STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081001	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR REST HOME	160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 01/31/24 through 02/02/24.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #2) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL2 dated 06/01/23 revealed diagnoses included dementia with behavior, delusional, hypertension, chronic obstructive pulmonary disease, oxygen dependency, history of urinary tract infection. Review of the Resident #1's Resident Register revealed an admission date of 09/09/2019. Review of Resident #1's TB skin testing record	D 234		

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D 234	Continued From page 1	D 234		

revealed:
-There was documentation of a skin test placed on 06/27/2019.
-There was documentation the skin test was read as negative.
-There was no date of when the test was read.
-There was no documentation of a name of the person who read the test as negative.
-There was no documentation of a second TB skin test.

Interview with the Administrator on 02/02/24 at 8:49am revealed:
-She was unaware TB tests were not up to date.
-The medication aide (MA) supervisor was responsible for making sure resident TB skin tests were completed and up to date.
-The MA supervisor position was currently vacant.
-She, the Resident Care Coordinator (RCC), and the "grounds" Supervisor were responsible to make sure TB skin tests were up to date.
-Not having TB tests up to date has been an oversight.
-She could find no documentation of a second TB test was completed for Resident #1.

2. Review of Resident #2's current FL2 dated 12/06/23 revealed diagnoses included diabetes mellitus type 2, hypertension, history of cerebrovascular accident, right sided hemiplegia, major depressive disorder, chronic pain, and peripheral neuropathy.

Review of Resident #2's Resident Register revealed an admission date of 01/08/20.

Review of Resident #2's record revealed there was no documentation of any 2-step TB skin testing completed for Resident #2.

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D 234	Continued From page 2 Interview with Resident #2 on 02/01/24 at 11:38am revealed: -He did not know if a 2-step TB skin test was completed upon admission or while residing at the facility. -He denied having any symptoms associated with an active TB infection. Interview with the facility's contracted Licensed Health Professional Support (LHPS) nurse on 02/02/24 at 12:35pm revealed: -She was contracted by the facility in February 2023 and was responsible for completing a 2-step TB test for newly admitted residents. -She did not know if a 2-step TB test was completed for Resident #2 since he was admitted on 01/08/20. Interview with the Administrator on 02/01/24 at 11:50am revealed: -When a resident was admitted to the facility, the facility's contracted LHPS nurse placed a TB skin test, read the results three days later, and documented the results, signed, and dated the results. -The former medication aide (MA) supervisor was responsible for placing Resident #2's TB skin test results in Resident #2's record. -She did not know why Resident #2 did not have a first or second step TB skin test results in his record. -She could not find any documentation that a 2-step TB skin test was completed for Resident #2. -The Business Office Manager (BOM) and MA supervisor were responsible for completing resident record audits to check for missing documents including 2-step TB test results since the former MA supervisor left but did not have a chance to complete record audits for all the	D 234		

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 234	Continued From page 3 residents yet.	D 234		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to maintain a record of menu substitutions indicating what food was served to residents. The findings are: Interview with one resident during the facility tour on 02/01/24 at 11:20am revealed: -The facility started serving sandwiches and chips for lunch a few weeks ago. -She got a sandwich and chips every day for lunch. Interview with a second resident during the facility tour on 02/01/24 at 11:24am revealed: -The meals served were frequently different from	D 292		

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D 292	Continued From page 4	D 292		

the menu posted.
-The same food items were frequently repeated.
-Sandwiches and chips were often served at lunch.

Interview with a third resident during the facility tour on 02/01/24 at 11:26am revealed:
-The facility served her a sandwich and chips every day at lunch for a few weeks now.

Interview with a fourth resident on 02/01/24 at 11:38am revealed:
-The facility started serving sandwiches and chips during lunch around December 2023.
-He was served a sandwich and chips for lunch on 01/31/24.
-He received a sandwich and chips at least 3 times per week for lunch.

Review of the lunch menu for 01/31/24 revealed the menu consisted of spaghetti, meat sauce, steamed broccoli, tossed salad, dressing, toasted Italian bread, peaches, mandarin oranges.

Observation of the lunch meal service on 01/31/24 at 11:30am revealed the residents were served ham and cheese sandwiches, graham crackers, sour cream and onion chips, tea and coffee.

Review of the dinner menu for 01/31/24 revealed the menu consisted of baked chicken, scalloped potatoes, spinach/lemon, biscuit, devil's food cake, margarine.

Observation of the dinner meal service on 01/31/24 at 4:45pm revealed the residents were served hot dogs, tater tots, vanilla pudding or sugar free chocolate pudding, chili/slaw, ketchup, mustard, tea, and coffee.

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D 292	Continued From page 5 Review of the facility's meal substitution log for the month of January revealed: -The substitution log had 7 columns for 7 days of the week, and 3 rows with breakfast, lunch and dinner listed in each column. -The month at the top of the page was January. -There were no dates documented on the log. -The month of January had no entries of any substitutions; the page was blank. Interview with the dietary manager on 01/31/24 at 4:57pm revealed: -She substituted food for dinner because the residents requested home made chili and hotdog's. -She got confused and looked at the wrong menu at lunch time. -She served sandwiches and chips which were on the menu for 02/01/24. -She documented what was served on the February meal substitution list because she was confused as to what day it was. -The January substitution meal calendar was blank because she did not realize it was 01/31/24. -She thought the date was 02/01/24. Interview with the Administrator on 02/02/24 at 8:49am revealed: -She was not aware the menu was not followed for 2 meals on 01/31/24. -She thought the menu was followed most of the time. -She expected the menu to be followed, except when they do special things for the residents and get takeout which usually occurs once a week.	D 292		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 6 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents who had a physician's order for regular 2000 ADA diet (#1, #2, #3) and increased protein and low salt (#3). The findings are: 1. Review of Resident #1's FL2 dated 06/01/23 revealed: Diagnoses included dementia with behavior, delusional, hypertension, chronic obstructive pulmonary disease, and oxygen dependency. -There was a physician's order for a regular diet 2000 ADA. Review of facility's therapeutic diet list posted on the kitchen bulletin board on 01/31/24 at 9:30am revealed Resident #1 was to be served a regular diet. Review of the facility's regular 2000 ADA diet lunch menu for 01/31/24 revealed 4 oz spaghetti, ½ cup steamed broccoli, 1 cup tossed salad/dressing, 2 slices toasted Italian bread, ½ cup peaches, 1 tsp margarine, and 1 cup coffee/tea/water. Observation of the lunch meal and beverage service on 01/31/24 at 11:30am revealed Resident #1 was served and consumed a ham	D 310		

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D 310	Continued From page 7	D 310		

and cheese sandwich, graham crackers, sour cream and onion potato chips, coffee, cream and sugar, and light mayonnaise.

Review of the facility's regular 2000 ADA diet dinner menu for 01/31/24 revealed 3 oz baked chicken, ½ cup scalloped potatoes, ½ cup spinach/lemon, 2 pieces of bread, 1 cup devil's food cake, 1 tsp margarine, 1 cup milk/beverage.

Observation of the dinner meal and beverage service on 01/31/24 at 4:45pm revealed Resident #1 was served and consumed one hot dog, tater tots, vanilla pudding, slaw, chili and coffee with cream and sugar.

Interview with the Nurse Practitioner (NP) on 02/0224 at 10:27am revealed:
-Resident #1 is pre diabetic.
-She is on a regular diet, 2000 ADA.

Refer to the interview with the Dietary Manager (DM) on 02/01/24 at 10:56am.

Refer to interview with Business Office Manager (BOM) on 02/01/24 at 4:19pm.

Refer to interview with Administrator on 02/02/24 at 8:49am.

2. Review of Resident #2's FL2 dated 12/06/23 revealed:
-Diagnoses included diabetes type 2, hypertension, right side hemiplegia, history cerebral vascular accident, insulin dependent, and major depression.
-Resident #2 had a diet order for diabetic diet.

Review of Resident #2's diet order dated 09/16/21 revealed diabetic 2000 ADA.

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D 310	Continued From page 8 Review of the facility's therapeutic list posted on the kitchen bulletin board on 01/31/24 at 9:30am revealed diabetic diet but had no calorie specifications. Review of the facility's diabetic 2000 ADA lunch menu revealed 4 oz spaghetti, ½ cup steamed broccoli, 1 cup tossed salad/dressing, 2 slices toasted Italian bread, ½ cup unsweetened peaches, 1 tsp margarine, and 1 cup unsweetened coffee/tea/water. Observation of the lunch meal and beverage service on 01/31/24 at 11:30am revealed Resident #2 was served and consumed a ham and cheese sandwich, light mayonnaise, graham crackers, sour cream and onion potato chips, unsweetened coffee. Review of the facility's diabetic 2000 ADA diet dinner menu for 01/31/24 revealed 3 oz baked chicken, ½ cup scalloped potatoes, ½ cup spinach/lemon, 2 pieces of bread, chocolate diet pudding, 1 tsp margarine, 1 cup unsweetened beverage. Observation of the dinner meal and beverage service on 01/31/24 at 4:45pm revealed Resident #2 was served and consumed a hot dog, sugar free chocolate pudding, tater tots, chili, slaw, coffee with Splenda and cream, ketchup and mustard. Refer to the interview with the DM on 02/01/24 at 10:56am. Refer to the interview with the BOM on 02/01/24 at 4:19pm.	D 310		

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D 310	Continued From page 9 Refer to the interview with the Administrator on 02/02/24 at 8:49am. 3. Review of Resident #3's FL2 dated 01/09/24 revealed: -Diagnosis included pemphigus vulgaris (a rare long-term condition caused by a problem with immune system causing blisters in the mouth and skin). -There was a diet order for regular 2000 ADA, increased protein, low salt. Review of facility's therapeutic diet list posted on the kitchen bulletin board revealed resident #3 was not included on the therapeutic diet list. Review of the facility's regular 2000 ADA diet dinner menu for 01/31/24 revealed 3 oz baked chicken, ½ cup scalloped potatoes, ½ cup spinach/lemon, 2 pieces of bread, 1 cup devil's food cake, 1 tsp margarine, 1 cup milk/beverage. Observation of the lunch meal and beverage service on 01/31/24 at 11:30am revealed Resident #3 was served and consumed a ham and cheese sandwich, graham crackers, sour cream and onion potato chips, coffee, cream and sugar. Review of the facility's regular 2000 ADA diet dinner menu for 01/31/24 revealed 3 oz baked chicken, ½ cup scalloped potatoes, ½ cup spinach/lemon, 2 pieces of bread, 1 cup devil's food cake, 1 tsp margarine, 1 cup milk/beverage. Observation of the dinner meal and beverage service on 01/31/24 at 4:45pm revealed Resident #3 was served and consumed one hot dog, tater tots, vanilla pudding, slaw, chili, ketchup, mustard, and tea.	D 310		

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D 310	Continued From page 10 Refer to the interview with the DM on 02/01/24 at 10:56am. Refer to the interview with the BOM on 02/01/24 at 4:19pm. Refer to the interview with the Administrator on 02/02/24 at 8:49am. _____ Interview with the DM on 02/01/24 at 10:56am and 1:01pm revealed: -She was responsible for making sure the dietary list was up to date. -She was unaware Resident #1, #2, and #3 were on calorie restrictions. -She just now started looking at the calorie restrictions and realized she was missing several residents on the therapeutic diet list. -The medication aides were responsible to inform her when diet orders change. -She audited resident records "about once a month" to be sure "everything" was up to date. -Lack of communication could be the reason why she was unaware of Resident #1 being on a 2000 ADA diet. Interview with the BOM on 02/01/24 at 4:19pm revealed: -The MA supervisor was responsible for making sure diet orders were up to date. -The MA supervisor position was currently vacant, and no one had been designated to ensure the diet orders were updated. -She planned to double check behind them to be sure orders were up to date. -She planned to get new copies of orders so she could follow up on all residents. - "It just fell through the cracks," as to why orders were missing.	D 310		

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D 310	Continued From page 11 Interview with the Administrator 02/02/24 at 8:49am revealed: -The MA Supervisor was responsible for making sure diet orders were up to date but that position was currently vacant. -She, the BOM, Dietary Manager, and the "grounds" Supervisor tried to fill in and make sure diet orders were updated. -This was an oversight as to why it had not been getting done.	D 310		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities;	D 316		

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D 316	Continued From page 12 and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post a current, monthly activity calendar on the first day of the month for the 27 residents residing in the facility. The findings are: Observation of the main hallways and common areas on 01/31/24 at 11:15am revealed there was no activity calendar posted in the facility. Interview with a resident on 01/31/24 at 10:52am revealed the facility used to have an activities calendar posted in the hallway but did not have a calendar posted for at least a "few months". Interview with a medication aide (MA) on 01/31/24 at 2:30pm revealed she started working for the facility about 3 weeks ago and had never seen an activities calendar posted. Interview with the Administrator on 02/01/24 at 11:50am revealed: -She did not have a current Activities Director working for the facility, but she had been trained and the facility cook was designated to complete the activity calendar each month. -The facility did not have an activities calendar posted on 01/31/24 because the cook had taken the calendar down to make a new calendar for	D 316		

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D 316	Continued From page 13 the month of February 2024. -She did not know why the February 2024 activity calendar was not posted in the hallway. Interview with the cook on 02/01/24 at 2:05pm revealed: -She had not filled out an activity calendar because she did not have time to. -She could not remember when she took down the last activity calendar that was posted in the hallway.	D 316		
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 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: Observation of the main hallways and common areas on 01/31/24 at 11:15am revealed there was no activity calendar posted in the facility. Observation of the facility on 01/31/24 from 9:00am through 5:15pm revealed there were no activities provided for the residents during those times.	D 317		

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COLONIAL MANOR REST HOME	160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 317	Continued From page 14 Interview with 5 residents on 01/31/24 from 9:15am through 10:52am revealed: -The first resident stated the facility did not offer any weekly activities. -The second resident talked to other residents to keep herself occupied or sat in her room because the facility did not offer any activities. -The third resident stated the facility used to have an activities calendar posted in the hallway but did not have a calendar posted for at least a "few months" and she was "bored" and would like activities offered. -The fourth resident stated he stayed in his room or watched television in the living room to keep himself busy because the facility did not offer him any activities. -The fifth resident stated the last time the facility offered an activity was when the facility cook helped her make a wreath and gingerbread house to decorate her room for Christmas. Interview with a medication aide (MA) on 01/31/24 at 2:30pm revealed: -She started working for the facility about 3 weeks ago and had never seen an activities calendar posted. -She had never seen any activities offered to the residents. -She did not know who was responsible for offering activities to the residents. Interview with the Administrator on 02/01/24 at 11:50am revealed: -She did not have a current Activities Director working for the facility, but she had been trained and the facility cook was designated to complete the activity calendar each month. -The MA supervisor and a personal care aide (PCA) were responsible for offering the activities listed on the calendar to the residents.	D 317		

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D 317	Continued From page 15 -Sometimes one of the facility residents would do activities with the other residents. -She did not know if any activities were offered to the residents this week. -The facility did not have an activities calendar posted on 01/31/24 because the cook had taken the calendar down to make a new calendar for the month of February 2024. -She did not know why the February 2024 activity calendar was not posted in the hallway. Interview with the MA supervisor on 02/02/24 at 11:50am revealed: -She offered activities to the residents when she had time. -She started her weekly work shifts on 02/01/24 and did not do any activities with the residents on 02/01/24 or 02/02/24 because she did not have time because she was administering medications to the residents and helping other staff with resident care. -She did not know when an activity was last offered to the residents.	D 317		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or	D 344		

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clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#3) related to an antidepressant medication, an anti-inflammatory, a medication used to treat nerve pain, and a muscle relaxant.

The findings are:

Review of Resident #3's current FL2 dated 01/17/24 revealed:
-Diagnoses included depression, severe sepsis, and chronic low back pain.
-Current level of care was documented as hospital.
-Recommended level of care was documented as domiciliary.

a. Review of Resident #3's current FL2 dated 01/17/24 revealed there was an order for fluoxetine (a medication used to treat depression) take "20mg 40mg" daily.

Review of Resident #3's physician's orders dated 01/17/24 revealed there was an order for fluoxetine 40mg take 1 capsule daily.

Review of Resident #3's 01/17/24-01/31/24 electronic medication administration record (eMAR) revealed:
-There was an entry for fluoxetine 40mg take 1 capsule daily.
-There was documentation fluoxetine 40mg was administered daily at 8:00am from 01/17/24-01/31/24.

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Review of Resident #3's 02/01/24-02/02/24 eMAR revealed:
-There was an entry for fluoxetine 40mg take 1 capsule daily.
-There was documentation fluoxetine 40mg was administered daily on 02/01/24 and 02/02/24 at 8:00am.

Refer to the interview with the medication aide (MA) supervisor on 02/01/24 at 3:36pm.

Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/24 at 4:08pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/24 at 9:35am.

Refer to the interview with the interview with Resident #3's primary care provider (PCP) on 02/02/24 at 10:25am.

Refer to the interview with the MA supervisor on 02/02/24 at 11:50am.

Refer to the interview with the Administrator on 02/02/24 at 12:15pm.

b. Review of Resident #3's current FL2 dated 01/17/24 revealed there was an order for prednisone (a medication used to treat inflammation) take "20mg 60mg" twice daily.

Review of Resident #3's 01/17/24-01/31/24 electronic medication administration record (eMAR) revealed:
-There was an entry for prednisone 20mg take 3 tablets (60mg) twice daily.
-There was documentation prednisone 60mg was administered twice daily at 8:00am and 8:00pm.

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Review of Resident #3's 02/01/24-02/02/24 eMAR revealed:
-There was an entry for prednisone 20mg take 3 tablets (60mg) twice daily.
-There was documentation prednisone 60mg was administered twice daily at 8:00am and 8:00pm on 02/01/24 and 8:00am on 02/02/24.

Refer to the interview with the medication aide (MA) supervisor on 02/01/24 at 3:36pm.

Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/24 at 4:08pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/24 at 9:35am.

Refer to the interview with the interview with Resident #3's primary care provider (PCP) on 02/02/24 at 10:25am.

Refer to the interview with the MA supervisor on 02/02/24 at 11:50am.

Refer to the interview with the Administrator on 02/02/24 at 12:15pm.

c. Review of Resident #3's current FL2 dated 01/17/24 revealed there was an order for gabapentin (a medication used to treat nerve pain) take "300mg 600mg" twice daily.

Review of Resident #3's physician's orders dated 01/17/24 revealed there was an order for gabapentin 600mg take 1 tablet twice daily.

Review of Resident #3's 01/17/24-01/31/24 electronic medication administration record

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(eMAR) revealed:
-There was an entry for gabapentin 600mg take 1 tablet twice daily.
-There was documentation gabapentin 600mg was administered twice daily at 8:00am and 8:00pm.

Review of Resident #3's 02/01/21-02/02/24 eMAR revealed:
-There was an entry for gabapentin 600mg take 1 tablet twice daily at 8:00am and 8:00pm.
-There was documentation gabapentin 600mg was administered at 8:00am and 8:00pm on 02/01/24 and 8:00am on 02/02/24.

Refer to the interview with the medication aide (MA) supervisor on 02/01/24 at 3:36pm.

Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/24 at 4:08pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/24 at 9:35am.

Refer to the interview with the interview with Resident #3's primary care provider (PCP) on 02/02/24 at 10:25am.

Refer to the interview with the MA supervisor on 02/02/24 at 11:50am.

Refer to the interview with the Administrator on 02/02/24 at 12:15pm.

d. Review of Resident #3's current FL2 dated 01/17/24 revealed there was an order for cyclobenzaprine (a medication used to treat muscle spasms) take "10mg 5mg" twice daily as needed.

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D 344	Continued From page 20 Review of Resident #3's physician's orders dated 01/17/24 revealed there was an order for cyclobenzaprine 5mg take 1 tablet twice daily as needed for muscle spasms. Review of Resident #3's 01/17/24-01/31/24 electronic medication administration record (eMAR) revealed: -There was an entry for cyclobenzaprine 5mg take 1 tablet twice daily as needed for muscle spasms. -There was documentation that cyclobenzaprine 5mg was administered on 02/26/24 and 02/28/24 once daily with no time documented. Review of Resident #3's 02/01/24-02/02/24 eMAR revealed: -There was an entry for cyclobenzaprine 5mg take 1 tablet twice daily as needed for muscle spasms. -There was no documentation cyclobenzaprine 5mg was administered. Refer to the interview with the medication aide (MA) supervisor on 02/01/24 at 3:36pm. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/24 at 4:08pm. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/24 at 9:35am. Refer to the interview with the interview with Resident #3's primary care provider (PCP) on 02/02/24 at 10:25am. Refer to the interview with the MA supervisor on 02/02/24 at 11:50am.	D 344		

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D 344	Continued From page 21 Refer to the interview with the Administrator on 02/02/24 at 12:15pm. Interview with the medication aide (MA) supervisor on 02/01/24 at 3:36pm revealed: -When a resident returned from the hospital with a new FL2, the MA on duty should fax the new FL2 to the pharmacy. -She did not know if the MA faxed Resident #3's FL2 dated 01/17/24 to the pharmacy on 01/17/24 because there was not a confirmation of the fax left in her office. -She did not know there were medications on Resident #3's FL2 dated 01/17/24 that contained orders for different dosages for the same medications. -She was responsible for reviewing all new orders for residents. -There was no system in place to make sure she had reviewed all new orders. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/24 at 4:08pm revealed: -The most current medication orders for Resident #3 faxed to the pharmacy from the facility was a physician's orders sheet dated 01/17/24. -The pharmacy did not receive a fax for Resident #3's FL2 dated 01/17/24. Interview with the Resident Care Coordinator (RCC) on 02/02/24 at 9:35am revealed: -The MA supervisor or MAs were supposed to document on a shift report sheet when the primary care provider (PCP) was notified or contacted to clarify or get new orders. -There was no documentation on a shift report sheet that Resident #3's PCP was notified of unclear medication orders or that new medication	D 344		

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orders were obtained.
-She did not know why the MA or MA supervisor did not call to clarify the medications on Resident #3's FL2 dated 01/17/24 that had multiple dosages documented next to the name of the medication.
-She did not know who documented the medications on Resident #3's FL2 dated 01/17/24.
-The MA supervisor was responsible for clarifying all medication orders that were unclear or questionable.
-She instructed the MA supervisor about 2 weeks prior to complete medication administration record (MAR) audits and compare the medications on the MAR to the medications ordered for residents.
-She did not know why the MA supervisor did not find that some of the medications ordered for Resident #3 had multiple dosages.

Interview with the interview with Resident #3's PCP on 02/02/24 at 10:25am revealed:
-She signed medication orders for Resident #3 on 01/17/24 that were printed by the facility on 01/07/24.
-Resident #3 was sent to the local hospital emergency department (ED) on 01/17/24 and returned to the facility with a new FL2 and some of the medications ordered had multiple dosages listed next to the medication.
-The most current medication orders were the orders listed on Resident #3's FL2 dated 01/17/24.
-The facility did not call or notify her that some of the medications ordered on Resident #3's FL2 dated 01/17/24 contained different dosages on the same order for the medications.
-She expected the facility staff to call to clarify any medication orders that were unclear, incomplete,

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D 344	Continued From page 23 or questionable. Interview with the MA supervisor on 02/02/24 at 11:50am revealed: -The MA was responsible for faxing the FL2 or new medication orders to the pharmacy when a resident returned from the local hospital. -She was responsible for clarifying medication orders. -She did not notify Resident #3's PCP of the medications with multiple dosages ordered because she did not realize some of the medications on Resident #3's FL2 had multiple dosages ordered. -She was not working when Resident #3 returned from the hospital and did not know if Resident #3's FL2 was faxed to the pharmacy. -She wrote down in a notebook when she faxed new orders to the pharmacy but did not have a system in place to track when other MAs faxed orders. Interview with the Administrator on 02/02/24 at 12:15pm revealed: -She did not know Resident #3's FL2 dated 01/17/24 had some medications ordered with multiple dosages on the same order. -The MA that received new orders for residents was responsible for faxing the orders to the pharmacy. -The new orders were supposed to be left on the MA supervisor's desk and not filed in the resident's record until the MA supervisor could review the orders for accuracy. -Fax confirmations to the pharmacy were supposed to be filed in a folder in the MA supervisor's office. -The MA or MA supervisor was responsible to call to clarify medication orders that were unclear or incomplete.	D 344		

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D 344	Continued From page 24 -She did not know why the MA or MA supervisor did not call Resident #3's PCP to clarify the medications on Resident #3's FL2 that had multiple dosages ordered.	D 344		