinol to the pharmacy. -She was not aware that Resident #1 had a bottle of allopurinol in the medication cart that had been dispensed in August of 2022. -Resident #1 had not reported any symptoms of gout to her.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 358	Continued From page 52 Interview with a fourth MA on 05/18/23 at 4:15pm revealed: -She had documented Resident #1's allopurinol as not administered in April 2023. -She had faxed the refill request for Resident #1's allopurinol to the pharmacy but could not remember which day. -If a medication was not delivered to the facility from the pharmacy within a day of the refill request being sent, the MAs were supposed to fill out a medication request form and place it in the DRC's office mailbox for her to follow up on. -She thought she had notified the DRC about Resident #1's allopurinol not being delivered. -She was not aware that Resident #1 had a bottle of allopurinol available for administration on the medication cart. -She did check Resident #1's bottles of medication but had not seen the allopurinol. -Resident #1 had not reported symptoms of gout to her. Telephone interview with the DRC on 05/19/23 at 11:45am revealed: -One of the MAs had made her aware that Resident #1 was out of allopurinol in April and needed a new prescription in order to receive a refill. -On 04/24/23 she had notified Resident #1's PCP that a new prescription of allopurinol was needed at the pharmacy because Resident #1 was out of the medication. -She did not receive a response from Resident #1's PCP, so on 04/25/23 at 1:51pm she sent another message to the PCP regarding the allopurinol refill. -She did not receive a response from Resident #1's PCP on 04/25/23, so that Thursday, 04/27/23, she had the PCP sign a new	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 53	D 358		

physician's order sheet and faxed that to the pharmacy.
-She did not remember if she or the MAs did a medication cart audit in April to catch that Resident #1's allopurinol was going to run out.
-Resident #1 was alert and oriented and able to make his needs known.
-He had not reported any symptoms of gout in the last month.

Telephone interview with the ED on 05/19/23 at 1:20pm revealed she was not aware that Resident #1 had not been administered 10 doses of allopurinol in April 2023.

Refer to telephone interview with the DRC on 05/19/23 at 11:45am.

Refer to telephone interview with the ED on 05/19/23 at 1:20pm.

b. Review of Resident #1's current FL2 dated 02/09/23 revealed an order for atorvastatin (a medication used to treat high cholesterol) 20mg at bedtime.

Review of Resident #1's April 2023 medication administration record (MAR) revealed:
-There was an entry for atorvastatin 20mg every night at bedtime scheduled at 8:00pm.
-There was documentation that atorvastatin was only administered on 04/01/23, 04/02/23, and 04/10/23, the remaining days were either left blank or documented as not administered.
-There was documentation on 04/03/23, 04/04/23, 04/08/23 and 04/25/23 that atorvastatin was not administered due to the medication not being available.

Review of Resident #1's May 2023 MAR from

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	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 54 05/01/23 through 05/17/23 revealed: -There was an entry for atorvastatin 20mg every night at bedtime scheduled at 8:00pm. -There was documentation that atorvastatin was not administered 05/01/23, 05/02/23, or 05/03/23; there was no documented reason why. Observation of medications on hand for Resident #1 on 05/18/23 at 9:12am revealed there was one medication card for atorvastatin 20mg, take 1 tablet at bedtime with a dispensed date of 05/03/23 and 15 out of 30 dispensed tablets remaining. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He could not remember if the MAs had told him that he did not receive atorvastatin for most of April 2023. -He had not noticed any new symptoms since the beginning of April when he was not receiving atorvastatin. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed: -Resident #1 had a current order for atorvastatin 20mg every night at bedtime. -The pharmacy dispensed atorvastatin for Resident #1 on 02/27/23 for 30 tablets, and on 05/03/23 for 30 tablets. -The prescription was not refilled automatically because it did not have refills available, and the prescription needed to be renewed by the primary care provider (PCP). -The facility had sent a refill request for Resident #1's atorvastatin on 04/02/23 so they sent a message back to the facility relaying that a new prescription was needed since there were no available refills from the previous prescription.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 55 Interview with a MA on 05/18/23 at 10:50am revealed: -When a medication was not administered, the MAs documented it on the MAR by putting a circle around their initials. -Blank spaces on the MAR indicated the medication was either not administered or the MA forgot to document. -The MAs did MAR audits every Monday at the same time as doing the medication cart audits. -During the audits the MAs looked for any medications that needed to be reordered from the pharmacy, then the facility's Director of Resident Care (DRC) did medication cart and MAR audits too. -She remembered Resident #1 running out of atorvastatin but thought the PCP was waiting to send the refill until after collecting lab work. -Resident #1 was able to make his needs known and had not reported any new symptoms to her in April 2023. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She was not aware that Resident #1 was not administered 27 out of 30 doses of atorvastatin for April 2023 and three doses in May 2023. -She did not hold off on reordering the medication until after obtaining lab work, she had just not been notified that the prescription needed to be renewed at the pharmacy. -She expected the MAs to administer medications as ordered and to reorder medications prior to them running out. -The facility staff should notify her about any prescriptions that needed to be renewed two weeks prior to the medication running out so that she could send a prescription with refills to the pharmacy and the pharmacy could deliver the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 56	D 358		

medication before it ran out.
-Resident #1 would not experience any acute side effects from not receiving atorvastatin, but not taking it for a month could cause his cholesterol level to raise.

Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed:
-Resident #1 had told him that he ran out of a few of his medications in April 2023 but he did not remember atorvastatin being mentioned as one of them.
-All of Resident #1's medications should be filled monthly by the facility's contracted pharmacy.

Interview with a second MA on 05/18/23 at 2:45pm revealed:
-The MAs were supposed to do medication cart audits between the 1st and the 5th of each month and refill any medications that were either out or low.
-If a medication quantity was down to 5 tablets, the MAs were supposed to take the sticker off the medication card, put it on a pharmacy reorder form, and fax it to the pharmacy.
-She remembered Resident #1 not having atorvastatin available for administration in April 2023 but she had not requested a refill from the pharmacy because she figured one of the afternoon shift MAs had already requested it.
-The DRC did audits of the MARs but she did not know how often or if she was aware that Resident #1 had been out of atorvastatin so many days.

Interview with a third MA on 05/18/23 at 3:40pm revealed:
-She remembered Resident #1 running out of atorvastatin in April 2023.
-If a medication did not arrive from the pharmacy within a day of it being reordered, the MAs told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 57 the DRC and she would follow-up with the pharmacy or the PCP. -The MAs were expected to refill medications when the quantity of tablets remaining was down to 5 or 6 doses. -To request a refill of a medication from the pharmacy the MAs pulled the barcode sticker off the medication card and placed it on a pharmacy reorder sheet and faxed it to the pharmacy. -She could not remember if she had faxed a refill request for Resident #1's atorvastatin to the pharmacy but she knew she would have requested the refill if she had been the MA to use the last dose. -She had not followed up with the DRC regarding Resident #1 being out of atorvastatin for so many days. Interview with a fourth MA on 05/18/23 at 4:15pm revealed: -She had documented Resident #1's atorvastatin as not administered in April 2023. -She had faxed the refill request for Resident #1's atorvastatin to the pharmacy but could not remember which day. -If a medication was not delivered to the facility from the pharmacy within a day of the refill request being sent, the MAs were supposed to fill out a medication request form and place it in the DRC's office mailbox for her to follow up on. -She thought she had notified the DRC about Resident #1's atorvastatin not being delivered. Telephone interview with the DRC on 05/19/23 at 11:45am revealed: -One of the MAs had made her aware that Resident #1 was out of atorvastatin in April and needed a new prescription in order to receive a refill. -On 04/24/23 she had notified Resident #1's PCP	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 58 that a new prescription of atorvastatin was needed at the pharmacy because Resident #1 was out of the medication. -She did not receive a response from Resident #1's PCP, so on 04/25/23 at 1:51pm she sent another message to the PCP regarding the atorvastatin refill. -She did not receive a response from Resident #1's PCP on 04/25/23, so that Thursday, 04/27/23, she had the PCP sign a new physician's order sheet and faxed that to the pharmacy. -She did not remember if she or the MAs did a medication cart audit in April to catch that Resident #1's atorvastatin was going to run out. -Resident #1 was alert and oriented and able to make his needs known and had not reported any new symptoms in the previous month. Telephone interview with the ED on 05/19/23 at 1:20pm revealed she was not aware that Resident #1 had not been administered 27 doses of atorvastatin in April 2023 and 3 doses in May 2023. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. c. Review of Resident #1's current FL2 dated 02/09/23 revealed an order for FiberCon (a fiber supplement used to treat constipation) 625mg take 1 tablet every night at bedtime. Review of Resident #1's April 2023 medication administration record (MAR) revealed: -There was an entry for FiberCon 625mg take 1 tablet at bedtime scheduled at 8:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 59 -There was documentation FiberCon was not administered on 04/14/23, 04/17/23, 04/18/23, 04/19/23, 04/20/23, or 04/22/23 through 04/30/23, and there was no documentation FiberCon was administered on 04/21/23. -There was no documented reason why FiberCon was not administered. Review of Resident #1's May 2023 MAR from 05/01/23 through 05/17/23 revealed: -There was an entry for FiberCon 625mg take 1 tablet at bedtime scheduled at 8:00pm. -There was documentation FiberCon was not administered 05/01/23 and 05/02/23 with the reason documented as the medication was not available. Observation of medications on hand for Resident #1 on 05/18/23 at 9:12am revealed there was one medication card with FiberCon 625mg tablets with a dispensed date of 05/03/22 and 15 out of 30 dispensed tablets remaining. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He did not know that he had not received FiberCon 15 times in April 2023 and two times in May 2023. -He had not experienced constipation or abdominal bloating or cramping in April or early May. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed: -Resident #1 had an active order for FiberCon 625mg take 1 tablet at night for constipation. -The pharmacy dispensed FiberCon for Resident #1 on 02/27/23 for 30 tablets, and on 05/03/23 for 30 tablets.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 60 -The prescription was not refilled automatically because it did not have refills available, and the prescription needed to be renewed by the primary care provider (PCP). -They had not received a refill request from the facility for Resident #1's FiberCon. Interview with a MA on 05/18/23 at 10:50am revealed: -When a medication was not administered, the MAs documented it on the MAR by putting a circle around their initials. -If there was a blank space on the MAR and no initials, it indicated either the medication was not administered, or the MA forgot to document. -She did not remember Resident #1 running out of FiberCon. -On the MAR, she documented administering FiberCon to Resident #1 on 04/15/23 and 04/16/23 and if it had been running low she would have reordered it. -The MAs did MAR audits every Monday at the same time as doing the medication cart audits. -During the audits the MAs looked for any medications that needed to be reordered from the pharmacy, then the facility's Director of Resident Care (DRC) did medication cart and MAR audits too. -Resident #1 was able to make his needs known, and had not reported symptoms of constipation to her in April or May 2023. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She was not aware that Resident #1 was not administered 15 out of 30 doses for April 2023 or the first two doses for May 2023. -She expected the MAs to administer medications as ordered and to reorder medications prior to them running out.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 61 -The facility staff should notify her about any prescriptions that needed to be renewed two weeks prior to the medication running out so that she could send a prescription with refills to the pharmacy and the pharmacy could deliver the medication before it ran out. -Possible adverse effects from not receiving FiberCon as ordered included an increased risk of constipation, but he was also prescribed a laxative and a stool softener. -Resident #1 had not complained of constipation symptoms and staff had not reported any symptoms of constipation to her on behalf of Resident #1. Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed: -Resident #1 had told him that he ran out of a few of his medications in April 2023. -All of Resident #1's medications should be filled monthly by the facility's contracted pharmacy. -Resident #1 had not mentioned experiencing any symptoms of constipation to him and he spoke to Resident #1 almost daily. Interview with a second MA on 05/18/23 at 2:45pm revealed: -The MAs were supposed to do medication cart audits between the 1st and the 5th of each month and refill any medications that were either out or low. -If a medication quantity was down to 5 tablets, the MAs were supposed to take the sticker off the medication card, put it on a pharmacy reorder form, and fax it to the pharmacy. -She did not remember Resident #1 running out of FiberCon tablets and he had not reported any symptoms of constipation to her. Interview with a third MA on 05/18/23 at 3:40pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

(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 62 revealed: -She remembered Resident #1 running out of FiberCon in April 2023 but since he was also taking a stool softener had never reported feeling constipated. -She could not remember requesting a refill of Resident #1's FiberCon from the pharmacy. -If a medication did not arrive from the pharmacy within a day of it being reordered, the MAs told the DRC and she would follow-up with the pharmacy or the PCP. -The MAs were expected to refill medications when the quantity of tablets remaining was down to 5 or 6 doses. -To request a refill of a medication from the pharmacy the MAs pulled the barcode sticker off the medication card and placed it on a pharmacy reorder sheet and faxed it to the pharmacy. Interview with a fourth MA on 05/18/23 at 4:15pm revealed: -She had documented Resident #1's FiberCon as not administered 9 times in April 2023 and 2 times in May 2023. -She had faxed the refill request for Resident #1's FiberCon to the pharmacy but could not remember which day. -If a medication was not delivered to the facility from the pharmacy within a day of the refill request being sent, the MAs were supposed to fill out a medication request form and place it in the DRC's office mailbox for her to follow up on. -She thought she had notified the DRC about Resident #1's FiberCon not being delivered. -Resident #1 had not reported symptoms of constipation to her. Telephone interview with the DRC on 05/19/23 at 11:45am revealed: -One of the MAs had made her aware that	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 358	Continued From page 63 Resident #1 was out of FiberCon in April and needed a new prescription in order to receive a refill. -On 04/24/23 she had notified Resident #1's PCP that a new prescription of FiberCon was needed at the pharmacy because Resident #1 was out of the medication. -She did not receive a response from Resident #1's PCP, so on 04/25/23 at 1:51pm she sent another message to the PCP regarding the FiberCon refill. -She did not receive a response from Resident #1's PCP on 04/25/23, so that Thursday, 04/27/23, she had the PCP sign a new physician's order sheet and faxed that to the pharmacy. -She did not remember if she or the MAs did a medication cart audit in April to catch that Resident #1's FiberCon was going to run out. -Resident #1 was alert and oriented and able to make his needs known. -Resident #1 had not reported any symptoms of constipation in the last month. Telephone interview with the ED on 05/19/23 at 1:20pm revealed she was not aware that Resident #1 had not been administered 15 doses of FiberCon in April 2023 and 2 doses in May 2023. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. d. Review of Resident #1's current FL2 dated 02/09/23 revealed an order for omeprazole (a medication used to treat symptoms of heartburn) 20mg take 1 tablet every morning.	D 358		

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D 358	Continued From page 64 Review of Resident #1's April 2023 medication administration record (MAR) revealed: -There was an entry for omeprazole 20mg take 1 tablet daily scheduled at 8:00am. -There was documentation omeprazole was not administered on 04/11/23, and 04/26/23 through 04/30/23. -There was no documented reason why omeprazole was not administered. Observation of medications on hand for Resident #1 on 05/18/23 at 9:12am revealed there was one medication bottle containing omeprazole 20mg tablets with a dispensed date of 04/25/23 and dispensed quantity of 90 tablets and the bottle was a third of the way full. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He did not know that he had not received omeprazole 6 times in April 2023. -He did not remember experiencing heart burn or indigestion in April 2023. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed: -Resident #1 had an active order for omeprazole 20mg daily. -The pharmacy dispensed omeprazole 20mg tablets for Resident #1 on 02/27/23 for 30 tablets, and on 05/03/23 for 30 tablets. -The prescription was not refilled automatically because it did not have refills available, and the prescription needed to be renewed by the primary care provider (PCP). -They had not received a refill request from the facility for Resident #1's omeprazole.	D 358		

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	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 65 Interview with a MA on 05/18/23 at 10:50am revealed: -When a medication was not administered, the MAs documented it on the MAR by putting a circle around their initials. -If there was a blank space on the MAR and no initials, it indicated either the medication was not administered, or the MA forgot to document. -Resident #1 received omeprazole from the Veteran's Affairs (VA) pharmacy and the refills took a long time to be delivered once they were requested. -The facility was waiting on Resident #1's POA to bring in his omeprazole once the VA pharmacy delivered it to him. -She could not remember if she had requested a refill of Resident #1's omeprazole or followed up with the Director of Resident Care (DRC) about him being out of omeprazole. -The MAs did MAR audits every Monday at the same time as doing the medication cart audits. -During the audits the MAs looked for any medications that needed to be reordered from the pharmacy, then the facility's DRC did medication cart and MAR audits too. -Resident #1 was able to make his needs known and had never complained to her about having symptoms of heartburn or indigestion. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She was not aware that Resident #1 was not administered 6 doses of omeprazole in April 2023. -She expected the MAs to administer medications as ordered and to reorder medications prior to them running out. -The facility staff should notify her about any prescriptions that needed to be renewed two weeks prior to the medication running out so that	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 66 she could send a prescription with refills to the pharmacy and the pharmacy could deliver the medication before it ran out. -Possible adverse effects from not receiving omeprazole as ordered included a sensation of indigestion or heartburn. -Resident #1 had not complained of heartburn and staff had not reported any symptoms of indigestion to her on behalf of Resident #1. Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed: -Resident #1 had told him that he ran out of a few of his medications in April 2023. -All of Resident #1's medications should be filled monthly by the facility's contracted pharmacy. -There were a couple medications that he was able to receive an additional supply of through a second pharmacy and omeprazole was one of those medications. -He only filled the omeprazole from the VA pharmacy so the MAs would have a back-up supply of it if they ever needed it. -He thought he remembered Resident #1 mentioning having some indigestion to him in April 2023 but not recently. Interview with a second MA on 05/18/23 at 2:45pm revealed: -The MAs were supposed to do medication cart audits between the 1st and the 5th of each month and refill any medications that were either out or low. -If a medication quantity was down to 5 tablets, the MAs were supposed to take the sticker off the medication card, put it on a pharmacy reorder form, and fax it to the pharmacy. -She did not remember Resident #1 running out of omeprazole and or if she had requested a refill of omeprazole from the pharmacy.	D 358		

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	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 67 -Resident #1 had not reported any symptoms of reflux or indigestion to her. Interview with a third MA on 05/18/23 at 3:40pm revealed: -The MAs were expected to refill medications when the quantity of tablets remaining was down to 5 or 6 doses. -To request a refill of a medication from the pharmacy the MAs pulled the barcode sticker off the medication card and placed it on a pharmacy reorder sheet and faxed it to the pharmacy. -She did not work day shift so had not administered omeprazole to Resident #1 or realized he had run out. -Resident #1 had not reported any symptoms of acid reflux or indigestion to her. Telephone interview with the DRC on 05/19/23 at 11:45am revealed: -One of the MAs had made her aware that Resident #1 was out of omeprazole in April and needed a new prescription in order to receive a refill. -On 04/24/23 she had notified Resident #1's PCP that a new prescription of omeprazole was needed at the pharmacy because Resident #1 was out of the medication. -She did not receive a response from Resident #1's PCP, so on 04/25/23 at 1:51pm she sent another message to the PCP regarding the omeprazole refill. -She did not receive a response from Resident #1's PCP on 04/25/23, so that Thursday, 04/27/23, she had the PCP sign a new physician's order sheet and faxed that to the pharmacy. -She did not remember if she or the MAs did a medication cart audit in April to catch that Resident #1's omeprazole was going to run out.	D 358		

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D 358	Continued From page 68 -Resident #1 was alert and oriented and able to make his needs known. -Resident #1 had not reported any symptoms of acid reflux or indigestion in the last month. Telephone interview with the ED on 05/19/23 at 1:20pm revealed she was not aware that Resident #1 had not been administered 6 doses of omeprazole in April 2023. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm. e. Review of Resident #1's current FL2 dated 02/09/23 revealed an order for torsemide (a diuretic medication used to treat fluid volume overload) 20mg daily. Review of Resident #1's April 2023 medication administration record (MAR) revealed: -There was an entry for torsemide 20mg daily scheduled at 8:00am. -There was documentation that torsemide was not administered 04/26/23 through 04/30/23. -There was no documented reason why torsemide was not administered. Review of Resident #1's May 2023 MAR revealed: -There was an entry for torsemide 20mg daily scheduled at 8:00am. -There was documentation that torsemide was not administered 05/02/23 or 05/03/23. -There was no documented reason why torsemide was not administered. Observation of medications on hand for Resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 69 #1 on 05/18/23 at 9:12am revealed there was one medication card containing torsemide 20mg tablets, take 1 tablet daily, with a dispensed date of 05/03/23 and 13 out of 30 dispensed tablets remaining. Observation of Resident #1 on 05/17/23 at 4:03pm revealed: -He was sitting in his recliner chair in his room. -His footrest was up and his legs were elevated. -There was no edema observed to his bilateral lower legs. Interview with Resident #1 on 05/17/23 at 4:00pm revealed: -He did not remember if he had missed any doses of his torsemide. -He did not have any swelling to his legs or increased shortness of breath in the last month. Telephone interview with a representative from the facility's contracted pharmacy on 05/18/23 at 1:50pm revealed: -Resident #1 had an active order for torsemide 20mg daily. -The pharmacy dispensed torsemide for Resident #1 on 02/27/23 for 30 tablets, and on 05/03/23 for 30 tablets. -The prescription was not refilled automatically because it did not have refills available, and the prescription needed to be renewed by the primary care provider (PCP). -The facility had requested a refill of Resident #1's torsemide on 03/13/23 but the pharmacy had sent a fax back to the facility to notify them that there were no torsemide refills available and a new prescription was needed. Interview with a MA on 05/18/23 at 10:50am revealed:	D 358		

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D 358	Continued From page 70 -When a medication was not administered, the MAs documented it on the MAR by putting a circle around their initials. -Resident #1 ran out of torsemide at the end of April because the pharmacy needed a new prescription in order to dispense additional refills. -She had called Resident #1's PCP to request a new torsemide order when she realized Resident #1 was out of torsemide on 04/26/23, but she had not documented the call. -The MAs did MAR audits every Monday at the same time as doing the medication cart audits. -During the audits the MAs looked for any medications that needed to be reordered from the pharmacy, then the facility's Director of Resident Care (DRC) did medication cart and MAR audits too. -Resident #1 was able to make his needs known, and had never complained to her about having symptoms of fluid overload such as shortness of breath or swelling to his arms or legs. -She had not observed any swelling to Resident #1's body in the last month. Interview with Resident #1's PCP on 05/18/23 at 11:20am revealed: -She was not aware that Resident #1 was not administered torsemide from 04/26/23 to 04/30/23, or on 05/01/23 to 05/02/23. -Resident #1 was prescribed torsemide to prevent swelling to his legs or fluid overload in his body due to his diagnosis of congestive heart failure. -She expected the MAs to administer medications as ordered and to reorder medications prior to them running out. -The facility staff should notify her about any prescriptions that needed to be renewed two weeks prior to the medication running out so that she could send a prescription with refills to the pharmacy and the pharmacy could deliver the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 71	D 358		

medication before it ran out.
-Resident #1 did not currently have any swelling, it just occurred from time to time.
-She did not have concerns about Resident #1 experiencing adverse effects from missing 7 doses of torsemide.

Telephone interview with Resident #1's power of attorney (POA) on 05/18/23 at 12:15pm revealed:
-Resident #1 had told him that he ran out of a few of his medications in April 2023.
-All of Resident #1's medications should be filled monthly by the facility's contracted pharmacy.
-Resident #1 took torsemide to help reduce fluid volume in his chest, and he had not mentioned any symptoms of fluid overload or shortness of breath to him.
-He thought that if Resident #1 had missed 5 consecutive doses of torsemide, Resident #1 would have experienced some symptoms and told him he was out of the medication.

Interview with a second MA on 05/18/23 at 2:45pm revealed:
-The MAs were supposed to do medication cart audits between the 1st and the 5th of each month and refill any medications that were either out or low.
-If a medication quantity was down to 5 tablets, the MAs were supposed to take the sticker off the medication card, put it on a pharmacy reorder form, and fax it to the pharmacy.
-She remembered Resident #1 being out of torsemide, but he did not report or exhibit symptoms of swelling or fluid overload when he did not receive torsemide.
-She requested a refill of torsemide from the pharmacy by taking the barcode sticker off the medication card and faxing it to the pharmacy, but she could not remember when she had done

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D 358	Continued From page 72 that. Telephone interview with the DRC on 05/19/23 at 11:45am revealed: -One of the MAs had made her aware that Resident #1 was out of torsemide in April and needed a new prescription in order to receive a refill. -On 04/24/23 she had notified Resident #1's PCP that a new prescription of torsemide was needed at the pharmacy because Resident #1 was out of the medication. -She did not receive a response from Resident #1's PCP, so on 04/25/23 at 1:51pm she sent another message to the PCP regarding the torsemide refill. -She did not receive a response from Resident #1's PCP on 04/25/23, so that Thursday, 04/27/23, she had the PCP sign a new physician's order sheet and faxed that to the pharmacy. -She did not remember if she or the MAs did a medication cart audit in April to catch that Resident #1's torsemide was going to run out. -Resident #1 was alert and oriented and able to make his needs known. -Resident #1 had not reported any symptoms of fluid volume overload in the last month. Telephone interview with the ED on 05/19/23 at 1:20pm revealed she was not aware that Resident #1 had not been administered 5 doses of torsemide in April 2023 and 2 doses in May 2023. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the ED on 05/19/23 at 1:20pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 73 4. Review of Resident #2's current FL2 dated 03/20/23 revealed: -Diagnoses included diabetes mellitus and chronic kidney disease stage 3. -There was an order for atorvastatin (used to treat high cholesterol and high triglycerides) 10mg 1 tablet one time a day. Review of Resident #2's record revealed: -She was readmitted to the facility from a rehabilitation facility on 03/23/23. -There were 2 requests to clarify if simvastatin (used to treat high cholesterol) 40mg was to be administered faxed to the primary care provider (PCP) on 03/31/23 at 10:00am and 2:15pm. Review of Resident #2's physician's orders revealed: -There was an order dated 03/31/23 for atorvastatin 40mg 1 tablet at bedtime. -There was an order dated 05/04/23 for atorvastatin 40mg 1 tablet at bedtime. Review of Resident #2's March 2023 medication administration record (MAR) for 03/23/23 to 03/31/23 revealed: -There was an entry for atorvastatin 10mg one time a day 03/23/23-03/31/23. -Atorvastatin was documented as administered on 03/26/23, 03/28/23, 03/29/23 and 03/31/23. -Atorvastatin was not documented as administered, indicated by circled initials, on 03/23/23, 03/25/23, 03/27/23 and 03/30/23. -There was no documentation on 03/24/23 that atorvastatin 40mg was not administered or administered as indicated by a blank space. -The exceptions noted on the back of the MAR indicated on 03/25/23, not in community and on 03/27/23, not available. -Atorvastatin 10mg was discontinued on the MAR	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 74 on 03/30/23. Review of Resident #2's April 2023 MAR revealed: -There was an entry for atorvastatin 40mg one at bedtime. -Atorvastatin was not documented as administered on 04/05/23, 04/11/23-04/14/23 and 04/25/23-04/28/23. -Atorvastatin was not documented as administered, indicated by circled initials, on 04/01/23-04/04/23, 04/06/23-04/10/23, 04/15/23-04/16-23, 04/20/23-04/24/23 and 04/29/23-04/30/23. -The exceptions noted on the back of the MAR indicated on 04/01/23, 04/15/23 and 04/29/23 as not given-not in community and on 04/06/23, 04/10/23 and 04/20/23 as not available-not given. Review of Resident #2's May 2023 MAR from 05/01/23 to 05/17/23 revealed: -There was an entry for atorvastatin 40mg one at bedtime. -Atorvastatin was documented as administered on 05/02/23-05/03/23, 05/05/23-05/07/23, 05/09/23-05/11/23 and 05/16/23-05/17/23. -Atorvastatin was not documented as administered, indicated by circled initials, on 05/01/23, 05/04/23, 05/08/23, 05/13/23-05/15/23. -There was no documentation on 05/12/23 that atorvastatin 40mg was not administered or administered as indicated by a blank space. -The exceptions noted on the back of the MAR indicated on 05/08/23, 05/13/23-05/15/23 as not available-not given. Observation of Resident #2's medications on hand on 05/17/23 at 2:00pm revealed: -There was a full bottle of atorvastatin 40mg available for administration.	D 358		

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	HAL034087	A. BUILDING: _____ B. WING _____	R 05/19/2023

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D 358	Continued From page 75 -Atorvastatin was dispensed on 05/14/23 for 90 tablets from Resident #2's preferred pharmacy. Telephone interview with a representative from Resident #2's family pharmacy on 05/17/23 at 4:11pm revealed: -Resident #2's family member had some medications filled for Resident #2 at this pharmacy occasionally. -The pharmacy did not have an order for Resident #2's atorvastatin 10mg or 40mg nor simvastatin 40mg and had never dispensed any of them. Telephone interview with a representative from the facility's contracted pharmacy on 05/17/23 at 4:28pm revealed: -Resident #2 did not receive medications from this pharmacy. -The pharmacy only profiled medications for facility residents that used outside pharmacies. -There was no order for atorvastatin 10mg or 40mg nor simvastatin 40mg profiled for Resident #2. -There was no request to fill Resident #2's atorvastatin or simvastatin and they had never dispensed either. Telephone interview with a representative from Resident #2's mail-order pharmacy on 05/17/23 at 4:37pm revealed: -Resident #2 had an electronic physician's order for atorvastatin 40mg take 1 tablet at bedtime dated 05/11/23, but no previous order. -The pharmacy did not supply assisted living facilities. -The pharmacy received the order electronically from Resident #2's primary care provider (PCP) and the medication was shipped to the resident's home.	D 358		

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D 358	Continued From page 76 -There was no previous order for atorvastatin 10mg or 40mg nor simvastatin 40mg dispensed for Resident #2 from this pharmacy. Interview with a medication aide (MA) on 05/17/23 at 2:40pm revealed: -A circled initial on the MAR indicated that the resident was not administered that medication and the reason for not administering medications would be written on the back of the MAR with date, time and initials of the medication aide (MA). -First shift (7:00am-3:00pm) MAs perform medication cart audits on Mondays of each week. -If first shift MAs did not finish auditing for all residents, then second shift (3:00pm-11:00pm) would finish auditing where first shift stopped. -The MAs would request any missing medication and inform the Director of Resident Care (DRC) of any medications not received so that she could follow up with the pharmacy or PCP. -Resident #2 returned from a rehabilitation facility the last week of March 2023. -She worked the evening Resident #2 was readmitted and noticed the order was for atorvastatin 10mg and she thought that was an odd dose and Residents #2 had taken simvastatin 40mg during her previous admission. -She did not have the previous simvastatin 40mg medication in the cart after she was out to the hospital and rehabilitation since early February 2023. -She knew Resident #2 would not have some medications on the first day or two she was readmitted because her family member would get most of her medications from a mail order pharmacy. -She saw the next week in March 2023 that Resident #2 still did not have her atorvastatin 10mg and she faxed a request to clarify her	D 358		

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D 358	Continued From page 77	D 358		

cholesterol medication order to the PCP the morning and afternoon of 03/31/23.
-The PCP returned a faxed order for atorvastatin 40mg one at bedtime.
-She informed the DRC via telephone when she had to fax the PCP to clarify the atorvastatin order.
-She did not know if the DRC followed up on the medication.
-She worked 2 or 3 evenings in April 2023 and Resident #2 still did not have her atorvastatin and she again informed the DRC via telephone but could not remember dates.
-She spoke with Resident #2's family member on 04/29/23 or 04/30/23 and told her they still did not have her atorvastatin that was ordered when she was readmitted.
-She worked evening shift on 05/13/23 and saw that Resident #2 still did not have her atorvastatin and she called Resident #2's pharmacy number on one of her other medications and was told it would be shipped.
-She spoke to Resident #2's family member again who said she had spoken to her PCP a few days before and they would ship the atorvastatin to her home then she would bring it.
-Resident #2's family member brought in the atorvastatin 05/16/23.

Telephone interview with a representative from Resident #2's PCP on 05/18/23 at 9:19am revealed:
-Resident #2 had an order for atorvastatin 40mg take one tablet at bedtime sent to her pharmacy via electronic prescription on 05/11/23.
-Her PCP expected any medications he ordered to be administered as ordered.
-She had blood work on 03/20/23 before returning from the rehabilitation facility and her cholesterol was within normal range, but her triglycerides

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D 358	Continued From page 78	D 358		

were slightly elevated.
-The facility could have contacted the PCP's office and an electronic order would have been sent to her preferred pharmacy.
-There was no documentation that facility staff requested prescription for her atorvastatin until 05/11/23, it was unclear how the prescription was requested and who requested it.
-If there were a prescription faxed to the facility in March 2023; the PCP may just not have been able to see it in the current file.
-The PCP did not believe there would be any detrimental affects from Resident #2 not receiving her atorvastatin 40mg from 03/23/23-05/15/23.

Telephone interview with Resident #2's family member on 05/18/23 at 12:00pm revealed:
-Resident #2 returned to the facility in later March 2023 after rehabilitation from a hip fracture that occurred in February 2023.
-She had Resident #2's medications sent from her mail order pharmacy.
-She did not remember if Resident #2's atorvastatin was among her orders when she was readmitted, but knew it was ordered at the rehabilitation facility.
-Resident #2 did not have any blood work completed since the rehabilitation facility in later March.
-Her PCP obtained blood work in his office.
-When the pharmacy received an order, it would take 7-10 days for it to be processed and the medication mailed to her home.
-She took the medication to the facility for staff to administer to Resident #2.
-She was contacted late April 2023 or early May 2023 (she could not remember the date) by an MA from the facility and informed that she did not have her cholesterol medication.
-At that time, she called Resident #2's PCP and

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D 358	Continued From page 79 requested a prescription to her mail order pharmacy. -She received the medication and took it to the facility earlier this week. Interview with a second (MA) on 05/18/23 at 3:35pm revealed: -Her circled initial on the MAR meant that she did not have that medication to give the resident, or the resident would not take the medication. -She did not know of a set schedule and shift to perform medication cart audits, but she did a quick audit each shift to see that all the resident's medications were in the cart to administer. -She did not usually work on Resident #2's unit and could not remember if she had her atorvastatin on the evenings that she worked. -If she circled her initials on nights she worked, she did not have had the medication to give to the resident, or the resident refused. -If she saw that a resident did not have a medication, she would call pharmacy to request it be sent and call or leave a message for the DRC to follow up on the request. Refer to telephone interview with the DRC on 05/19/23 at 11:45am. Refer to telephone interview with the Executive Director on 05/19/23 at 1:20pm. Based on observations, record review and interviews, it was determined Resident #2 was not interviewable. Telephone interview with the Director of Resident Care (DRC) on 05/19/23 at 11:45am revealed: -She and the Executive Director (ED) did medication cart audits but they were sporadic. -The MAs did their own medication cart audits	D 358		

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D 358	Continued From page 80 usually once per month. -Medication cart audits included checking the MAR for circled initials which indicated a medication was not administered, and then checking if any medications needed to be reordered. -If she saw circled initials in the MAR she looked at the back of the MAR sheet to see the documented reason why the medication was not administered and if it needed to be refilled. -Within the last month she had created "Medication Request" sheets for the MAs to fill out with the resident's name, date of birth, and what medication was running low so that she could either follow up with the pharmacy for a refill or the PCP for a renewed prescription. -She kept the Medication Request sheets that were filled out by the MAs so that she could follow up and ensure the medications were delivered. -She expected MAs to reorder medication within 7 days of running out of the medication and to work with the DRC if they had trouble with getting the medication from the pharmacy. -If MAs were not able to get a resident's medication, she expected them to inform her in person or leave a medication request form for her so that she could follow up and get the resident's medication to administer. -She expected all medications to be administered as ordered. Telephone interview with the ED on 05/19/23 at 1:20pm revealed: -The MAs were trained when and how to reorder medications prior to them running out and to follow up with the DRC if the pharmacy did not deliver a medication after the refill was requested. -The DRC was expected to complete audits of the medication carts at least once per month to look for order accuracy between the medication	D 358		

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D 358	Continued From page 81 cards and the MAR and that all the ordered medications were available to administer to the residents for the month. -The DRC was responsible for ensuring all ordered medications were available on the medication carts and to reorder any medications prior to them running out if the MAs had not already done so. -When the MAs documented their initials with a circle around it, it indicated the medication had not been administered. -If the MAs circled their initials they were expected to document on the back side of the MAR what the reason was for the medication not being administered. -The DRC was responsible for checking the MARs for circles and following up with the MA, the pharmacy or the PCP to resolve the reason for the medication not being administered. -She expected all medications to be administered as ordered by the doctor and to be refilled as soon as possible if they were not available on the medication cart. -The facility would pay for a medication to be delivered until the family were able to get medications from an outside pharmacy. -The MAs should be faxing refill requests to the pharmacy when a medication was down to its last 7 doses. -If a MA was having trouble getting a medication refill delivered from the pharmacy, they were expected to notify the DRC and work together with her to get the medication into the facility by calling the PCP or the pharmacy. _____ The facility failed to ensure medications were administered as order for 4 of 5 sampled residents including a resident who did not receive anti-anxiety medication 31 times in January 2023, 28 times in February 2023, 3 times in March and	D 358		

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D 358	Continued From page 82 April 2023, and 7 times in May 2023 which placed the resident at risk for increased agitation and insomnia (#4), a resident who was not administered an antipsychotic medication 22 days in March 2023, 30 days in April 2023, and 5 days in May 2023 which placed the resident at risk for increased behaviors, and there was no documentation between March 2023 and May 2023 that the facility administered sliding scale insulin as ordered when the resident's FSBS was greater than 200 which placed the resident at risk for hypoglycemia, and the resident was not administered a pain medication as ordered which placed the resident at risk for increased pain (#5), and a resident who did not receive his cholesterol medication 27 out of 30 doses in April 2023 and three doses in May 2023 which placed him at increased risk for a raise in his cholesterol level, and did not receive his acid reflux medication 6 times placing him at risk for experiencing heartburn or acid indigestion, and did not receive his diuretic from 04/26/23 through 05/02/23 which placed him at risk for increased edema and swelling which could cause skin breakdown or shortness of breath (#1), and a resident who had an order for medication to treat high cholesterol and the medication was not available placing the resident at risk for increased cholesterol or triglycerides (#2). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, July 1, 2023.	D 358		