STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026069	A. BUILDING: _____ B. WING _____	R 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigations from August 20, 2024, to August 21, 2024. The complaint investigations were initiated by the Cumberland County Department of Social Services on July 3, 2024, and August 16, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 6 of 6 large square metal floor vents on both hallways and in the dining room and 2 of 2 metal floor vents in the women's common bathroom were clean and free of hazards including floor vents that were loose and lifted from the floor, and had electrical and duct tape with missing paint, rust, and a thick coating of dirt and debris. The findings are: Observations of the Magnolia hallway on 08/20/24 at 10:04am and 08/21/24 at 7:50am revealed: -There were two large metal floor vents on the hallway floor. -There was a square metal floor vent to the right	D 079		

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D 079	Continued From page 1 of room #7. -The floor vent was not secured at the floor. -The left side of the floor vent was raised and protruding above the floor. -The left side of the floor vent had a small open area between the floor vent and the flooring. -There was black electrical tape at the corner of the far left portion of the floor vent. -There was black electrical tape at the corner of the far right portion of the floor vent. -There was silver duct tape at the corner of the far left portion of the floor vent. -There was gray debris and a thick coating of dust in the floor vent openings. -There was a second square metal floor vent further down the hallway closer to the exit door. -The second floor vent was loose and lifted up slightly from the floor. -The floor vent had missing paint and rust around the border edges of the vent. -There was gray debris and a thick coating of dust in the floor vent openings. Observation of the Magnolia hallway on 08/21/24 at 7:43am revealed: -A female resident with a rolling walker was walking barefooted down the hall. -When the resident reached the floor vent near room #7, the resident was unable to push the wheels of the walker over the taped area of the edges of the floor vent. -A staff person intervened and assisted the resident with pushing the walker over the floor vent and the resident walked over the protruding, dirty vent with her bare feet. Based on observations, interviews and record reviews, it was determined that the female resident was not interviewable.	D 079		

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D 079	Continued From page 2 Observations of the dining room on 08/20/24 at 10:06am and 08/21/24 at 7:52am revealed: -There were two large metal floor vents on the dining room floor, one near the center of the dining room and one near the entrance to the Dogwood hallway. -The square metal floor vent near the center of the dining room had missing paint and rust. -The floor vent was loose, and the metal corners lifted up away from the floor. -The was a small remnant of blue tape near the center of one side of the vent. -There was gray debris and a thick coating of dust in the floor vent openings. -The second metal floor vent in the dining room had missing paint and rust. -The second metal floor vent lifted slightly around the edges and was not secured. -The second metal floor vent had a thick coating of dust in the floor vent openings. Observations of the Dogwood hallway on 08/20/24 at 10:06am and 08/21/24 at 7:53am revealed: -There were two large square metal floor vents on the hallway floor. -There was a metal floor vent to the right of room #10. -The floor vent was loose and had black electrical tape on all four edges of the vent. -There was gray debris and a thick coating of dust in the floor vent openings. -There was a second metal floor vent further down the hallway to the right of room #11. -The second floor vent had missing paint around the border of the vent. -There was gray debris and a thick coating of dust in the floor vent openings. Interview with a medication aide (MA) on	D 079		

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D 079	Continued From page 3 08/21/24 at 7:53am revealed: -The floor vents in the hallways and dining room had been in that condition for a while (could not specify timeframe). -She thought the owner was going to replace the vents sometime within the last year, but she was not sure why the vents were not replaced. -She had not seen any residents trip over the floor vents. Interview with the Maintenance Staff on 08/21/24 at 7:45am revealed: -The same floor vents had been in the facility since the facility was built years ago (could not specify date). -He put duct tape on a floor vent on Magnolia hallway about 2 weeks ago because the vent was loose and lifting up from the floor. -The floor vents were a trip hazard, but no one had been hurt due to the floor vents to his knowledge. Interview with the Executive Director (ED) on 08/21/24 at 7:48am revealed: -He would put the floor vents in the hallway and dining room on a list of things for the owner to order. -He just took pictures today, 08/21/24, of the floor vents and sent to the owner. Observations of women's bathroom on 08/20/24 at 9:50am revealed: -There was a resident entering the bathroom bare feet and using a rollator -The floor vent near the door was rusty and damaged. -There was debris build up inside of the floor vent near the door. -The floor vent near the back wall was rusty and damaged.	D 079		

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D 079	Continued From page 4 Interview with the maintenance staff on 08/20/24 at 11:19am revealed: -The bathroom floor vents were to be replaced but he did not know when the bathroom floor vents were to be replaced. -He did not know how long the old rusty vents had been in the bathroom. Interview with the ED on 08/20/24 at 9:53am revealed: -He did not know how long the vents had been in place in the women's bathroom. -Residents or staff complained about residents stubbing over the floor vents. -He would have maintenance to replace the vents immediately.	D 079		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that a hand bell or other signaling device was in place for 1 of 1 sampled resident (#3) who was non-ambulatory and required total assistance by staff for activities of daily living including transferring and ambulation.	D 119		

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D 119	Continued From page 5 The findings are: Review of Resident #3's current FL-2 dated 07/16/24 revealed: -Diagnoses included stroke, vascular dementia, diabetes type 2, hypertension, hypothyroidism, glaucoma, sleep apnea, and gout. -The resident was documented as non-ambulatory and incontinent of bowel and bladder. -The resident was documented as requiring total care by staff with personal care tasks. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on 07/08/24. -The resident required staff assistance for dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, hair/grooming, skin care, positioning and turning, scheduling appointments, and orientation to time and place. -The resident had a wheelchair. Review of Resident #3's current assessment and care plan dated 07/26/24 revealed: -The resident was non-ambulatory and had a geri-chair with tabletop. -The resident had limited range of motion in her left upper extremity. -The resident had daily incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required total assistance by staff with toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #3's licensed health	D 119		

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professional support (LHPS) review dated 07/11/24 revealed:
-Staff assisted the resident with locomotion and transfers.
-The resident had hospice services in place.

Observation of Resident #3 on 08/21/24 at 6:06pm revealed:
-The resident's room was the last room on the left on Magnolia hallway near the exit door.
-The resident had a private room with no roommate.
-The resident was lying in a hospital bed with bilateral half bedrails in the up position.
-There was no call bell or other signaling device in the resident's room.

Interview with Resident #3 on 08/21/24 at 6:06pm revealed:
-Staff assisted her with bathing, dressing, transferring, and ambulation.
-It usually required 1 or 2 staff to assist her with transferring.
-She had a geri-chair for ambulation with staff assistance.
-She did not have a call bell or any other device to call for help.
-When she needed assistance, she called loudly for help.
-Staff usually came but sometimes she had to yell several times and wait for a while (could not give a timeframe).

Observation of Resident #3 on 08/21/24 at 6:10pm revealed:
-Resident #3 yelled out for help in a loud voice 3 times in a row.
-There was no staff in the hallway near the resident's room.
-No staff came to check on the resident.

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D 119	Continued From page 7 Interview with the Executive Director (ED) in the dining room on 08/21/24 at 6:14pm revealed: -The facility did not have electric call bells. -The facility was a special care unit (SCU) and Resident #3 was the only resident cognitive enough to call for help when she needed it. -Resident #3 was non-ambulatory and could not get out of bed without assistance by staff. -Resident #3 usually called out for help when she needed it. -She usually wanted a soda or just someone to talk to when she called out for help. -Staff could usually hear Resident #3 when she called for help. -He did not hear Resident #3 call out for help at 6:10pm but he just heard her now. -Resident #3 did not have hand bell but he would obtain one for her. Interview with the Administrator on 08/21/24 at 6:24pm revealed: -He had just started his position as the Administrator about 3 weeks ago. -He was not aware Resident #3 did not have hand bell to call for assistance. -He would obtain a hand bell for the resident today, 08/21/24.	D 119		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to	D 273		

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D 273	Continued From page 8 meet the routine and acute health care needs for 1 of 5 sampled residents (#2) related to receiving monthly injections and completing weekly labs. The findings are: Review of Resident #2 current FL2 dated 05/02/24 revealed: Diagnosis included vascular dementia, chronic obstructive pulmonary disease, secondary Parkinson, obstructive sleep apnea, depression, hypothyroidism, congestive heart failure and diabetes mellitus type II. Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 04/04/24. a. Review of Resident #2's current FL2 dated 05/02/24 revealed there was an order for haloperidol deaconates (DEC) 100 mg/mL injection 1 mL monthly (Haloperidol is used to treat psychosis and bipolar disorder.) Review of Resident #2's June 2024 electronic medical administration record (eMAR) revealed: -There was an entry for haloperidol DEC injection 1 mL (100mg/mL) intramuscularly every month by a mental health nurse or home health nurse to administer. -There was an entry of the haloperidol DEC injection 100mg/mL being administered on 06/13/24 and initialed by a medication aide (MA). Review of Resident #2's July 2024 electronic medical administration record (eMAR) revealed: -There was an entry for haloperidol DEC injection 1 mL (100mg/mL) intramuscularly every month by a mental health nurse or home health nurse to administer.	D 273		

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D 273	Continued From page 9 -There was not an entry of the haloperidol DEC injection 100mg/mL documented as administered. Observation of Resident #2's medication on hand on 08/21/24 at 2:53pm revealed there was haloperidol injection 100mg/mL dated 04/17/24 on the medication cart. Telephone interview with the Resident #2's home health nurse on 08/21/24 at 4:38pm revealed: -Resident #2 referral for home health services was received on 07/19/24 because the facility did not have a skilled nurse to administer the monthly haloperidol injection. -Resident #2 home health services started on 07/21/24. -Resident #2 haloperidol injections were administered on site monthly around the 13 th of each month. Interview with Resident #2's psychiatric nurse on 08/21/24 10:47am revealed: -Resident #2 received monthly injections of haloperidol injection 100mg/mL to treat his behavior issues. -The haloperidol 100mg/ml injections were administered on site by a home health nurse. -There was a gap in administering the haloperidol DEC injection 100mg/mL to Resident #2 because the facility did not have the correct syringes on site. -The haloperidol injection 100mg/mL that was on site had expired and she submitted a new order to the Psychiatrist (date was not provided). -Resident #2 had behaviors had improved since he has been receiving the haloperidol injection. -She could not administer the haloperidol injection because the facility did not have the correct syringe on site.	D 273		

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D 273	Continued From page 10 Interview with a MA on 08/21/24 at 2:53pm revealed: -Resident #2's haloperidol injections were administered on site by a home health nurse once a month. -A MA would document on the MAR as administered once the home health nurse administered Resident #2's haloperidol injection. Interview with the Resident Care Coordinator (RCC) on 08/21/24 at 5:57pm revealed: -Resident #2's haloperidol injection order came on 04/12/24. -There was a home health agency that provided services to Resident #2 but come not administer the haloperidol injection because the agency did not have a psychiatric nurse. Interview with the Executive Director on 08/21/24 at 5:41pm revealed: -There had been a gap in service because Resident #2 had to be referred to a home health agency that did not provided psychiatric services. -The new Psychiatric Nurse could not administer the haloperidol injection because there was not a syringe on site. -He was not aware a syringe could be purchased at the local pharmacy. -He or the RCC were responsible for coordinating services for residents. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. b. Review of a physician order dated 06/28/24 for clozapine 50mg 1 ½ (75mg) 1 tablet once daily. Review of a pharmacy dispense report for	D 273		

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clozapine revealed:
-There were lab results for 06/09/24 with a 3800 ANC (per UL).
-There were lab results for 07/03/24 with a 6100 ANC (per UL).
-There were no lab results for August 2024.

Telephone interview with Resident #2's Pharmacist on 08/21/24 at 3:29pm revealed:
-There was an order for clozapine 50mg 1 ½ (75mg) tablet once daily.
-There were 30 tablets of clozapine 50mg dispensed on 08/09/24 for a 30 day supply.
-The labs results were not accessible.

Interview with Resident #2's psychiatric nurse on 08/21/24 at 10:47am revealed:
-She thought Resident #2 was having his blood drawn weekly.
-The facility used a contracted lab company to complete the blood work.
-Her last review of Resident #2's labs were normal.
-She could not remember the date of the last lab review.

Interview with the Executive Director (ED) on 08/21/24 at 1:42pm revealed:
-He was not aware Resident #2's labs were not being completed weekly.
-Resident #2 had been receiving the clozapine 50mg 1½ tablet once daily.
-He reviewed the lab results for residents once received.
-He and the Resident Care Coordinator (RCC) were responsible for ensuring labs were completed on all residents.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was

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D 273	Continued From page 12 not interviewable.	D 273		
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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#5) observed during the medication pass including errors with a medication for mood disorders and a medication for treatment of liver disease; and for 1 of 3 residents (#2) sampled for record review including an error with a medication for anxiety and agitation and an antibiotic for infection. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 29 opportunities during the 8:00am medication passes on 08/20/24 and 08/21/24. Review of Resident #5's current FL-2 dated 01/25/24 revealed diagnoses included Alzheimer's disease, schizophrenia, cirrhosis (liver disease), chronic kidney disease, hypertension, and insomnia.	D 358		

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D 358	Continued From page 13 a. Review of Resident #5's current FL-2 dated 01/25/24 revealed an order for Lactulose Solution 10gm/15ml give 15ml 3 times a day, decrease to twice a day if more than 8 stools per day. (Lactulose is a laxative that may be used to treat liver disease.) Observation of the 8:00am medication pass on 08/20/24 revealed the medication aide (MA) prepared and administered Resident #5's Lactulose Solution at 10:40am, 1 hour and 40 minutes beyond the allowed time frame. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lactulose Solution 10gm/15ml give 15ml 3 times a day, decrease to twice a day if more than 8 stools per day -Lactulose Solution was scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Lactulose Solution was documented as administered from 08/01/24 - 08/20/24 (8:00am) except on 08/10/24 at 2:00pm when the resident was out of the facility. Observation of Resident #5's medications on hand on 08/20/24 at 1:20pm revealed: -There was a bottle of Lactulose Solution dispensed on 08/03/24. -The instructions were to give 15ml 3 times a day (decrease to twice a day if more than 8 stools per day). Interview with the MA on 08/20/24 at 1:20pm revealed: -Resident #5's 8:00am medications were administered late that morning, 08/20/24. -Resident #5 was asleep when she went to the	D 358		

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resident's room that morning around 8:30am - 8:45am.
-She went back to Resident #5's room around 9:00am but a hospice aide was assisting the resident with bathing.
-She went back to administer medications to the resident sometime after the resident had finished bathing.

Interview with a second MA on 08/20/24 at 3:35pm revealed:
-She notified Resident #5's primary care provider (PCP) that Resident #5's 8:00am Lactulose dose was administered late that morning (08/20/24).
-The PCP instructed to administer Resident #5's Lactulose 2:00pm scheduled dose at 3:00pm and the 8:00pm scheduled dose at 9:00pm on 08/20/24.

Interview with the Special Care Coordinator (SCC) on 08/20/24 at 1:35pm revealed:
-Resident #5 sometimes liked to sleep late but medications should be administered within one hour before or after the scheduled time.
-They were in the process of changing some of the scheduled administration times to 9:00am so there were not as many medications due to be administered at 8:00am.
-Medications should not be administered too close together to prevent any side effects.

Interview with the Executive Director (ED) on 08/20/24 at 1:41pm revealed:
-The MAs had a one-hour window to administer medications on time.
-If medications were late, the MAs should notify him or the SCC.
-He or the SCC could contact the resident's provider to determine if late medications could still be administered.

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D 358	Continued From page 15 Interview with the Administrator on 08/20/24 at 1:46pm revealed: -The MAs had one hour before and after the scheduled time to administer medications. -If the MAs were running late with the medication pass, they should notify the SCC and the resident's provider. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Attempted telephone interview with Resident #5's PCP on 08/21/24 at 12:12pm was unsuccessful. b. Review of Resident #5's current FL-2 dated 01/25/24 revealed an order for Valproic Acid Solution 250mg/5ml take 20ml (1,000mg) every 12 hours. (Valproic Acid is used to treat mood disorders.) Observation of the 8:00am medication pass on 08/20/24 revealed the medication aide (MA) prepared and administered Resident #5's Valproic Acid Solution at 10:39am, 1 hour and 39 minutes beyond the allowed time frame. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Valproic Acid Solution 250mg/5ml take 20ml (1,000mg) every 12 hours scheduled at 8:00am and 8:00pm. -Valproic Acid Solution was documented as administered from 08/01/24 - 08/20/24 (8:00am). Observation of Resident #5's medications on hand on 08/20/24 at 1:20pm revealed: -There was a bottle of Valproic Acid Solution	D 358		

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dispensed on 08/03/24.
-The instructions were to take 20ml every 12 hours.

Interview with the MA on 08/20/24 at 1:20pm revealed:
-Resident #5's 8:00am medications were administered late that morning, 08/20/24.
-Resident #5 was asleep when she went to the resident's room that morning around 8:30am - 8:45am.
-She went back to Resident #5's room around 9:00am but a hospice aide was assisting the resident with bathing.
-She went back to administer medications to the resident sometime after the resident had finished bathing.

Interview with the Special Care Coordinator (SCC) on 08/20/24 at 1:35pm revealed:
-Resident #5 sometimes liked to sleep late but medications should be administered within one hour before or after the scheduled time.
-They were in the process of changing some of the scheduled administration times to 9:00am so there were not as many medications due to be administered at 8:00am.
-Medications should not be administered too close together to prevent any side effects.

Interview with the Executive Director (ED) on 08/20/24 at 1:41pm revealed:
-The MAs had a one-hour window to administer medications on time.
-If medications were late, the MAs should notify him or the SCC.
-He or the SCC could contact the resident's provider to determine if late medications could still be administered.

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D 358	Continued From page 17 Interview with the Administrator on 08/20/24 at 1:46pm revealed: -The MAs had one hour before and after the scheduled time to administer medications. -If the MAs were running late with the medication pass, they should notify the SCC and the resident's provider. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Interview with Resident #5's mental health provider (MHP) on 08/21/24 at 10:47am revealed: -Resident #5's Valproic Acid should be administered on time. -She was not immediately concerned about the late dose of Valproic Acid administered on 08/20/24 since the resident's next dose was not scheduled until 8:00pm. 2. Review of Resident #2 current FL2 dated 05/02/24 revealed: -Diagnosis included vascular dementia, chronic obstructive pulmonary disease, secondary Parkinson, obstructive sleep apnea, depression, hypothyroidism, congestive heart failure and diabetes mellitus type II. -There was a physician order for Alprazolam 1mg tablet twice daily for agitation. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 1mg 1 tablet twice daily as needed (PRN) for agitation. -Alprazolam 1mg 1 tablet was documented as administered three times on 08/01/24 at 9:39am, 2:50pm and 9:56pm.	D 358		

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D 358	Continued From page 18 Review of Resident #2's controlled drug log revealed Alprazolam 1mg 1 tablet twice daily was documented as administered on 08/01/24 at 9:39am, 2:50pm and 10:00pm. Interview with Resident #2's psychiatric nurse on 08/21/24 at 10:47pm revealed Resident #2 taking the Alprazolam 1mg may have potential cause of over sedation. Interview with the medication aide (MA) on 08/21/24 at 6:15pm revealed: -She reviewed residents' orders on the eMAR to ensure she administered the current doses to residents. -She could not remember why the 3rd doses of Alprazolam was administered. Interview with the Executive Director on 08/21/24 at 5:41pm revealed: -The Alprazolam 1mg should not had been administered 3 times a day on 08/01/24. -The medication aides (MA) were to follow the medication orders. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.	D 358		
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	D 367		

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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 interviews and record reviews, the facility failed to ensure that medication administration record was accurate for 1 of 5 residents sampled (#2) related to documentation of administration of medications to treat depression.

The findings are:

Review of Resident #2's current FL2 dated 05/02/24 revealed diagnoses included vascular dementia, chronic obstructive pulmonary disease, secondary Parkinson, obstructive sleep apnea, depression, hypothyroidism, congestive heart failure and diabetes mellitus type II.

a. Review of Resident #2's current FL2 dated 05/02/24 revealed there was a physician order for Clozapine 50mg 1 tablet daily. (Clozapine is used to treat mood disorders.)

Review of Resident #2's physician's order revealed there was an order dated 06/28/24 for

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D 367	Continued From page 20 Clozapine 50mg 1½ (75mg) 1 tablet once daily. Review of Resident #2's physician's order revealed the Clozapine 50mg 1 tablet daily was discontinued on 06/28/24. Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Clozapine 50mg 1 tablet once daily at 8:00am. -Clozapine 50mg 1½ tablet daily was documented as administered on 06/29/24 - 06/30/24 at 8:00am. Interview with a medication aide (MA) on 08/21/24 at 5:17pm revealed: -She did not remember administering the Clozapine to Resident #2 on 06/29/24 and 06/30/24. -If she administered the Clozapine to Resident #2, it was because the medication had not been discontinued in the system by the Resident Care Coordinator (RCC) or the Executive Director (ED) and the medication was populating to be administered. -The RCC or ED had to remove all discontinued medications from the eMAR to prevent the discontinued medication from populating on the eMAR. -If the discontinued medication order has been received but had not been discontinued in the system, it would populate on the eMAR, and she had to click on the medication which may show as administered. Interview with Resident #2's psychiatric nurse on 08/21/24 at 10:47am revealed she changed the Clozapine 50mg 1 tablet daily to Clozapine 50mg 1½ tablet (75mg) once daily on 06/28/24.	D 367		

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D 367	Continued From page 21 Refer to the interview with the RCC on 08/21/24 at 5:57pm. Refer to the interview with the ED on 08/21/24 at 5:41pm. b. Review of Resident #2's current FL2 dated 05/02/24 revealed there was a physician order for Quetiapine 50mg 1 tablet twice daily. (Quetiapine is used to treat depression and bipolar disorder.) Review of Resident #2's physician's order revealed there was an order dated 07/24/24 to discontinue the use of quetiapine 50mg 1 tablet at 4pm. Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Quetiapine 50mg 1 tablet twice daily at 8:00am and 4:00pm. - Quetiapine 50mg 1 tablet twice daily was documented as administered on 07/25/24 and 07/27/24 at 4:00pm. -There was an entry for Quetiapine 50mg 1 tablet once daily at 8:00am. - Quetiapine 50mg 1 tablet once daily was documented as administered on 07/28/24 and 07/31/24 at 8:00am. Interview with a medication aide (MA) on 08/21/24 at 5:17pm revealed: -She did not remember administering the Quetiapine to Resident #2. -If she administered the any discontinued medication to Resident #2, it was because the medication had not been discontinued in the system by the Resident Care Coordinator (RCC) or the Executive Director (ED).	D 367		

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D 367	Continued From page 22 -The RCC or ED had to remove all discontinued medications from the eMAR to prevent the discontinued medication from populating on the eMAR. -If the discontinued medication order has been received but had not been discontinued in the system, it would populate on the eMAR, and she has to click on the medication which may show as administered. Interview with Resident #2's psychiatric nurse on 08/21/24 at 10:47am revealed the Quetiapine 50mg was changed to 1 tablet daily at 8:00am on 07/24/24. Interview with the RCC on 08/21/24 at 5:57pm revealed the Quetiapine 50mg 1 tablet twice daily was discontinued on 07/24/24. Refer to the interview with the RCC on 08/21/24 at 5:57pm. Refer to the interview with the ED on 08/21/24 at 5:41pm. _____ Interview with the Resident Care Coordinator (RCC) on 08/21/24 at 5:57pm revealed: -The pharmacy discontinued medications when they received the order from the provider. -The provider sent the facility a copy of the discontinued medication orders. -When the discontinued medication orders were received, he or the Executive Director (ED) approved the medication to be discontinued in the system and the medication removed from the electronic medication administration record (eMAR). -If the discontinued orders were submitted after 5pm on Friday, the order would remain active in	D 367		

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D 367	Continued From page 23 the system over the weekend if the medication aides (MA) did not call the so the medication could be approved to be discontinued. -Only he or the ED could approve medication to be discontinued in the system. Interview with the ED on 08/21/24 at 5:41pm revealed: -Once a discontinued order was received, he compared the order to any progress notes and would follow up with the pharmacy. -After speaking with the pharmacy, he would approve the medication to be discontinued in the system. -He or the RCC had the authority to approve medications to be discontinued in the system. -The MAs should not administer discontinued medications to residents.	D 367		