Received via electronic mail 09/28/23.

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FORM APPROVED

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
	HAL034108	A. BUILDING: _____ B. WING _____	R 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/RECORD VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(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 conducted a follow up survey on August 29, 2023.	{D 000}	all deficiencies are directly due to residents receiving VA benefits. We struggle with accuracy of meds. along with order changes and refills and coordinating with VA. The last survey all corrections were made. This survey were other issues but still VA. We have provided	
{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: FOLLOW-UP TO A TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#2 and #3) who had orders for an antipsychotic, a pain medication, a high cholesterol medication, and a vitamin supplement (#2) and an anticholinergic medication (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 07/05/23 revealed diagnoses included nephritis, Crohn's disease, and chronic obstructive pulmonary disease. a. Review of Resident #2's Physician's Order	{D 358}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Greta B. Shuler — TITLE: Administrator — (X6) DATE: 9-26-23

Reviewed and acknowledged 10/04/23. C Proctor

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{D 358}	Continued From page 1 dated 07/12/23 revealed an order for atorvastatin (used to treat and reduce high cholesterol) 40mg take once daily at bedtime. Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 40mg 1 tablet at bedtime scheduled at 8:00pm. -There was documentation atorvastatin was not administered on 20 of 31 opportunities from 07/01/23 to 07/20/23 at 8:00pm due to being out of stock. Observation of Resident #2's medications on hand on 08/29/23 at 1:15pm revealed there was a bottle labeled atorvastatin 40mg with a dispensed 07/18/23 for 30 tablets available to be administered. Interview with the Resident Care Coordinator (RCC) on 08/29/23 at 1:15pm: -She occasionally administered medications to residents. -Resident #2 was a veteran and had his medications delivered from the Veteran's Administration (VA) pharmacy via mail. -It was difficult to contact his primary care provider (PCP) at the VA to obtain an order or refill on his medications. -Some of his medications could be filled for an emergency supply at the local pharmacy, but not all of them. -She could not remember if Resident #2's atorvastatin was one that could be filled for an emergency supply or not. -The medication aides (MA) should have notified her, the Business Office Manager (BOM) or the Assistant Administrator (AA) when a medication was low or out, so that one of them could call the	{D 358}	a backup plan is attached. Moving forward Staff has been trained how to reorder VA medication. Due to medication take 7-10 days to recieve all VA meds will come to office managment first and will be reordered as soon as med is recieved at the facility. Resident #2 will be recieving medication from local Pharmacy so this will not accure again. Along c training on VA medication, House Pharmacy held a train class with ~~CMA~~ Staff to inform them on how they work who to contact for question How to reorder medication any medication question will be directed to RCD. 9-15-23	

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{D 358}	Continued From page 2 VA PCP and pharmacy to have the medication delivered as soon as possible. -She expected all medications to be administered as ordered. Interview with Resident #2 on 08/29/23 at 1:55pm revealed: -He took atorvastatin prescribed by his provider at the VA for high cholesterol. -He knew it was out for a couple weeks last month (July 2023) and the staff tried to get it from the VA pharmacy. -The VA pharmacy mailed his medications, so it took a week or so to get them but in the meantime, sometimes the facility used a local pharmacy to have his medications refilled. -He did not know if the facility attempted to have his atorvastatin filled at the local pharmacy or not. -He was not concerned that he did not have his atorvastatin for a couple weeks. -His VA provider checked his cholesterol occasionally and would probably check it on his next visit. Telephone interview with the previous MA on 08/29/23 at 3:20pm revealed: -Resident #2 ran out of his atorvastatin in early July 2023, he could not remember the dates. -He was a VA resident and received his medications through the mail. -When he saw that a VA resident was running out of a medication, he would either call the VA PCP and pharmacy himself or let the RCC, Administrator or BOM know to have the medication refilled. -He could not remember how long Resident #2 was out of atorvastatin. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at	{D 358}	Currently All medications are in stock and given as orders are directed. The VA residents will have a backup fill with Walgreens for anything not available in the VA pharmacy. RCD checks meds. weekly to assure availability. Training is being added for accuracy with all medication administration tasks. Next training is 9-28-23 given by Southern Pharmacy. 9-15-23	

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{D 358}	Continued From page 3 3:40pm revealed: -The pharmacy only profiled Resident #2's medications, because he was a veteran and received his medications from the VA. -They added orders to and removed discontinued or expired orders from his eMAR, but had never dispensed any atorvastatin to the facility for Resident #2. Telephone interview with a pharmacist at Resident #2's VA Pharmacy on 08/29/23 at 4:08pm revealed: -The pharmacy dispensed medications on request and usually for a 3-month supply. -Refills needed to be requested about 2 weeks ahead of running out of medication due to mail delivery time. -Resident #2 had an order for atorvastatin 40mg take one at bedtime dated 07/05/23. -His atorvastatin was dispensed on 04/27/23 for a 3-month supply and 07/05/23 for a 3-month supply that could take 7-10 days to arrive. -The 04/27/23 delivery should have lasted through the first 3 weeks of July 2023. -There was no documentation that the facility requested a refill before the 07/05/23 order. -He could not speak to any affects Resident #2 might have had as a result of not being administered his atorvastatin. Attempted telephone interview with Resident #2's PCP on 08/29/23 at 2:15pm and 4:26pm was unsuccessful. Refer to the interview with the Administrator on 08/29/23 at 1:25pm. b. Review of Resident #2's Physician's Order dated 07/12/23 revealed an order for aripiprazole (used to treat psychosis) 5mg take ½ tablet	{D 358}	Addendum:RCD or Administrator will consult with family/responsible person or guardians to obtain payment or information needed, when there is a delay in having medications ordered or delivered on time to avoid any resident missing administration of medications.	

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{D 358}	Continued From page 4 (2.5mg) once daily for mental health. Review of Resident #2's August 2023 eMAR from 08/01/23-08/29/23 revealed: -There was an entry for aripiprazole 5mg take ½ tablet (2.5mg) once daily scheduled at 8:00am for 08/01/23-08/02/23 and for 08/15/23-08/29/23 and 9:00am for 08/03/23-08/14/23. -There was documentation aripiprazole 2.5mg was not administered on 5 of 29 opportunities on 08/02/23 at 8:00am and 08/03/23-08/05/23 and 08/08/23 at 9:00am due to being out of stock. Observation of Resident #2's medications on hand on 08/29/23 at 1:15pm revealed there was a bottle labeled aripiprazole 5mg give ½ tablet daily was dispensed 08/16/23 for 30 tablets was available to be administered. Interview with the Resident Care Coordinator (RCC) on 08/29/23 at 1:15pm: -She occasionally administered medications to residents. -Resident #2 was a veteran and had his medications delivered from the VA pharmacy via mail. -It was difficult to contact his PCP at the VA to obtain an order or refill on his medications. -Some of his medications could be filled for an emergency supply at the local pharmacy, but not all of them. -She could not remember if Resident #2's aripiprazole was one that could be filled for an emergency supply or not. -The MA should have notified her, the BOM or the AA when a medication was low or out, so that one of them could call the VA PCP and pharmacy to have the medication delivered as soon as possible. -She expected all medications to be administered	{D 358}	Staff had training on VA Medication Resident #2 will recieve Aripiprazole 5mg from local pharmacy moving foward. MA Staff will report to office staff if Resident is out of medication	9-15-23

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{D 358}	Continued From page 5 as ordered. Interview with Resident #2 on 08/29/23 at 1:55pm revealed: -He took aripiprazole prescribed by his provider at the VA for high anxiety. -He knew it was out for about a week this month (August 2023) and the staff had tried to get it from the VA pharmacy. -The VA pharmacy mailed his medications, so it took a week or so to get them but in the meantime, sometimes the facility used a local pharmacy to have his medications refilled. -He did not know if the facility attempted to have his aripiprazole filled at the local pharmacy or not. -He was not concerned that he did not have his aripiprazole for a week. -He did not feel any anxiety during the week he was out of aripiprazole. Interview with a MA on 08/29/23 at 8:50am revealed: -He began work at the facility in mid-August 2023. -Resident #2 was a VA resident and received his medications through the mail. -He was trained to inform the RCC, Administrator or BOM when a resident needed to have a medication refilled. -Resident #2's aripiprazole was out for a few days when he started working, but had since been delivered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at 3:40pm revealed: -The pharmacy only profiled Resident #2's medications, because he was a veteran and received his medications from the VA. -The pharmacy added orders to and removed discontinued or expired orders from his eMAR,	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

but had never dispensed any aripiprazole to the facility for Resident #2.

Telephone interview with a pharmacist at Resident #2's VA Pharmacy on 08/29/23 at 4:08pm revealed:
-The pharmacy dispensed medications on request and usually for a 3-month supply.
-Refills needed to be requested about 2 weeks ahead of running out of medication due to mail delivery time.
-Resident #2 had an order for aripiprazole 5mg take ½ tablet once a day dated 04/27/23.
-His aripiprazole was dispensed on 04/27/23 for a 3-month supply and on 08/16/23 for a 3-month supply that could take 7-10 days to arrive.
-The 04/27/23 delivery should have lasted through the first 3 weeks of July 2023.
-There was no documentation that the facility requested a refill before the 08/16/23 refill request.
-He could not speak to any affects Resident #2 might have had as a result of not being administered his aripiprazole.

Attempted telephone interview with Resident #2's PCP on 08/29/23 at 2:15pm and 4:26pm was unsuccessful.

Refer to the interview with the Administrator on 08/29/23 at 1:25pm.

c. Review of Resident #2's Physician's Order dated 07/12/23 revealed an order for gabapentin (used to treat pain) 300mg take 1 capsule 3 times a day for pain.

Review of Resident #2's August 2023 eMAR from 08/01/23-08/29/23 revealed:
-There was an entry for gabapentin 300mg take 1

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{D 358}	Continued From page 7 capsule 3 times a day scheduled at 8:00am, 12:00pm and 8:00pm. -There was documentation gabapentin 300mg was not administered on 17 of 85 opportunities on 08/14/23-08/19/23 at 8:00am and 12:00pm, and 08/12/23 and 08/14/23-08/17/23 at 8:00pm due to being out of stock. -There was one administration opportunity left blank on 08/13/2023 at 8:00pm. Observation of Resident #2's medications on hand on 08/29/23 at 1:15pm revealed there was a bottle labeled gabapentin 300mg give 1 capsule 3 times a day dispensed 08/18/23 for 270 capsules available to be administered. Interview with the RCC on 08/29/23 at 1:15pm: -She occasionally administered medications to residents. -Resident #2 was a veteran and had his medications delivered from the VA pharmacy via mail. -It was difficult to contact his PCP at the VA to obtain an order or refill on his medications. -Some of his medications could be filled for an emergency supply at the local pharmacy, but not all of them. -She could not remember if Resident #2's gabapentin was one that could be filled for an emergency supply. -The MA should have notified her, the BOM or the AA when a medication was low or out, so that one of them could call the VA PCP and pharmacy to have the medication delivered as soon as possible. -She expected all medications to be administered as ordered. Interview with Resident #2 on 08/29/23 at 1:55pm revealed:	{D 358}	Resident #2 gabapentin order changed from 2 times a day to 3 times a day VA Pharmacy did not have new order and would n't refill due to it was to soon according to their orders. Resident # 2 will recieve this medication from local pharmacy moving forward 9-15-23	

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{D 358}	Continued From page 8 -He took gabapentin prescribed by his provider at the VA for pain. -He knew it was out about a week ago this month (August 2023) and the staff had tried to get it from the VA pharmacy. -The VA pharmacy mailed his medications, so it took a week or so to get them but in the meantime, sometimes the facility used a local pharmacy to refill his medications. -He did not know if the facility attempted to have his gabapentin filled at the local pharmacy or not. -He did not have any pain during the week he was out of gabapentin. Interview with a MA on 08/29/23 at 8:50am revealed: -He began work at the facility in mid-August 2023. -Resident #2 was a VA resident and received his medications through the mail. -He was trained to inform the RCC, Administrator or BOM know when a resident needed to have a medication refilled. -Resident #2's preservision was out for a few days in the middle of August 2023, but had since been delivered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at 3:40pm revealed: -The pharmacy only profiled Resident #2's medications, because he was a veteran and received his medications from the VA. -The pharmacy added orders to and removed discontinued or expired orders from his eMAR, but had never dispensed any gabapentin to the facility for Resident #2. Telephone interview with a pharmacist at Resident #2's VA Pharmacy on 08/29/23 at 4:08pm revealed:	{D 358}		

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{D 358}	Continued From page 9 -The pharmacy dispensed medications on request and usually for a 3-month supply. -Refills needed to be requested about 2 weeks ahead of running out of medication due to mail delivery time. -Resident #2 had an order for gabapentin 300mg take 1 capsule once time a day dated 04/27/23. -His gabapentin was dispensed on 04/27/23 for a 3-month supply and on 06/20/23 for a 1-month supply that could take 7-10 days to arrive. -There was no documentation of a report of a lost delivery and so he was not sure why a 1-month refill was requested on 06/20/23. -The 04/27/23 delivery should have lasted through the first 3 weeks of July 2023. -There was no documentation that the facility requested a refill since the 06/20/23 refill request. -He could not speak to any affects Resident #2 might have had as a result of not being administered his gabapentin. Attempted telephone interview with Resident #2's PCP on 08/29/23 at 2:15pm and 4:26pm was unsuccessful. Refer to the interview with the Administrator on 08/29/23 at 1:25pm. d. Review of Resident #2's Physician's Order dated 07/12/23 revealed an order for preservision (a vitamin supplement used to prevent the risk of progression of age-related macular degeneration) take 1 capsule 2 times a day. Review of Resident #2's August 2023 eMAR from 08/01/23-08/29/23 revealed: -There was an entry for preservision take 1 capsule 2 times a day scheduled at 8:00am and 8:00pm. -There was documentation preservision was not	{D 358}		

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{D 358}	Continued From page 10 administered on 18 of 57 opportunities on 08/11/23-08/12/23 and 08/14/23-08/19/23 at 8:00am and 08/11/23-08/12/23, 08/14/23-08/20/23 and 08/22/23 at 8:00pm due to being out of stock. -There was one administration opportunity left blank on 08/13/2023 at 8:00pm. Observation of Resident #2's medications on hand on 08/29/23 at 1:15pm revealed there was a bottle labeled preservision take 1 capsule 2 times a day dispensed 08/16/23 for 120 tablets available to be administered. Interview with the RCC on 08/29/23 at 1:15pm: -She occasionally administered medications to residents. -Resident #2 was a veteran and had his medications delivered from the VA pharmacy via mail. -It was difficult to contact his PCP at the VA to obtain an order or refill on his medications. -Some of his medications could be filled for an emergency supply at the local pharmacy, but not all of them. -She could not remember if Resident #2's preservision was one that could be filled for an emergency supply or not. -The MAs should have notified her, the BOM or the AA when a medication was low or out, so that one of them could call the VA PCP and pharmacy to have the medication delivered as soon as possible. -She expected all medications to be administered as ordered. Interview with Resident #2 on 08/29/23 at 1:55pm revealed: -He took vitamins prescribed by his provider at the VA.	{D 358}	Staff training on VA medication. Resident #2 will recieve medication from local pharmacy moving forward. MA staff will report to office staff if Resident is out of medication 9-15-23	

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{D 358}	Continued From page 11 -He knew it was out about a week ago this month (August 2023 the staff had tried to get it from the VA pharmacy. -The VA pharmacy mailed his medications, so it took a week or so to get them but in the meantime, sometimes the facility used a local pharmacy. -He did not know if the facility attempted to have his preservision filled at the local pharmacy or not. -He was not concerned that he did not receive his preservision since it was a vitamin. Interview with a MA on 08/29/23 at 8:50am revealed: -He began work at the facility in mid-August 2023. -Resident #2 was a VA resident and received his medications through the mail. -He was trained to inform the RCC, Administrator or BOM when a resident needed to have a medication refilled. -Resident #2's preservision was out for a few days when he started working, but had since been delivered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at 3:40pm revealed: -The pharmacy only profiled Resident #2's medications because he was a veteran and received his medications from the VA. -The pharmacy added orders to and removed discontinued or expired orders from his eMAR, but had never dispensed any preservision to the facility for Resident #2. Telephone interview with a pharmacist at Resident #2's VA Pharmacy on 08/29/23 at 4:08pm revealed: -The pharmacy dispensed medications on	{D 358}		

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	HAL034108	A. BUILDING: _____ B. WING _____	R 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/RECORD VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(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 12 request and usually for a 3-month supply. -Refills needed to be requested about 2 weeks ahead of running out of medication due to mail delivery time. -Resident #2 had an order for preservision take 1 capsule 2 times a day dated 05/09/23. -His preservision was dispensed on 05/09/23 for a 2-month supply and on 08/16/23 for a 2-month supply that could take 7-10 days to arrive. -There was no documentation that the facility requested a refill between the 05/09/23 and 08/16/23 dispense dates. -He could not speak to any affects Resident #2 might have had as a result of not being administered his preservision. Attempted telephone interview with Resident #2's PCP on 08/29/23 at 2:15pm and 4:26pm was unsuccessful. Refer to the interview with the Administrator on 08/29/23 at 1:25pm. 2. Review of Resident #3's current FL-2 dated 07/05/23 revealed: -Diagnoses included schizophrenia, diabetes mellitus type 2 and hypertension. -There was an order for benztropine (an anticholinergic medication used to treat involuntary movements of side effects caused by certain psychiatric drugs) 1mg ½ tablet (0.5mg) 2 times a day. Review of Resident #3's previous physician's order dated 05/19/2023 revealed an order for benztropine 1mg take 1/2 tablet 2 times a day. Review of Resident #3's July 2023 electronic medication administration record (eMAR) revealed:	{D 358}		

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{D 358}	Continued From page 13 -There was an entry for benztropine 1mg ½ tablet 2 times a day scheduled at 8:00am and 8:00pm. -There was documentation benztropine 0.5mg was not administered on 18 of 62 opportunities on 07/01/23-07/06/23 and 07/08/23-07/11/23 at 8:00am and 07/01/23-07/04/23, 07/06/23-07/07/23 and 07/09/23-07/10/23 at 8:00pm due to being out of stock. Observation of Resident #3's medications on hand on 08/29/23 at 1:20pm revealed there was a bottle labeled benztropine 0.5mg take 1/2 tablet 2 times a day dispensed 07/11/23 for 180 tablets available to be administered. Interview with the Resident Care Coordinator (RCC) on 08/29/23 at 1:15pm: -She occasionally administered medications to residents. -Resident #3 was a veteran and had his medications delivered from the Veteran's Administration (VA) pharmacy via mail. -It was difficult to contact his primary care provider (PCP) at the VA to obtain an order or refill on his medications. -Some of his medications could be filled for an emergency supply at the local pharmacy, but not all of them. -She could not remember if Resident #3's benztropine was one that could be filled for an emergency supply or not. -The medication aides (MA) should have notified her, the Business Office Manager (BOM) or the Assistant Administrator (AA) when a medication was low or out, so that one of them could call the VA PCP and pharmacy to have the medication delivered as soon as possible. -She expected all medications to be administered as ordered.	{D 358}	Staff had training on VA Medication. MA Staff will report to office if Resident is out of medication and will be ordered as soon as facility recieve medication to make sure this does not occure agin. 9-15-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034108	A. BUILDING: _____ B. WING _____	R 08/29/2023

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{D 358}	Continued From page 14 Interview with Resident #3 on 08/29/23 at 1:52pm revealed: -He took benztropine prescribed by his provider at the VA for tremors. -He was out of his benztropine at the first week of July and the staff had tried to get it from the VA pharmacy. -The VA pharmacy mailed his medications, so it took a week or so to get them but, in the meantime, sometimes the facility used a local pharmacy. -He did not know if the facility attempted to have his benztropine filled at the local pharmacy. -He was not concerned that he did not receive his benztropine and he did not have any increased tremors during the time he did not receive his medication, Telephone interview with the previous MA on 08/29/23 at 3:20pm revealed: -Resident #3 ran out of his benztropine in early July 2023, he could not remember the dates. -He was a VA resident and received his medications through the mail. -When he saw that a VA resident was running out of a medication, he would either call the VA PCP and pharmacy himself or let the RCC, Administrator or BOM know to have the medication refilled. -He could not remember how long Resident #3 was out of benztropine. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at 3:40pm revealed: -The pharmacy only profiled Resident #3's medications because he was a veteran and received his medications from the VA. -They added orders to and removed discontinued or expired orders from his eMAR, but had never	{D 358}	Provided is the Sample form that we will use to document VA resident medication tracking.	9-15-23

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 15 dispensed any benztropine to the facility for Resident #3. Telephone interview with a pharmacist at Resident #3's VA Pharmacy on 08/29/23 at 4:08pm revealed: -The pharmacy dispensed medications on request and usually for a 3-month supply. -Refills needed to be requested about 2 weeks ahead of running out of medication due to mail delivery time. -Resident #3 had an original order for benztropine 0.5 mg take ½ tab 2 times a day dated 05/19/23. -His benztropine was dispensed on 05/22/23, 07/11/23 and on 08/02/23 each time for a 3-month supply that could take 7-10 days to arrive. -There was documentation that the facility requested a refill on 06/27/23, but did not document a reason, such as a lost shipment. -He could not speak to any affects Resident #3 might have had as a result of not being administered his benztropine. Attempted telephone interview with Resident #3's PCP on 08/29/23 at 2:15pm and 4:26pm was unsuccessful. Attempted telephone interview with Resident #3's psychiatric provider on 08/29/23 at 2:15pm and 4:26pm was unsuccessful. Refer to the interview with the Administrator on 08/29/23 at 1:25pm. _____ Interview with the Administrator on 05/23/23 at 1:25pm revealed: -Residents that were seen at the VA clinic received their medications from the VA pharmacy through the mail.	{D 358}	VA log form will be checked weekly by RCD and office manager for accuracy on VA meds.	9-15-23 GS

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{D 358}	Continued From page 16 -It was difficult to contact the VA PCP and then any medications took 2 weeks to be delivered. -Some medications could be filled for a temporary supply at local pharmacies, but most could not. -She expected MAs to inform the RCC, BOM or AA when VA resident medications were low so they could call the VA PCP and pharmacy to have them delivered on time. -She expected medications to be administered as ordered.	{D 358}		

Sample only					
Resident	**DOB**	**VA ID #**			
John Doe	10-20-54	8080			
	date received	**amount received**	**supply days**	**date reordered**	**method of reorder**
atorvastatin	9-1-23	30	1 month	9-5-23	mail
aripriprazole	9-1-23	90	3months		mail
benztropine					
Resident	**DOB**	**VA ID #**			
Jane Doe	1-3-46	7878			
	date received	**amount received**		**date reordered**	**method of reorder**
gabapentin					
preservision					

VA providers can now view medication directly that are prescribed to VA enrolled patients by community providers and filled at Walgreen pharmacies

VA pharmacy can not file prescriptions wrote by outside doctor → that doctor has to send notes to VA provider for them to look over new orders sign off and send to VA pharmacy so they have new order and can file new orders

VA Residents can get reimburesment if they have to use out-side pharmacy to get script Save everything
VA Residents can get 14 day supply till Resident recieves medication through mail

Submit reimburesment request to local VA Community Care office.

Leigh Haen
RCC
9.21.23

VA Emergency Medication Refills

VA has established an Emergency Prescription Refill Program to assist enrolled Veterans who are out or almost out of medications. Veterans can receive a 10-day supply of VA prescribed medication by:

- Going to any Big Chain Pharmacy
- Bring your VA prescription, medication bottle/supply item (with VA RX label on it) showing available refills, and the last refill date within the last 90 days
- Bring your VA ID Card and another form of identification like a driver's license
- Ask the pharmacist to call *Heritage Health Solutions Customer Care Center* at toll free **1-866-265-0124**, where a Customer Care Representative will qualify the request by asking a few questions
- No controlled drugs will be processed under this program. If a controlled drug is needed, you must contact your local VA facility Emergency Department.

For questions about this Emergency Prescription Program or help with another medication related question, please call the VA Pharmacy Call Center at the numbers below or the number on your prescription bottle or label. The VA Pharmacy Call Centers and *Heritage Health Solutions Customer Care Center* **(1-866-265-0124)** can tell you if your preferred Pharmacy is participating in the Emergency Prescription Refill Program.

- James J. Peters Bronx VA Medical Center: 1-888-327-9670
- VA Hudson Valley HCS : 1-888-389-6528
- VA New Jersey HCS VA Pharmacy Call Center: 1-800-480-5590 (You may receive a "normal hours of operation message." If so, please remain on the line and a technician will answer the call.)
- VA New York Harbor HCS Pharmacy Call Center: 1-631-863-4832
- Northport VA Medical Center: 1-800-799-3023 or 631-863-4826 (You may receive a "normal hours of operation message." If so, please remain on the line and a technician will answer the call.)

The Pharmacy Call Centers are open on Saturday and Sunday from 8:00am to 4:30pm and weekdays with extended hours.

Some residents do not have VA ID so we will try to get it for them. GS