Received 01-02-24

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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
	HAL088014	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

(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 Transylvania Department of Social Services completed an annual survey from 11/14/23 - 11/16/23.	D 000	Response to the cited deficiencies do not constitute an admission or agrrement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with State Laws.	
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure at least one staff person was always on the premises, on night shift, who successfully completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 9 of 14 shifts from 11/01/23 through 11/14/23. The findings are:	D 167	10A NCAC 13F .0507 Training on Cardo-Pulmonary Resuscitation ED and/or Care Coordinator will ensure that at least one person on premises is CPR certified at all time and identified on the schedule daily. ED and/or Care Coordinator will review the schedule daily during Stand Up to ensure that at least one staff member is CPR certified and identified on each shift. RDO and/or ACD will review the schedule weekly during site visits to ensure that at least one staff member is CPR Certified and identified on each shift. Community conducted staff CPR training by RN on 11/28/23	01/02/24 01/02/24 01/02/24 11/28/23

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly B. Lang — TITLE: Executive Director — (X6) DATE: 1-2-24

STATE FORM 6899 J1W211 If continuation sheet 1 of 38

Reviewed + Acknowledged SMJ 01-02-24

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D 167	Continued From page 1 Review of the CPR certified staff list revealed the Resident Care Coordinator (RCC), Business Office Coordinator, 3 medication aides (MAs) and one PCA were the only staff currently certified to perform CPR. Review of the staff schedule and time punch detail cards for 11/01/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 6:42am. Review of the staff schedule and time punch detail cards for 11/04/23 revealed there were no CPR certified staff that worked night shift from 6:27pm - 12:00am. Review of the staff schedule and time punch detail cards for 11/05/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 6:00am and 6:33pm - 12:00am. Review of the staff schedule and time punch detail cards for 11/06/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 5:54am and 6:38pm - 12:00am. Review of the staff schedule and time punch detail cards for 11/07/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 5:54am. Review of the staff schedule and time punch detail cards for 11/11/23 revealed there were no CPR certified staff that worked night shift from 6:00pm -12:00am. Review of the staff schedule and time punch detail cards for 11/12/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 5:51am and 6:24pm - 12:00am.	D 167		

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D 167	Continued From page 2 Review of the staff schedule and time punch detail cards for 11/13/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 5:54am and 7:03pm - 12:00am. Review of the staff schedule and time punch detail cards for 11/14/23 revealed there were no CPR certified staff that worked night shift from 12:00am - 5:52am and 6:27pm - 12:00am. Interview with the Administrator on 11/16/23 at 9:55am revealed: -Within the past few weeks, the facility had several staff leave employment who were CPR certified. -This was primarily a problem on the night shift. -Corporate was aware this was an issue but currently had no date scheduled for a CPR class for facility staff. -She should have been monitoring the schedule more closely to ensure there was a staff member in the facility at all times who was CPR certified. The facility failed to ensure at least one staff was always on the premises who had completed a course in CPR within the last 24 months on night shift for 9 of 14 shifts from 11/01/23 through 11/14/23. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 2, 2024.	D 167		

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D 201	Continued From page 3	D 201		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201	10A NCAC 13F .0604(e)(1)(A)(B)(C) Personal Care and Other Staffing RDO provided inservice training for the ED/BOC and Care Coordinator on staffing rule area and requirements. Staff schedule will be review by the ED, BOC and Care Coordinator daily at Stand Up to ensure that staffing requirements are being met and arrangements made to add additional staff where needed. ED and/or BOC will update posting and recruiting for all staff positions open no less than weekly. ED will review labor report daily to ensure all staff are coded and working in the correct department. RDO will review the recruitment site and efforts of the Community no less than 2xs weekly for applicants for 30 days. RDO will review the labor reports no less than weekly to ensure all staff are coded and working in the correct department for no less than 30 days.	11/17/23 01/02/24 01/02/24 01/02/24 01/02/24 01/02/24

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D 201	Continued From page 4	D 201		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to ensure the required staffing hours were met during 11 shifts based on a census of 35 residents from 10/25/2023 through 11/09/2023.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/2023 revealed the facility was a licensed Assisted Living with a capacity of 64 residents.

Review of the facility's census record from 10/25/2023 through 11/09/2023 revealed that there was a census of 35 residents which required 28 staff hours on first and second shifts and 14 staff hours on third shift.

Review of the staff time records from 10/25/2023 through 11/09/2023 revealed:
Review of staff timecard punches revealed:
-On 10/25/2023, 21 staff hours were provided on first shift leaving a shortage of 7 staff hours.
-On 10/26/2023, 22.87 staff hours were provided on first shift leaving a shortage of 5.13 staff hours.
-On 10/27/2023, 26 staff hours were provided on first shift leaving a shortage of 2 staff hours.
-On 10/28/2023, 28 staff hours were provided on first shift leaving a shortage of 10.87 staff hours.
-On 10/29/2023, 28 staff hours were provided on first shift leaving a shortage of 3.77 staff hours.

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D 201	Continued From page 5 -On 10/31/2023, 28 staff hours were provided on first shift leaving a shortage of 6.65 staff hours. -On 11/02/2023, 28 staff hours were provided on first shift leaving a shortage of 10.20 staff hours. -On 11/03/2023, 28 staff hours were provided on first shift leaving a shortage of 9.30 staff hours. -On 11/04/2023, 28 staff hours were provided on first shift leaving a shortage of 16.07 staff hours. -On 11/05/2023, 28 staff hours were provided on first shift leaving a shortage of 4 staff hours. -On 11/09/2023, 28 staff hours were provided on first shift leaving a shortage of 18.17 staff hours. Interview with a resident on 11/14/2023 at 9:45am revealed: -There was never enough staff on all shifts but especially on nights and weekends. -He often did not get his eye medication at night but was unsure if it was due to staffing issues. -The staff was supposed to be assisting him with showers several times a week and that was not happening. Interview with a medication aide (MA) on 11/15/23 at 6:06am revealed: -Staffing had just recently gotten better in the past 2 weeks. -Prior to 2 weeks ago, he worked as the only MA with one personal care aide (PCA) on night shift. -No one was going without care, but he and the PCA had to hustle to get everything done for the residents. Interview with a PCA on 11/15/2023 at 10:44am revealed: -She worked 1st shift in activities. -She had been filling in as a PCA on the floor occasionally for 1st shift. -There were not enough staff to provide all the personal care needed for the residents.	D 201		

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D 201	Continued From page 6 -She did not not always have time to get showers completed for the residents. Interview with a second MA on 11/15/23 at 1:55pm revealed: -Sometimes they were unable to complete showers during the week so they would move the resident's shower to the weekend. -Sometimes hydration passes and snack passes were not done. -Often there was just one MA and one PCA on night shift. -If the MA was upstairs administering medications, the MA needed the PCA to remain downstairs to answer any call lights. -There were often not enough staff to complete care needs of the residents. Interview with a third MA on 11/15/2023 at 2:00pm revealed: -She worked 3rd shift from 6pm until 6am. -Almost every night the facility was short on staffing for 3rd shift. -Administration had not come in to help on the floor on 3rd shift. - If Administrative staff were in the building, they worked in their offices. -She had worked 110 hours in two weeks. -She had been unable to get personal care and hygiene tasks completed for residents during her shifts because of staffing issues. -She had not had time to get a snack pass or hydration pass done. -Showers were not getting done due to being short staffed. -She had concerns when both staff were upstairs having to do personal care, the residents who were downstairs were left unattended. -She was aware all residents were not getting changed at night.	D 201		

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D 201	Continued From page 7 -Day shift staff were expected to complete what night shift could not complete, but day shift could not get everything completed due to being short staffed. Interview with a second PCA on 11/15/23 at 4:14pm revealed: -On weekends, it was difficult to get resident care tasks completed on time due to being the only PCA working that shift. -Residents waited longer to get personal care completed. -All resident care tasks could not get accomplished in her scheduled working window when she was the only PCA on the floor. Interview with a third PCA on 11/15/23 at 4:31pm revealed: -Often, she was alone on the floor during her shifts. -She worked alone most of the time. -It had been difficult to get showers completed. -Showers could not get completed within her scheduled working hours when she the only PCA working. Interview with the Resident Care Coordinator (RCC) on 11/15/2023 at 4:17pm revealed: -She was aware of the facility being short staffed on day shift and filled in on the floor many times. -She was a new RCC and was trying to work with the Administrator to hire more staff. -She came in on the weekends to help cover shifts. -She was unsure of the ratio for staff to residents on day and night shifts. Interview with the Administrator on 11/16/2023 at 9:56am revealed: -She was aware of several shifts being short	D 201		

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D 201	Continued From page 8 staffed. -She and the RCC worked on the floor at times. -The RCC had been working on the floor at least twice a week. -She had to utilize the Business Office Coordinator (BOC) to also fill in on the floor. -She had job postings posted on multiple websites. -Due to the physical location of the facility in the county, it was difficult to find staff. The facility failed to provide the required number of staffing hours on 11 of 15 shifts between 10/26/2023 through 11/09/2023 which resulted in residents not getting showers, hydration and snack passes not being done, and timely personal hygiene not occurring. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 2, 2024.	D 201		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The	D 254	10A NCAC 13F .0801(b) Resident Assessment ED and Care Coordinator attended training for Care Coordinator Orientation. Care Coordinator will review all assessments to ensure that all annuals are up to date. Care Coordinator will add Care Plan Assessment to the Matrix scheduler to ensure they are completed on time. ED will monitor and review Matrix scheduler monthly to ensure all assessments are completed	11/29/23 & 11/30/23 01/02/24 01/02/24 01/02/24

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D 254	Continued From page 9 assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#2 and #3) had a care plan completed within 30 days of admission and at least annually thereafter. The findings are: 1. Review of Resident #2's current FL2 dated 04/21/23 revealed: -Diagnoses included high blood pressure and anemia (low amount of red blood cells to carry oxygen throughout the body). -He was semi-ambulatory. -He was intermittently disoriented. Review of Resident #2's care plan dated 09/12/22	D 254		

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D 254	Continued From page 10	D 254		

revealed:
-He required supervision with bathing.
-He required limited assistance with eating.
-He was independent with toileting, ambulation, dressing, grooming and transfers.
-There was no subsequent care plan available for review.

Interview with the RCC on 11/15/23 at 6:24am revealed:
-She had discovered on 11/14/23 there were several care plans that had never been completed or had not been updated annually.
-She had been in her position as RCC for less than 6 weeks.
-She was unaware prior to 11/14/23 there were care plans that had never been completed or had not been updated annually.

Interview with a personal care aide (PCA) on 11/15/23 at 10:29am revealed:
-She had never looked at any of the resident's care plans.
-The care plans were kept in the resident's charts.
-She would go to the medication aide (MA) or the Resident Care Coordinator (RCC) if she did not know what to do for a resident.

Interview with a second PCA on 11/15/23 at 10:38am revealed:
-It was common sense to know how to care for the residents.
-If the resident was verbally unable to tell her what they needed, she would ask the RCC.

Interview with the Administrator on 11/16/23 at 9:55am revealed:
-There had been several RCC's in the last few months that had worked at the facility.

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D 254	Continued From page 11 -The RCC was responsible for completing and updating the care plans. -She was unaware the care plans were not being completed timely and updated annually. -She needed additional training on resident care plans because her knowledge base was weak in that area. 2. Review of Resident #3's current FL2 dated 03/09/23 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease, atrial fibrillation, major depressive disorder- single episode. -She was ambulatory -She was intermittently disoriented. Review of Resident #3's record revealed a care plan had not been completed. Refer to interview with the RCC on 11/15/23 at 6:24am. Refer to interview with PCA on 11:15/23 at 10:29am. Refer to interview with a second PCA on 11:15/23 at 10:38am. Refer to interview with Administrator on 11/16/23 at 9:55am.	D 254		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment:	D 263	10A NCAC 13F .0801(b) Resident Assessment ED and Care Coordinator attended training for Care Coordinator Orientation. Care Coordinator will add Care Plan Assessment to the Matrix scheduler to ensure they are completed on time and signed by the Physician. ACD and/or ED will monitor and review Care Plans monthly to ensure that they are completed and signed by the Physician.	11/29/23 & 11/30/23 01/02/24 01/02/24

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D 263	Continued From page 12 (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 and #5) had a care plan that was signed by a provider within 15 days of the residents' being assessed. The findings are: Review of Resident #1's care plan dated 02/11/23 was not signed by the Primary Care Physician (PCP) within 15 days of completion. Review of Resident #5's care plan dated 02/15/23 was not signed by the PCP within 15 days of completion. Interview with a Medication Aide (MA) on 11/15/2023 at 10:15am revealed: -She was checked off as a MA on 11/14/2023. -She had never been trained to read the resident care plan. -She was aware care plans are kept in the medical charts. -She had never looked at the care plans. -She would ask the Resident Care Coordinator (RCC) or MA what to do for the resident. In person interview with MA on 11/15/2023 at 10:38am revealed: -She was aware every resident care plan is different. -Care plans are in the resident medical record.	D 263		

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D 263	Continued From page 13 -She would look at the care plans to see what assistance the resident required. -She would ask the RCC if the resident could not vocalize their needs. In person interview with Personal Care Assistant (PCA) on 11/152023 at 10:44am revealed: -Most residents could tell you what type of assistance they need. -The RCC would tell you what each new resident assistance was required. -Care plans are in the medical records. -She had not looked at care plans recently. -The last care plan she had looked at was the last admission over a month ago. Interview with the Administrator on 11/16/2023 at 9:56am revealed: -She was unaware care plans had not been signed within the 15 days of completion. -The former RCC was completing care plans and would not "tell her" how to complete them. -Care plans are to be completed every 6 months or annually, uncertain. -She will be attending a two day training at the end of month.	D 263		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4	D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service ED and Care Coordinator provided inservice training to Dietary staff on Therapeautic diets. Dietary Manager and/or Dietary staff will review and serve meals according to the correct diet order. ED and/or Care Coordinator will review diet order changes in daily Stand Up meeting with Dietary Manager. ED and/or Care coordinator will monitor meals weekly to ensure correct diets are being served.	11/24/23 01/02/24 01/02/24 11/24/23 & ongoing

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D 310	Continued From page 14 sampled residents (#4) were served physician ordered therapeutic diets related to mechanical soft, entire meal with ground meats. 1. Review of Resident #4's current FL2 dated 03/09/23 revealed diagnoses included hypothyroidism, hyperlipidemia, hypertension, acute angle-closure and glaucoma. Review of Resident #4's Physician order's dated 03/09/23 revealed regular diet, mechanical soft, entire meal with ground meats. Review of the regular lunch meal menu for 11/14/23 revealed Garlic Herb Pork Roast, fresh cooked yams, peas and onions, baked roll, beverage choice, and grapes. Observation of the lunch meal and beverage service on 11/14/23 at 11:50am revealed Resident #4 was served pork tenderloin cut in bite size pieces, peas, biscuit, cake, water, tea. Interview with the Business Office Manager (BOM) on 11/14/23 at 12:20pm revealed: -The cook had given her the meal tray to give Resident #4. -She had been aware the resident had special food orders consisting of mechanical soft, ground meats only. -She did not know the meat was not ground meat. Interview the cook on 11/14/23 at 12:10pm revealed: -She should have ground up the pork tenderloin "a little better." -There were no pictures posted in the kitchen of what exactly the food was supposed to look like, but she was trained by the Dietary Manager (DM) how to ground up the meat.	D 310		

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D 310	Continued From page 15 -When she prepared the food for lunch, the DM was not there and she thought she did it right, but after looking at it, it was not ground up like it should have been. Interview with the Dietary Manager (DM) on 11/14/23 at 12:22pm revealed: -The pork tenderloin was not served as mechanical soft, ground meat as ordered. -She had not posted pictures in the kitchen for cooks to look at when she was unavailable. -There was a mobile app all kitchen staff were trained to use. -The app could be assessed on the smartphones and provided pictures of all types of diets that were ordered to ensure meals prepared correctly. Interview with the Family Nurse Practitioner, (FNP) revealed: -If Resident #4 did not get the appropriate diet, there would be a concern for dysphagia (difficulty swallowing). -He had not ordered this diet for the resident. Interview with the Administrator on 11/16/23 at 9:54am revealed: -All FL2's had diets listed and the diet orders 3were given to the DM. -Staff were trained by the DM on how to prepare therapeutic diets. -Staff received training for special diets and how to prepare food.	D 310		
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,	D 358	10A NCAC 13F .1004(a) Medication Administration Care Coordinator and Med Techs completed a MAR to Cart Review of all MARs to ensure medications were available to be administered. ED and Care Coordinator attended Care Coordinator orientation training.	11/17/23 & 11/20/23 11/29/23 & 11/30/23

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D 358	Continued From page 16 prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 5 sampled residents (#2 and #4) which included a medicated eye drop used for treatment of glaucoma (#2 and #4), medication used for anxiety (#3), insomnia (#1 and #3), prevention of heart attacks and strokes (#1 and #5), anxiety and depression (#5) and for high cholesterol (#1). The findings are: Review of the facility's medication policy dated September 2021 revealed: -The medication aide (MA) should contact the pharmacy or the pharmacy's "on-call" pharmacist and communicate to him/her the medication order in its entirety. -The pharmacist should then make whatever arrangements necessary with a predetermined local pharmacy (back-up pharmacy) or if the back-up pharmacy cannot supply, with any other local retail pharmacy or hospital pharmacy, to obtain the medication(s) in time to be administered within the timeframes. -If arrangements are made through a pharmacy other than the "back-up pharmacy", the pharmacist should inform the MA by return phone call. -The MA should not contact the back-up	D 358	ACD, ED and Care Coordinator provided training to Med Aides on medication administration and to ensure that medications are being administered as written and as often as written by Physician. ED and/or Care Coordinator will perform cart audit no less want 1x weekly for accuracy of medication administration. Care Coordinator and/or Med Aides will fax all orders to pharmacy for review and documented on the EMAR. ED and/or Care Coordinator will check all orders prior to approval to ensure order accuracy and that the order matches what is in the Matrix EMAR system using the order processing system.	12/13/23 01/02/24 01/02/24 01/02/24

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D 358	Continued From page 17 pharmacy without first contacting the contracted pharmacy or the pharmacist "on call"; and only then to arrange for the order to be picked up and delivered. -If all attempts to contact the pharmacist "on call" fail, the MA should take whatever steps necessary to secure the required medication(s), including contacting the "back-up pharmacy" directly. -The Community may need to pick up the medication(s) from the "back-up" pharmacy or other alternate source of supply. 1. Review of Resident #2's current FL2 dated 04/21/23 revealed: -Diagnoses included high blood pressure and anemia. -He was intermittently disoriented. Review of Resident #2's ophthalmic report dated 04/05/23 revealed: -Resident #2 was being seen every 6 months for follow-up on the treatment of his glaucoma (an eye condition that if left untreated can lead to blindness due to internal eye pressure). -Resident #2's Opthalmologist wrote an order for Latanoprost 0.005% eye drops daily, one drop in each eye. Review of Resident #2's electronic medication administration record (eMAR) for September 2023 revealed: -There was an entry for Lananoprost 0.005% eye drops, instill one drop in both eyes at 7:00pm daily. -On 09/14/23, 09/15/23, 09/19/23, 09/21/23, and 09/22/23, Latanoprost was documented as not administered due to being "on hold". -On 09/20/23 Latanoprost was documented as not administered due to "drug item not available -	D 358		

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D 358	Continued From page 18 pharmacy". -On 09/23/23, 09/27/23, and 09/30/23, Latanoprost was documented as not administered due to "waiting on pharmacy". -On 09/24/23 Latanoprost was documented as not administered due to being "refused". Review of Resident #2's eMAR for October 2023 revealed: -There was an entry for Lananoprost 0.005% eye drops, instill one drop in both eyes at 7:00pm daily. -On 10/01/23 and 10/03/23, Latanoprost was documented as not administered due to being "on hold - waiting on pharmacy". -On 10/02/23 Latanoprost was documented as not administered due to being "on hold". -On 10/04/23 Latanoprost was documented as not administered due to being "on hold - pharmacy". -On 10/05/23 Latanoprost was documented as not administered due to "drug/item unavailable". Review of Resident #2's eMAR for 11/01/23 - 11/13/23 revealed: -There was an entry for Lananoprost 0.005% eye drops, instill one drop in both eyes at 7:00pm daily. -On 11/07/23, 11/08/23, 11/10/23, and 11/13/23, Latanoprost was documented as not administered due to being "on hold". -On 11/12/23 Latanoprost was documented as not administered due to being "on hold - waiting on pharmacy". Observation of medication available for administration to Resident #2 on 11/14/23 at 2:47pm revealed Latanoprost 0.005% eye drops were not available on the medication cart or in the facility for Resident #2.	D 358		

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D 358	Continued From page 19 Interview with Resident #2 on 11/14/23 at 9:30am during initial tour revealed: -The staff often did not have his eye drops. -He needed his eye drops so he would not go blind. -He did not get his eye drops regularly and was worried about his vision. Interview with the Resident Care Coordinator (RCC) on 11/15/23 at 3:07pm revealed: -She made a phone call to the pharmacy on 11/14/23 and discovered the last time Latanoprost was ordered for Resident #2 was 10/04/23. -Latanoprost should be discarded 28 days after it was opened. -The Latanoprost was not reordered on 11/01/23, but it should have been. -If a medication was unable to be reordered, she was supposed to be made aware by the medication aide (MA). -She was trained by the previous RCC to document a medication was "on hold" if the facility was waiting to receive it from the pharmacy. Interview with a MA on 11/15/23 at 5:57am revealed: -She administered Resident #2 his last Latanoprost eye drop on 11/06/23. -The Latanoprost was still unavailable for administration to Resident #2 on 11/07/23. -As of 11/13/23, Resident #2's Latanoprost had not yet been delivered by the pharmacy. -Getting medications timely from the pharmacy had been a problem for several months. -She continued to call the pharmacy about medications that were unavailable for adminstration to the residents until they were	D 358		

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D 358	Continued From page 20 delivered to the facility. Interview with a second MA on 11/15/23 at 6:06am revealed: -He did not have the Latanoprost to administer to Resident #2 on 11/09/23. -He incorrectly documented on the eMAR he had administered Latanoprost to Resident #2 on 11/09/23. -If he used the last of any medication, he just reordered the medication on the computer and the medication would come in "within a week." -He could fax the pharmacy for a stat order if he was missing a medication, but he had never done that. -He was trained by a previous RCC to document the medication was "on hold" if they were waiting to receive it from the pharmacy. Telephone interview with Resident #2's Ophthalmologist on 11/15/23 at 8:01am revealed: -Resident #2 had a diagnosis of glaucoma. -Resident #2 was seen every 6 months for ongoing follow-up and treatment of his glaucoma. -Resident #2 had an order for Latanoprost 1 eye drop in each eye daily for treatment of his glaucoma. -He was not aware Resident #2 had not been administered his Latanoprost daily as ordered, over the past several weeks. -If Resident #2 did not receive his Latanoprost daily, he could lose his vision permanently. -The Latanoprost needed to be given every day to be effective. Interview with the facility's primary care provider (PCP) on 11/15/23 at 8:52am revealed: -Resident #2 should be receiving all his medications as ordered. -He had not been made aware Resident #2 was	D 358		

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D 358	Continued From page 21 not receiving his Latanoprost. -Resident #2 was being followed by an Ophthalmologist for his glaucoma. Interview with a third MA on 11/15/23 at 1:55pm revealed: -Resident #2 often verbalized that his eyes bothered him a lot. -When Resident #2 did not have his Latanoprost he got "very upset". -There were numerous occasions in the past few weeks Resident #2's Latanoprost was not available for administration. -She was told by the previous RCC, if a medication was not available in the facility to document "on hold" and "waiting on pharmacy" on the eMAR. -She completed a cart audit every week and sent a list of all medications missing or in need or reordering to the pharmacy via fax. -She was not aware if the facility had a back-up pharmacy. Interview with a representative from the facility's contracted pharmacy on 11/16/23 at 8:59am revealed: -Resident #2 had an order for Latanoprost 0.005% one drop in each eye daily. -One bottle of Latanoprost was delivered to the facility on 08/03/23. -The next bottle of Latanoprost was delivered to the facility on 10/05/23. -There had been no Lantanoprost ordered for Resident #2 from the facility since 10/05/23. -Latanoprost was good for 30 days once opened and should then be discarded according to the manufacturer. -There had not been a supply issue with Latanoprost. -If they received an order for it by phone or fax, it	D 358		

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would be available to the facility by the next day.
-If for some reason the pharmacy did not have the medication, the facility had 2 back-up pharmacies they could use to ensure residents had their medications.

Interview with the Administrator on 11/16/23 at 9:55am revealed:
-There was no excuse for medication not being available for administration to the residents.
-The facility utilized a contracted pharmacy out of state, but also had 2 local back-up pharmacies that could deliver medications to the facility.
-Medications should be reordered several days before the last medication was administered.
-The previous RCC had trained the MAs to document a medication was "on hold" if it had not been received from the pharmacy.
-Her expectations were for the MAs to let the RCC know if there was a medication that had not been received from the pharmacy resulting in the resident missing a dose of a medication.
2. Review of Resident #3's current FL2 dated 03/09/23 revealed diagnoses of chronic obstructive pulmonary disease, hypertension, major depressive disorder-single episode, and atrial fibrillation.

a. Review of Resident #3's physician orders dated 03/09/23 revealed:
-There was an order for diazepam (a medication used to treat anxiety) 2mg tablet to be administered at bedtime.
-There were no orders to hold diazepam.

Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for diazepam 2mg tablet scheduled to be administered at 8:30pm.

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D 358	Continued From page 23 -Diazepam 2mg was documented as not administered for 12 out of 30 occasions. -On 09/19/23, 09/21/23 - 09/24/23, and 09/26/23 - 09/28/23, there was documentation diazepam was not administered, with a note "on hold." -On 09/20/23, 09/25/23, and 09/29/23, there was documentation diazepam was not administered, with a note "waiting on pharmacy." Review of Resident #3's October 2023 eMAR revealed: -There was an entry for diazepam 2mg tablet scheduled to be administered at 8:30pm. -Diazepam 2mg tablet was documented as not administered for 29 of 31 occasions. -On 10/01/23 - 10/03/23, 10/07/23 - 10/09/23, 10/14/23 - 10/15/23 and 10/21/23 - 10/22/23 there was documentation diazepam was not administered with the reason documented as "waiting on pharmacy." -On 10/05/23 and 10/06/23 there was documentation diazepam was not administered, with the reason documented as "drug unavailable." -On 10/10/23 - 10/11/23, 10/13/23, 10/17/23 - 10/20/23, and 10/23/23 - 10/31/23 there was documentation diazepam was not administered, with the reason documented "on hold." On 10/12/23 there was documentation diazepam was not administered, with the reason documented as "oh hold, drug unavailable." Review of Resident #3's November 2023 eMAR (11/01/23 - 11/14/23) revealed: -There was an entry for diazepam 2mg tablet scheduled to be administered at 8:30pm. -Diazepam 2mg tablet was documented as not administered for 6 of 14 occasions. -On 11/01/23 - 11/03/23 and 11/06/23 there was documentation diazepam was not administered,	D 358	10A NCAC 13F .0802(e) Resident Care Plan	

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with the reason documented "on hold."
-On 11/04/23 and 11/05/23 there was documentation diazepam was not administered, with the reason documented "waiting on pharmacy."

Observation of medications on hand on 11/15/23 at 3:00pm for Resident #3 revealed diazepam 2mg was available for administration.

Interview with a medication aide (MA) on 11/15/23 at 1:26pm revealed:
-She had been aware diazepam was not given to Resident #3 as ordered.
-She believed it was an issue with the pharmacy being out of stock of diazepam for Resident #3.
-She informed the Resident Care Coordinator (RCC) and the Administrator that diazepam was often out of stock for Resident #3.
-The resident would often get upset when she did not get her medications as prescribed.

Interview with the RCC on 11/15/23 at 12:46pm revealed:
-She was aware Resident #3's diazepam had not been available for administration.
-She talked to the pharmacy and Administrator about Resident #3's diazepam not being available to be administered to Resident #3.

Interview with a representative from the facility's contracted pharmacy on 11/16/23 at 9:20am revealed:
-The pharmacy had not been out of stock of Resident #3's diazepam.
-There were no orders received from the facility for diazepam for the month of October.
A new order for diazepam for Resident #3 was received from the facility on 11/06/23.
-Medication refills could be requested either by

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CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

(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 phone or electronically. Interview with the Administrator on 11/16/23 at 9:56am revealed: -If MAs did not have the medication available, it was an expectation to let the RCC or Administrator know. -There was a problem with communication with the pharmacy. -There had been no system in place to perform medication cart audits until the last month. b. Review of Resident #3's physician orders dated 03/09/23 revealed: -There was an order for zolpidem 10 mg tablet to be administered at 8:30pm (used for sleeplessness). -There were no orders to hold zolpidem. Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for zolpidem 10mg tablet to be administered at 8:30pm. -Zolpidem 10mg was documented as not administered for 4 of 30 occasions. -On 09/18/23 and 09/19/23, there was documentation zolpidem was not administered, with the reason documented "waiting on pharmacy". -On 09/20/23, there was documentation zolpidem was not administered, with the reason documented "waiting on prescription". -On 09/21/23, there was documentation zolpidem was not administered, with the reason documented "on hold". -Review of Resident #3's October 2023 eMAR's revealed: -There was an entry for zolpidem 10mg tablet to	D 358	10A NCAC 13F .0802(e) Resident Care Plan	

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D 358	Continued From page 26 be administered at 8:30pm. -Zolpidem 10mg was documented as not administered for 10 out of 31 occasions. -On 10/22/23, there was documentation zolpidem was not administered, with the reason documented "waiting on pharmacy". -On 10/23/23 through 10/31/23, there was documentation zolpidem was not administered, with the reason documented "on hold". Review of Resident #3's November eMAR (11/01/23-11/14/23) revealed: -There was an entry for zolpidem 10mg tablet scheduled to be administered at 8:30pm. -Zolpidem 10mg was documented as not administered on 6 of 14 occasions. -On 11/01/23 through 11/03/23, there was documentation zolpidem was not administered, with the reason documented "on hold". -On 11/04/23 and 11/05/23, there was documentation zolpidem was not administered, with the reason documented "waiting on pharmacy". -On 11/06/23, there was documentation zolpidem was not administered, with the reason "on hold". Observation of the medications on hand for Resident #3 on 11/15/23 at 3:00pm revealed there was no zolipdem available on cart due to a discharge order for zolpidem on 11/06/23. Interview with a medication aide (MA) on 11/15/23 at 1:26pm revealed: -She had been aware zolpidem had not been given to Resident #3 as ordered. -She believed it was an issue with pharmacy being out of stock. -She informed the Resident Care Coordinator (RCC) and Administrator that zolpidem was often out of stock for Resident #3.	D 358		

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D 358	Continued From page 27 -The resident would often get upset when she did not get her medications as prescribed. Interview with the Resident Care Coordinator (RCC) on 11/15/23 at 12:48pm revealed: -She knew Resident #3's zolpidem was not available to be administered. -She talked to the pharmacy and Administrator about the zolpidem not being available for the resident. Interview with a representative from the facility's contracted Pharmacy on 11/16/23 at 9:20am revealed: -The pharmacy had not been out of stock on Resident #3's zolpidem. -There were no orders for zolpidem in for the month of October. -The facility last requested zolpidem was 09/09/23. -Orders could be requested either by phone or electronically. 3. Review of Resident #4's current FL2 dated 03/09/23 revealed: -Diagnosis of acute angle closer glaucoma, unspecified eye. -An order for latanoprost 0.005%, instill one drop in each eye at bedtime. Review of Resident #4's physician order dated 03/09/23 revealed an order for latanoprost 0.005% to be administered, instilling one drop in both eyes at bedtime. Review of Resident #4's electronic medication administration record (eMAR) for September 2023, October 2023, and November 2023 revealed administer latanoprost drops, 0.005%, instill one drop in both eyes at bedtime.	D 358		

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D 358	Continued From page 28 Review of Resident #4's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for latanoprost 0.005% scheduled to be administered at 7:00pm. -Latanoprost 0.005% was documented as not administered for 10 of 30 occasions. -On 09/15/23, there was documentation latanoprost was not administered, with the reason documented as "on hold". -On 09/16/23, 09/17/23, 09/23/23 and 09/24/23, there was documentation latanoprost was not administered, with the reason documented "waiting on pharmacy". -On 09/25/23, there was documentation latanoprost was not administered, with the reason documented "on hold". -On 09/27/23, there was documentation latanoprost was not administered, with the reason documented "waiting for the pharmacy". -On 09/28/23, there was documentation latanoprost was not administered, with the reason documented "refused." -On 09/29/23, there was documentation latanoprost was not administered, with the reason documented "on hold". -On 09/30/23, there was documentation latanoprost was not administered, with the reason documented "waiting for the pharmacy." Review of Resident #4's October 2023 eMAR revealed: -There was an entry for latanoprost 0.005% scheduled to be administered at 7:00pm. -Latanoprost 0.005% was documented as not administered 12 of 31 occasions. -On 10/01/23, 10/07/23, 10/08/23, 10/14/23 and 10/15/23, there was documentation latanoprost was not administered, with the reason	D 358	10A NCAC 13F .0802(e) Resident Care Plan	

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D 358	Continued From page 29 documented "waiting on the pharmacy". -On 10/16/23, there was documentation latanoprost was not administered, with the reason documented "on hold". -On 10/21/23 and 10/22/23, there was documentation latanoprost was not administered, with the reason documented "waiting on the pharmacy". -On 10/23/23, 10/28/23, 10/29/23, and 10/30/23, there was documentation latanoprost was not administered, with the reason documented "on hold". Review of Resident #4's November eMAR (11/01/23-11/14/23) revealed: -There was an entry for latanoprost 0.005% scheduled to be administered at 7:00pm -Latanoprost 0.005% was documented as not administered 3 of 14 occasions. -On 11/12/23, there was documentation latanoprost was not administered, with the reason documented as "waiting on pharmacy". -On 11/13/23 and 11/14/23, there was documentation latanoprost was not administered, with the reason documented "on hold". Observation of the medications on hand for Resident #4 on 11/15/23 at 4:00pm revealed there was no latanoprost 0.005% available for administration. Interview with the medication aide (MA) on 11/15/23 at 1:56pm revealed: -She knew latanoprost had not been administered to Resident #4 as ordered. -She did not know if latanoprost had been reordered. -She participated in cart audits once a week. -She had been told by the Resident Care Coordinator (RCC) and the Administrator when	D 358		

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D 358	Continued From page 30 medications were not available it had been an issue with the pharmacy. Interview with the RCC on 11/15/23 at 12:48pm revealed: -She was aware Resident #4's latanoprost was not available to administer. -She had recently talked to the pharmacy and Administrator about the issue. -After she had talked to the Administrator, the medications would then come to facility and would be available to administer. -She had reported having orders and faxing them to the pharmacy and she would not get the medications. -She had not understood why it would take so long other than the pharmacy was out of stock. Interview with a representative from the facility's contracted pharmacy on 11/16/23 at 9:20am revealed: -There had never been an issue with the pharmacy not having the latanoprost available to send to the facility. -If the facility requested the medication, the medication was delivered. -The facility had not been requesting medication refills timely when they ran out of the latanoprost for Resident 34. Interview with the Administrator on 11/16/23 at 9:56am revealed: -If MAs did not have the medications available, it was an expectation to let the RCC or Administrator know. -There was a problem with communication with the pharmacy. -There had been no system in place to perform medication cart audits until the last month.	D 358		

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D 358	Continued From page 31 Interview with Resident #4's Ophthalmologist on 11/16/23 at 4:51pm revealed: -He was unaware Resident #4 was not receiving her latanoprost. -If she did not get her medications, her eye pressure could build up and could lead to blindness. 4. Review of Resident #1's current FL2 dated 12/22/22 revealed diagnoses of Huntington's disease and cognitive impairment. a. Review of Resident #1's physician orders dated 12/22/22 revealed there was an order for aspirin (medication used to prevent heart attacks and strokes) 81mg tablet to be administered at bedtime. Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg to be administered at bedtime. -Aspirin was documented as not administered for 28 out of 30 occasions. -On 09/03/23 through 09/30/23, there was documentation aspirin was not administered, with a note "waiting on pharmacy." Review of Resident #1's October 2023 eMAR revealed: -There was an entry for aspirin 81mg to be administered at bedtime. -Aspirin was documented as not administered for 18 of 31 occasions. -On 10/01/23, 10/03/23, 10/05/23 - 10/07/23 and 10/10/23 -10/22/23, there was documentation aspirin was not administered, with a note "waiting on pharmacy." -On 10/01/23 there was documentation aspiring	D 358		

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D 358	Continued From page 32 was not administered, with a note "on hold." b. Review of Resident #1's physician orders dated 12/22/22 revealed there was an order for pravastatin (medication used to treat high cholesterol) 80mg take ½ tablet twice daily. Review of Resident #1's September 2023 eMAR revealed: -There was an entry for pravastatin 80mg to be administered twice daily. -Pravastatin 80mg was documented as not administered for 13 of 30 occasions. -On 09/18/23 through 09/30/23, there was documentation pravastatin was not administered with a note "waiting on pharmacy." Review of Resident #1's October 2023 eMAR revealed: -There was an entry for pravastatin 80mg to be administered twice daily. -Pravastatin 80mg was documented as not administered for 11 of 31 occasions. -On 10/01/23 through 10/04/23 there was documentation pravastatin was not administered with a note "waiting on pharmacy." -On 10/10/23 through 10/12/23 there was documentation pravastatin was not administered with a note "on hold." -On 10/25/23 there was documentation pravastatin was not administered with a note "resident unavailable." c. Review of Resident #1's physician orders dated 12/22/22 revealed there was an order for zolpidem (medication used to treat insomnia) 5mg tablet to be administered at bedtime. Review of Resident #1's October 2023 eMAR revealed:	D 358		

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D 358	Continued From page 33 -There was an entry for zolpidem 5mg tablet to administered at bedtime. -Zolpidem was documented as not administered for 4 of 30 occasions. Interview with a medication aide (MA) on 11/15/23 at 2:00pm revealed: -She was aware of the missing medications for Resident #1. -She usually did cart audits. -She would write down what was missing and leave a note for the Resident Care Coordinator (RCC). -She could not see if the medication had been reordered. -She would try to call the pharmacy on night shift to follow-up, however, she could not get anyone to answer. -They used an out of state pharmacy -When medications were not available to be administered, she was instructed by the Administrator and former RCC to write a note, "on hold, waiting on pharmacy." -Her expectation was that all medications for the residents should always be in the building, and they should never run out. Interview with Resident #1's Primary Care Provider (PCP) on 11/16/23 at 9:30am revealed: -He was unaware that medications were not available to be administered. -When orders were written, he expected them to be followed. -He had not placed any medication on hold. -Staff did not notify him of any missing medications. -He had never been contacted to place an order on hold. -If aspirin was not given daily Resident #1 could have a stroke.	D 358		

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D 358	Continued From page 34 -If pravastatin was not given as scheduled, it could cause Resident #1's cholesterol to go up with possible side effects of a heart attack or stroke. Interview with the RCC on 11/14/23 at 3:17pm revealed: -She was aware medications were missing for Resident #1. -Resident #1's spouse picked up medications from a local pharmacy and brough medications to the facility. -She was unsure of the procedure to ensure that the medication ended up on the eMAR. -She instructed the MAs to fill out a paper MAR and administer medications. -She was aware of issues with getting the spouse to bring in the medications. -She was aware the local pharmacy was not going to fill her medications in a multi-dose pack. Interview with the Administrator on 11/16/23 at 9:56am revealed: -She was aware there were missing medications. -The process for ordering medications for Resident #1 was to call the spouse to inform of the medication needed refilling and spouse would be responsible for picking up and bringing the medications to the pharmacy. -The previous RCC had instructed the MAs to put "on hold, waiting on pharmacy" if the medication was missing. -Her expectation was all residents' medications were in the building within 24 hours of an order. -Cart audits were to be completed weekly and each MA was assigned residents to complete the cart audits for. -The procedure was started 5 weeks ago. -She was not aware if the MA was informing the PCP when there was missing medication to	D 358		

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D 358	Continued From page 35 obtain a hold order. 5. Review of Resident #5's current FL2 dated 02/25/23 revealed diagnoses included dementia, major depressive disorder, diabetes, and anxiety. -Review of Resident #5's physician order dated 07/03/23 revealed an order for gabapentin 100mg, take one capsule three times daily for anxiety and depression. Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 100mg capsule to be taken 3 times a day. -Gabapentin 100mg was documented as not administered 17 of 30 occasions. -From 09/24/23 - 09/30/23 gabapentin was documented as "on hold, waiting on pharmacy." Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/16/23 at 10:00am revealed: -Gabapentin 100mg was filled on 08/30/23 (90 pills) in the multi-dose pack from the pharmacy. -The gabapentin in the multi-dose pack was delivered to the facility on 08/30/23. -there had been no refills of the gabapentin for Resident #5 since 08/30/23. Interview with a medication aide (MA) on 11/15/23 at 2:00pm revealed: -She was aware of the missing medications for Resident #5. -She usually did cart audits. -She would write down what was missing and leave a note for the Resident Care Coordinator (RCC). -She could not see if the medication had been	D 358		

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D 358	Continued From page 36 reordered. -She would try to call pharmacy on night shift to follow-up, however, she could not get anyone to answer. -They used an out of state pharmacy -When medications were not available to be administered, she was instructed by the Administrator and former RCC to write a note, "on hold, waiting on pharmacy." Interview with Resident #5's Primary Care Provider (PCP) on 11/16/23 at 9:30am revealed: -He was unaware that medications were not available to be administered. -When orders were written, he expected them to be followed. -He had not placed any medication on hold. -Staff did not notify him of any missing medications for Resident #5. -He had never been contacted to place an order on hold. Interview with the Administrator on 11/16/23 at 9:56am revealed: -She was aware that there had been medications unavailable for administration to Resident #5. -The previous RCC had instructed the MAs to put "on hold, waiting on pharmacy" if the medication was missing. -Her expectation was all residents' medications were in the building within 24 hours of an order. -Cart audits were to be completed weekly and each MA was assigned residents to complete the cart audits for. -The procedure was started 5 weeks ago. -She was not aware if the MA was telling the RCC when a medication was missing or not. -She was not aware if the MA was informing the PCP when there was missing medication to obtain a hold order.	D 358		

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D 358	Continued From page 37 The facility failed to administer medications as ordered to two residents (#2 and #4) with a diagnosis of glaucoma resulting in the possibility of deterioration of eye pressure resulting in irreversible blindness. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 01/02/24.	D 358		