STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 12/05/23.	D 000		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a minimum of 14 hours of a variety of group activities were provided each week for the residents. The findings are: Review of the activity calendar posted in the hallway revealed: -The activity calendar was for November 2023. -There were activities scheduled each day from Sunday through Saturday. -All of the activities on Mondays through Thursdays were scheduled between 4:00pm to 6:30pm. -Every Friday there was a movie scheduled from 5:00pm to 7:00pm, with exercise scheduled from 6:00pm to 6:30pm. -Every Saturday the activity was exercise from 6:00pm to 6:30pm. -Each week had 14 hours of scheduled activities except for the week of 11/19/23 through 11/25/23 which had 12 hours; including no activities on 11/23/23 and a Halloween party from 5:00pm to 7:00pm on Friday 11/24/23.	D 317		

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D 317	Continued From page 1 -The activities included crafts, shopping, card games, color-by-number, one-on-one, bingo, nail care, movie, exercise, social get together, and name that tune. Review of the Activity Participation Log for October 2023 revealed: -From 10/01/23 through 10/31/23, there was one activity listed for each day below a census of residents. -On 10/04/23, there was documentation that no residents participated in the activity of name that tune. -On 10/14/23, there was documentation that no residents participated in the activity of exercise. -On 10/16/23, there was documentation that no residents participated in the activity of crafts. -On 10/17/23, there was documentation that no residents participated in the activity of card games. Review of the Activity Participation Log for November 2023 revealed: -From 11/01/23 through 11/30/23, there was one activity listed for each day below a census of residents. -On 11/02/23, there was documentation that no residents participated in the activity of movie. -On 11/04/23, there was documentation that no residents participated in the activity of exercise. -On 11/08/23, there was documentation that no residents participated in the activity of one-on-one. -On 11/10/23, there was documentation that no residents participated in the activity of movie. -On 11/11/23, there was documentation that no residents participated in the activity of exercise. -On 11/14/23, there was documentation that no residents participated in the activity of card games.	D 317		

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-On 11/17/23, there was documentation that no residents participated in the activity of movie.
-On 11/18/23, there was documentation that no residents participated in the activity of exercise.
-On 11/20/23, there was documentation that no residents participated in the activity of crossword.
-On 11/22/23, there was documentation that no residents participated in the activity of sing-along.
-On 11/23/23, there was documentation that no residents participated in the activities due to Thanksgiving.
-On 11/25/23, there was documentation that no residents participated in the activity of exercise.
-On 11/27/23, there was documentation that no residents participated in the activity of crafts.
-On 11/29/23, there was documentation that no residents participated in the activity of name that tune.

Observation of the facility on 12/05/23 at 4:20pm revealed:
-There was a lounge with two residents sitting on two couches, watching television.
-There were activity supplies which included word search books, magazines, coloring supplies, board games, puzzles, books, and a box of craft supplies.

Observation of the facility during various hours on 12/05/23 from 8:30am to 5:30pm revealed:
-There were no activities provided for the residents during those times.
-The residents' scheduled evening mealtime was 5:00pm.

Interview with a resident on 12/05/23 at 2:55pm revealed:
-In the last three months, she was only aware of four activities being offered at the facility.
-One of the activities was cards and a board

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game, another was going outside to do a coloring activity, along with having a Halloween party and going to a church for Thanksgiving.
-She did not know which staff was responsible for activities.
-She would like to have more activities offered during the week such as Bingo, painting, or crafts.
-The activity calendar was outdated, and the staff did not follow the activity calendar.
-There were no activities done at 5:00pm like the activity calendar had scheduled, because that was when they were having supper.
-The staff were always busy cooking, cleaning and helping the residents so she did not know when they would have time to offer a group activity.
-There were activity supplies in the lounge, but she did not always want to color, and sometimes she could not find another resident who wanted to play a game with her.

Interview with a second resident on 12/05/23 at 2:58pm revealed:
-The facility offered an activity usually once every two weeks.
-There used to be a staff member who was responsible for coming to the facility to do activities, but she did not know who was responsible for doing activities now.
-If the residents wanted something to do, they could walk around outside.
-There was no activity calendar for the residents to reference, and even when there was a current activity calendar posted, they did not do the activities listed.
-She would like to be offered more activities such as Bingo, cards or shopping.

Interview with a third resident on 12/05/23 at

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3:03pm revealed:
-Every other week a church group was at the facility and played Bingo with the residents.
-The previous Saturday, 12/02/23, the residents had an outing to a church for a Christmas party.
-The facility staff had not offered activities to the residents in about a year; activities were always offered by outside groups visiting the facility.
-There was no activity calendar for the residents to reference.
-He would like to do more activities such as corn hole or other outdoor activities.

Interview with a fourth resident on 12/05/23 at 3:05pm revealed:
-There were no activities offered at the facility during the week.
-The activities that were listed on the activity calendar were not offered.
-He would be interested in more activities such as playing chess or checkers.

Interview with a fifth resident on 12/05/23 at 3:55pm revealed:
-There was a church group who came to the facility every Sunday.
-The staff did activities with the residents for holidays only, usually once per month.
-The last activity he remembered was bingo, and prior to that was a Halloween craft.
-He did not know which staff usually offered activities.
-There were no activities offered on a regular basis.
-The facility had an activity calendar posted, but they did not "stick to it".
-He would be interested in participating in activities such as painting, crafts or games.

Interview with a medication aide (MA) on

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D 317	Continued From page 5 12/05/23 at 4:05pm revealed: -The facility used to have an activity staff who floated between the facility and another facility. -The activity staff used to do activities at the facility around 3 days per week. -She did not know if the activity staff still came to the facility, or who was responsible for doing activities, because she usually worked night shift. Interview with the Director on 12/05/23 at 4:15pm revealed: -She was responsible for ensuring 14 hours of scheduled activities were completed each week. -The Activity Director dropped down to working part-time, so she had been creating the activities calendar. -The activities staff who used to come to the facility to offer activities had not came to the facility in a while, and she could not remember how long. -Some days, staff offered more activities than others, such as going on an outing for Thanksgiving. -Every Sunday, a church visited the facility for Sunday school and preaching. -The facility had word searches and coloring supplies available for the residents to use, but most of the residents preferred to stay in their rooms. -Every other week she offered for the residents to play Bingo. -She had not been able to offer activities for the residents every day due to time constraints. Interview with the Resident Care Coordinator (RCC) on 12/05/23 at 5:10pm revealed: -The Director was responsible for ensuring activities were completed. -The Director usually did activities 2 to 3 times per week.	D 317		

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D 317	Continued From page 6 -Some recent activities included making a scarecrow craft and coloring. -Staff did not always follow the activities as they were listed on the activity calendar. -The residents said they wanted more activities, but when activities were offered the residents did not always participate. Telephone interview with the Administrator on 12/05/23 at 5:15pm revealed: -She did not know who at the facility had been doing activities with the residents, but the Director was responsible for ensuring activities were done. -She was not aware that the facility had not been offering a minimum of 14 hours of scheduled activities each week for the residents. -She expected staff to offer at least 14 hours of activities each week.	D 317		
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, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) who had orders for sliding-scale insulin (#1) and orders to discontinue an anti-psychotic medication and an	D 358		

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D 358	Continued From page 7 anti-tremor medication (#3). The findings are: 1. Review of Resident #1's current FL2 dated 04/20/23 revealed: -Diagnoses included hypertension, schizoaffective disorder, hyperlipidemia, and anxiety. -There was an order for Humalog (a fast-acting insulin used to control high blood sugar) sliding-scale insulin (SSI), check fingerstick blood sugar (FSBS) before each meal and inject per SSI parameters: 70-179 = 0 units, 180-200 = 2 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 10 units, and 351-400 = 12 units. Review of Resident #1's October 2023 medication administration record (MAR) revealed: -There was an entry for Humalog SSI: check FSBS before each meal and inject per SSI parameters: 70-179 = 0 units, 180-200 = 2 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 10 units, and 351-400 = 12 units scheduled at 7:00am, 11:00am, and 4:00pm. -There was documentation the incorrect amount of SSI was administered 40 out of 93 opportunities with examples as follows: -On 10/01/23 at 11:00am, FSBS was 310 and 7 units was documented as administered and 10 units should have been administered. -On 10/06/23 at 7:00am, FSBS was 331 and 7 units was documented as administered and 10 units should have been administered. -On 10/12/23 at 11:00am, FSBS was 373 and 7 units was documented as administered and 12 units should have been administered. -On 10/18/23 at 7:00am, FSBS was 288 and 5 units was documented as administered and 7 units should have been administered.	D 358		

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-On 10/24/23 at 11:00am, FSBS was 315 and 7 units was documented as administered and 10 units should have been administered.
-Resident #1's FSBS results from 10/01/23 through 10/31/23 ranged from 214 to 399.

Review of Resident #1's November 2023 MAR revealed:
-There was an entry for Humalog SSI: check FSBS before each meal and inject per parameters: 70-179 = 0 units, 180-200 = 2 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 10 units, and 351-400 = 12 units scheduled at 7:00am, 11:00am, and 4:00pm.
-There was documentation the incorrect amount of SSI was administered 6 out of 90 opportunities with examples as follows:
-On 11/07/23 at 7:00am, FSBS was 291 and 10 units was documented as administered and 7 units should have been administered.
-On 11/12/23 at 4:00pm, FSBS was 299 and 10 units was documented as administered and 7 units should have been administered.
-On 11/13/23 at 11:00am, FSBS was 291 and 5 units was documented as administered and 7 units should have been administered.
-On 11/25/23 at 4:00pm, FSBS was 365 and 10 units was documented as administered and 12 units should have been administered.
-Resident #1's FSBS results from 11/01/23 through 11/30/23 ranged from 180 to 432.

Review of Resident #1's December 2023 MAR from 12/01/23 through 12/05/23 revealed:
-There was an entry for Humalog SSI: check FSBS before each meal and inject per parameters: 70-179 = 0 units, 180-200 = 2 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 10 units, and 351-400 = 12 units scheduled at 7:00am, 11:00am, and 4:00pm.

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D 358	Continued From page 9 -There was documentation the incorrect amount of SSI was administered 2 out of 13 opportunities with examples as follows: -On 12/02/23 at 7:00am, FSBS was 240 and 7 units was documented as administered and 5 units should have been administered. -On 12/04/23 at 4:00pm, FSBS was 222 and 7 units was documented as administered and 5 units should have been administered. -Resident #1's FSBS results from 12/01/23 through 12/05/23 ranged from 222 to 337. Observation of medications on hand for Resident #1 on 12/05/23 at 1:30pm revealed there was one full Humalog insulin pen with a dispensed date of 11/16/23 and an opened date of 12/04/23. Telephone interview with a representative from the facility's contracted pharmacy on 12/05/23 at 12:45pm revealed the pharmacy dispensed 4 Humalog insulin pens for Resident #1 on 11/16/23. Interview with a medication aide (MA) on 1/05/23 at 2:10pm revealed: -She was not aware she had administered the incorrect units of SSI to Resident #1. -When she checked Resident #1's FSBS, she wrote the value on the MAR, then administered the SSI to him. -She thought she had just wrote down the incorrect amount of SSI administered on the MAR, because she always checked how many units she was supposed to administer prior to administering SSI to Resident #1. -Resident #1's FSBS was always at the high end of his range, and he was never symptomatic. -She did not know if any staff at the facility was responsible for auditing the MARs for accurate insulin administration.	D 358		

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D 358	Continued From page 10 Telephone interview with a representative from Resident #1's primary care provider's (PCP) office on 12/05/23 at 3:06pm revealed: -Resident #1 had a diagnosis of Type 2 diabetes. -The SSI range on Resident #1's MAR was the same range the PCP had ordered for him. -The PCP visited Resident #1 at the facility so staff did not send MARs to the PCP's office for him to review. -Resident #1's last visit from his PCP was in June 2023. -Resident #1 did not have any hospital visits or appointments due to high or low blood sugar. -She was not able to advise on adverse effects for receiving the incorrect amount of insulin based on his FSBS results before meals. Interview with Resident #1 on 12/05/23 at 3:50pm revealed: -When the MA checked his FSBS, she always told him what his FSBS result was. -He did not know what his sliding scale order was and did not check how many units of insulin he was being administered. -His FSBS values were mostly high, but he did not have symptoms. -He was receiving a no concentrated sweets (NCS) diet, but he ate a lot of sugary snacks and sometimes drank soda. -Whenever the MA told him that he had a FSBS reading was in the 300's, he would drink a lot of water to try to help bring his blood sugar down. Interview with a second MA on 12/05/23 at 4:05pm revealed: -When she checked Resident #1's FSBS, she wrote the result on a sticky note then transcribed the FSBS result onto the MAR. -She would check the FSBS result against	D 358		

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Resident #1's SSI order and prime his insulin pen with however many units he should receive per his sliding scale order.
-Nobody had told her that she had administered the incorrect amount of insulin to Resident #1.
-She did not know if anybody at the facility audited the MARs for accurate insulin administration.
-Resident #1 never reported having symptoms of high blood sugar to her.

Interview with the Director on 12/05/23 at 4:45pm revealed:
-She was not aware that Resident #1 had been administered insulin incorrectly between October and December 2023.
-She audited the MARs weekly, but checked for holes on the MAR rather than accuracy of insulin administration.
-Staff had not reported incorrect insulin administration to her.
-Resident #1 had not reported symptoms of high blood sugar.
-She expected the MAs to administer Resident #1's Humalog SSI exactly how it was ordered.

Interview with the Resident Care Coordinator (RCC) on 12/05/23 at 5:10pm revealed:
-She was not responsible for auditing MARs for accurate medication administration.
-She was not aware that Resident #1 had been administered the incorrect amount of insulin per his sliding scale order.
-Resident #1 did not report symptoms of high blood sugar in the previous 3 months.
-The MAs were expected to administer insulin to Resident #1 per his SSI order and to document on the MAR the amount of insulin they administered.

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Telephone interview with the Administrator on 12/05/23 at 5:15pm revealed:
-She was not aware that Resident #1's insulin had been administered incorrectly.
-The MAs were responsible for administering medications as ordered or reporting errors to either the RCC or the Director.

2. Review of Resident #3's current FL2 dated 08/15/23 revealed diagnoses included disorganized schizophrenia, insomnia, anxiety and drug-induced tremor.

a. Review of Resident #3's current FL2 dated 08/15/23 revealed there was an order for paliperidone (an antipsychotic medication used to treat schizophrenia) 3mg twice daily.

Review of Resident #3's physician's order dated 10/23/23 revealed an order to discontinue paliperidone.

Review of Resident #3's October 2023 medication administration record (MAR) revealed:
-There was an entry for paliperidone 3mg, take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation paliperidone was administered twice daily from 10/01/23 through 10/23/23, then once daily at 8:00pm from 10/24/23 through 10/31/23; there was no order for paliperidone 3mg once daily to be administered from 10/24/23 through 10/31/23.

Review of Resident #3's November 2023 MAR revealed:
-There was an entry for paliperidone 3mg, take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation paliperidone was

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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
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administered twice daily from 11/01/23 through 11/30/23.

Review of Resident #3's December 2023 MAR from 12/01/23 through 12/05/23 revealed:
-There was an entry for paliperidone 3mg, take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation paliperidone was administered twice daily on 12/01/23, 12/04/23, and at 8:00am on 12/05/23.

Observation of medications on hand for Resident #3 on 12/05/23 at 1:50pm revealed there was one medication card containing paliperidone 3mg tablets with a dispensed date of 11/15/23 and with 20 out of 28 tablets remaining in the medication card.

Telephone interview with a representative from the facility's contracted pharmacy on 12/05/23 at 12:45pm revealed:
-Resident #3 had a current order with the pharmacy for paliperidone 3mg twice daily.
-The pharmacy had not received an order dated 10/23/23 to discontinue paliperidone.
-Paliperidone was dispensed for Resident #3 on 09/13/23, 10/22/23, and 11/08/23 for a quantity of 56 tablets each time split between two cards containing 28 tablets each.

Interview with a medication aide (MA) on 12/05/23 at 2:10pm revealed:
-If a medication order changed during her shift, she was responsible to hand write the new order on the MAR.
-Only the RCC and Director were allowed to fax new medication orders to the pharmacy.
-Resident #3's mental health provider (MHP) called the facility on 10/23/23 and advised that

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	HAL085012	A. BUILDING: _____ B. WING _____	12/05/2023

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she was going to discontinue Resident #3's paliperidone, but she never saw that the discontinue order had been sent to the facility.
-She told the Resident Care Coordinator (RCC) about Resident #3's paliperidone order not being discontinued from the MAR a week or two after she thought the order was supposed to have changed, and the RCC told her she would look into it.
-She continued to administer Resident #3's paliperidone because it was on the MAR as a current medication.

Telephone interview with a nurse from Resident #3's MHP's office on 12/05/23 at 2:30pm revealed:
-Resident #3 had been prescribed paliperidone for her diagnosis of schizophrenia.
-Resident #3's MHP discontinued her order for paliperidone on 10/23/23 because she switched Resident #3 to an intramuscular version of the medication.
-A copy of Resident #3's order to discontinue paliperidone had been faxed to the facility and the facility was responsible for implementing any order changes.
-There was no risk of harm or adverse effects for Resident #3 receiving paliperidone after it was discontinued, she just did not need to be taking it.

Interview with Resident #3 on 12/05/23 at 2:50pm revealed:
-She remembered her MHP telling her she was going to discontinue paliperidone, but she did not know if she had been receiving it or not.
-She did not have any change to her symptoms in the previous couple of months; she felt good.

Interview with a second MA on 12/05/23 at 4:05pm revealed:

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-She was not aware that Resident #3's paliperidone had been discontinued.
-Paliperidone was on Resident #3's MAR and available in the medication cart, so she had been administering it.

Interview with the Director on 12/05/23 at 4:45 revealed:
-She remembered seeing Resident #3's order to discontinue paliperidone, but thought that the RCC had faxed it to the pharmacy, had crossed out the entry on the MAR and removed the medication from the medication cart.
-The facility did not have a process for tracking new orders and medication order changes.
-She and the RCC communicated via text message, phone, or in-person about orders they faxed or orders that needed to be processed.
-Whoever filed Resident #3's order to discontinue paliperidone in her record would have been responsible for ensuring the MAR was updated and the medication was removed from the medication cart.
-If a MA was aware there was an order change and they did not see the order changed on the MAR, they were responsible for notifying her or the RCC.
-She was not aware that Resident #3 had been receiving paliperidone since it was discontinued on 10/23/23.

Interview with the RCC on 12/05/23 at 5:10pm revealed:
-She remembered Resident #3 having medication order changes, but did not specifically remember her paliperidone being discontinued.
-She and the Director were responsible for faxing new orders to the pharmacy, then removing the medication from the medication cart and updating the MAR.

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-She and the Director tried to communicate with each other when they processed a new order, but there was no documentation system to refer to.

Telephone interview with the Administrator on 12/05/23 at 5:15pm revealed:
-She was not aware that Resident #3 had been receiving a medication that had been discontinued in October 2023.
-She expected the staff who received the order change to fax it to the pharmacy, remove the medication from the medication cart, and cross the medication off on the MAR.

b. Review of Resident #3's current FL2 dated 08/15/23 revealed there was an order for benztropine (a medication used to treat tremors, insomnia and nightmares) 1mg twice daily.

Review of Resident #3's physician's order dated 10/23/23 revealed an order to decrease benztropine to 0.5mg twice daily.

Review of Resident #3's physician's order dated 11/20/23 revealed an order to decrease benztropine to 0.5mg daily for one week then discontinue.

Review of Resident #3's October 2023 MAR revealed:
-There was an entry for benztropine 1mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation benztropine 1mg was administered twice daily from 10/01/23 through 10/23/23.
-There was an entry for benztropine 0.5mg twice daily.
-There was documentation benztropine 0.5mg was administered twice daily at 8:00am and 8:00pm from 10/24/23 through 10/31/23.

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D 358	Continued From page 17 Review of Resident #3's November 2023 MAR revealed: -There was an entry for benztropine 0.5mg twice daily scheduled at 8:00am and 8:00pm. -There was documentation benztropine 0.5mg was administered twice daily from 11/01/23 through 11/19/23. -There was an entry for benztropine 0.5mg once daily scheduled at 8:00am. -There was documentation benztropine 0.5mg was administered once daily at 8:00am from 11/20/23 through 11/30/23. Review of Resident #3's December 2023 MAR from 12/01/23 through 12/05/23 revealed: -There was an entry for benztropine 0.5mg once daily scheduled at 8:00am. -There was documentation benztropine 0.5mg was administered at 8:00am on 12/01/23, 12/02/23, 12/04/23 and 12/05/23. Observation of medications on hand for Resident #3 on 12/05/23 at 1:50pm revealed there was one medication card with benztropine 0.5mg tablets, to administer one tablet daily, with a dispensed date of 10/30/23 and there were 3 out of 16 dispensed tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 12/05/23 at 12:45pm revealed: -Resident #3 had a current order for benztropine 0.5mg once daily. -The pharmacy received a new prescription for Resident #3's benztropine on 11/20/23 to decrease the dose from 0.5mg twice daily to 0.5mg once daily, but there was only a quantity of 7 tablets on the prescription and no refills. -The pharmacy did not receive any orders to	D 358		

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discontinue Resident #3's benztropine.
-The pharmacy last dispensed benztropine on 11/20/23 for 7 tablets and had not dispensed any since.

Interview with a MA on 12/05/23 at 2:10pm revealed:
-She was aware that Resident #3's benztropine dose had been decreased, but not discontinued.
-The entry for benztropine was on Resident #3's MAR and since there were benztropine 0.5mg tablets remaining on the medication cart, she had been administering it.
-The Director and RCC were responsible for faxing medication order changes to the pharmacy.

Telephone interview with a nurse from Resident #3's MHP's office on 12/05/23 at 2:30pm revealed:
-Resident #3 was being tapered off of benztropine because the MHP did not think it was necessary for her to be on the medication.
-Resident #3 had been prescribed benztropine for Parkinson-like tremors due to taking antipsychotic medications, but she no longer needed the medication.
-The facility had been faxed the order to decrease benztropine to 0.5mg once daily for 7 days then discontinue and the MHP expected the medication to be discontinued as ordered.
-There were no adverse effects for Resident #3 continuing to receive benztropine.

Interview with Resident #3 on 12/05/23 at 2:50pm revealed:
-She did not know if she had been receiving benztropine or not.
-She denied having symptoms of tremors or nightmares.

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D 358	Continued From page 19 Interview with the Director on 12/05/23 at 4:45pm revealed: -She was aware that Resident #3 had an order to taper down her dose of benztropine, but not to completely discontinue it. -The facility did not have a process for tracking new orders and medication order changes. -She and the RCC communicated via text message, phone, or in-person about orders they faxed or orders that needed to be processed. -Whoever filed Resident #3's order to taper down and then discontinue benztropine in her record would have been responsible for ensuring the MAR was updated and the medication was removed from the medication cart. Interview with the RCC on 12/05/23 at 5:10pm revealed: -She remembered Resident #3's benztropine dose decreasing but did not know it was supposed to be discontinued. -She and the Director were responsible for faxing new orders to the pharmacy, then removing the medication from the medication cart and updating the MAR. -She and the Director tried to communicate with each other when they processed a new order but there was no documentation system to refer to. Telephone interview with the Administrator on 12/05/23 at 5:15pm revealed: -She was not aware that Resident #3 had been receiving a medication that had been discontinued. -She expected the staff who received the order change to fax it to the pharmacy, remove the medication from the medication cart, and cross the medication off on the MAR.	D 358		