

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/27/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWNDALE MANOR

**601 LAKESIDE DRIVE
GARNER, NC 27529**

(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 an annual and follow-up survey on September 26, 2023 through September 27, 2023.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff sampled (A) who administered medications had completed the state-approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired as a supervisor-in-charge (SIC) and medication aide (MA) on 10/28/22. -There was documentation of Staff A completing the medication administration clinical skills validation checklist on 11/11/22. -There was documentation of Staff A passing the MA written exam on 02/17/17. -There was no MA verification form for Staff A. -There was no documentation of Staff A	D 125	Having everyone to do 15 hour class	11/1/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Levi Allen TITLE *Administrator* (X6) DATE *10/25/23*

STATE FORM

6899

C9B211

If continuation sheet 1 of 35

Reviewed and Acknowledged SCM 10/31/23

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D 125	Continued From page 1 completing the state-approved 5, 10, or 15-hour MA training courses. Review of residents' July 2023 - September 2023 electronic medication administration records (eMARs) on 09/27/23 revealed: -Staff A documented administering medications on 10 of 31 days from 07/01/23 - 07/31/23, including 07/06/23, 07/07/23, 07/09/23 - 07/11/23, 07/13/23, 07/15/23, 07/18/23, 07/22/23, and 07/24/23. -Staff A documented administering medications on 8 of 31 days from 08/01/23 - 08/31/23, including 08/02/23, 08/03/23, 08/08/23, 08/11/23, 08/15/23, 08/19/23, 08/20/23, and 08/26/23. -Staff A documented administering medications on 1 of 27 days from 09/01/23 - 09/27/23, which was 09/27/23. Observation of the 8:00am medication pass on 09/27/23 revealed: -Staff A made 2 medication errors with a resident during the medication pass. -Staff A did not use proper technique when using an insulin pen to administer long-acting insulin to the resident by failing to do a 2-unit air shot and by failing to hold the injection in for at least 6 seconds to ensure the full amount of insulin was administered. -Staff A administered rapid-acting insulin to the same resident without checking the resident's blood sugar just prior to administering the insulin to determine if the insulin should have been held based on parameters ordered by the primary care provider. Telephone interview with Staff A on 09/27/23 at 5:50pm revealed: -She started working and administering medications at the facility almost a year ago.	D 125	15 hour class will be finished by 11/1/2023 and all med-techs will attend.	11/1/23

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D 125	Continued From page 2 -She also worked as a personal care aide (PCA) and today, 09/27/23, was the first time she had administered medications for this month because she had been working on the floor as a PCA. -She thought she had completed either the 5-hour and 10-hour or the 15-hour MA training courses at a previous facility. -She had not completed either of the MA training courses at this facility. -She thought the Administrator was going to get the previous facility to fax her training certificates to this facility. Interviews with the Administrator on 09/27/23 at 4:55pm and 5:21pm revealed: -Staff A previously worked at another assisted living facility and should have the state-approved 15-hour MA training course from there. -She had been responsible for the personnel files since November 2021. -She thought Staff A had documentation of having the 15-hour MA training course from the other facility on file at this facility. -She usually checked the personnel files "all the time" but she had not checked Staff A's personnel file for MA qualifications because Staff A did not work as a MA too often. -She had been unable to reach anyone at the previous facility today, 09/27/23, about Staff A's MA training courses.	D 125		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 3 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure supervision was provided for 1 of 5 (#2) sampled residents who had 18 falls within a 7-month period who sustained injuries and sent to the local hospital emergency room for evaluation and treatment. The findings are: Review of the facility's Fall Policy (no date) revealed: -In the event of a fall, residents were assessed and monitored for the next 72 hours. -If a resident hits their head or had an injury, they were to be sent out by the emergency medical service(EMS). -The family was to be called and an incident report was to be done and put on the Resident Care Coordinator 's(RCC) desk and sent to DHHS and doctor also. -The facility was to institute a fall mat, bed and chair alarm if warranted by the physician. Review of Resident #2's current FL-2 dated 02/06/23 revealed: -Diagnoses included Parkinson's Disease, neuropathy, and falls. -The resident was intermittently disoriented and non-ambulatory. Review of a local hospital emergency room (ER) after visit summary report dated 08/30/23 revealed: -Chief complaint was a fall, injury to the head, and urine retention.	D 270	Resident was sent to hospital and was then sent to skilled.	10/1/23	

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D 270	Continued From page 4 -An indwelling catheter was placed. Review of Resident #2's Incident/Accident (I/A) reports revealed: -On 04/10/23 at 4:30pm, the resident was found on the floor in the bathroom, no injuries were observed. -On 04/28/23 at 2:40pm, the resident slid off the bed onto the floor in the presence of a family member, no injuries were observed. -On 05/02/23 at 10:36am, the resident was transferring from bed to wheelchair and missed the chair and landed on the floor, no injuries were observed. -On 05/06/23 at 3:00pm, the resident got out of bed trying to walk to get in his wheelchair and fell on the floor, no injuries were observed. -On 06/03/23 at 11:15am, the resident was found sitting on the mat in front of his bed, no injuries were observed. -On 06/06/23 at 2:22pm, the resident was found on the floor in his room, no injuries were observed. -On 06/21/23 at 8:30pm, the resident was found on the floor, there was a knot under his eye and a cut, and he was sent to the local hospital ER. -On 07/21/23 at 3:00pm, the resident was found on the floor in his room, no injuries were observed. -On 08/25/23 at 8:30pm, the resident was found on the floor in his room, no injuries were observed. -On 08/27/23 at 11:20pm, the resident was found on the floor in his bathroom, no injuries observed. -On 08/30/23 at 7:05pm, the resident was found on the floor near the front desk, there was a swollen eye and a cut about his eye, resident was sent to the local hospital ER. Review of the facility's progress notes revealed:	D 270			

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D 270	Continued From page 5 -Resident #2 had a fall on 02/12//23 in his room, a family was present and and called out for staff. -Resident #2 had a fall on 02/20/23 in the bathroom, no injuries were observed. -Resident #2 had a fall on 02/25/23 in his room, no injuries were observed. -Resident #2 had a fall on 03/24/23 in his room, no injuries were observed. -Resident #2 had a fall on 03/25/23 in his room, no injuries were observed. -Resident #2 had a fall on 09/01/23 in his room, no injuries were observed. -Resident #2 had a fall on 09/25/23 in his room, no injuries were observed. Observation of Resident #2's room on 09/26/23 at 3:30pm revealed: -The resident was lying in a hospital bed with the remote in his hand attempting to turn the TV on. -There was a fall mat on the floor, and bed and chair alarms. -There was a catheter bag hanging on the side of the bed. -The call bell cord was laying across the bed in reach of the resident. Observation of Resident #2's room on 09/27/23 at 10:00am revealed: -The resident was sitting on the toilet in the bathroom by himself for about 3 minutes before the personal care aide (PCA) entered the room. (The surveyor did not know how long he had been sitting there before surveyor entered the room). -A walker was in front of the resident sitting on the toilet. -An alarm was placed on the resident's clothing. Interview with the personal care aide (PCA on 09/27/23 at 10:05am revealed:	D 270		

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D 270	Continued From page 6 -She placed Resident #2 on the toilet and placed the alarm from the wheelchair on the resident's clothing in case he tried to get up off the toilet by himself, the alarm would sound. -She left the room for a couple of minutes to check on another resident. Telephone interview with Resident #2's family member on 09/26/23 at 3:50pm revealed: -She was aware of the resident's falls. -He was sent to the local hospital ER a "couple" of times due to falling and hitting his head. -He would not call for help from staff and tried to get out of bed by himself and fall. -She thought about ordering a helmet for the resident to prevent head injury. Interview with a second PCA on 09/27/23 at 11:00am revealed: -Resident #2 had a lot of falls. -The resident tried to get out of bed by himself and sometimes got caught on the catheter bag and tubing and fell. -He had the catheter for about a month or two. Interview with a medication aide (MA) on 09/27/23 at 8:00am revealed: -She worked on the third shift from 11:00pm to 7:00am. -Resident #2 tried to get out of bed by himself and would fall on the floor. -The resident had a bed alarm, chair alarm, and a fall mat on the floor. -When he had a fall, he was placed in the "hot box" which meant staff would monitor him for 72 hours per facility policy and document on he communication log and progress notes. Interview with the Resident Coordinator (RCC) on 09/27/23 at 5:33pm revealed:	D 270		

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D 270	Continued From page 7 -Resident #2 had a lot of falls due to trying to get out of bed by himself. -Staff monitored the resident every two hours and he was placed at the front desk in his wheelchair for close monitoring when not in bed. -Staff had not been told to monitor the resident every 30 minutes or every hour after a fall. -After a fall, the resident was placed in the "hot box" for staff to check on the resident for 72 hours every two hours. -Falls were communicated to staff on a communication log (composition book) kept at the nurses's station and verbally between shifts. Interview with the Director of Health Services (DHS) on 09/27/23 at 5:45pm revealed: -The RCC was responsible for direct resident care oversight. -She was aware of Resident 2's multiple falls. -The facility did not have the staff to monitor Resident #2 more than every two hours per facility policy Interview with the Administrator on 09/27/23 on 6:00pm revealed: -She was aware of Resident #2's falls. -Interventions were implemented such as bed and chair alarms, a new hospital bed with a scoop mattress (to be delivered this week), occupational therapy/physical therapy (OT/PT), and a fall mat. -The resident tried to get out of bed by himself and would fall. -The facility did not have the staff to provide the resident with one-to-one supervision. -She talked to the family member about getting a sitter, but she declined to do so. -She expected the resident to be monitored every two hours, which was standard policy. -The resident was brought to the front desk for	D 270	Resident was sent to an skilled facility after being upgraded.	10/1/23

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D 270	Continued From page 8 close monitoring when out of the bed. -There was usually someone at the front desk during the day. Interview with Resident #2's primary care provider (PCP) on 09/26/23 at 10:30am revealed: -She was aware of the resident's multiple falls due to Parkinson's Disease. -The facility put fall interventions in place for the resident. -The facility was not able to provide one-to-one monitoring. -She expected the facility to provide supervision per facility policy. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable.	D 270		
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 provide referral and follow-up for 3 of 5 sampled residents(#1, #2, #3) related to neurology appointments not being scheduled as ordered (#2, #3) and the physician not being notified of blood pressure values outside of ordered parameters (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 02/06/23 revealed:	D 273		

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D 273	Continued From page 9 -Diagnoses included Parkinson's Disease, neuropathy, and falls. -The resident was intermittently disoriented and non-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 02/07/23. Review of Resident #2's physician progress note dated 03/21/23 revealed there was a referral to neurology. Review of Resident #2 physician progress note dated 06/13/23 revealed: -There was an entry to follow-up with neurology. -There was a notation that Resident #2's family had an established relationship with a local neurologist, who the resident last saw in December 2022. Based on observations, record reviews and interviews, it was determined Resident #2 was not interviewable. Refer to interview with the Resident Care Coordinator on 09/27/23 at 5:33pm Refer to interview with the Director of Health Services on 09/27/23 at 5:45pm Refer to interview with the Administrator on 09/27/23 at 6:00pm. Refer to interview with the primary care provider (PCP) on 09/26/23 at 10:30pm. 2. Review of Resident #3's current FL-2 dated 09/06/23 revealed: -Diagnoses included contractures of joints of bilateral hands.	D 273	RCC is to follow-up on and referral and follow-ups from residents coming back from hospital. Med-techs will read discharge notes and make sure RCC gets them. RCC will make sure that this happens.	10/1/23	

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D 273	Continued From page 10 -The resident was non-ambulatory. -The resident was constantly disoriented. Review of Resident #3's Resident Register revealed an admission date of 09/27/19. Review of Resident #3's local emergency room discharge summary dated 03/21/23 revealed an order to follow-up with neurology due to a seizure. Review of Resident #3's physician progress note dated 08/15/23 revealed an order to follow up with neurology. Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable. Refer to interview with the Resident Care Coordinator on 09/27/23 at 5:33pm. Refer to interview with the Director of Health Services on 09/27/23 at 5:45pm. Refer to interview with the Administrator on 09/27/23 at 6:00pm Refer to interview with the primary care provider (PCP) on 09/26/23 at 10:30am. Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 5:33pm revealed: -She had been the RCC for about 5 months. -She was trained by the previous RCC to review and process all medications orders from providers and discharge summary visits. -She was not trained to review and schedule appointments or referral orders. -She did not know that was her responsibility.	D 273		

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D 273	Continued From page 11 -She was often on call and expected to cover for PCAs and MAs when they "called out" from work. -She had never made an appointment for a resident since becoming the RCC. Interview with the Director of Health Services (DHS) on 09/27/23 at 5:45pm revealed: -Her responsibilities included making sure FL-2s and care plans were completed on residents. -The RCC was responsible for processing medication orders and making appointments for the residents. Interview with the Administrator on 09/27/23 at 6:00pm revealed: -The RCC was responsible for making appointments for residents per her job description. -She did not know why appointments were not made for Resident #2 and Resident #3. -She expected appointments to be made for residents as ordered. Interview with the PCP on 09/26/23 at 10:30am revealed: -She did not know if neurology appointments were made for Resident #2 and Resident #3. -She expected appointments for residents to be scheduled as ordered. 3. Review of Resident #1's current FL-2 dated 06/27/23 revealed diagnoses included Parkinson's disease and hypertension. Review of a physician's orders dated 08/21/23 revealed there was an order to check Resident #1's blood pressure (BP) once a week, on Wednesday, in the evening, for one month and inform the physician if the systolic BP was greater than 160 and the diastolic BP was greater than	D 273		

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D 273	Continued From page 12 100. Review of Resident #1's electronic medication administration records (eMARs) for August 2023 revealed: -There was an entry for Resident #1's BP to be checked once a week, on Wednesday, in the evening, for one month, at 6pm and inform the physician if the systolic BP was greater than 160 or the diastolic BP was greater than 100 with a start date of 08/22/23. -Resident #1's blood pressures were documented daily from 08/23/23 to 08/31/23. -Resident #1's BP was documented as 179/96 on 08/23/23 at 6pm and there was documentation in the electronic progress notes the resident's physician was notified of the BP. -The resident's BP was documented as 173/70 on 08/24/23 at 6pm and there was no documentation the resident's physician was notified of the BP. -The resident's BP was documented as 173 (there was no diastolic number recorded) on 08/30/23 at 6pm and there was no documentation the resident's physician was notified of the BP. Review of Resident #1's electronic medication administration records (eMARs) for September 2023 revealed: -There was an entry for Resident #1's BP to be checked once a week, on Wednesday, in the evening, for one month, at 6pm and inform the physician if the systolic BP was greater than 160 or the diastolic BP was greater than 100 with a start date of 08/22/23. -Resident #1's blood pressures were documented daily from 09/01/23 to 09/20/23. -Resident #1's BP was documented as 196/102 on 09/06/23 at 6pm and there was no documentation the resident's physician was	D 273		

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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 273	Continued From page 13 notified of the BP. -The resident's BP was documented as 164/80 on 09/08/23 at 6pm and there was no documentation the resident's physician was notified of the BP. -The resident's BP was documented as 165/92 on 09/10/23 at 6pm and there was no documentation the resident's physician was notified of the BP. -The resident's BP was documented as 161/75 on 09/11/23 at 6pm and there was no documentation the resident's physician was notified of the BP. -The resident's BP was documented as 162/104 on 09/18/23 at 6pm and there was no documentation the resident's physician was notified of the BP. Interview with the medication aide (MA) on 9/27/23 at 4:05pm revealed: -She was aware Resident #1's BP was to be reported to the PCP "if the top number was over a certain amount or the bottom number was lower." -The BP was to be reported to the PCP by email if it was outside of the parameters. -She had to report Resident #1's BP to the PCP once but did not remember the date. Interview with the Resident Care Coordinator (RCC) on 9/27/23 at 4:25pm revealed: -The MA was responsible for BP checks. -The BP was to be reported to the PCP if parameters were in place. -BP was reported to the PCP by calling a triage nurse and the triage nurse would notify the PCP or on call provider. -She was responsible for checking behind the MA to make sure the blood pressures were reported but had not checked. -The Director of Health Services checked the BP	D 273		

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D 273	Continued From page 14 reports behind the RCC sometimes. Interview with the Administrator on 09/27/23 at 4:35pm revealed: -The MA and RCC completed the BP checks. -The RCC checked behind the MA for PCP notification of BPs. -The Director of Health Services checked behind the RCC for PCP notification of BPs. -Parameters were documented and the PCP was notified by email, phone call or fax. Interview with the Director of Health Services on 09/27/23 at 4:35pm revealed: -Documentation that the PCP was called for BP parameter concerns should have been documented on the eMAR. -The MA should have followed the PCP order and called the PCP when the BP was out of the parameter. -The MA should have notified the RCC if she was unable to reach the PCP to report the BP. Telephone interview of the Resident's PCP on 09/29/23 at 11:37am revealed: -She was aware of the order written for BP checks for Resident #1. -The facility should have contacted her if the BP was out of the parameters. -She was not contacted for clarification of the order when the order used the "and" symbol and the eMAR used the word "or" when referring to the parameters. (She did not clarify whether or not she wanted to know if one or the other was high.) -She received a faxed notification of Resident #1's BP on 08/23/23. -She received no other notifications from the facility on Resident #1's BP.	D 273	RCC is to follow up and make sure all medications are on cart and parameter are followed.		10/1/23

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D 338	Continued From page 15	D 338		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to treat a resident (#4) with respect and dignity related to staff informing the resident she had to eat in the dining room and not in her room as she chose and staff having a loud verbal altercation in front of residents resulting in one resident (not in sample) being visibly upset and tearful. The findings are: 1. Review of Resident #4's current FL-2 dated 03/27/23 revealed: -Diagnoses included obesity, chronic diastolic congestive heart failure, rhabdomyolysis, hypothyroidism, hypertension, arthritis, urinary retention, and hidradenitis. -The resident was assessed as oriented. -The resident required the use of a wheelchair or walker for mobility. Interview with Resident #4 on 09/26/23 at 8:55am revealed: -The staff were nice to her for the most part. -The resident did not like the way the Administrator had treated her regarding her eating her meals in her room. -She did not remember the date, but it was since she had COVID and that was within the last month or so.	D 338	It is our policy for all residents to eat in dining room unless they are sick. We will continue to follow our policy. Discussion with resident and administrator talked about our policy. Administrator apologized for misunderstanding and resident said she would try to go to dining room.	10/1/23

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D 338	Continued From page 16 -She did not want to go to the dining room as there was very little social interaction between the residents. -Most of the residents would eat and leave. -She still had a cough from time to time and everyone glared at her when she coughed which made her feel uncomfortable. -There was a day when her family member was at the facility and the Administrator tried to involve her family member into making her go to the dining room for her meal. -The family member refused to get involved saying the resident had a right to eat in her room. -The Administrator tried to force her into going down to the dining room telling her she needed to go for the socialization. -The resident told the Administrator that if she made her go to the dining room for her meals that she would give her 2 weeks notice that she would be moving out of the facility. Interview with a personal care aide (PCA) on 09/27/23 at 2:55pm revealed: -Resident #4 stayed in her room for her meals. -There were not a lot of residents in the dining room who were able or wanted to socialize. -Resident #4 had frequent visitors and was pleasant when the staff assisted her. -There were several staff who liked to help Resident #4 because she was nice, and they were able to have conversations with her. -Most of the residents were not able to do that (converse). Interview with Resident #4's family member on 09/27/23 at 3:45pm revealed: -Resident #4 liked to stay in her room for her meals. -She had snacks and drinks that she could share with visitors.	D 338		

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D 338	Continued From page 17 -The family visited Resident #4 frequently and was here the day the Administrator tried to "make" Resident #4 go to the dining room for her meal. -The Administrator tried to get the family member to "help make" Resident #4 go to the dining room which the family member refused to do. -The family member told the Administrator that Resident #4 did not enjoy going to the dining room and preferred to eat in her room. -The nurse (Director of Clinical Services) came down to Resident #4's room. -She talked with the family member and told the family member that Resident #4 did not have to eat in the dining room, but it would be good for her to do so to be around other people and not stay in her room all the time. -The family member told the nurse (Director of Clinical Services) that Resident #4 did not enjoy going to the dining room and preferred to eat in her room. -Resident #4 was visibly upset that she was being "forced" to go to the dining room. -The Administrator finally "backed off" and Resident #4 was allowed to stay in her room for her meal. Interview with Resident Care Coordinator on 09/27/23 at 6:07pm revealed: -She was not aware of Resident #4 being told she had to go to the dining room for her meals. -She was not sure why Resident #4 would be told she had to go to the dining room to eat. Interview with the Director of Clinical Services (DSC) on 9/27/23 at 6:25pm revealed: -She remembered when Resident #4's family member was visiting and was upset. -She walked down to Resident #4's room and Resident #4 and her family member, and the	D 338		

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D 338	Continued From page 18 Administrator were in the resident's room. -She asked Resident #4's family member what was wrong. -The family member replied, "I am not happy right now, the Administrator told me to take Resident #4 to the dining room". -The DCS told Resident #4 she did not have to go to the dining room. -The Administrator left the room. -Resident #4 told her she did not like being forced. -The DSC informed the resident that no one would force her to go to the dining room. Interview with the Administrator on 9/27/23 at 6:19pm revealed: -She was aware of the residents having rights. -Everyone should comply with the Residents Rights. -She told Resident #4 she could eat in her room but that was when she was sick with COVID. -Resident #4 should go to the dining room so she can socialize with other residents. -She "asked" Resident #4's family member to "help" get her to go to the dining room. -The facility had a policy for residents eating in the dining room. Review on 09/27/23 at 6:30pm of the "policy" (no date) for residents eating in the dining room revealed: -Residents will be allowed to come to breakfast, in appropriate robes and house coats; however, all residents are encouraged to dress for lunch and supper. -As a rule, all residents will eat in the dining room. -Meals will be served in their rooms only if the resident has a temporary illness or is bedridden. -This administration feels that the social interaction during meal time is very important to	D 338			

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D 338	Continued From page 19 the residents feeling of self-esteem. 2. Observation of the back dining room on 09/26/23 at 8:20am revealed: -There were 6 residents seated in the dining room. -Two of the residents were being assisted by staff to eat by giving verbal cues as needed. -One male resident was visibly upset and tearful. Attempted interview with the male resident was unsuccessful due to his emotional state. The male resident said, "we are all one people, and we all need to get along". Interview with the personal care aide (PCA) on 09/26/23 at 8:45am revealed: -The male resident was upset because of a verbal confrontation between 2 PCAs earlier that morning. -She and another PCA "had words" this morning about the other PCA coming in late and then taking over the assignment that she had already completed the work. -She did not realize the male resident had overheard them arguing. -She had apologized to him already and tried to reassure him during breakfast that everything was okay. -She knew that they were wrong and should have not acted that way, especially in front of residents. Interview with Resident Care Coordinator on 09/27/23 at 6:07pm revealed: -She was responsible for the PCAs. -She was aware of those 2 PCAs not getting along. -She was not aware of their verbal confrontation on 09/26/23.	D 338			

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D 338	Continued From page 20 -She tried not to schedule them on the same days/shifts but if she had to schedule them, they were assigned to different halls. -The Administrator would change the schedule if necessary. -The Administrator was the person responsible for disciplinary actions. -She was not aware of any disciplinary actions for any altercations. Interview with the Administrator on 9/27/23 at 6:19pm revealed: -She was aware of the 2 PCAs not getting along. -The staff should not argue in front of the residents. -They were not scheduled to work on the same hall. -She scheduled 2 PCAs on each hall if she had 4 PCAs working. -She scheduled 1 PCA on each hall with a floater if she had 3 PCAs working.	D 338		
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 and in accordance with	D 358		

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D 358	Continued From page 21 the facility's policies for for 1 of 2 residents (#5) observed during the medication pass including errors with a medication used to control blood glucose levels (#5) and for 3 of 5 residents (#1, #2, #3) sampled for record review including errors with a medication for diabetes (#2), a topical antifungal medication (#3), and an antibiotic used to treat and prevent urinary tract infections (#1). The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 09/27/23. a. Review of Resident #5's current FL-2 dated 10/13/22 revealed: -Diagnoses included Type 2 diabetes mellitus, hypertension, cerebrovascular accident, morbid obesity, hyperlipidemia, anxiety, depression, and edema. -There was an order to check fingerstick blood sugars (FSBS) four times daily before meals and at bedtime, call primary care provider (PCP) if FSBS greater than 450. -There was an order for Novolog insulin, inject 20 units subcutaneously three times daily with meals, hold if FSBS is less than 120 or if resident does not eat that meal (Novolog is rapid-acting insulin that is used to help lower blood sugars at meal times). Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS four times daily before meals and at bedtime, call PCP if FSBS greater than 450, scheduled for 6:30am, 11:30am, 5:30pm, and 8:00pm. -Resident #5's FSBS levels ranged from 74 - 439	D 358		

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D 358	Continued From page 21 the facility's policies for for 1 of 2 residents (#5) observed during the medication pass including errors with a medication used to control blood glucose levels (#5) and for 3 of 5 residents (#1, #2, #3) sampled for record review including errors with a medication for diabetes (#2), a topical antifungal medication (#3), and an antibiotic used to treat and prevent urinary tract infections (#1). The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 09/27/23. a. Review of Resident #5's current FL-2 dated 10/13/22 revealed: -Diagnoses included Type 2 diabetes mellitus, hypertension, cerebrovascular accident, morbid obesity, hyperlipidemia, anxiety, depression, and edema. -There was an order to check fingerstick blood sugars (FSBS) four times daily before meals and at bedtime, call primary care provider (PCP) if FSBS greater than 450. -There was an order for Novolog insulin, inject 20 units subcutaneously three times daily with meals, hold if FSBS is less than 120 or if resident does not eat that meal (Novolog is rapid-acting insulin that is used to help lower blood sugars at meal times). Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS four times daily before meals and at bedtime, call PCP if FSBS greater than 450, scheduled for 6:30am, 11:30am, 5:30pm, and 8:00pm. -Resident #5's FSBS levels ranged from 74 - 439	D 358	Staff was taken off med cart and put on the floor as CNA. RCC is making sure all medications and protocol is followed.	9/28/23 9/28/23

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D 358	Continued From page 22 from 09/01/23 - 09/27/23. -Resident #5's FSBS was documented as 233 at 6:30am on 09/27/23. -There was an entry for Novolog insulin inject 20 units subcutaneously three times a day with meals. Hold if FSBS is less than 120 or if patient does not eat that meal, scheduled for 8:00am, 12:30pm, and 6:00pm. Observation of the 8:00am medication pass from 8:00am - 8:20am on 09/27/23 revealed: -The medication aide (MA) prepared Novolog insulin 20 units in an insulin syringe. -The MA administered the insulin into Resident #5's right abdomen at 8:05am. -The MA did not check the resident's FSBS during the observed medication pass. An attempted interview with Resident #5 on 09/27/23 at 8:09am was unsuccessful. Interview with the MA on 09/27/23 at 8:10am revealed: -She normally worked third shift but was filling in on first shift today. -The morning FSBS checks were usually done by the third shift MAs. -She checked Resident #5's FSBS around 5:30am that morning and it was 233. A second interview via telephone with the MA on 09/27/23 at 11:00am revealed: -Third shift MAs were responsible for FSBS but third shift MAs did not administer any morning insulin. -The FSBS results were entered into the eMAR and written down and given to the first shift MA. -First shift MAs were responsible for the administration of morning insulins. -She followed the instructions for FSBS checks	D 358		

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D 358	Continued From page 23 on the resident's eMAR and administered the insulin this morning based on Resident #5's eMAR. -Breakfast was usually served at 8:00am. Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 4:25pm revealed: -The MAs on third shift were responsible for FSBS checks. -The MA should not have checked the resident's FSBS at 5:30am. -The MA should have checked the FSBS no more than 30 minutes before the insulin was administered. -Breakfast used to be served at 7:00am, but was recently changed to 8:00am. Interview with the Administrator on 09/27/23 at 11:34am revealed: -Third shift MAs and first shift MAs were responsible for checking residents' FSBS before breakfast. -The MAs should check the residents' FSBS no more than 30 minutes before they ate breakfast. -The MA should have checked Resident #5's FSBS no more than 30 minutes before administering the insulin during the 8:00am medication pass on 09/27/23. -The pharmacy needed to be contacted to have the times changed on the eMAR. Interview with Resident #5's PCP on 09/27/23 at 10:14am revealed: -FSBS levels taken at 5:30am were too soon for insulin scheduled to be administered at breakfast. - The MA should have checked the FSBS at the time insulin was administered. -The resident's FSBS could drop below the parameter if it was checked too long before insulin was administered.	D 358		

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D 358	Continued From page 24 b. Review of Resident #5's current FL-2 dated 10/13/22 revealed there was an order for Levemir insulin pen, inject 50 units subcutaneously in the morning and 32 units subcutaneously at bedtime. (Levemir is a long-acting insulin used to lower blood sugar. According to the manufacturer, the Levemir insulin pen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles prior to administration. Once the needle is injected into the skin and the button is pressed to administer the medication, the pen should be left in place for at least six seconds to ensure that the full dose of medication is injected.) Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir insulin pen inject 50 units in the morning scheduled for 8:00am. -There was an entry to check fingerstick blood sugar (FSBS) four times daily at meals and at bedtime. -The resident's FSBS ranged from 74 - 439 from 09/01/23 - 09/27/23. Observation of the 8:00am medication pass from 8:00am - 8:20am on 09/27/23 revealed: -The medication aide (MA) dialed the Levemir insulin pen to 50 units and administered the insulin into Resident #5's left abdomen at 8:06am. -The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 50 units to ensure no air bubbles were present and insulin was flowing from the pen. -The MA removed the insulin pen from Resident #5's skin immediately after the injection and did	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 25 not hold the insulin pen in the skin after injecting the needle and pressing the button to allow the full dose of insulin to be injected. Telephone with the MA on 09/27/23 at 11:00am revealed: -She had training on the use of insulin pens by a nurse at the facility, but she was unsure when the training was done. -She had been employed at the facility for almost one year. -She was taught to perform a 2-unit air shot prior to dialing up the ordered dose of insulin to prime the insulin pen. -She did not perform the 2-unit air shot for Resident #5's Levemir insulin pen this morning because she was "in a rush". -She was unable to recall any specific instructions to hold the pen in place after injecting the insulin. Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 4:25pm revealed: -The MAs were trained on the proper technique for use of insulin pens when they were hired. -The MAs had been instructed to perform a 2-unit air shot prior to dialing the insulin pen to the ordered dose. -The MA should have primed the insulin pen with 2 units before administration of the correct dose and held the pen in place for a few seconds after pressing the button to ensure that the resident received the full dose prescribed. Interview with the Administrator on 09/27/23 at 11:34am revealed: -MAs were trained on insulin pens when they were hired. -The MA should have primed the pen with a 2-unit air shot, then adjusted the pen to the correct insulin dose.	D 358		

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D 358	Continued From page 26 -After the skin was cleaned and the needle was injected, the MA should have held the pen in place, or the resident may not have received the proper dose. Interview with Resident #5's primary care provider (PCP) on 09/27/23 at 10:14am revealed that the MAs needed to hold the pen in place after pushing the button to ensure that the resident received the full dose of insulin prescribed. 2. Review of Resident #2's current FL-2 dated 02/06/23 revealed: -Diagnoses included Parkinson's Disease, neuropathy, and falls. -The resident was intermittently disoriented and non-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 02/07/23. Review of Resident #2's local hospital emergency room visit report dated 06/22/23 revealed there was an order for Metformin HCL 500mg, 1 tablet two times a day with meals for diabetes mellitus. Telephone interview with the facility's contracted pharmacist on 09/27/23 at 4:15pm revealed: -Metformin 500mg HCL was ordered on 06/22/23 by a local hospital emergency room physician for Resident #2. -There was a notation in the pharmacy system that the family brought the supply of Metformin 500mg HCL to the facility (she did not know the quantity). -The pharmacist first dispensed Metformin 500mg HCL on 07/21/23 for Resident #2 for a quantity of 14 tablets for a 7-day supply until a prescription from the primary care provide (PCP) was received.	D 358		

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D 358	Continued From page 27 -The pharmacist dispensed Metformin 500mg HCL on 08/23/23 for a quantity of 36 tablets. -The pharmacist dispensed Metformin 500mg HCL on 09/06/23 for a quantity of 60 tablets. Review of Resident #2's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin HCL 500mg, 1 tablet two times a day with meals for diabetes mellitus to be administered at 8:00am and 5:00pm. -There was documentation Metformin HCL 500mg, 1 tablet was administered from 08/01/23 through 08/31/23 at 8:00am. -There was documentation Metformin HCL 500mg, 1 tablet was administered from 08/01/23 through 08/31/23 at 5:00pm except 08/04/23 with the notation medication needed to be ordered, 08/17/23 with the notation out of medicine, and 08/21/23 through 08/23/23 with the notation out of medicine, prescription refill needed. -Metformin HCL 500mg, 1 tablet was documented as not administered 5 times as ordered in August 2023 at 5:00pm. Observation of Resident #2's medications on hand on 09/27/23 at 3:15pm revealed there were 47 tablets of Metformin 500mg HCL remaining in the bubble card with a dispensed date of 09/06/23 for a quantity of 60 tablets. Attempted telephone interview with Resident #2's family member on 09/26/23 at 3:50pm was unsuccessful. Interview with the medication aide (MA) on 09/27/23 and 1:30pm revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring medications were in the	D 358		

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D 358	Continued From page 28 facility and conducting medication cart audits. -The MAs could electronically order medication from the pharmacy as well. Interview with the RCC on 09/27/23 at 5:33pm revealed: -She was responsible for ensuring medications were on the medication cart and notifying the provider when a prescription was needed. -The medication aides could also order medications from the pharmacy when the medication was not in the facility. -She tried to conduct a medication cart audit every Friday, but she was often on call to fill in when a personal care aide (PCA) or a MA "called out" from work. -She expected the MAs to notify her if a medication needed to be refilled or a new prescription was needed. Interview with the Director of Health Services (DHS) on 09/27/23 at 5:45pm revealed the RCC was responsible for ensuring medication and treatment orders were processed and medication were in the facility. Interview with the Administrator on 09/27/23 at 6:00pm revealed: -The RCC was responsible for ensuring medications were in the facility and notifying the provider when a new prescription was needed. -Medication cart audits were to be conducted weekly. -She expected medications to be available on the medication cart. Telephone interview with the primary care provider (PCP) on 09/29/23 at 11:33am revealed: -The Metformin medication was ordered when Resident #2 was in the hospital by a physician	D 358		

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D 358	Continued From page 29 because his blood sugar was high. -She remembered there being an issue with the prescription for Resident #2's Metformin, but could not recall the details. -She remembered being asked to write a prescription for the Metformin for Resident #2 when she came to the facility during one of her weekly visits. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable. 3. Review of Resident #3's current FL-2 dated 09/06/23 revealed: -Diagnoses included contractures of joints of bilateral hands. -The resident was non-ambulatory and constantly disoriented. Review of Resident #3's Resident Register revealed an admission date of 09/27/2019. Review of Resident #3's physician progress visit note dated 09/13/23 revealed: -Resident #3 had bilateral contractures to both hands. -She used an anti-fungal ointment. Review of Resident #3's physician medication orders dated 08/08/23 revealed an order for Remedy 2% Antifungal ointment, apply two times daily to left hand for fungal infection until healed. (Remedy is a medication used to treat a fungal infection). Review of Resident #3's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Remedy Antifungal 2%	D 358			

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D 358	Continued From page 30 ointment, apply two times daily to left hand for fungal infection until healed to be administered at 8:00am and 8:00pm. -There was documentation Remedy Antifungal 2% ointment was applied to the left hand from 08/10/23 through 08/31/23 at 8:00am and 8:00pm. Review of Resident #3's September 2023 eMAR revealed: -There was an entry for Remedy Antifungal 2% ointment, apply two times daily to left hand for fungal infection until healed to be administered at 8:00am and 8:00pm. -There was documentation Remedy Antifungal ointment was applied to the left hand from 09/01/23 through 09/22/23 at 8:00am and 8:00pm. -There was documentation Remedy Antifungal 2% ointment was not applied to the left hand from 09/23/23 through 09/26/23 at 8:00am and 8:00pm because the medication needed to be ordered from the pharmacy. -The Remedy Antifungal 2% ointment was not administered eight times in September 2023. Telephone interview with facility's contracted pharmacist on 09/27/23 at 4:15pm revealed: -Remedy Antifungal 2% ointment was dispensed on 08/09/23 for 1 tube. -Remedy Antifungal 2% ointment was dispensed on 09/25/23 for 1 tube. -One tube of the medication should last about one to two months. Observation of Resident #3's medications on hand on 09/27/23 at 3:15pm revealed there was no Remedy Antifungal 2% ointment on the medication cart.	D 358			

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D 358	Continued From page 31 Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable. Interview with the medication aide (MA) on 09/27/23 and 1:30pm revealed: -The Resident Care Coordinator (RCC) was responsible for ordering medications and conducting medication cart audits. -The MAs could electronically order medication from the pharmacy as well. Interview with the Resident Care Coordinator on (RCC) 09/27/23 at 5:33pm revealed: -She was responsible for ensuring medications were on the medication cart. -The medication aides could also order medications from the pharmacy when the medication was not in the facility. -She tried to conduct a medication cart audit every Friday, but she was often on call to fill in when a personal care aide (PCA) or a MA "called out" from work. -She expected the MAs to notify her if a medication needed to be refilled or a new prescription was needed. Interview with the Director of Health Services (DHS) on 09/27/23 at 5:45pm revealed the RCC was responsible for ensuring medication and treatment orders were processed and medications were in the facility. Interview with the Administrator on 09/27/23 at 6:00pm revealed: -The RCC was responsible for ensuring medications were ordered from the pharmacy and available on the medication cart. -Medication cart audits were to be conducted weekly.	D 358			

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D 358	Continued From page 32 -She expected medications to be available on the medication cart. Telephone interview with the PCP on 09/29/23 at 11:33am revealed the Remedy Antifungal medication was ordered for Resident #3 to treat a fungal infection of the left hand. 4. Review of Resident #1's current FL-2 dated 06/27/23 revealed: -Diagnoses included Parkinson's disease, hypertension, chronic cystitis, and bladder muscle dysfunction-overactive. -There was an order for Macrobid 100mg capsule take one at bedtime to help prevent urinary tract infections. Review of Resident #1's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Macrobid 100mg, 1 capsule at bedtime to prevent urinary tract infections. -The Macrobid was not administered on 08/08/23, 08/09/23 and 08/10/23. -There was documentation for the reason the Macrobid was not administered due to "ordered from pharmacy" on 08/08/23, "coming in batch" on 08/09/23 and "not available" on 08/10/23. Interview with Resident #1 on 09/26/23 at 9:45am revealed: -She had resided at the facility for almost 2 years. -The facility ran out of her medications every month because they did not order the medications on time. Interview with medication aide (MA) on 9/27/23 at 12:03pm revealed:	D 358			

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D 358	Continued From page 33 -All medications were on cycle refill. -She was unsure why Resident #1 ran out of Macrobid. Interview with another MA on 09/27/23 at 4:05pm revealed: -The facility medications were on cycle refill and the medications were delivered on 2nd or 3rd shift. -She was unsure why Resident #1 ran out of the Macrobid. Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 4:25pm revealed the facility medications were on cycle refill so she was unsure why Resident #1's Macrobid was unavailable on 08/08/23, 08/09/23 and 08/10/23. Interview with the Director of Health Services on 09/27/23 at 4:35pm revealed: -She did not administer medications. -The MAs administered medications. -The RCC was responsible for checking medication administration behind the MA. Interview with the Administrator on 09/27/23 at 4:35pm revealed: -The MAs were responsible for administering medications. -The RCC was responsible for checking medication administration behind the MA. Telephone interview with the Pharmacy Director on 09/27/23 at 4:55pm revealed: -Macrobid was prescribed for Resident #1 to prevent urinary tract infections. -The facility medications were on batch cycle refill so a 1-month supply of medications were sent each month. -Failure to administer the Macrobid daily could put	D 358			

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D 358	Continued From page 34 the resident at risk for urinary tract infections. Observation of medications on hand on 09/27/23 revealed there was a quantity of 13 Macrobid pills available on the cart.	D 358			