STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 000}	Initial Comments The Adult Care Licensure Section and the Rockingham County Department of Social Services conducted a follow-up survey on September 13, 2023.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure physician notification for 1 of 3 sampled residents (#2) related not completing orders to obtain a podiatry consult and an eye doctor consult. The findings are: Review of Resident #2's current FL2 dated 03/07/23 revealed diagnoses included Type 2 diabetes mellitus, anxiety, major depression disorder, Vitamin B12 deficiency, and vitamin D deficiency. Review of Resident #2's Resident Register revealed an admission date of 03/02/23. 1. Review of Resident #2's current FL2 dated 03/07/23 revealed an order to obtain a podiatry consult for diabetic foot care, corns, and calluses. Review of Resident #2's care notes revealed there was no documentation the resident had seen a podiatrist since her admission on 03/02/23.	D 273		

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D 273	Continued From page 1 Observation of Resident #2 in the common television room on 09/13/23 at 3:30pm revealed: -Resident #2 was wearing open toe sandals. -Resident #2's toenails were not excessively long. -Resident #2 had no sores or wounds visible on her feet. Interview with Resident #2 on 09/13/23 at 3:35pm revealed: -She came to the facility in March 2023. -She had not seen a foot doctor (podiatrist) since she came to the facility. -She trimmed her own fingernails and toenails. Telephone interview with Resident #2's primary care provider (PCP) on 09/13/23 at 5:05pm revealed: -He wanted diabetic residents to be seen by podiatry to ensure there were no issues with their feet since toenail care or any foot sores or wounds often presented problems with healing in diabetics. -He was not informed Resident #2's order to obtain a podiatry consult had not been completed. -He expected the facility to have completed a referral to podiatry at least in 6 months since the resident's admission in March 2023, or let him know there was an issue with obtaining the consult. Interview with a medication aide/Supervisor (MA/S) on 09/13/23 at 5:20pm revealed: -He was responsible to inform the Executive Director (ED) when a resident had an order for a referral to an outside agency or provider. -He thought he had informed the ED that Resident #2 had an order to see a podiatrist on the admitting FL2 dated 03/07/23. -The ED was responsible to schedule residents'	D 273		

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appointments and transport the residents to appointments.

Interview with the ED on 09/13/23 at 5:30pm revealed:
-The facility was using the services of a mobile podiatry provider at one time, but no longer.
-The ED was responsible for scheduling all appointments and coordinating outside provider visits.
-She recalled Resident #2 was scheduled to be seen by a podiatrist, but the appointment had to be cancelled by the ED because she had staffing issues at a sister facility and was unable to transport Resident #2 to the appointment.
-She was unable to provide the exact date and time of the missed appointment.
-She thought Resident #2 had an upcoming rescheduled appointment but was unable to access the schedule to confirm.

2. Review of Resident #2's current FL2 dated 03/07/23 revealed an order to obtain an eye consult for cataracts and diabetic eye care.

Review of Resident #2's care notes revealed there was no documentation the resident had seen a provider for eye care since her admission on 03/02/23.

Observation of Resident #2 in the common television room on 09/13/23 at 3:30pm revealed:
-Resident #2 was watching a television show.
-Resident #2 was not wearing glasses

Interview with Resident #2 on 09/13/23 at 3:35pm revealed:
-She came to the facility in March 2023.
-She had not seen a provider for her eyes since she came to the facility.

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-She did not wear glasses and had not experienced vision problems.

Telephone interview with Resident #2's primary care provider (PCP) on 09/13/23 at 5:05pm revealed:
-He wanted diabetic residents to be seen by an eye care provider to ensure there were no issues with their eyes since diabetes can pose a increased threat to changes in vision and damage to the eyes.
-He was not informed Resident #2's order to obtain an eye doctor consult had not been completed.
-He expected the facility to have completed a referral to related to her eyes at least in 6 months since the resident's admission in March 2023, or let him know there was an issue with obtaining the consult.

Interview with a medication aide/Supervisor (MA/S) on 09/13/23 at 5:20pm revealed:
-He was responsible to inform the Executive Director (ED) when a resident had an order for a referral to an outside agency or provider.
-He thought he had informed the ED that Resident #2 had an order to see an eye doctor on the admitting FL2 dated 03/07/23.
-The ED was responsible to schedule residents' appointments and transport the residents to appointments.

Interview with the ED on 09/13/23 at 5:30pm revealed:
-The ED was responsible for scheduling all appointments and coordinating outside provider visits.
-She had 2 additional sister facilities that she scheduled residents' appointments and was responsible for transporting the residents to the

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D 273	Continued From page 4 appointments. -She thought Resident #2 had an upcoming eye care appointment but was unable to access the schedule to confirm.	D 273		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#2) related to an order for monthly weights and vital signs. The findings are: Review of Resident #2's current FL2 dated 03/07/23 revealed: -Diagnoses included Type 2 diabetes mellitus, anxiety, major depression disorder, Vitamin B12 deficiency, and vitamin D deficiency. -There was an order for vital signs (blood pressure, temperature, pulse rate, and respirations) and weights monthly. Review of Resident #2's electronic medication administration records (eMARs) for July 2023, August 2023 and September 2023 (09/01/23 - 09/07/23) revealed there was no entry for monthly vital signs and/or monthly weight.	{D 276}		

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{D 276}	Continued From page 5 Interview with a pharmacist from the facility's contracted pharmacy on 09/13/23 at 011:35am revealed: -The pharmacy started providing services to the facility in May 2023. -The pharmacy did not receive the FL2 dated 03/07/23 for Resident #2. -The pharmacy did not receive an order for monthly vital signs and weights for Resident #2. Interview with Resident #2 on 09/13/23 at 3:35pm revealed: -The facility staff did not routinely weigh her or take her blood pressure, temperature and check her pulse. -The primary care provider (PCP) usually checked her vital signs and weight when he saw her. -She weighed herself occasionally and had not had any significant change. Telephone interview with Resident #2's PCP on 09/ at 2:00pm revealed: -He expected all orders on residents' discharge summaries and FL-2 to be followed. -All orders should be started, and he would discontinue orders if he felt they were not necessary during his next visit in the facility. -He wanted Resident #2 weighed and vital signs taken each month in order for him to keep check on her general health. -If a resident had a health issue that required more frequent monitoring of weight (like swelling) or vital signs (like high blood pressure) he would order those to be taken more frequently. -He did not know the facility had not implemented the order for monthly weights and vital signs. -He expected the facility to implement the order for monthly weights and check vital signs when	{D 276}		

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{D 276}	Continued From page 6 they were ordered in March 2023. Interview with a medication aide/Supervisor (MA/S) on 09/13/23 at 3:50pm revealed: -He was responsible to send all orders to the pharmacy for processing. -The facility had changed pharmacies 2 times in the last year. -The facility did not do routine weight and vital sign checks monthly for all residents. -The pharmacy was responsible to enter orders, including vital signs and weights, on the residents' eMARs. -He was responsible to ensure orders on the FL2 were on the eMARs and implemented. -He was responsible to check the residents' FL2 orders and all subsequent orders against the eMARs. -He had overlooked the orders for monthly weights and vital signs on Resident #2's FL2 dated 03/07/23. Interview with the Executive Director (ED) on 09/13/23 at 5:30pm revealed: -The MA/S was responsible to ensure all medication orders were implemented as written unless the PCP changed the order. -The MA/S was responsible to ensure all orders were on the eMAR or facility documentation sheets -The ED did not have a system in place to routinely audit residents' orders compared to the eMAR. -She did not know Resident #2's order for monthly weights and vital signs had not been implemented. On 09/13/23 at 3:30pm, the MA/S checked Resident #2's vital signs, per request, with results as follows:	{D 276}		

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{D 276}	Continued From page 7 -Resident #2's weight was 157.8 pounds. -Resident #2's blood pressure was 107/79. -Resident #2's pulse rate was 88 beats per minute and temperature was 97.2 degrees Fahrenheit.	{D 276}		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record	D 280		

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reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) assessment was completed at least quarterly for 2 of 3 sampled residents (#2 and #3) with LHPS tasks of collecting fingerstick blood samples and insulin injections (#2), and ambulation with an assistive device (#3).

The findings are:

1. Review of Resident #2's current FL2 dated 03/07/23 revealed:
-Diagnoses included Type 2 diabetes mellitus, anxiety, major depression disorder, Vitamin B12 deficiency, and vitamin D deficiency.
-There was an order to check fingerstick blood sugar (FSBS) 3 times a day and as needed for high or low blood sugar symptoms.

Review of Resident #2's physician's orders revealed:
-There was a subsequent physician's order dated 03/25/23 to check FSBS 4 times a day before meals and at bedtime.
-There was an order dated 03/20/23 for insulin aspart (a rapid acting insulin) inject 5 units subcutaneously with meals, hold for FSBS less than 150.
-There was an order dated 03/29/23 for insulin glargine (a long acting insulin) inject 20 units subcutaneously at bedtime.

Review of Resident #2's LHPS assessments on 09/12/23 revealed:
-The most recent LHPS assessment was completed 03/13/23.
-Medication through injection and collecting and testing of fingerstick blood samples (FSBS) were listed as marked tasks.
-There was no subsequent LHPS evaluation for

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review.

Review of Resident #2's July 2023, August 2023, and September 2023 (09/01/23 - 09/13/23) electronic Medication Administration Records (eMARs) revealed:
-There were entries for check FSBS 4 times a day before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm, and 8:00pm with FSBS values documented for each opportunity on the eMARs.
-There were entries for insulin aspart inject 5 units subcutaneously with meals, hold for FSBS less than 150 and insulin glargine inject 20 units subcutaneously at bedtime with documentation for administration as ordered.

Interview with Resident #2 on 09/13/23 at 3:35pm revealed she received checks of FSBS and insulin injections every day.

Refer to the telephone interview with a consultant nurse on 09/13/23 at 2:11pm.

Refer to the interview with the Executive Director (ED) on 09/13/23 at 5:30pm.

2. Review of Resident #3's current FL2 dated 02/15/23 revealed:
-Diagnoses included blindness due to cataracts, stage 3 chronic kidney disease, metabolic encephalopathy.
-He was semi-ambulatory.
-He was incontinent of bladder and bowel.

Review of Resident #3's Resident Register revealed an admission date of 06/20/20.

Review of Resident #3's Licensed Health Professional Support (LHPS) assessments

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revealed:
-The most recent LHPS assessment was completed 03/14/23.
-Ambulation using assistive devices that required physical assistance was identified as a task for Resident #3.
-"Resident may require physical assistance and guidance when navigating stairs or unfamiliar environments" was documented on the LHPS evaluation.
-There was no subsequent LHPS evaluation for review.

Observation of Resident #3 on 09/13/23 at 1:00pm revealed Resident #3 was ambulating on his own toward the dining room using a cane.

Interview with Resident #3 on 09/13/23 at 1:10pm revealed he used his cane to help steady his walking.

Refer to the telephone interview with a consultant nurse on 09/13/23 at 2:11pm.

Refer to the interview with the Executive Director (ED) on 09/13/23 at 5:30pm.

_____

Telephone interview with a consultant nurse on 09/13/23 at 2:11pm revealed:
-She had contracted with the facility for a short time after March 2023.
-She had not done LHPS reviews for the facility while she was contracted.

Interview with the Executive Director (ED) on 09/13/23 at 5:30pm revealed:
-She was responsible for ensuring the residents' LHPS.
-She was not a nurse and could not do the LHPS.
-She knew the LHPS reviews were due quarterly

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D 280	Continued From page 11 for all residents with an identified task. -The last LHPS were done in March 2023 by a contracted nurse. -The nurse contracted in March 2023 was no longer available to do the LHPS reviews for the facility. -She had contracted another nurse for a short while after March 2023 but not to do LHPS reviews. -She had a contracted pharmacy for a short while that offered the services of a LHPS nurse for reviews but she not longer used the pharmacy and no LHPS reviews were completed by that pharmacy's nurse. -She had been looking for a nurse to update residents' LHPS but had not found one. -There had been no LHPS review after 03/14/23 done for the residents.	D 280		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure follow up on recommendations written by the Licensed Health Support Professional (LHPS) nurse for 1 of 3 sampled residents (#2) related to a referral to	D 281		

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podiatry and an eye care provider.

The findings are:

Review of Resident #2's current FL2 dated 03/07/23 revealed:
-Diagnoses included Type 2 diabetes mellitus, anxiety, major depression disorder, Vitamin B12 deficiency, and vitamin D deficiency.
-There was an order to obtain a podiatry consult for diabetic foot care, corns, and calluses.
-There was an order to obtain an eye consult for cataracts and diabetic eye care.

Review of Resident #2's Resident Register revealed an admission date of 03/02/23.

Review of Resident #2's LHPS assessments revealed:
-The most recent LHPS assessment was completed 03/13/23.
-The recommended changes in Plan of Care were "please follow-up on physician's referral for podiatry, and eye exam[sp. examination]".
-There was no subsequent LHPS evaluations for review.

Review of Resident #2's progress notes revealed from 03/013/23 to 09/07/23 revealed:
-There was no documentation the resident had seen a podiatrist since her admission on 03/02/23.
-There was no documentation the resident had seen a provider for eye care since her admission on 03/02/23.

Telephone interview with Resident #2's primary care provider (PCP) on 09/13/23 at 5:05pm revealed:
-He wanted diabetic residents to be seen by an

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eye care provider to ensure there were no issues with their eyes since diabetes could pose an increased threat to changes in vision and damage to the eyes.
--He wanted diabetic residents to be seen by podiatry to ensure there were no issues with their feet since toenail care or any foot sores or wounds often presented problems with healing in diabetics.
-He expected the facility to have completed a referral to related to her eyes and feet at least in 6 months since the resident's admission in March 2023.

Telephone interview with a consultant nurse on 09/13/23 at 2:11pm revealed:
-She had contracted with the facility for a short time after March 2023.
-She had not done LHPS reviews for the facility while she was contracted.

Interview with the medication aide/Supervisor (MA/S) on 09/13/23 at 5:20pm revealed:
-He was responsible to inform the Executive Director (ED) when a resident had an order for a referral.
-He was the only medication staff routinely working at the facility.
-He was responsible for ensuring the recommendations on the LHPS reviews were completed.
-He had not followed up on the LHPS recommendation due to staff shortages and responsibility for providing medications, preparing meals, and housekeeping.

Interview with the Executive Director (ED) on 09/13/23 at 5:30pm revealed:
-The ED was responsible for overseeing health care for the residents, including arranging for

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D 281	Continued From page 14 LHPS reviews to be done. -The MA/S was responsible to complete recommendations made on the LHPS review. -Resident #2 had not seen a podiatrist or had an eye care consult ordered 03/07/23 due to staff shortages and her management responsibilities for this facility and 2 sister facilities. -She thought Resident #2 had podiatry and eye exam appointments scheduled within the next month, but was unable to access the schedule to confirm.	D 281		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to a topical pain medication. The findings are: Review of Resident #1's current FL2 dated 07/09/23 revealed diagnoses included cellulitis, intertrigo (a superficial inflammation of the skin) and history of cerebral vascular accident.	{D 358}		

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{D 358}	Continued From page 15 Review of Resident #1's physician's orders dated 07/27/23 revealed an order for diclofenac 1% gel (a topical gel to relieve pain), apply to left forearm 3 times a day. Review of Resident #1's July 2023 medication administration record (MAR) from 07/27/23-07/31/23 revealed there was no entry for diclofenac 1% gel, apply to left forearm 3 times a day. Review of Resident #1's August and September 2023 (09/01/23-09/13/23) MARs revealed there was no entry for diclofenac 1% gel, apply to left forearm 3 times a day. Observation of Resident #1's medication on hand for administration on 09/13/23 at 10:45am revealed there was no diclofenac 1% gel available for administration. Interview with the medication aide/Supervisor (MA/S) on 09/13/23 at 10:50am revealed: -He was responsible for checking new medication orders and ensure they were delivered by the pharmacy. -He did not know Resident #1 had an order for diclofenac gel for her left arm and had not seen the order dated 07/27/23. -Resident #1 had a compression sleeve on her left forearm for painful soft tissue and had other pain medications ordered as well. -She did not complain of pain in the left arm very often. Interview with Resident #1 on 09/13/23 at 11:05pm revealed: -She had elbow pain and an area of skin that was painful sometimes on her left arm.	{D 358}		

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{D 358}	Continued From page 16 -The PCP at the facility ordered a compression sleeve that helped relieve the arm pain more than pain medications. -She had some creams she used for her skin, but did not think either of them were diclofenac. -She used diclofenac gel before, and it helped with her pain. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/13/23 at 11:25am revealed: -The pharmacy did not have an order for Resident #1 for diclofenac 1% gel. -The pharmacy had never dispensed diclofenac 1% gel to the facility for Resident #1. -Most of Resident #1's medications were only profiled and possibly filled by another pharmacy. Telephone interview with the pharmacist at Resident #1's previous pharmacy on 09/13/23 at 12:05am revealed: -The pharmacy did not have an order for Resident #1 for diclofenac 1% gel. -The pharmacy had never dispensed diclofenac 1% gel to Resident #1 or the facility. Interview with Resident #1's PCP on 09/13/23 at 4:42pm revealed: -He called in a telephone order for Resident #1 on 07/27/23 for diclofenac 1% gel apply 3 times a day. -Resident #1 voiced no further complaints of arm pain after she received the compression sleeve that he ordered and may not need the diclofenac. Interview with the Executive Director (ED) on 09/13/23 at 2:00pm revealed: -The MA/S was responsible for administering medications as ordered. -The MA/S was responsible to review the PCP	{D 358}		

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{D 358}	Continued From page 17 visits for orders and make sure the medication was received from the pharmacy. -She was responsible for overseeing the duties of the MA/S. -She did not have a system in place to routinely audit medication carts and residents' eMARs for accuracy. -She contacted the Administrator if there were any issues with medications that she could not resolve.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367		

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reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, and #2) including inaccurate documentation of a pain reliever (#1), and a vitamin D supplement (#2).

The findings are:

1. Review of Resident #2's current FL2 dated 03/07/23 revealed:
-Diagnoses included Type 2 diabetes mellitus, anxiety, major depression disorder, Vitamin B12 deficiency, and vitamin D deficiency.
-There was an order for Vitamin D2 1.25mg take 1 tablet once a week. (Vitamin D is a supplement used to treat Vitamin D deficiency.)

Review of Resident #2's medication clarification orders dated 05/15/23 revealed an order to continue taking Vitamin D2 1.25mg 1 capsule once a week in the morning.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule every 7 days scheduled at 8:00am daily.
-Vitamin D2 was documented as administered daily from 07/01/23 to 07/31/23, instead of weekly as ordered.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule every 7 days scheduled at 8:00am daily.
-Vitamin D2 was documented as administered daily from 08/01/23 to 08/31/23, instead of weekly as ordered.

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D 367	Continued From page 19 Review of Resident #2's September 2023 eMAR from 09/01/23 to 09/13/23 revealed: -There was an entry for Vitamin D2 1.25mg (50,000 units) take 1 capsule every 7 days scheduled at 8:00am daily. -Vitamin D2 was documented as administered daily from 09/01/23 to 09/13/23, instead of weekly as ordered. Observation of medication on hand for administration for Resident #2 on 09/13/23 at 4:00pm revealed: -Resident #2 had a medication bubble card labeled Vitamin D2 1.25mg (50,000 units) take 1 capsule every 7 days dispensed 09/06/23 for 4 capsules. -There were 4 capsules remaining of 4 capsules dispensed on 09/06/23. -The green liquid filled capsules were packaged in 4 individual bubbles on the medication bubble card. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/13/23 at 11:35am revealed: -The pharmacy dispensed Resident #2's vitamin D2 1.25mg on a medication bubble card one capsule every 7 days. -There was a medication bubble card with 4 capsules dispensed on 06/09/23, 07/09/23, 08/05/23 and 09/06/23. -No additional vitamin D2 1.25mg was documented as dispensed for Resident #2. Interview with Resident #2 on 09/13/23 at 4:15pm revealed: -She received her medications routinely each day. -She was administered one vitamin capsule (big	D 367		

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green one) every Friday only.
-She knew it was administered weekly on Friday, because it was larger than her other medications and was a green capsule.

Interview with the medication aide/Supervisor (MA/S) on 09/13/23 at 5:20pm revealed:
-He was responsible to check the medications prepared by the pharmacy compared to the eMARs when the medications were delivered monthly for accuracy.
-The medication cards were supposed to be compared to the residents' medication orders for accuracy.
-He was supposed to read each entry on the eMAR and compare to the directions listed on the medication package.
-He should check off the medication displayed on the eMAR computer screen when preparing, administer the medications, then return to the computer screen to click administered on the computer screen.
-He administered one green capsule of Resident #2's vitamin D2 1.25mg every Friday morning.
-The pharmacy was responsible for entering medications on the eMAR and scheduling medications.
-The pharmacy had entered the administration time as scheduled daily at 8:00am instead of weekly on Friday at 8:00am.
-He overlooked the incorrect documentation daily for Resident #2's Vitamin D2 1.25mg in July 2023, August 2023, and September 2023.

Refer to interview with the Executive Director (ED) on 09/13/23 at 5:30pm.

2. Review of Resident #1's current FL2 dated 07/09/23 revealed:
-Diagnoses included cellulitis, intertrigo (a

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superficial inflammation of the skin) and history of cerebral vascular accident.
-There was an order for naproxen sodium 220mg take 1 tablet 1 time a day (used to treat moderate pain)

Review of Resident #1's July 2023 medication administration record (MAR) revealed:
-There was an entry for naproxen sodium 220mg take 1 tablet 2 times a day scheduled at 8:00am and 8:00pm.
-Naproxen sodium was documented as administered 2 times a day from 07/01/23 to 07/31/23.

Review of Resident #1's August 2023 MAR revealed:
-There was an entry for naproxen sodium 220mg take 1 tablet 2 times a day scheduled at 8:00am and 8:00pm.
-Naproxen sodium was documented as administered 2 times a day from 08/01/23 to 08/31/23.

Review of Resident #3's September 2023 MAR from 09/01/23 to 09/13/23 revealed:
-There was an entry for naproxen sodium 220mg take 1 tablet 2 times a day scheduled at 8:00am and 8:00pm.
-Naproxen sodium was documented as administered 2 times a day from 09/01/23 to 09/12/23.

Observation of medication on hand for administration for Resident #1 on 09/13/23 at 10:45am revealed:
-Resident #1 had a bottle labeled naproxen sodium 220mg take 1 tablet 1 time a day dispensed on 07/13/23 for 90 tablets from Resident #1's previous pharmacy.

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D 367	Continued From page 22 -There were approximately 30 tablets remaining of 90 tablets dispensed on 07/13/23. Interview with the medication aide/Supervisor (MA/S) on 09/13/23 at 10:50am revealed: -He was responsible to check the medications prepared by the pharmacy compared to the MARs when the medications were delivered monthly for accuracy. -The medications were supposed to be compared to the residents' medication orders for accuracy. -He hand copied all of Resident #1's MARs from her previous facility when she was admitted the 1st week of July 2023 and entered the naproxen sodium incorrectly. -He also wrote her August and September 2023 MARs and overlooked the incorrect documentation 2 times a day for Resident #1's naproxen sodium. -He was supposed to read each entry on the MAR and compare to the directions listed on the medication package. -He should check off the medication displayed on the MAR when preparing, administer the medications, then return to the MAR to initial that he administered the medication. -In the rush to administer all the residents' medications, he just initialed that he administered her naproxen 2 times a day. -He administered Resident #1's naproxen sodium every morning, she did not receive a 2nd tablet in the evening. Interview with Resident #1 on 09/13/23 at 11:05pm revealed: -She was administered naproxen and acetaminophen for her arm and elbow pain. -She was sure she took a tablet in the morning, because it was blue. -She did not remember ever taking the blue tablet	D 367		

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D 367	Continued From page 23 in the evening. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/13/23 at 11:25am revealed: -The pharmacy had an order for Resident #1 for naproxen sodium 220mg take 1 tablet 1 time a day. -The pharmacy had never dispensed Resident #1's for naproxen sodium 220mg to the facility. -Most of Resident #1's medications were only profiled and possibly filled by another pharmacy. Telephone interview with the pharmacist at Resident #1's previous pharmacy on 09/13/23 at 12:05am revealed: -The pharmacy had an order for Resident #1 for naproxen sodium 220mg take 1 tablet 1 time a day. -Resident #1's naproxen sodium was dispensed on 07/13/23 for 90 tablets to equal a 3-month supply. Interview with Resident #1's PCP on 09/13/23 at 4:42pm revealed: -Resident #1 had an order for naproxen sodium 1 time a day along with other medications for mild pain. -She should only receive naproxen sodium 1 time a day. -He expected the facility staff to check to see that his orders were carried out and medications were administered as ordered and documented correctly. -He had been monitoring Resident #1's pain regimen since she was newly admitted in July 2023, and he needed an accurate record of what helped her. Refer to interview with the Executive Director	D 367		

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D 367	Continued From page 24 (ED) on 09/13/2023 at 5:30pm. _____ Interview with the Executive Director (ED) on 09/13/23 at 5:30pm revealed: -The MA/S was responsible to administer medications and document the administration correctly. -The MA/S was responsible to review the eMAR entries for accuracy. -She was responsible to oversee the duties of the MA/S. -She did not have a system in place to routinely audit residents' eMARs for accuracy. -She contacted the Administrator if there were any issues with medications that she could not resolve. -The Administrator periodically came to the facility.	D 367		