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D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual and followup survey and a complaint investigation on 01/17/24 to 01/18/24. The complaint was initiated by the Guilford County Department of Social Services on 01/05/2024.	D 000		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 3 of 5 sampled residents (#2, #3, and #5) related to a resident who had an order for an eye drop (#3), a resident who had an order for anti-anxiety medication, an antipsychotic medication, and an antibiotic (#2), and a resident who had a steroid taper order (#5). The findings are: 1. Review of Resident #3's current FL2 dated 02/28/23 revealed: -Diagnoses included, left above-knee amputation, type 2 diabetes mellitus, bipolar disorder,	D 358		

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hypertension, history of stroke, hyperlipidemia and peripheral vascular disease.
-There was an order for Travoprost 0.004g ophthalmic solution (used to treat increased pressure in the eye caused by open-angle glaucoma) instill one drop in both eyes at bedtime.

Review of Resident #3's electronic medication administration record (eMAR) for November 2023 revealed:
-There was an entry for Travoprost 0.004g ophthalmic solution instill one drop in both eyes at bedtime with a scheduled administration time of 8:00pm.
-Travoprost 0.004g ophthalmic solution was documented as administered daily at 8:00pm from 11/01/23-11/22/23 and 11/26/23-11/30/23.
-There was documentation Travoprost was not administered on 11/23/23 through 11/25/23 due to resident being out of the facility.

Review of Resident #3's eMAR for December 2023 MAR revealed:
-There was an entry for Travoprost 0.004g ophthalmic solution instill one drop in both eyes at bedtime with a scheduled administration time of 8:00pm.
-Travoprost was documented as administered daily at 8:00pm from 12/01/23-12/31/23.

Review of Resident #3's eMAR for January 2024 MAR revealed:
-There was an entry for Travoprost 0.004g ophthalmic solution instill one drop in both eyes at bedtime with a scheduled administration time of 8:00pm.
-Travoprost was documented as administered daily at 8:00pm from 01/01/24-01/17/24.

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D 358	Continued From page 2 Observation of Resident #3's medications on hand on 01/18/24 at 11:00am revealed Travoprost 0.004g ophthalmic solution was not available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/18/24 at 3:00pm revealed: -The facility dispensed Travoprost 0.004g ophthalmic solution 1 drop in both eyes at bedtime on 08/30/23 with a 1-month supply; there were 12 refills remaining on the prescription. -There had been no other requests to refill Travoprost for Resident #2. Telephone interview with Resident #3's ophthalmologist on 01/18/24 at 3:13pm revealed: -Resident #3 was prescribed Travoprost 0.004g ophthalmic solution on 02/06/23 due to a diagnosis of open-angle glaucoma. -Resident #3 should still be administered Travoprost nightly for the remainder of her life to prevent loss of vision, increased eye pressure and requirement for laser eye surgery. -Resident #3's original prescription for Travoprost was written in February 2023 with 12 refills. -If the facility had issues with obtaining Travoprost for Resident #2, they should have called the ophthalmologist's office. Interview with Resident #3 on 01/18/24 at 3:30pm revealed: -Resident #3 could not see out of her right eye due to blurry vision. -Resident #3 stated that this had been ongoing since coming to the facility over a year ago. -She was getting Travoprost 4 months ago and has not been offered the medication in the past 3 months.	D 358		

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Interview with a medication aide (MA) on 01/18/24 at 11:00am revealed:
-She did not know why Resident #3's Travoprost was not available on the medication cart, but she would reorder it.
-Travoprost was last ordered in August 2023.
-She had not administered Travoprost to Resident #3.

Interview with a second MA on 01/18/24 at 4:00pm revealed:
-Resident #3 was supposed to be administered Travoprost daily at bedtime.
-She thought she last administered medication to Resident #3 in December 2023.
-She did not know that Resident #3 was out of Travoprost.
-Resident #3 started complaining last week about not being able to see.
-MAs were to reorder medication within a week of the medication running out.

Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 4:30pm revealed:
-Third shift MAs were responsible for conducting cart audits.
-The RCC, Administrator, and MAs were responsible for reordering medications through the eMAR system and sending new orders to the pharmacy.
-MAs were responsible for informing the RCC when a medication was missing from the cart and for reordering medication prior to the medication running out.

Interview with the Administrator on 01/18/24 at 5:12pm revealed:
-She did not know if Resident #3 had been administered the Travoprost.
-She discarded the Travoprost eyedrops on

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01/17/24 because the medication had expired.
-She administered medication to Resident #3, but not the Travoprost.
-She and initialed the eMAR in November 2023, December 2023, and January 2024 documenting administration of Travoprost, although she had not administered Travoprost to Resident #3.

2. Review of Resident #2's current FL2 dated 01/02/24 revealed diagnoses included anxiety disorder, bi-polar mood disorder, and schizophrenia.

a. Review of Resident #2's current FL2 dated 01/02/24 revealed there was an order for hydroxyzine (used to treat anxiety) 25mg 1 capsule twice daily as needed.

Review of Resident #2's previous FL2 dated 10/23/23 revealed an order for hydroxyzine 25mg 1 capsule twice daily as needed for anxiety.

Review of Resident #2's electronic Medication Administration Record (eMAR) for November 2023 revealed:
-There was an entry for hydroxyzine 25mg 1 capsule twice daily as needed for anxiety.
-There was documentation that 2 doses of hydroxyzine were administered; one dose on 11/16/24 and 11/20/24.

Review of Resident #2's eMAR for December 2023 revealed:
-There was an entry for hydroxyzine 25mg 1 capsule twice daily as needed for anxiety.
-There was documentation that 6 doses of hydroxyzine were administered; one dose on 12/12/24, 12/14/23, 12/17/23 and 12/22/23, and two doses on 12/21/24.

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Review of Resident #2's eMAR from 01/01/24 through 01/17/24 revealed:
-There was an entry for hydroxyzine 25mg 1 capsule twice daily as needed for anxiety.
-There was no documentation hydroxyzine was administered between 01/01/24 and 01/17/24.

Observation of medication available for administration to Resident #2 on 01/17/24 at 3:57pm revealed hydroxyzine 25mg 1 capsule twice daily as needed was not available.

Review of Resident #2's mental health provider's (MHP) progress note dated 11/16/23 revealed:
-Resident #2 was seen for follow up for anxiety disorders.
-Symptoms included palpitations, chest discomfort, racing thoughts, excessive worrying, fear of losing control, repetitive behaviors, and sleep disturbance.
-Symptoms were relieved by medication and quiet environment.
-Associated symptoms included irritability, agitation, and depression symptoms.
-Resident #2 was to take hydroxyzine 25mg 1 capsule twice daily as needed for anxiety.
-Resident #2 was stable on current medications including hydroxyzine.

Review of the facility's pharmacy communication forms revealed:
-Hydroxyzine 25mg capsules were requested by the facility on 01/04/24 and on 01/11/24.
-The pharmacy responded on 01/04/24 and on 01/11/24 that they sent the new/refill authorization request form to be signed by Resident #2's provider.
-The New/Refill Authorization Request form sent from the pharmacy to the facilty was dated 12/15/23 and needed to be authorized by the

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D 358	Continued From page 6 physician. Telephone interview with the facility's contracted pharmacy on 01/18/24 at 2:55pm revealed: -Resident #2 had an order for hydroxyzine 25mg 1 capsule twice daily as needed. -The pharmacy received a new order for hydroxyzine on 11/16/23 for 1 refill of 180 capsule. -The pharmacy did not send 180 capsules to the facility at once; they only sent out a 15-day supply of hydroxyzine with each request. -Hydroxyzine was dispensed to the facility on 11/01/23, 11/27/23, and 12/15/23 with a quantity of 30 tablets each time (15-day supply). -Hydroxyzine was requested by the facility on 01/04/24 and 01/11/24. -The pharmacy should have been able to dispense hydroxyzine to the facility after 12/15/23 because there were still capsules remaining to dispense from the order on 11/16/23. -The pharmacy representative who received the refill request for hydroxyzine may have been going by the number of refills rather than the number of capsules remaining. -The pharmacy dispensed 30 capsules of hydroxyzine to the facility on 01/18/24. Interview with Resident #2 during the tour of the facility on 01/17/24 at 9:38pm revealed: -The facility was out of her medication used to treat stress and anxiety. -She had not had the medication in over a week, and she had stress and anxiety at times during the day. -She usually took her anxiety medication once or twice a day. -She did not know the name of the medication, but it was a green oval capsule. -She asked the medication aides (MA) for the	D 358		

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anxiety medication and she was told she had to wait to see her mental health provider (MHP) before she could get it.
-She quit asking MAs for hydroxyzine over a week ago.

Interview with a MA on 01/17/24 at 3:58pm revealed:
-Resident #2 did not have hydroxyzine available on the medication cart..
-She did not know when Resident #2's hydroxyzine ran out, but she thought she requested hydroxyzine from the pharmacy on 01/14/24.
-MAs were to reorder medication 5 or 6 days prior to the resident running out of a medication.
-Resident #2 needed a new prescription for hydroxyzine, but she had to see her MHP before she was able to get a new prescription.
-She thought Resident #2 had an appointment scheduled soon, but she did not know if it was with with her primary care provider (PCP) or MHP.
-The Resident Care Coordinator (RCC) was responsible for reaching out to Resident #2's PCP and MHP for appointments.

Interview with the RCC on 01/18/24 at 10:49am revealed:
-Resident #2 was administered hydroxyzine twice daily as needed.
-She was not sure when Resident #2 ran out of hydroxyzine.
-MAs were responsible for reordering medications within 5 days of running out of the medication.
-MAs tried to reorder hydroxyzine for Resident #2, but the pharmacy faxed documentation that they were unable to refill the medication without authorization from her MHP.

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-Resident #2 last saw her MHP in November 2023 and received a new prescription for hydroxyzine.
-Resident #2 had a scheduled appointment with her MHP on 02/16/24; she had not tried to see if she could be seen sooner.
-Resident had a scheduled appointment with her PCP on 01/19/24 and staff would see if the PCP could authorize a refill of hydroxyzine for Resident #2; the PCP provided services within the same practice as the MHP, but at a different location.

Second interview with the RCC on 01/18/24 at 11:28am revealed:
-She administered medication to Resident #2.
-Resident #2 usually requested hydroxyzine daily, twice a day.
-She had not noticed Resident #2 had any increased anxiety.
-The pharmacy last dispensed hydroxyzine to the facility on 11/27/23 and 12/15/23.
-MAs contacted the pharmacy to request refills on 01/04/24 and 01/11/24 and received documentation that the providers authorization was needed each time to refill the prescription.
-She called the pharmacy on 01/18/24 and the pharmacy told her they received a prescription for Resident #2 for 180 tablets of hydroxyzine in November 2023.
-The pharmacy last dispensed hydroxyzine to the facility in December 2023.
-She told the pharmacy representative that she did not understand how Resident #2 could be out of hydroxyzine if 180 capsules were dispensed in November 2023.
-The pharmacy only dispensed 30 capsules to the facility at a time.
-She did not realize there were capsules remaining from the November 2023 order.
-She was just going by what the pharmacy said

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when they faxed the notice documenting they needed authorization from the medical provider for a new refill.
-The pharmacy representative stated that they would send a refill of hydroxyzine to the facility on 01/18/24.

Interview with Resident #2 on 01/18/24 at 3:54pm revealed:
-She was administered her green capsule today, 01/18/24.
-She had been out of the green capsule so long and was scared she would do something like getting angry.

Interview with a MA on 01/18/24 at 4:17pm revealed:
-She knew Resident #2 was out of hydroxyzine.
-She and the RCC tried to reorder hydroxyzine from the pharmacy, but they send it to the facility.
-Resident #2 asked her for hydroxyzine during the time the facility did not hydroxyzine available, but she had not noticed any increased anxiety or irritability.

Interview with the Administrator on 01/18/24 at 5:17pm revealed:
-MAs sent requests for refills of hydroxyzine to the pharmacy and the pharmacy responded that Resident #2's provider needed to complete a reauthorization for hydroxyzine.
-The pharmacy also faxed the request for reauthorization for hydroxyzine to Resident #2's provider.
-The RCC reached out to Resident #2's PCP, but the PCP would not provide an authorization for a refill of hydroxyzine.
-The RCC reached out to Resident #2's MHP multiples times and did not get a response.
-The facility tried to reorder the medication and

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tried to reach out to Resident #2's MHP regarding the order for hydroxyzine; she believed the pharmacy was at fault and not the facility.

Attempted telephone interview with Resident #2's MHP on 01/18/24 at 10:04am was unsuccessful.

b. Review of a notice from Resident #2's gastroenterologist on 12/10/23 revealed:
-Resident #2 had biopsies taken during a recent upper endoscopic examination (date not indicated).
-The biopsies showed that Resident #2 had bacteria called H. pylori in her stomach.
-H. pylori could cause inflammation, ulcers, and it was a risk factor for gastric cancer.
-If the gastroenterologist's office had not made contact, the facility was to contact the gastroenterologist's office to get Resident #2 started on appropriate antibiotics.

Review of Resident #2's record revealed a physician's order for clarithromycin (an antibiotic used to treat h. pylori bacteria) 500mg 1 tablet twice daily for 14 days.

Review of the facility's contracted pharmacy's communication note dated 12/11/23 revealed:
-There was an issue with clarithromycin 500 tablets having a drug interference with another medication.
-The pharmacy recommended that the facility clarify the use of clarithromycin and the other medication with the provider and monitor Resident #2 while on clarithromycin.
-The pharmacy dispensed clarithromycin to the facility and gave instructions to consult the prescriber regarding the medication issue.
-There was a physician's response dated 12/20/23 to decrease Resident #2's other

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medication for two weeks until clarithromycin was discontinued then resume the other medication at its original dosage.

Review of the facility's progress notes for Resident #2 for December 2023 revealed:
-On 12/11/23, there was documentation RCC called and left a message for a nurse at Resident #2's gastroenterologist's office, advising the facility could not administer clarithromycin due to the drug interaction between clarithromycin and another medication.
-On 12/13/23, there was documentation the RCC made a second phone call to Resident #2's gastroenterologist's office concerning the drug interaction issue and there had been no call back as of 12/13/23.
-On 12/18/23, there was documentation the RCC called Resident #2's gastroenterologist's office about the continued issue with Resident #2's medication and there still had not been a call back from the gastroenterologist's office.
-On 12/20/23, there was documentation the provider called back to the facility and stated to decrease the dosage of the medication that interfered with clarithromycin and to administer the clarithromycin.
-On 12/26/23, there was documentation the RCC called Resident #2's gastroenterologist's office because the number of days ran out (on the electronic medication administration record (eMAR)) for administration of clarithromycin and wanted to know if there was a new order to continue the full dosage of the medication; the RCC was waiting a call back.
-On 12/28/23, The RCC called Resident #2's gastroenterologist's office again and was still awaiting a call back.

Review of Resident #2's eMAR for December

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2023 revealed:
-There was an entry for clarithromycin 500mg 1 tablet twice daily for 2 weeks scheduled for administration at 8:00am and 8:00pm between 12/11/23 and 12/25/23.
-There was documentation 13 of 28 doses of clarithromycin were administered between 12/11/23 and 12/25/23.
-There was documentation clarithromycin was not administered on 12/11/23 at 8:00pm through 12/18/23 at 8:00pm due to omit-other and on 12/19/23 at 8:00am due to withheld per DR/RN orders.
-There was documentation Resident #2 was out of the facility from 12/29/23 through 01/02/24.
-There was documentation clarithromycin 500mg was discontinued on 12/25/23.

Observation of medication available for administration to Resident #2 on 01/18/24 at 10:42am revealed clarithromycin 500mg 1 tablet twice daily for 2 weeks was not available.

Telephone interview with the facility's contracted pharmacy on 01/18/23 at 2:55pm revealed:
-Clarithromycin 500mg 1 tablet twice daily for 2 weeks was dispensed to the facility on 12/11/23 with a quantity of 28 tablets.
-The pharmacy entered the start date as 12/11/25 and the stop date of 12/25/25 for clarithromycin so that the antibiotic would discontinue from the eMAR after 14 days of administration.

Interview with Resident #2 on 01/18/24 at 3:54pm revealed she remembered she was supposed to be administered antibiotics, but she did not remember for how long or how many days the antibiotics were administered to her.

Interview with a medication aide (MA) on

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D 358	Continued From page 13 01/18/24 at 4:17pm revealed: -Resident #2 was not administered clarithromycin for 14 days. -There was medication remaining in the medication cart when the medication ended on the eMAR. -she thought the remaining doses of clarithromycin were returned to the pharmacy. Interview with the RCC on 01/18/24 at 4:28pm revealed: -She did not ask Resident #2's gastroenterologist if Resident #2 was to be administered clarithromycin for 14 days beginning on 01/20/24, but he knew she was not getting it. -Resident #2 ended up going to the hospital for an unrelated issue and could not finish the dose. (There was documentation Resident #2 was out of the facility on 12/29/23 through 01/21/24.) -When Resident #2 returned from the hospital, the remaining doses of clarithromycin were sent back to the pharmacy. -The facility's contracted pharmacy entered the start and stop dates for clarithromycin. -The facility could not administer clarithromycin past the stop date of 01/25/24 and needed a physician's order to administered clarithromycin past the pharmacy's stop date of 01/25/24 on the eMAR. Interview with the Administrator on 01/18/24 at 5:17pm revealed: -She or the RCC should have reached out to Resident #2's gastroenterologist to see if he wanted her to complete the full 14-day dose of clarithromycin. -She had not reached out to the gastroenterologist regarding the 14-day treatment of clarithromycin.	D 358		

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D 358	Continued From page 14 Attempted interview with Resident #2's gastroenterologist on 01/18/24 at 10:04am was unsuccessful. c. Review of Resident #2's previous FL2 dated 10/23/23 revealed an order for quetiapine (used to treat schizophrenia and bi-polar disorder) 200mg 1 tablet at bedtime. Review of the facility's contracted pharmacy's communication note dated 12/11/23 revealed: -There was an issue with an antibiotic prescribed on 12/11/23 having an interference with quetiapine 200mg 1 tablet at bedtime. -The pharmacy recommended that the facility clarify the use of the antibiotic and quetiapine 200mg 1 tablet at bedtime. -There was a physician's response dated 12/20/23 to decrease Resident #2's quetiapine to 100mg 1 tablet at bedtime for two weeks until the antibiotic was discontinued then resume quetiapine 200mg 1 tablet at bedtime. Review of Resident #2's electronic Medication Administration Record (eMAR) for December 2023 revealed: -The was documentation the antibiotic was administered twice daily from 8:00pm on 12/19/23 through 8:00pm on 12/25/23. -There was an entry for quetiapine 100mg 1 tablet at bedtime until clarithromycin was complete scheduled for administration at 8:00pm. -There was documentation quetiapine 100mg was administered from 12/21/23 through 12/25/23. -There was an entry for quetiapine 200mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation quetiapine 100mg was administered at bedtime daily between	D 358		

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12/21/23 and 12/25/23.
-Both quetiapine 100mg and quetiapine 200mg were documented as administered at bedtime from 12/21/23 through 12/25/23.
-Quetiapine 100mg was documented as discontinued on 12/25/23.

Observation of medication available for administration to Resident #2 on 01/18/24 at 10:42am revealed quetiapine 100mg was not available.

Telephone interview with the facility's contracted pharmacy on 01/18/23 at 2:55pm revealed:
-Quetiapine 200mg 1 tablet at bedtime was dispensed to the facility on 12/07/23 and 01/04/24 with a quantity of 30 tablets.
-Quetiapine 100mg 1 tablet at bedtime until clarithromycin was complete was dispensed to the facility on 12/20/23.

Interview with Resident #2 on 01/18/24 at 3:54pm revealed she did not know if there had been any changes in her quetiapine order in December 2023.

Interview with MA on 01/18/24 at 4:17pm revealed she thought there was only one medication bubble card of quetiapine available for administration during the time Resident #2 was taking her antibiotic in December 2023, but she did not remember whether it was quetiapine 100mg or quetiapine 200mg.

Interview with the RCC on 01/18/24 at 4:28pm revealed:
-Quetiapine 100mg was administered to Resident #2 with her antibiotic for 6 days from 12/20/23 through 12/25/23.
-She pulled quetiapine 200mg off the medication

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cart and placed it on her desk when Resident #2 started quetiapine 100mg.
-She pulled the quetiapine 200mg from the medication cart so that it would not confuse the MAs and so they would not administer the quetiapine 200mg along with the 100mg.
-She thought there was just an error in documentation of quetiapine administration between 12/20/23 and 12/25/23.

Interview with the Administrator on 01/18/24 at 5:17pm revealed:
-The RCC was working on the medication cart on 12/20/23 when the order was received for Resident #2 to reduce quetiapine 200mg at bedtime to 100mg at bedtime until the antibiotic was completed.
-The RCC pulled the quetiapine 200mg from the medication cart when the order for quetiapine 100mg was delivered to the facility.
-The RCC placed quetiapine 200mg back in the medication cart with the quetiapine 100mg was finished.
-The MAs did not administer quetiapine 200mg when Resident #2 was being administered antibiotics.
-She did not know the MAs documented quetiapine 200mg were administered in addition to the 100mg, but 200mg were not administered between 12/20/23 and 12/25/23.

Attempted interview with Resident #2's gastroenterologist on 01/18/24 at 10:04am was unsuccessful.

3. Review of Resident #5's current FL2 dated 01/08/24 revealed diagnoses included chronic obstructive pulmonary disease (COPD) with exacerbation, generalized weakness, and osteoporosis.

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Review of Resident #5's hospital discharge summary dated 11/28/23 revealed:
-Resident #5 had been hospitalized due to a COPD exacerbation.
-He would be discharged to the assisted living facility to begin palliative care due to a diagnosis of end-stage COPD.
-There was an order for prednisone (a steroid medication used to reduce inflammation) 10mg, take 3 tablets (30mg) daily with breakfast for 2 days, then 2 tablets (20mg) daily with breakfast for 2 days, then 1 tablet (10mg) daily with breakfast for 2 days.

Review of Resident #5's November 2023 eMAR revealed:
-There was an entry for prednisone 10mg take 3 tablets (30mg) with breakfast for 2 days scheduled at 8:00am, with a start date of 11/30/23 and a stop date of 12/01/23.
-There was no documentation prednisone 30mg was administered on 11/30/23.

Review of Resident #5's December 2023 eMAR revealed:
-There was an entry for prednisone 10mg take 3 tablets (30mg) with breakfast for 2 days scheduled at 8:00am on 12/01/23.
-There was no documentation prednisone 30mg was administered on 12/01/23.
-There was an entry for prednisone 10mg take 2 tablets (20mg) with breakfast for 2 days scheduled at 7:00am on 12/02/23 and 12/03/23.
-There was no documentation prednisone 20mg was administered on 12/02/23 through 12/03/23.
-There was an entry for prednisone 10mg take 1 tablet with breakfast for 2 days scheduled at 7:00am on 12/04/23 and 12/05/23.
-There was no documentation prednisone 10mg

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D 358	Continued From page 18 was administered on 12/04/23 through 12/05/23. Review of the pharmacy's packing slip proof-of-delivery dated 11/29/23 revealed the facility acknowledged receipt of 12 prednisone 10mg tablets for Resident #5 at 10:59pm. Observation of medication on hand for Resident #5 on 1/18/24 at 10:35am revealed there was no prednisone 10mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 01/18/24 at 9:45am revealed the pharmacy dispensed a quantity of 12 prednisone 10mg tablets to the facility on 11/29/23 for an order to take 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily for 2 days. Interview with a MA on 01/18/24 at 10:45am revealed: -Resident #5 had an order for prednisone when he returned from the hospital at the end of November 2023. -She did not remember what the specific order was but remembered seeing the prednisone on the medication cart. -She thought she had administered the prednisone to Resident #5 as ordered. -There was no documentation that she administered prednisone to Resident #5 because after the pharmacy had entered the medication order in the eMAR system, it had not yet been approved by facility management to allow her to document the administration. -She had told the RCC that Resident #5's prednisone entry on the eMAR needed to be approved the first day that she worked on that medication cart and saw that the order was	D 358		

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flagged, but had not mentioned it to the RCC again after that because the order dropped off the eMAR when the taper finished.
-Only the RCC or the Administrator had the clearance to approve order entries in the eMAR.
-She did not remember if the prednisone entry had ever been approved in the eMAR to allow the MAs to document administration of Resident #5's prednisone.

Interview with Resident #5 on 01/18/24 at 11:05am revealed:
-He did not remember receiving prednisone the week after he returned from the hospital.
-He thought his breathing had improved after his hospital discharge at the end of November 2023.

Interview with a second MA on 01/18/24 at 4:05pm revealed:
-She remembered Resident #5's prednisone taper showing up on the eMAR but being flagged as needing approval.
-The order entry needed to be approved by either the RCC or the Administrator before the MAs could click on the entry to document administration of the medication.
-She did not remember seeing any prednisone for Resident #5 on the medication cart.
-She thought she remembered telling either the RCC or the Administrator about the flagged prednisone order for Resident #5.
-If there was no documentation on the eMAR that prednisone was administered to Resident #5, it indicated the medication had not been administered.

Interview with the RCC on 01/18/24 at 4:30pm revealed:
-She was not aware that Resident #5 had a prednisone ordered upon discharge from the

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hospital on 11/28/23 that he had never received.
-She tried to complete audits of the eMARs every other month, but had not audited Resident #5's eMAR since he returned from the hospital.
-Either she, the Administrator, or a MA who had special training were responsible for approving new medication orders on the eMAR that had been entered into the system by the pharmacy.
-Whichever supervisor was on shift when a resident returned from the hospital with new medication orders was responsible for faxing the orders to the pharmacy and approving the entries on the eMAR.
-Sometimes she approved order entries in the eMAR system right as the pharmacy entered them, and sometimes she waited to approve the entry until the medication arrived at the facility from the pharmacy.
-She did not remember approving an entry in the eMAR system for Resident #5's prednisone.
-None of the MAs had notified her about a prednisone order being flagged as needing approval on the eMAR in November or December 2023.
-None of the MAs had notified her that there was prednisone in the medication cart for Resident #5 without an entry in the eMAR to document administering the prednisone.
-She had not sent any prednisone for Resident #5 back to the pharmacy due to non-use.

Interview with the Administrator on 01/18/24 at 5:15pm revealed:
-Upon delivery to the facility, one of the MAs had taken Resident #5's prednisone into the medication room, and a different MA put the prednisone on the medication cart.
-She had cleared the flag and approved the entry on Resident #5's prednisone order on 11/29/23 so the MA could administer the prednisone as

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ordered.
-Resident #5's prednisone had not been sent back to the pharmacy, and since it was no longer on the medication cart, she thought the MAs had administered the prednisone and failed to document it.
-She had not been aware that there was no documentation of Resident #5 receiving the prednisone taper from 11/30/23 through 12/05/23.
-She and the RCC audited the eMARs every month, but she did not audit medications that were short-term like Resident #5's prednisone, so she had not noticed the missing documentation for that medication.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 01/18/24 at 2:10pm was unsuccessful.

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The facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents including a resident with a diagnosis of open angled glaucoma who required an eyedrop nightly, indefinitely, placing the resident at risk for loss of vision, increased eye pressure, and laser eye surgery (#3); a resident who did not have an as needed anti-anxiety medication available and needed it; and the resident had a bacteria in her stomach and required a 14-day treatment of antibiotics which placed the resident at risk for inflammation, ulcers, and gastric cancer (#2); and a resident with a diagnosis of end-stage COPD was hospitalized due to COPD exacerbation and had a steroid order to reduce inflammation and there was no documentation the steroid was administered (#5). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in

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D 358	Continued From page 22 accordance with G.S. 131D-34 on 01/18/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	D 358		