PRINTED: 06/20/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041082	A. BUILDING: _____ B. WING _____	R-C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CONCORD OF GREENSBORO	3301 GAR PLACE GREENSBORO, NC 27406

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[illegible]	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/29/24 through 05/30/24.	[illegible]		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall secure referral and follow up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: [illegible] VIOLATION: Based on observations, interviews, and record reviews, the facility failed to ensure health care follow-up was completed for 2 of 5 sampled residents (#1 and #3) related to following up with a resident's primary care provider (PCP) after office visits (#3) and a resident who missed an appointment for an intermittent nonmedicated ration (INR) (#1). The findings are: 1. Review of Resident 3's current FL2 dated 03/15/24 revealed diagnoses included cellulitis, muscle weakness, osteomyelitis, and lack of coordination. a. Review of Resident #3's care plan dated 01/18/24 revealed Resident #3 required supervision with ambulation and bathing and did not require assistance with any other activities of daily living. Review of Resident #3's PCP's After Visit Summary dated 05/10/24 revealed there was documentation of the nature of the visit or if there were any orders	D 273	Referrals and discharged summaries will be reviewed and initials by RCC or RCA and LD before placing in Residents charts as they are received within 48hrs. RCC and ED will monitor weekly RCC/ ED will conduct a follow up phone Call within 48hrs to ensure the orders match on the Quick Mar as orders arrives. RCC and ED will monitor weekly	07/09/24 07/09/24 07/09/2024 07/09/2024

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Hydia Parker, TITLE Administrator (X6) DATE 07/10/2024

STATE FORM [illegible] 6899 If continuation sheet 1 of 22

Reviewed and Acknowledged Keisha Banks 07/23/2023

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D 273	Continued From page 1 Review of Resident #3's PCP's After Visit Summary dated 05/22/24 revealed there were instructions documented by the PCP to change Resident #3's dressing to his right, lower leg daily, wash with soap, and pat dry. Review of Resident #3's electronic medication administration record (eMAR) for May 2024 revealed: -There was an entry with a start date of 02/23/24 for dry dressing for right leg blisters every day as needed. -There was not an entry to change dressing to his right, lower leg daily, wash with soap, and pat dry, as instructed on 05/22/24. Interview with Resident #3 on 05/30/24 at 11:43am revealed: -His right swelled so much that his skin would split. -His right leg itched, and he scratched it causing open areas on his skin. -He completed his own showers and staff did not assess his skin. -When he saw his PCP on 05/10/24, his right leg had been in the process of healing. -His PCP dressed his right leg to make it heal faster. -Resident #3 told the facility staff the dressing on his right leg needed to be changed daily. -Staff told him he needed an order for home health because the staff did not dress the legs. -The dressing on his right leg had been in place from the time it was applied on 05/10/24 until he was seen at his PCP's office on 05/22/24. -On 05/22/24, his PCP changed his dressing and told him it needed to be changed daily. -He gave the copy of the PCP's after visit summary dated 05/22/24 to the Resident Care	D 273		

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D 273	Continued From page 2 Coordinator (RCC) on 05/22/24 when he returned to the facility and assumed that she reviewed it. Interview with a medication aide (MA) on 05/30/24 at 11:15am revealed: -Staff did not assist Resident #3 with bathing, but staff checked on him while he was bathing. -She did not know Resident #3 had any skin breakdown on his right leg. -She did not know he was supposed to have daily dressing changes on his right lower leg. -She had not seen any dressing on Resident #3's right leg. Interview with a second MA on 05/30/24 at 3:09pm revealed: -If a resident returned to the facility with an after visit summary, she faxed the summary to the pharmacy, waited for a confirmation that it had been sent, and placed the after visit summary on the RCC's desk. -The RCC or the Administrator were responsible for following up with any orders or questions about orders. -She had not seen an after visit summary for Resident #3. Interview with a third MA on 05/30/24 at 3:33pm revealed: -She assisted with transporting residents to appointments. -Resident #3 told her that his new PCP provided transportation to his appointments, so she did not take him to his appointment scheduled with the PCP on 05/10/24 or on 05/22/24. -She never saw an after visit summary and thought he turned it in to the RCC. -If she had transported Resident #3 to his appointments on 05/10/24 or on 05/22/24, she would have followed up with the PCP and let the	D 273		

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RCC or the Administrator know.
-She had not noticed any dressing to Resident #3's right leg.
-The facility staff were not allowed to do dressings on Resident #3's leg and she would have told the PCP that Resident #3 needed to have home health services.

Interview with a personal care aide (PCA) on 05/30/24 at 1:08pm revealed:
-She only changed Resident #3's bedding because he did not ask her to help with any other activities of daily living.
-She had not noticed any wounds or dressing on Resident #3's right leg.

Interview with a second PCA on 05/30/24 at 1:11pm revealed she did not assist Resident #3 with any personal care and had not notice any wounds or dressing on Resident #3's right leg.

Interview with the RCC on 05/30/24 at 11:43am revealed:
-She did not know Resident #3 had a dressing on his right leg.
-He used to have a dressing on his left leg, but it had healed.
-She did not notice any dressing on Resident #3's right leg after his PCP appointment on 05/10/24 or after his PCP appointment on 05/22/24.
-She saw the PCP's after visit summary dated 05/10/24 and there was no documentation of any order changes or new orders for Resident #3.
-She did not follow up with Resident #3's PCP after his visit on 05/10/24 to see if there were any new orders.
-She did not see the PCP's after visit summary dated 05/22/24 until 05/29/24 when Resident #3 gave it to her.
-She had not asked Resident #3 for his after visit

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D 273	Continued From page 4 summary dated 05/22/24 or followed up with his PCP to see if there were any new orders prior to 05/29/24. -Resident #3 liked to "handle things" himself and made his own appointments. -if she had received Resident #3's PCP's after visit summary dated 05/22/24 on that date, she would have followed up with the PCP and sent the summary to the pharmacy. Interview with Resident #3's PCP on 05/30/24 at 8:53am revealed: -She saw Resident #3 for the first time on 05/10/24 and he had right lower leg venous stasis dermatitis and 2 venous stasis ulcers. -She dressed his leg on that day and gave Resident #3 verbal instructions that his leg needed to be dressed daily. -She saw Resident #3 again on 05/22/24 and he still had the same dressing on that she applied on his visit on 05/11/24. She changed his dressing again on 05/30/24 and he had purulent, odorous draining to his right lower leg. -She ordered an antibiotic and a steroid cream on 05/22/24. -She documented instructions on Resident #3's after visit summary to change the dressing to his right lower leg daily, wash with soap, and pat dry; elevate the right leg for swelling. -She expected the staff to follow the instructions for daily dressing changes and elevating Resident #3's right leg. -She expected the facility to follow up with her if they needed an order or if they were unable to change Resident #3's dressing daily. -Resident #3 had an appointment for 05/31/24 and if he still had infection on 05/31/24, she planned to send him to the emergency room to make sure he did not have infection in his bone.	D 273		

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D 273	Continued From page 5 -She thought the facility staff would be able to change Resident #3's dressing to his right lower leg, but they had not. -She was also referring Resident #3 to home health. -Possible outcomes of not changing Resident #3's dressing to his right lower leg daily, washing the leg with soap, patting it dry and elevating the right leg for swelling included: worsening edema, venous insufficiencies, non-healing wounds, and worsening infection. Interview with the Administrator on 05/30/24 at 12:11pm revealed: -She did not know about the dressing on Resident #3's right leg or that his PCP wanted it to be changed daily. -Skin assessments were completed for residents who required assistance with bathing on shower days. -Skin assessments were completed for all residents once a week, but Resident #3 refused skin assessments. -She and the RCC were responsible for reviewing after visit summaries and for following up with providers. -If Resident #3 did not provide his PCP's after visit summary after his visit on 05/22/24, she or the RCC should have called Resident #3's PCP to see if there had been any changes or new orders. b. Review of Resident #3's current FL2 dated 03/18/24 revealed: -There was an order for folic acid (used to treat low levels of folate) 1mg 1 tablet daily. -There was an order for januvia (used to lower blood sugar levels) 100mg 1 tablet daily. -There was an order for methotrexate (used to treat rheumatoid arthritis) 2.5mg 1 tablet weekly.	D 273		

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D 273	Continued From page 6 -There was an order for pantoprazole (used to treat heartburn) 40mg 1 tablet daily. -There was an order for vitamin B-12 (used to treat vitamin B-12 deficiency) 500mcg 1 tablet daily. Review of Resident #3's physician's orders dated 04/24/24 revealed an order for methotrexate 4 tablets (10mg) on Fridays; discontinue methotrexate 2.5mg 1 tablet weekly. Review of Resident #3's after visit summary dated 05/22/24 revealed there were instructions to stop folic acid 1mg, januvia 100mg, methotrexate 2.5mg, pantoprazole, and vitamin B-12. Review of Resident #3's electronic medication administration record (eMAR) for 05/01/24 through 05/29/24 revealed: -There was an entry for folic acid 1mg 1 tablet daily scheduled for administration at 8:00am; there was documentation folic acid was administered daily from 05/01/24 through 05/29/24. -There was an entry for januvia 100mg 1 tablet daily scheduled for administration at 8:00am; there was documentation folic acid was administered daily from 05/01/24 through 05/29/24. -There was an entry for methotrexate 2.5mg 4 tablets daily scheduled for administration at 6:00am on Fridays; there was documentation methotrexate was administered on 05/03/4. 05/10/24, 05/17/24, and on 05/24/24. -There was an entry for pantoprazole 40mg 1 tablet daily scheduled for administration at 7:00am; there was documentation pantoprazole was administered daily from 05/01/24 through 05/29/24.	D 273		

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D 273	Continued From page 7 -There was an entry for vitamin B-12 500mcg 1 tablet daily scheduled for administration at 8:00am; there was documentation vitamin B-12 was administered from 05/01/24 through 05/29/24 Interview with Resident #3 on 05/30/24 at 11:43am revealed: -He gave the copy of the PCP's after visit summary dated 05/22/24 to the RCC on 05/22/24 when he returned to the facility and assumed that she reviewed it. -When he saw his PCP on 05/22/24, she reviewed all his medications listed on his eMAR and stopped some of the medications that he did not need; his PCP documented on the eMAR medications that needed to be stopped and continued. -He showed the RCC the eMAR that his PCP documented on and told the RCC that some of his medications were to be stopped. -The RCC told him that the medications could not be stopped without an order to stop them and that he needed to follow up with his PCP. -Resident #3's PCP took him off medications that he did not need, but Resident #3 thought he was still receiving the medications. Interview with the RCC on 05/30/24 at 11:43am revealed: -Resident #3 liked to "handle things" himself and made his own appointments. -She did not see the PCP's after visit summary dated 05/22/24 until 05/29/24 when Resident #3 gave it to her. -She had not asked Resident #3 for his after visit summary dated 05/22/24 or followed up with his PCP to see if there were any new orders prior to 05/29/24. -She did not know until 05/29/24 that Resident	D 273		

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D 273	Continued From page 8 #3's PCP wanted to discontinue some of his medications. -If she had received Resident #3's PCP's after visit summary dated 05/22/24 on that date, she would have followed up with the PCP and sent the summary to the pharmacy. Interview with a MA on 05/30/24 at 3:33pm revealed: -She assisted with transporting residents to appointments. -Resident #3 told her that his new PCP provided transportation to his appointments, so she did not take him to his appointment scheduled with the PCP on 05/10/24 or on 05/22/24. -She never saw an after visit summary and thought he turned it in to the RCC. -If she had transported Resident #3 to his appointments on 05/10/24 or on 05/22/24, she would have followed up with the PCP and let the RCC or the Administrator know. Interview with Resident #3's PCP on 05/30/24 at 8:53am revealed: -She saw Resident #3 for the first time on 05/10/24 and he requested to stop some of his medications at that visit. -She wanted to wait until she received laboratory results prior to discontinuing medications. -She spent a lot of time reviewing Resident #3's medical history and past hospital reports. -She saw Resident #3 on 05/22/24 and reviewed each medication on Resident #3's eMAR and discussed with him which medications could be discontinued. -Resident #3 was on medications that he did not need and some of the medications had been previously prescribed without Resident #3 having a diagnosis that validated taking the medication. -She included a list of medication that were to be	D 273		

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D 273	Continued From page 9 discontinued on the PCP's after visit summary dated 05/22/24, and she expected for them to be discontinued. -She expected for the facility to follow up with her if they had questions regarding discontinuing any medications or if they needed an order to discontinue any of the medications. Interview with the Administrator on 05/30/24 at 12:11pm revealed: -She did not know about documentation on Resident #3's PCP's after visit summary for medications to be stopped for Resident #3. -She and the RCC were responsible for reviewing after visit summary and for following up with providers. -If Resident #3 did not provide his PCP's after visit summary after his visit on 05/22/24, she or the RCC should have called Resident #3's PCP to see if there had been any changes or new orders. 2. Review of Resident #1's current FL2 dated 11/09/23 revealed: -Diagnoses included atrial fibrillation, current long-term anticoagulant use, and hypertension. -There was an order for coumadin (an anticoagulant/blood thinner) 7.5mg 1 tablet on Wednesdays. -There was an order for coumadin 5mg 1 to 2 tablets once a day as directed. Review of Resident #1's physician's orders dated 12/26/23 revealed: -There was an order for coumadin 7.5mg 1 tablet on Wednesdays. -There was an order for coumadin 5mg tablet once a day on Monday, Tuesday, Thursday, Friday, Saturday and Sunday.	D 273		

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D 273	Continued From page 10 Review of Resident #1's after visit summary from the heart clinic dated 03/08/24 revealed: -Resident #1's International Normalized Ratio (INR, a laboratory test to determine blood clotting time for long-term anticoagulant use patients) and the therapeutic level was 2-3. -Resident #1's INR on 03/08/24 was 1.7. -There was a one time order to take coumadin 5mg 1 and 1 half (7.5mg) on 03/08/24. -There was an order to then take coumadin 5mg once daily Mondays, Tuesdays, Wednesdays, Fridays and Saturdays. -There was an order to take coumadin 5mg 1/2 tablet (2.5mg) once daily on Sundays and Thursdays. -There was a scheduled return appointment and INR check for Resident #1 on 03/22/24. Review of Resident #1's record revealed: -There was no documentation Resident #1 attended an appointment on 03/22/24 to have her INR checked. -There was no documentation of an INR check was completed between 03/08/24 and 05/16/24. Review of Resident #1's after visit summary from the heart clinic dated 05/16/24 revealed: -Resident #1's INR on 05/16/24 was 2.9. -There was a scheduled return appointment for Resident #1 to have an INR performed on 06/06/24. Attempted telephone interview with Resident #1's heart clinic provider on 05/29/24 at 3:05pm was unsuccessful. Interview with the Administrator on 05/29/24 at 3:30pm revealed that Resident #1 refused to go to the 03/22/24 appointment to check her INR.	D 273		

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D 273	Continued From page 11 Interview with Resident #1 on 05/30/24 at 9:15am revealed: -She took coumadin to thin her blood, but she could not remember the date she last had her blood drawn. -She never refused to get her blood drawn or go to an appointment and went when staff told her it was time. Attempted telephone interview with Resident #1's family member on 05/30/24 at 9:56am was unsuccessful. Telephone interview with Resident #1's primary care provider (PCP) on 05/30/24 at 2:00pm revealed: -Resident #1 had coumadin anticoagulant therapy due to atrial fibrillation to prevent blood clots. -He did not know that Resident #1 had not had an INR check from 03/08/24 to 05/16/24. -Resident #1 should have her INR checked on a regular schedule at the coumadin clinic, usually 2 times a month. -He had not been informed of her refusal to attend an appointment or have her INR checked. -If her INR on 03/08/24 was 1.7 and then 2.9 on 05/16/24, he felt she was therapeutic on her current doses of coumadin and she did not incur any harm from not having her INR checked for 9 weeks. -He expected the facility staff to ensure Resident #1 and all residents kept their scheduled appointments. -He deferred all care regarding Resident #1's coumadin dose and INR checks to the heart clinic. Interview with the facility transporter on 05/30/24 at 3:35pm revealed: -She transported residents to appointments	D 273		

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D 273	Continued From page 12 according to the appointment book and then logged each residents' next appointment, if scheduled, in the appointment book. -She did not take Resident #1 to her appointment on 03/08/24 because she was transporting another resident and so she was not aware of the 03/22/24 appointment. -The staff that transported residents to appointments were responsible for reviewing the after visit summary for follow up appointments and to log the next appointment into the appointment book so that no appointment was missed. -She was busy transporting other residents since then and did not notice that Resident #1 had not been back to the heart clinic since 03/08/24. Interview with the Resident Care Coordinator (RCC) on 05/30/23 at 3:20pm revealed: -Resident #1 went to regular scheduled appointments to the coumadin clinic to have her INR checked. -The heart clinic sent an after visit summary for each day's visit with the INR result, new orders for the continued coumadin dose and the next appointment date. -The facility transporter usually transported Resident #1 to the heart clinic, but she was unsure who transported her on 03/08/24. -Staff who took Resident #1 to the heart clinic should have logged her next appointment for 03/22/24 in the appointment book. -The Administrator, the staff in charge and she were responsible for reviewing resident after visit summaries for new orders and appointments. -Resident #1's 03/22/24 appointment was missed. -She did not realize that Resident #1 had not had her INR checked until 05/15/24 when she called the heart clinic to make her an appointment due	D 273		

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D 275	Continued From page 13	D 275		

to her legs swelling.
-The heart clinic staff informed her that Resident had not kept her appointment and had not had her INR checked since 03/08/24.

Second interview with the Administrator on 05/30/24 at 4:00pm revealed:
-She, the RCC, and the transporter were responsible to review after visit summaries for resident follow up appointments and orders.
-Staff who transported residents to appointments were responsible to log the next appointment in the appointment book.
-Resident #1's follow up appointment for 03/22/24 was just missed.
-She did not realize that Resident #1 did not have an INR check since 03/08/24 until the RCC called to make her an appointment at the heart clinic for edema.
-She expected the staff to review after visit summaries and to make sure follow up appointments were attended as scheduled.

The facility failed to ensure follow-up with a resident's PCP after he attended appointments and the resident had venous stasis dermatitis and 2 venous stasis ulcers on his right leg with instructions for daily dressing changes that were not completed which resulted in the resident having purulent, odorous draining to his right lower leg, and he needed to be treated with an antibiotic and a steroid cream, and the PCP also provided instructions for some of the resident's medications to be discontinued and there was no follow-up with the PCP for orders to discontinue the medications (#3); and a resident who was administered coumadin daily and missed a return appointment to have an INR check completed as ordered which placed the resident at risk of developing blood clots or increased bleeding risk

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D 273	Continued From page 14 (#1). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on May 30, 2024. THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED July 14, 2024.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record	D 367	RCC, ED will be responsible for conducting a rigorous triple check of all medications against the orders on the MAR system to prevent errors and ensure facility compliance weekly.	7/2/2024

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D 367	Continued From page 15 reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 5 residents, (#1) including documentation of administration of an anticoagulant (medication used to prevent blood clots). The findings are: Review of Resident #1's current FL2 dated 11/09/23 revealed: Diagnoses included atrial fibrillation, current long-term anticoagulant use, and hypertension. -There was an order for coumadin (an anticoagulant/blood thinner) 7.5mg 1 tablet on Wednesdays. -There was an order for coumadin 5mg 1 to 2 tablets once a day as directed. Review of Resident #1's physician's orders dated 12/26/23 revealed: -There was an order for coumadin 7.5mg 1 tablet on Wednesdays. -There was an order for coumadin 5mg tablet once a day on Monday, Tuesday, Thursday, Friday, Saturday and Sunday. Review of Resident #1's after visit summary (AVS) from the heart clinic dated 03/08/24 revealed an order for coumadin 5mg tablet once a day on Saturday, Monday, Tuesday, Wednesday and Friday. Review of Resident #1's after visit summary (AVS) from the heart clinic dated 05/16/24 revealed an order to continue coumadin 5mg tablet once a day on Saturday, Monday, Tuesday, Wednesday, and Friday. Review of Resident #1's March 2024 electronic	D 367		

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D 367	Continued From page 16 medication administration record (eMAR) 03/08/24 to 03/31/24 revealed: -There was an entry for coumadin 5mg take one (1) tablet every Saturday, Monday, Tuesday, Wednesday, and Friday at 5:00pm. -Coumadin 5mg was not documented as administered for 3 Tuesdays on 03/12/24, 03/19/24 and 03/26/24. Review of Resident #1's April 2024 eMAR revealed: -There was an entry for coumadin 5mg take one (1) tablet every Saturday, Monday, Tuesday, Wednesday and Friday at 5:00pm. -Coumadin 5mg was not documented as administered for 5 Tuesdays on 04/02/24, 04/09/24, 04/16/24, 04/23/24 and 04/30/24. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for coumadin 5mg take one (1) tablet every Saturday, Monday, Tuesday, Wednesday and Friday at 5:00pm. -Coumadin 5mg was not documented as administered for 4 Tuesdays on 05/07/24, 05/14/24, 05/21/24, and 05/28/24. Observation of medications on hand for Resident #1 on 05/29/24 at 3:35pm revealed: -There was a bubble card with 9 of 21 coumadin 5mg tablets available for administration. -The coumadin 5mg was labeled take 1 tablet every Saturday, Monday, Tuesday, Wednesday, Friday. -There were handwritten instructions on the label to give "every day except Sunday and Thursday". Attempted telephone interview with a representative at Resident #1's heart clinic on 05/29/24 at 3:05pm was unsuccessful.	D 367		

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D 367	Continued From page 17 Telephone interview with a representative from the facility's contracted pharmacy on 05/28/24 at 4:19pm revealed: -Resident #1 had an order dated 03/08/24 to administer coumadin 5mg 1 tablet on Saturday, Monday, Tuesday, Wednesday and Friday. -There was a current order dated 05/16/24 to continue to administer coumadin 5mg 1 tablet on Saturday, Monday, Tuesday, Wednesday and Friday. -The pharmacy dispensed Resident #1's coumadin 5mg the facility as follows; on 03/11/24 for a quantity of 24, on 03/29/24 for a quantity of 21, on 04/25/24 for a quantity of 21. -The pharmacy incorrectly entered Resident #1's coumadin 5mg order and did not allow for a documenting opportunity on Tuesdays. -The pharmacy staff were informed today, 05/29/24, of the inability of facility staff to document on Resident #1's coumadin 5mg on Tuesdays. -The pharmacy could have corrected the entry in March 2024 if the facility had notified pharmacy staff of the issue. Interview with a medication aide (MA) on 05/29/24 at 3:40pm revealed: -When she administered resident's medication from the medication cart drawer, she compared the medications to the eMAR and removed the medications from the bubble cards. -She administered Resident #1's medications on the evening of Tuesday 05/28/24. -She was familiar with Resident #1's coumadin dosages and knew she received 5mg on Tuesdays and so was sure she administered it. -She did not remember if Resident #1's coumadin 5mg populated on the eMAR screen for her to	D 367		

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administer the evening of 05/28/24 at 5:00pm.
-The Administrator, Resident Care Coordinator (RCC) or staff in charge (SIC) reviewed orders entered by pharmacy on the eMAR and MAs cannot document administration a medication until it was approved by one of them.
-The Administrator, RCC and SIC were responsible to audit medications in the medication carts to the residents' orders when medications were delivered on cycle fill from the pharmacy.

Interview with Resident #1 on 05/30/24 at 9:15am revealed:
-She took coumadin to thin her blood, but she did not know what dose she was currently ordered.
-She just took what the MA gave her to take and didn't know which tablet was coumadin or what color it was.
-She thought she had her coumadin every day.

Telephone Interview with a second MA on 05/30/24 at 10:13am revealed:
-She worked evenings and routinely administered Resident #1's coumadin dosages.
-Resident #1 was to be administered coumadin 5mg on most days including Tuesdays, she had a separate dose of 2.5mg for Sunday and Thursday.
-The RCC or SIC had written on the label to administer Resident #1's coumadin 5mg on the days it was due, so she was sure she administered it each Tuesday when it was due.
-She had not noticed that Resident #1's coumadin 5mg did not populate on the eMAR on Tuesdays.
-She was unsure if she could document a note that she administered her 5mg dose if it did not populate for documentation.
-She compared the medications to the eMAR and

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D 367	Continued From page 19 removed the medications from the bubble cards to administer, but she just administered Resident #1's coumadin 5mg because she knew she was ordered the medication. rawer, she compared the medications to the eMAR and removed the medications from the bubble cards. -She thought that the Administrator or RCC were responsible to approve eMAR orders and to audit medications in the medication carts to the residents' orders when medications were delivered on cycle fill from the pharmacy. Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/30/24 at 2:00pm revealed: -Resident #1 had atrial fibrillation and was at risk for blood clots if she did not receive a blood thinner. -Resident #1 was ordered coumadin 2.5mg and 5mg on various days according to her International Normalised Ratio (INR) prescribed by the heart clinic provider. -He deferred all orders and care in regard to her coumadin dosing to the heart clinic. -He felt Resident #1 had received the Tuesday dose of coumadin 5mg since her INR on 03/08/24 was 1.7 and her most current INR was 2.9 on 05/16/24. -Resident #1's INR was in her therapeutic range of 2-3. -He expected the facility staff to administer and document all medications as ordered. Interview with a third MA on 05/30/24 at 3:35pm revealed: -She worked as a MA in the facility and was also SIC. -She was responsible to audit the medication cart that contained Resident #1's medications.	D 367		

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D 367	Continued From page 20 -She contacted the facility's contracted pharmacy in March 2024 about a duplicate entry of Resident #1's coumadin, but she had not noticed that Resident #1's coumadin 5mg did not populate on the eMAR for the MAs to document administration. -MAs could have called to have pharmacy to correct the entry for Resident #1's Tuesday coumadin to populate, but it was preferred for her, the RCC or the Administrator to take care of orders on the eMAR. -When she audited Resident #1's medication, she compared the medication on hand to the eMAR. -The entry for her coumadin 5mg was correct on the eMAR but would not show what opportunities were able to be documented on each day. -She wrote the days of each dose on top of the bubble card label for Resident #1's coumadin doses. -MAs could have typed in coumadin 5mg was administered in the pass notes for Tuesday's doses, but she had never instructed any MAs to do so. Interview with the RCC on 05/30/24 at 3:20pm revealed: -The facility's contracted pharmacy entered all medication orders into the facility's eMAR system. -The pharmacy also completed audits of the carts during quarterly medication reviews, the last review was performed in April 2024. -She did not notice that Resident #1's Tuesday dose of coumadin 5mg did not populate for the MAs to document and so she did not instruct the MAs to document the Tuesday dose anywhere else. -She did not review residents' eMARs for missing holes in administration documentation. -She, the Administrator and the SIC reviewed a printout of residents' eMARs while replacing	D 367		

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D 367	Continued From page 21 medications in the medication carts during monthly cycle fill. -They would compare the medications that were delivered to the eMAR to ensure every medication was delivered, but not looking for documentation opportunities. -Just checking the eMAR against the medication bubble cards would not have revealed Resident #1's Tuesday opportunity for coumadin 5mg was missing. -She expected all MAs to document all administered medications. -If there was not a slot, MAs should document administration of that medication in the resident's notes. Interview with the Administrator on 05/30/24 at 4:00pm revealed: -She, the RCC and the SIC were responsible to audit the medications in the medication carts. -They would compare medications delivered during cycle fill from the pharmacy to the residents' eMARs but they weren't looking for missed documentation. -She knew in March 2024 that Resident #1's Tuesday dose of coumadin 5mg was not populating for the MAs to document administration. -She did not instruct MAs where else to document Resident #1's Tuesday dose of coumadin 5mg. -The SIC had called the pharmacy in March 2024 to clarify the days that Resident #1 was to have coumadin 5mg to have the entry corrected but didn't know why it was not corrected. -She expected MAs to document administration of all residents' medications as ordered.	D 367		