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
	HAL080014	A. BUILDING: _____ B. WING _____	R 02/01/2024

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BROOKDALE SALISBURY	2201 STATESVILLE BOULEVARD SALISBURY, NC 28147

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 01/31/24 and 02/01/24.	D 000	The following is the Plan of Correction for Brookdale Salisbury regarding the statement of deficiencies dated February 1st, 2024. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is sumitted as a confirmation of our on-going efforts to comply with statutory and regulatory requirements. in this document we have outlined specific actions in response to identified issues.We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvment to satisfy the objective	
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed at least quarterly for 1 of 5 sampled residents (Resident #2) with LHPS tasks of application and removal of assistive devices,	D 280		

Reviewed and Acknowledged K.M. 02/19/24

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D 280	Continued From page 1 medication administration through injections and collecting and testing of fingerstick blood samples (#2). The findings are: Review of Resident #2's current FL2 dated 03/17/23 revealed diagnoses included diabetes mellitus with diabetic neuropathy, absence of right leg below knee, and phantom limb syndrome with pain. a. Review of Resident #2's LHPS evaluation dated 01/04/24 revealed: -Medication administration through injections listed as a marked task. -Resident #2's previous LHPS evaluation was completed on 02/07/23. -There was no LHPS evaluation completed for Resident #2 between 02/07/23 and 01/04/24. Review of Resident #2's LHPS evaluation dated 02/07/23 revealed medication administration through injections was listed as a marked task. Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for insulin glargine 10 units daily scheduled for administration at 9:00pm. -Resident #2 was administered insulin glargine 10 units daily from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 eMAR revealed: -There was an entry for insulin glargine 10 units daily scheduled for administration at 9:00pm. -Resident #2 was administered insulin glargine 10 units daily from 12/01/23 to 12/31/23.	D 280	HWD will coordinate monthly with [redacted] Pharmacy to complete LHPS initial, quarterly and change in condition LHPS's with the support of the Area Nurse Manager/District Director of Clinical Services	2/6/2024

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D 280	Continued From page 2 Review of Resident #2's January 2024 eMAR revealed: -There was an entry for insulin glargine 10 units daily scheduled for administration at 9:00pm. -Resident #2 was administered insulin glargine 10 units daily from 01/01/24 to 01/29/23. Interview with a medication aide (MA) on 02/01/24 at 10:38am revealed: -She and the other MAs administered insulin if required by a sliding scale to Resident #2. -The MAs administered insulin glargine to Resident #2 daily. -Resident #2 had a prosthetic leg device but he did not need assistance from staff with placing or removing it. Interview with Resident #2 on 02/01/24 at 6:14pm revealed the MAs checked his blood glucose value 4 times daily and administered insulin up to 4 times daily. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 02/01/24 at 6:17pm. Refer to the interview with the Executive Director (ED) on 02/01/24 at 6:30pm. b. Review of Resident #2's LHPS evaluation dated 01/04/24 revealed: -Collecting and testing of fingerstick blood samples (FSBS) was listed as a marked task. -Resident #2's previous LHPS evaluation was completed on 02/07/23. -There was no LHPS evaluation completed for Resident #2 between 02/07/23 and 01/04/24.	D 280		

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D 280	Continued From page 3 Review of Resident #2's LHPS evaluation dated 02/07/23 revealed collecting and testing of fingerstick blood samples (FSBS) were listed as a marked task. Observation of a MA in Resident #2's room on 01/31/24 at 10:08am revealed: -The MA checked Resident #2's blood glucose value using Resident #2's continuous blood glucose monitoring system. -Resident #2's blood glucose value was 343. Interview with a medication aide (MA) on 02/01/24 at 10:38am revealed: -She and the other MAs checked Resident #2's blood glucose values four times daily. -Resident #2 had a continuous blood glucose monitoring system that showed his current blood glucose value without FSBS. -The MAs changed Resident #2's blood glucose monitoring system's sensor every two weeks and Resident #2's blood glucose values were displayed on Resident #2's phone. Interview with Resident #2 on 02/01/24 at 6:14pm revealed the MAs checked his blood glucose value 4 times daily and administered insulin up to 4 times daily. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 02/01/24 at 6:17pm. Refer to the interview with the Executive Director (ED) on 02/01/24 at 6:30pm. c. Review of Resident #2's LHPS evaluation dated 01/04/24 revealed:	D 280		

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D 280	Continued From page 4 -Application and removal of prosthetic devices was listed as a marked task. -Resident #2's previous LHPS evaluation was completed on 02/07/23. -There was no LHPS evaluation completed for Resident #2 between 02/07/23 and 01/04/24. Review of Resident #2's LHPS evaluation dated 02/07/23 revealed any other prescribed occupational or physical therapy (PT), transferring semi-ambulatory or non-ambulatory residents, were listed as marked tasks. Interview with a medication aide (MA) on 02/01/24 at 10:38am revealed Resident #2 had a prosthetic leg device but he did not need assistance from staff with placing or removing it. Observation of Resident #2 in his room on 02/01/24 at 6:10pm revealed there was a prosthetic leg device beside the bed. Interview with Resident #2 on 02/01/24 at 6:14pm revealed: -He had completed PT services within the last year. -He was able to transfer independently. Interview with a medication aide (MA) on 02/01/24 at 10:38am revealed Resident #2 had a prosthetic leg device but he did not need assistance from staff with placing or removing it. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 02/01/24 at 6:17pm. Refer to the interview with the Executive Director	D 280		

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D 280	Continued From page 5 (ED) on 02/01/24 at 6:30pm. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm revealed: -There were no LHPS evaluations completed for Resident #2 between 02/07/23 and 01/04/24. -She did not know that Resident #2 did not have quarterly LHPS evaluations completed prior to December 2023 as she started working at the facility in December 2023. -She, the LHPS nurse and the Executive Director (ED) were all responsible in a joint effort to ensure that LHPS evaluations were completed quarterly for residents with LHPS tasks. -She was a limited practice nurse (LPN) and could not complete LHPS assessments for the residents. Telephone interview with the LHPS nurse on 02/01/24 at 6:17pm revealed: -She started completing LHPS evaluations for the facility on 01/02/24. -She was a registered nurse and was the regional nurse for multiple facilities. -There was not an LHPS evaluation completed for Resident #2 between 02/07/23 and 01/04/24. -The HWD and the ED were responsible to ensure that LHPS evaluations were completed quarterly for residents with LHPS tasks. Interview with the Executive Director (ED) on 02/01/24 at 6:30pm revealed: -She was not aware that Resident #2 did not have quarterly LHPS evaluations completed prior to the survey. -The HWD was responsible to ensure LHPS evaluations were completed quarterly for residents with LHPS tasks.	D 280		

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D 358	Continued From page 6	D 358		
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 medication as ordered for 1 of 3 residents observed during the morning medication pass who had orders for a probiotic and vitamin supplement (#6), and for 2 of 5 sampled residents for record review (#1 and #3) who had missed administrations of a pain patch (#3), and who had an order for an antifungal powder that was not applied (#1). The findings are: The medication error rate was 7% as evidenced by 2 errors out of 28 opportunities during the 8:00am medication pass on 02/01/24. 1. Review of Resident #6's current FL2 dated 01/08/24 revealed diagnoses included aortic aneurysm, diabetes mellitus type 2, arthritis, hypertension, and thyroid disease. a. Review of Resident #6's current FL2 dated 01/08/24 revealed there was an order for cholecalciferol (a vitamin D supplement) 2,000 units daily.	D 358	Training conducted on 2/8/2024 with medication assistants on reordering medications and proper communication of medication issues with Health and Wellness Director, medication assistants, and Resident Care Coordinators.	2/8/24

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D 358	Continued From page 7 Observation of the morning medication pass on 02/01/24 at 8:30am revealed: -The medication aide (MA) removed 8 oral medications and a topical gel from the medication cart and compared each medication label to the medications due on the electronic medication administration record (eMAR). -The MA administered 8 tablets with water and one topical gel to Resident #6. -There were no cholecalciferol tablets administered to Resident #6. Review of Resident #6's February 2024 eMAR revealed: -There was an entry for cholecalciferol 2,000 units daily scheduled at 8:00am. -There was documentation cholecalciferol was not administered on 02/01/24 with the reason documented as "other." Review of Resident #6's January 2024 eMAR revealed: -There was an entry for cholecalciferol 2,000 units daily scheduled at 8:00am with a start date of 01/20/24. -There was documentation cholecalciferol was not administered on 01/21/24, 01/24/24, 01/25/24, or 01/26/24 with the reason documented as "other" or pharmacy action required. Observation of medication on hand for Resident #6 on 02/01/24 at 2:45pm revealed there was no cholecalciferol 2,000 unit tablets on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/24 at 2:00pm revealed they did not have a current	D 358		

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D 358	Continued From page 8 order for cholecalciferol 2,000 units daily for Resident #6 and had never dispensed cholecalciferol for Resident #6. Interview with Resident #6 on 02/01/24 at 3:20pm revealed: -She used to take a vitamin D supplement when she was self-administering her own medications. -She recently had to stop self-administering her medications because the facility staff told her she was no longer able to do so and they removed the medications from her room. -She did not check through the cup of pills the MA gave her in the morning to see which medications were included in the cup. Interview with a MA on 02/01/24 at 3:30pm revealed: -He had not administered cholecalciferol to Resident #6 on 02/01/24 at 8:00 am because there was no cholecalciferol for her on the medication cart. -The MAs were supposed to reorder medications for residents when they was running low or down to the last week's worth of tablets. -To reorder a medication, the MAs were able to click on a reorder button in the eMAR system, and it sent the request to the pharmacy. -He had documented Resident #6's cholecalciferol as administered on 01/22/24 and 01/23/24, but as not administered on 01/24/24 and 01/25/24. -He had never requested medication refills for Resident #6 because he thought one of the other MAs had already reordered it. Interview with the Resident Care Coordinator (RCC) on 02/01/24 at 3:45pm revealed: -She was not aware that Resident #6 did not have cholecalciferol available on the medication cart or	D 358		

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D 358	Continued From page 9 that she had not received it as ordered that morning on 02/01/24. -Resident #6 had stopped self-administering her medications on 01/20/24, so the cholecalciferol could have been in a bottle that was removed from her room and not added to the medication cart. -Resident #6's FL2 dated 01/08/24 had not been faxed to the pharmacy because at that time, Resident #6 was still self-administering her own medications and was not using the facility's contracted pharmacy. -Resident #6 was still using up the medications in bottles that she had from when she was self-administering her medications and none of her prescriptions had been ordered through the facility's contracted pharmacy yet. -The MAs were supposed to order medications from the pharmacy when they were down to 7 or 8 doses remaining. -To reorder medications, the MAs needed to fax a reorder request to the pharmacy, then call the pharmacy to ensure they received the refill request fax. -She did not know if any of the staff had requested a refill of Resident #6's cholecalciferol. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm revealed: -Resident #6 had failed her most recent assessment of her ability to self-administer her medications. -Cholecalciferol was a medication that Resident #6 had in her room and it was removed when her ability to self-administer was revoked. -She had requested an updated medication list from Resident #6's previous primary care provider (PCP) so she would know which medications and supplements to place on the medication cart, but had not received a response.	D 358		

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D 358	Continued From page 10 -Resident #6 switched from her previous PCP to the facility's PCP yesterday on 0/31/24. -She was not aware that Resident #6's cholecalciferol order had not been discontinued by the new PCP. -If cholecalciferol was showing as a medication that was due on the eMAR but the MA was not able to find it on the medication cart, she expected the MA to contact the pharmacy to request a refill. -She had not been aware that Resident #6 did not receive cholecalciferol as ordered during that morning's medication pass. Telephone interview with Resident #6's power of attorney (POA) on 02/01/24 at 6:00pm revealed: -When Resident #6 was told she could no longer self-administer her medications, all of the medications had been removed from her room. -She had been purchasing cholecalciferol for Resident #6 when she was self-administering her medications. -She had asked the facility staff if there were any medications that she needed to order until Resident #6 saw the new PCP, but she was not asked to bring in any medications for Resident #6. -The facility staff had not contacted her regarding Resident #6 being out of cholecalciferol. Interview with the Administrator on 02/01/24 at 6:10pm revealed: -She was not aware that Resident #6 had an order for cholecalciferol and that she had not been administered cholecalciferol 02/01/24 during the medication pass at 8:00 am due to the medication not being available on the medication cart. -If a medication was not available for administration, she expected the MA to contact	D 358		

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D 358	Continued From page 11 the pharmacy to request the refill. -Medications were supposed to be refilled one week prior to them running out so that residents did not miss any doses of their medications. -She was not aware the pharmacy did not have an order on file for Resident #6's cholecalciferol. Attempted telephone interview with Resident #6's PCP on 02/01/24 at 2:30pm was unsuccessful. b. Review of Resident #6's physician's order dated 01/31/24 revealed there was an order for lactobacillus acidophilus (a probiotic blend used to add good bacteria into the intestines) 1 tablet once daily. Observation of the morning medication pass on 02/01/24 at 8:30am revealed: -The medication aide (MA) removed 8 oral medications and a topical gel from the medication cart and compared each medication label to the medications due on the electronic medication administration record (eMAR). -The MA administered 8 tablets with water and one topical gel to Resident #6. -There were no lactobacillus acidophilus tablets administered to Resident #6. Review of Resident #6's February 2024 eMAR revealed: -There was an entry for lactobacillus capsule take 1 capsule daily scheduled at 8:00am. -There was documentation lactobacillus was not administered on 02/01/24 with the reason documented as "other." Observation of medications on hand for Resident #6 on 02/01/24 at 2:45pm revealed there was one medication card containing probiotic blend capsules with a dispensed date of 01/31/24 and 8	D 358		

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D 358	Continued From page 12 out of 8 dispensed tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/24 at 2:00pm revealed: -The pharmacy received an order for lactobacillus acidophilus for Resident #6 yesterday on 01/31/24. -The pharmacy dispensed 8 tablets of lactobacillus acidophilus under the name of probiotic blend on 01/31/24, so it would have been available in the facility for that morning's medication pass on 02/01/24. Interview with Resident #6 on 02/01/24 at 3:20pm revealed: -She met her new PCP at the facility yesterday on 01/31/24. -The new PCP had talked to her about starting on a probiotic to help her immune system. -She thought she had started the probiotic that morning on 02/01/24, but she did not check through the cup of pills the MA gave her to see which medications were included in the cup. Interview with a MA on 02/01/24 at 3:30pm revealed: -He had not administered lactobacillus acidophilus (probiotic blend) to Resident #6 that morning. -The probiotic blend was a new order from the previous day, and he had not realized it was already delivered from the pharmacy and available on the medication cart for administration. -He usually checked the medication cart for all the medications that showed up as being due on the eMAR, but he had overlooked the probiotic blend capsules since they were a new order.	D 358		

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D 358	Continued From page 13 Interview with the Resident Care Coordinator (RCC) on 02/01/24 at 3:45pm revealed: -She was not aware that Resident #6 had not received the lactobacillus acidophilus probiotic blend that morning as ordered. -Since the order for the probiotic had been written the previous day on 01/31/24, she did not know if the MA knew that medication was already available on the medication cart. -If a medication was showing up as being due on the eMAR, the MAs were expected to check the medication cart for the medication, or call the pharmacy to see if the medication had been ordered or dispensed yet. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm revealed: -She was not aware that the MA had not administered the lactobacillus acidophilus probiotic blend to Resident #6 that morning as ordered. -If a new medication showed up on the eMAR as being due for a resident, she expected the MA to check the medication cart for the new medication or follow up with either herself or the RCC to verify the new order rather than documenting it as not administered. Interview with the Administrator on 02/01/24 at 6:10pm revealed: -She was not aware that Resident #6 had an order for lactobacillus acidophilus probiotic blend and that she had not been administered the probiotic blend that morning due to the MA not seeing it on the medication cart. -MAs were expected to check the medication cart for all medications that were due prior to documenting that the medication was not administered.	D 358		

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D 358	Continued From page 14 Attempted telephone interview with Resident #6's primary care provider (PCP) on 02/01/24 at 2:30pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 05/10/23 revealed diagnoses included chronic systolic congestive heart failure, history of liver transplant, liver cell carcinoma, hypertension, and diabetic chronic kidney disease. Review of Resident #3's physician's order dated 10/26/23 revealed an order for fentanyl (a controlled substance pain medication used to treat moderate to severe pain) 25mcg/hour transdermal patch, apply 1 patch to skin every 72 hours. Review of Resident #3's physician's order dated 11/21/23 revealed an order to increase fentanyl patch to 50mcg/hour, apply 1 patch to skin every 72 hours. Review of Resident #3's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fentanyl transdermal patch 50mcg/hour, apply 1 patch every 72 hours for pain scheduled at every "72 hours." -There was documentation Resident #3's fentanyl patch was not administered on 01/08/24, 01/11/24, or 01/14/24. -The documented reason Resident #3's fentanyl patches were not applied were pharmacy action required on 01/08/24 and 01/14/24, and medication not on hand on 01/11/24. Review of Resident #3's controlled substance count sheets (CSCS) for January 2024 revealed there was no documentation Resident #3 had a fentanyl 50mcg patch applied on 01/08/24,	D 358		

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D 358	Continued From page 15 01/11/24 or 01/14/24. Review of Resident #3's progress notes for January 2024 revealed there was no documentation regarding Resident #3 being out of fentanyl patches or reporting having pain to the staff. Observation of medications on hand for Resident #3 on 02/01/24 at 12:00pm revealed there was a bag containing 6 fentanyl 50mcg patches with a dispensed date of 01/15/24 and a dispensed quantity of 10 patches. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/24 at 2:00pm revealed: -The pharmacy had dispensed 10 fentanyl 25mcg/hour patches on 11/13/23, 10 fentanyl 50mcg/hour patches on 11/22/23, and 10 fentanyl 50mcg/hour patches on 01/15/24. -He was unsure if the facility had sent a refill request for Resident #3's fentanyl patches between the beginning of January 2024 and when they dispensed a refill on 01/15/24. Interview with Resident #3 on 02/01/24 at 10:50am revealed: -The staff put fentanyl patches on her every couple of days. -She did not remember missing any fentanyl patches or having increased pain between 01/08/24 and 01/17/24. -She did not always like having the fentanyl patches on because sometimes they felt too strong for her but her power of attorney (POA) wanted her to continue using them. Telephone interview with Resident #3's hospice nurse on 02/01/24 at 11:25am revealed:	D 358		

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D 358	Continued From page 16 -Resident #3 was on hospice due to having metastatic cancer. -She was aware that Resident #3 sometimes refused her fentanyl patches but not that she had missed three doses, which was one week's worth, due to the patches running out and not being available. -The hospice nurses were supposed to check availability and quantity remaining of all hospice medications during their visits but she did not see documentation that Resident #3 was out of fentanyl patches. -Hospice was able to electronically send prescription refills to the pharmacy whenever a refill was requested. -Not having the fentanyl patches could place Resident #3 at risk for increased pain. -One of the hospice nurses had visited Resident #3 on 01/10/23 and there was no documentation about Resident #3 being out of fentanyl patches or reporting having any pain. -On 01/10/24 the hospice nurse documented that Resident #3 reported her pain-control regimen was effective. -She expected the staff to notify hospice right away if a pain medication ran out because they could have it ordered and delivered to the facility the same day it ran out. Interview with a medication aide (MA) on 02/01/24 at 3:30pm revealed: -He had worked and administered the last couple of Resident #3's fentanyl patches on 01/02/24 and 01/05/24. -He thought he remembered clicking the reorder button in the eMAR system to request a refill of Resident #3's fentanyl patches. -He usually told the hospice nurse in person if Resident #3's hospice medications were low, but he could not remember if he notified hospice	D 358		

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D 358	Continued From page 17 about her fentanyl patches being low or not. -Resident #3 had not reported any pain or increased level of her pain during the days she did not have a fentanyl patch on. Interview with the Resident Care Coordinator (RCC) on 02/01/24 at 3:45pm revealed: -She was not aware Resident #3 had missed three administrations of her fentanyl patches. -If a medication was showing as due on the eMAR but was not available in the medication cart for administration, the MA was expected to call hospice and the pharmacy and they could usually have the medication delivered the same day. -Resident #3 had not complained of pain or changed her activity level when she was out of fentanyl patches. -She did not know if any staff conducted audits of the eMARs to check for missed doses of medications. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 5:25pm revealed: -She was not aware that Resident #3 missed three doses of fentanyl patches. -The MAs should have noticed the fentanyl patches were low or had run out during their count of controlled substances and reordered more through hospice. -Every morning she ran a report on her computer which showed her any medications that had been documented as not administered. -She had not noticed Resident #3's fentanyl patches being documented as not administered but she had been out of the office for some days in January 2024 and could have missed it then. Interview with the Administrator on 02/01/24 at 6:10pm revealed:	D 358		

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D 358	Continued From page 18 -She was not aware that Resident #3 missed doses of her fentanyl pain patch. -The fentanyl patches should have been reordered prior to them running out. -The MAs who worked when Resident #3's fentanyl patches were running low or were completely out should have notified hospice, and then the HWD so she could follow up and ensure the fentanyl patches were reordered and delivered to the facility. -Whichever MA used the last patch should have ensured that someone at the facility was aware Resident #3 needed a refill of her fentanyl patches prior to leaving their shift. -The HWD audited the eMARs for medication errors or missed doses but she did not know if the HWD had caught the missed fentanyl doses. Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/01/24 at 2:30pm was unsuccessful. 3. Review of Resident #1's current FL2 dated 12/27/23 revealed: -Diagnoses included discitis, muscle weakness, atrial fibrillation, and major depressive disorder. -There was an order for Nystatin (a topical antifungal powder) 100,000 units/gram, apply topically under both breasts twice daily until 01/12/24. Review of Resident #1's physician's order dated 01/17/24 revealed there was an order to continue the use of Nystatin powder under breasts at this time. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin 100,000	D 358		

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D 358	Continued From page 19 units/gram powder apply to bilateral breasts twice daily for yeast infection until 01/12/24, scheduled at 8:00am and 8:00pm. -There was documentation Nystatin powder was not administered at 8:00am on 01/05/24, 01/06/24, or 01/07/24 with the reason documented as waiting on delivery on 01/05/24, as needs to be ordered on 01/06/24, and as pharmacy action required on 01/07/24. -There was documentation Nystatin powder was not administered at 8:00pm on 01/03/24, or from 01/09/24 through 01/12/24 with the reason documented as pharmacy action required on 01/03/24, and as "other" from 01/09/24 through 01/12/24. -There was no entry for Nystatin powder 100,000 units/gram under bilateral breasts twice daily from 01/17/24 through 01/31/24. Observation of medication on hand for Resident #1 on 01/31/24 at 3:30pm revealed: -There was one bottle of Nystatin 100,000 units/gram powder to apply under bilateral breasts twice daily for 14 days. -The bottle was one-third full. Interview with a medication aide (MA) on 01/31/24 at 3:25pm revealed: -Nystatin powder was on the medication cart for Resident #1 but it was not a current medication that showed up as being due on the eMAR so he did not administer it. -He did not know if Resident #1 had redness or irritation under her breasts. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/24 at 2:00pm revealed: -The pharmacy had received an order on 12/29/23 to apply Nystatin powder to Resident #1	D 358		

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D 358	Continued From page 20 twice daily for 14 days. -The pharmacy dispensed one 15-gram container of Nystatin 100,000 units/gram powder to the facility on 12/29/23. -The pharmacy had not received an order dated 01/17/24 to resume application of Nystatin powder for Resident #1. -The facility staff entered medication orders on the eMAR; that was not a service the pharmacy provided for the facility. Interview with Resident #1 on 02/01/24 at 11:10am revealed: -She had been receiving Nystatin powder under her breasts due to skin irritation and the Nystatin powder helped. -The staff had not applied Nystatin powder under her breasts in a couple of weeks and she had not requested it. -The irritation under her breasts was mostly resolved but she still applied her own barrier cream to the area as needed. Interview with the Resident Care Coordinator (RCC) on 02/01/24 at 3:45pm revealed: -She had not seen the order for Resident #1's Nystatin powder dated 01/17/24. -The order would have been received via email addressed to both her, the Health and Wellness Director (HWD) and the Administrator. -There was a MA who was training to help her in the office with orders who may have received this order from the printer and forgot to fax it to the pharmacy. -All new orders were supposed to be paired with an order tracking form; a copy of the order should be faxed to the pharmacy and stapled to the order tracking form along with the fax delivery receipt. -The order should have been entered into the	D 358		

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D 358	Continued From page 21 eMAR system, then checked for accuracy once received from the pharmacy. -When Resident #1 first was admitted to the facility on 12/29/23 she had some redness under her breasts but had not complained of pain or irritation since her original Nystatin order had been discontinued. -She was not aware of the dates that Resident #1 had not received the Nystatin powder as ordered. -The MA who had documented Resident #1's Nystatin as not administered on 01/05/24, 01/06/24, and 01/09/24 through 01/12/24 no longer worked at the facility other than "as needed." -If the Nystatin powder was delivered to the facility on 12/29/23, there was no reason to document it as not administered due to the medication not being available. -If the MA was not able to find the Nystatin powder on the medication cart, they were expected to notify her so that she could follow up on it. Interview with a MA on 02/01/24 at 4:15pm revealed: -She had been helping the RCC process medication orders. -She did not remember seeing Resident #1's Nystatin order from 01/17/24. -Either she, the RCC or a night shift MA would have placed Resident #1's order from 01/17/24 in her record. -The order should have been faxed to the pharmacy and entered into the eMAR system prior to being filed. -She did not know if Resident #1 had any redness or irritation under her breasts. -She did not remember there being an issue finding Resident #1's Nystatin powder from 01/03/24 through 01/12/24.	D 358		

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D 358	Continued From page 22 -She did not know if any staff were responsible for auditing the eMARs to check for medications not administered as ordered. Interview with the HWD on 02/01/24 at 5:25pm revealed: -She was not aware that Resident #1 was supposed to have been receiving Nystatin powder under her breasts since 01/17/24. -The order for Nystatin powder had been generated by the PCP after a visit then faxed to the facility. -Processing new PCP orders was the responsibility of either the RCC or the MA that was helping her. -The order had been faxed to the facility on 01/21/24. -She was not aware of any redness or irritation to Resident #1's skin. -She was not aware of the 8 missed doses of Nystatin between 01/03/24 and 01/12/24. -Medications were supposed to be administered as ordered. -If a medication showed up on the eMAR as being due for a resident, she expected the MA to check the medication cart for the medication or follow up with either herself or the RCC rather than documenting it as not administered. Interview with the Administrator on 02/01/24 at 6:10am revealed: -The RCC was responsible for receiving new orders from the PCP and entering the new order into the eMAR. -She was not aware there was a missed order for Nystatin powder for Resident #1 or that she had missed 8 doses of Nystatin powder between 01/03/24 and 01/12/24. -She expected medications to be administered as ordered.	D 358		

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D 358	Continued From page 23 -The HWD audited the eMARs for medication errors or missed doses and she did not know if the HWD had caught the missed Nystatin powder doses for Resident #1. Attempted telephone interview with Resident #1's PCP on 02/01/24 at 2:30pm was unsuccessful.	D 358		