STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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 and follow-up survey on September 18-19, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure documentation for 1 of 3 sampled medication aides (MA) who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff B) before administering medications, and 1 of 3 sampled MA's (Staff A) who had not passed the written medication aide examination within 60 days of completion of the medication clinical validation skills checklist. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 06/05/24. -Staff B was hired as a MA. -There was documentation Staff B completed the	D 125		

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D 125	Continued From page 1 5-hour state approved medication aide training on 05/31/22. -There was documentation Staff B completed the medication clinical validation skills checklist on 06/14/24. -There was documentation Staff B passed the written medication aide examination on 03/26/08. -There was no documentation Staff B completed the 10-hour state approved medication aide training. -There was no documentation of employment verification for the required documentation of the state approved 5-hour and 10-hour or 15-hour medication aide training for Staff B. Review of resident's August 2024 and September 2024 from 09/01/24 to 09/19/24 electronic medication administration records (eMAR) revealed there was documentation Staff B administered medications to the residents on 31 occasions. Interview with Staff B on 09/19/24 at 2:20pm revealed: -She did not have documentation of the state approved 10-hour medication aide training. -She had worked in several facilities and could not locate documentation that she completed the state approved 5-hour and 10-hour or 15-hour MA training. -She called the last facility she worked, and they could not locate her employee record. Interview with the Business Office Manager (BOM) on 09/19/24 at 1:30pm revealed: -She had documentation of the 5-hour state approved medication aide training for Staff B. -She did not have documentation of the 10-hour state approved medication aide training for Staff B.	D 125		

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D 125	Continued From page 2 -She did not have documentation of employment verification for Staff B. -She contacted Staff B's previous employers for documentation of the state approved medication aide training but had not received anything back. 2. Review of Staff A's personnel record revealed: -Staff A was hired on 03/21/24. -Staff A was hired as a MA. -There was documentation Staff A completed the state approved 15-hour medication aide training on 03/22/24. -There was documentation Staff A completed the medication clinical validation skills checklist on 03/22/24. -There was no documentation Staff A completed and passed the written medication aide examination. Review of resident's July 2024, August 2024, and September 2024 from 09/01/24 to 09/18/24 eMAR's revealed there was documentation Staff A administered medications to the residents on 55 occasions. Interview with Staff A on 09/19/24 at 11:30am revealed: -She had not completed and passed the written medication aide examination. -She was scheduled to take the examination several months ago but after she got logged into the computer and signed on, she was informed the computer she was using was not compatible with the software the testing site used. -She tried one other time to take the written medication exam and that time the testing center had trouble logging her on. -She was scheduled to take the written medication exam on 09/27/24.	D 125		

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D 125	Continued From page 3 Interview with the Business Office Manager (BOM) on 09/19/24 at 1:30pm revealed: -She did not have documentation that Staff A taken and passed the written medication aide examination. -Staff A signed in to take the written medication aide examination and was ready to test and the testing center told her computer browser was not compatible. Interview with the Administrator on 09/19/24 at 1:15pm revealed: -The BOM was responsible for making sure employee records were complete with the required documentation. -She knew Staff A had not completed and passed the medication aide training examination; there was a problem with the computer the last time she logged in to take the examination.	D 125		
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 administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to administering a fast-acting insulin for fingerstick blood sugars	D 358		

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D 358	Continued From page 4 (FSBS) over 450. The findings are: Review of Resident #1's current FL2 dated 07/19/24 revealed diagnoses including Type 2 diabetes mellitus. Review of Resident #1's physician's orders revealed: -There was an order dated 07/19/24 to check FSBS twice a day before breakfast and supper; inject Novolog (a fast-acting insulin) sliding scale insulin (SSI) subcutaneously (SQ) with parameters for 10 units for FSBS 250 to 350, and 4 additional units for FSBS greater than 350. -There was an order dated 08/09/24 to discontinue SSI. -There was an order dated 08/09/24 for Novolog insulin 7 units SQ 3 times a day with meals; hold for FSBS less than 100. -There was an order dated 08/09/24 to start Novolog 5 units SQ four times a day, as needed for FSBS greater than 450. Review of Resident #1's August 2024 electronic medication administration record (e MAR) from 08/10/24 to 08/31/24 revealed: -There was an entry for FSBS values scheduled 4 times a day at 7:00am,12:00pm, 5:00pm and 8:00pm. -Documented FSBS values ranged from 243 to 539. -There was an entry in the as needed (PRN) section of the eMAR dated 08/09/24 to start Novolog 5 units SQ four times a day, as needed for FSBS greater than 450 with site of injection, FSBS value and amount given areas for documentation. -There were 6 opportunities from 08/10/24 to	D 358		

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D 358	Continued From page 5 08/31/24 when FSBS values were documented over 450 with no documentation 5 units of Novolog insulin was administered as follows: -On 08/20/24 at 7:00am, the FSBS was 455 and 5 units of Novolog were not documented as administered. -On 08/21/24 at 7:00am, the FSBS was 490 and 5 units of Novolog were not documented as administered. -On 08/22/24 at 7:00am, the FSBS was 450 and 5 units of Novolog were not documented as administered. -On 08/26/24 at 12:00pm, the FSBS was 477 and 5 units of Novolog were not documented as administered. -On 08/26/24 at 5:00pm, the FSBS was 459 and 5 units of Novolog were not documented as administered. -On 08/27/24 at 8:00am, the FSBS was 455 and 5 units of Novolog were not documented as administered. Review of Resident #1's September 2024 eMAR from 09/01/24 to 09/17/24 revealed: -There were entries for FSBS values scheduled 4 times a day at 7:00am,12:00pm, 5:00pm and 8:00pm (09/01/24 to 09/06/24). -Documented FSBS values ranged from 213 to 540. -There was no entry for FSBS scheduled at 8:00pm from 09/07/24 to 09/17/24. -There was an entry in the as needed (PRN) section of the eMAR dated 08/09/24 to start Novolog 5 units subcutaneously four times a day, as needed for FSBS greater than 450 with site of injection, FSBS value and amount given areas for documentation but no scheduled for administration. -There were 4 opportunities from 09/01/24 to 09/06/24 when FSBS values were documented	D 358		

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D 358	Continued From page 6	D 358		

over 450 with no documentation 5 units of Novolog insulin was administered as follows:
-On 09/02/24 at 7:00am, the FSBS was 450 and 5 units of Novolog were not documented as administered.
-On 09/02/24 at 5:00pm, the FSBS was 510 and 5 units of Novolog were not documented as administered.
-On 09/11/24 at 7:00am, the FSBS was 464 and 5 units of Novolog were not documented as administered.
-On 09/11/24 at 5:00pm, the FSBS was 565 and 5 units of Novolog were not documented as administered.

Observation of Resident #1's medications on hand on 09/18/24 at 4:10pm revealed there was one partial pen on Novolog 100 units/ml open on 09/15/24 available for administration stored on the medication cart.

Interview with Resident #1's primary care provider (PCP) on 09/19/24 at 10:45am revealed:
-Resident #1 had repeated elevated blood sugars.
-She had managed Resident #1's blood sugar since her admission 06/04/24.
-She changed Resident #1's Novolog insulin from SSI to a fixed amount with meals and an additional dose for FSBS over 450 to help control very high FSBS values.
-She reviewed Resident #1's FSBS values with each weekly and had made changes to her long-acting and Novolog insulin to decrease the number of over FSBS over 450.
-She expected the facility to administer 5 additional units of Novolog for FSBS over 450 as ordered.

Interview with a medication aide (MA) on

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D 358	Continued From page 7 09/19/24 at 1:30pm revealed: -The former Resident Care Coordinator (RCC) or the Administrator reviewed medication orders entered by the contracted pharmacy and released the medications to show up on the eMAR for the MAs to administer. -She was not responsible for auditing eMARs and medications orders for completeness. -She did not routinely review medications on the residents' eMARs enetered in the as needed (PRN) section unless a resident requested a particular medication ordered and entered in the prn section. -She obtained FSBS as ordered on the eMARs and administered medications according to orders appearing on the scheduled eMAR. -She had not administered Novolog 5 units for FSBS over 450 because that order did not appear on the eMAR for routine administration. Interview with a second MA on 09/19/24 at 1:50pm revealed: -She routinely worked the second shift and administered medications, including scheduled insulin, for Resident #1. -Resident #1's Novolog administration had been changed a few times and currently was a fixed amount with meals. -Staff were trained by the contracted pharmacy Nurse to administer insulin and document the administration on the eMAR. -If there was no documentation for administration she would assume the medication was not administered. Interview with the Administrator on 09/19/24 at 3:00pm revealed: -The facility had been without an RCC for a few months. -The Administrator had been reviewing orders put	D 358		

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D 358	Continued From page 8 onto the residents' eMARs by the contracted pharmacy staff. -The Administrator passed medications in addition to her other duties due to MA staff turnover. -She randomly audited medications available on the medication cart for administration compared to the medications orders on the eMAR, especially when she was passing medications on the medication cart. -The RCC and/or the Administrator were responsible for ensuring medications were administered as ordered. -Due to time work load restraints, the Administrator had not audited Resident #1's medication ordered compared to the physician's orders -Resident #1's order for Novolog insulin 5 units for FSBS over 450 was added in the prn section of the eMAR and the MAs must have overlooked the order. Interview with Resident #1 on 09/19/24 at 3:30pm revealed: -She was recently admitted to the facility from another assisted living facility. -She had been receiving medications, including insulin, for diabetes for many years. -Her insulin doses had changed many time since she came to the facility. -She did not have an insulin related symptoms of blurred vision or sweating. -She wished the facility would get her old records and administer the same doses as before.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 9 (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 reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 2 of 5 sampled residents (#1,) related to documenting fingerstick blood sugars (FSBS) greater 450 (#1) and a medication to treat insomnia (#5). The findings are: 1. Review of Resident #1's current FL2 dated 07/19/24 revealed diagnoses including Type II diabetes mellitus. Review of Resident #1's physician's orders revealed: -There was an order on the current FL2 dated	D 367		

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D 367	Continued From page 10 07/19/24 to check FSBS twice a day before breakfast and supper; inject Novolog (a fast-acting insulin) sliding scale insulin (SSI) subcutaneously (SQ) with parameters for 10 units for FSBS 250 to 350, and 4 additional units for FSBS greater than 350. -There was an order on the current FL2 dated 07/19/24 for Lantus insulin (a long acting insulin) inject 40 units subcutaneously (SQ) twice a day. -There was an order dated 08/09/24 to discontinue SSI. -There was an order dated 08/09/24 for Novolog insulin 7 units SQ 3 times a day with meals; hold for FSBS less than 100. -There was an order dated 08/09/24 to start Novolog 5 units subcutaneously four times a day, as needed for FSBS greater than 450. -There was an order dated 08/16/24 to increase Novolog to 9 units SQ 3 times a day with meals; hold for FSBS less than 100. -There was an order dated 08/16/24 for Lantus inject 45 units SQ twice a day. -There was an order dated 09/06/24 to increase Lantus to 50 units SQ twice a day and increase Novolog to 11 units SQ 3 times a day with meals; hold for FSBS less than 100. -There was an order for dated 09/13/24 to inject 13 units SQ 3 times a day with meals; hold for FSBS less than 100. Review of Resident #1's September 2024 electronic medication administration record (eMAR) from 09/01/24 to 09/17/24 revealed: -There was an entry in the as needed (PRN) section of the eMAR for Novolog 5 units subcutaneously four times a day, as needed for FSBS greater than 450 with site of injection, FSBS value and amount given areas for documentation but no scheduled for administration.	D 367		

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D 367	Continued From page 11 -There were entries FSBS values scheduled 3 times a day at 7:00am,12:00pm, 5:00pm for Novolog SQ with meals, hold for FSBS less than 100 for orders dated 08/16/24, 09/06/24 and 09/13/24. -There was an entry for Lantus insulin twice a day inject 45 units SQ twice a day with site of injection and FSBS value, scheduled at 8:00am and 8:00pm, with documentation for FSBS values at 8:00pm from 09/01/24 to 09/06/24. The entry was marked discontinued on 09/06/24. -There was an entry for Lantus insulin twice a day inject 50 units SQ twice a day scheduled at 8:00am and 8:00pm, with no site no site of injection or FSBS value area. -There was no entry for FSBS scheduled at 8:00pm from 09/07/24 to 09/17/24. Observation of Resident #1's medications on hand on 09/18/24 at 4:10pm revealed there was one partial pen on Novolog 100 units/ml open on 09/15/24 available for administration stored on the medication cart. Interview with Resident #1's primary care provider (PCP) on 09/19/24 at 10:45am revealed: -Resident #1 had repeated elevated blood sugars. -She had managed Resident #1's blood sugar since her admission 06/04/24. -She changed Resident #1's Novolog insulin from SSI to a fixed amount with meals and an additional dose for FSBS over 450 to help control very high FSBS values. -She reviewed Resident #1's FSBS values with each weekly and had made changes to her long-acting and Novolog insulin to decrease the number of over FSBS over 450. -She expected the facility to obtain and document FSBS values 4 times a day.	D 367		

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D 367	Continued From page 12 -She did not know Resident #1 had no FSBS values for 8:00pm documented as ordered. Interview with a medication aide (MA) on 09/19/24 at 1:30pm revealed: -The former Resident Care Coordinator (RCC) or the Administrator reviewed medication orders entered by the contracted pharmacy and released the medications to show up on the eMAR for the MAs to administer. -She was not responsible for auditing eMARs and medications orders for completeness. -She did not routinely review medications on the residents' eMARs enetered in the as needed (PRN) section unless a resident requested a particular medication ordered and entered in the prn section. -She obtained FSBS as ordered on the eMARs and administered medications according to orders appearing on the scheduled eMAR. -She had not administered Novolog 5 units for FSBS over 450. Interview with a second MA on 09/19/24 at 1:50pm revealed: -She routinely worked the second shift and administered medications, including Novolog insulin, for Resident #1. -Resident #1's Novolog administration had been changed a few times and currently was a fixed amount with meals. -Staff were trained by the contracted pharmacy Nurse to administer insulin and document the administration on the eMAR. -If there was no documentation for administration, she would assume the medication was not administered. Interview with the Administrator on 09/19/24 at 3:00pm revealed:	D 367		

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-The facility had been without an RCC for a few months.
-The Administrator had been reviewing orders put onto the residents' eMARs by the contracted pharmacy staff.
-The Administrator passed medications in addition to her other duties due to MA staff turnover.
-She randomly audited medications available on the medication cart for administration compared to the medications orders on the eMAR, especially when she was passing medications on the medication cart.
-The RCC and/or the Administrator were responsible for ensuring medications were administered as ordered.
-Due to time work load restraints, the Administrator had not audited Resident #1's medication ordered compared to the physician's orders.
-She did not know Resident #1 had documented 8:00pm FSBS values until 09/07/24 when the Lantus order changed and the eMAR entry dropped the space for obtaining and documenting a FSBS value at 8:00pm.
-Resident #1's order for Novolog insulin 5 units for FSBS over 450 was added in the prn section of the eMAR and the MAs must have overlooked obtaining and documenting FSBS values at 8:00pm.

Interview with Resident #1 on 09/19/24 at 3:30pm revealed:
-She was recently admitted to the facility from another assisted living facility.
-She had been receiving medications, including insulin, for diabetes for many years.
-Her insulin doses had changed many times since she came to the facility.
-She did not have an insulin related symptoms of

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blurred vision or sweating.
-She wished the facility would get her old records and administer the same doses as before.

2. Review of Resident #5's current FL2 dated 07/19/24 revealed:
-Diagnoses included type 2 diabetes, congestive heart failure and hyperlipidemia.
-There was an order to check blood sugar levels four times a day.
-There was an order for trazodone 100mg 1 tablet at bedtime.

a. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry beginning 08/17/24 for Novolog insulin pen inject 4 units 3 times a day, hold if blood sugar less than 100 or resident not eating.
-There were spaces to document staff initials and blood glucose levels at 8:00am, 12:00pm 5:00pm.
-There were 14 blood glucose levels documented in the exception's notes ranging from 61 to 234
-There were 2 FSBS opportunities documented as not administered due to resident refused.

Review of Resident #5's September 2024 eMAR, 09/01/24-09/13/24 revealed:
-There was an entry for Novolog insulin pen inject 4 units 3 times a day, hold if blood sugar less than 100 or resident not eating.
-There were spaces to document staff initials and blood glucose levels at 8:00am, 12:00pm 5:00pm.
-There were 9 blood glucose levels documented in the exception's notes ranging from 64 to 125.
-There were 5 FSBS opportunities documented as not administered due to resident refused.

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D 367	Continued From page 15 Review of Resident #5's record revealed there was no other documentation of his blood glucose levels. Interview with Resident #5 on 09/18/24 at 2:15pm revealed staff checked his FSBS 4 times a day and he paid attention to his FSBS level that sometimes was low. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/19/24 at 9:52am revealed: -Resident #5 had a physician's order for Novolog insulin pen inject 4 units, hold if BS less than 100 or resident not eating. -Pharmacy staff entered orders into the facility's eMAR and the facility staff reviewed the orders. -It appeared that the FSBS button was activated when the 4-unit order was entered and the staff would have been able to document FSBSs. Interview with a medication aide (MA) on 09/19/24 at 11:00am revealed: -Resident #5 had FSBS and orders to hold if under 100 and he would refuse sometimes even if it were above 100. -When his order was 4 units with meals, she could not enter the FSBS in the eMAR but could make a note in the eMAR system. -She did not report being unable to document in the eMAR entry for Resident #5's FSBS to the RCC or Administrator. -She did not inquire about it to the pharmacy either, she just made notes of his FSBS. -There was no other place on paper that the MAs documented the number of units administered. Interview with a second MA on 09/19/24 at 1:55pm revealed:	D 367		

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-She had performed Resident #5's FSBS and administered his Novolog.
-She entered the FSBS in the eMAR notes because the Novolog 4 units FSBS entry did not populate for staff to document.
-She knew how to document in the eMAR notes and continued to do so but never informed any management or pharmacy that the entry would not allow staff to enter a FSBS.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/19/24 at 1:00pm revealed:
-Resident #5 had a current order to check his FSBS 4 times a day and an order to hold his Novolog if his FSBS was under 100.
-He sometimes refused the FSBS and at times refused to allow staff to obtain his FSBS was over 100.
-She looked at eMARs during her visits but did not visit in August 2024 and had not seen Resident #5 yet in September 2024.
-Staff had reported low FSBS and she had adjusted his insulin dose multiple times accordingly.
-She needed to see his FSBS in order to determine if his insulin regimen was appropriate.

Interview with the Resident Care Coordinator (RCC) on 09/18/24 at 2:20pm revealed:
-She started working as the RCC approximately 3 weeks prior but was still in training with the Administrator.
-She would be responsible to audit the medications on the medication carts and the eMAR documentation but had not set up a process to audit eMARs
-She did not see the missing FSBS on Resident #5's eMAR.
-Resident #5's FSBS could have been

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documented in the eMAR notes if the space did not populate in the eMAR entry for MAs.

Interview with the Administrator on 09/19/24 at 3:00pm revealed:
-The RCC and/or the Administrator were responsible for ensuring FSBS were documented.
-The facility had been without an RCC and had staff turnover and she would occasionally administer medications to residents.
She randomly audited the eMARs compared to available medications but she had not audited eMARs for missing documentation.
-The MAs could have documented all FSBS in the eMAR notes, even if the entry on the eMAR did not populate.
-She expected all MAs to document all FSBS on the eMAR of in the eMAR notes.

b. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry beginning for trazadone 100mg 1 tablet at bedtime for 9:00pm.
-There were 27 of 31 opportunities not documented (blank) from 08/05/24-08/31/24.
-There were no exception's notes for the 27 opportunities of missing documentation.

Review of Resident #5's September 2024 eMAR, 09/01/24-09/17/24 revealed:
-There was an entry beginning for trazadone 100mg 1 tablet at bedtime for 9:00pm.
-There were 13 of 17 opportunities not documented (blank) from 09/01/24-09/13/24.
-There were no exception's notes for the 13 opportunities of missing documentation.

Interview with Resident #5 on 09/18/24 at 2:15pm revealed:

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D 367	Continued From page 18 -He was sleeping well and took his trazadone every night. -He knew what the pill looked like and was sure the staff administered it to him. Observation of medications on hand for Resident #5 on 09/19/23 at 11:00am revealed there were 6 trazadone 100mg tablets in blister pack rolls for 6 nights doses. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/19/24 at 9:52am revealed: -Resident #5 had a physician's order for trazodone 100mg 1 at bedtime for insomnia. -Pharmacy staff entered orders into the facility's eMAR and the facility staff reviewed the orders. -There was no documentation that facility staff had reported not being able to document Resident #5's trazadone or that they could not see the order until 09/14/24. Interview with a medication aide (MA) on 09/19/24 at 11:00am revealed: -Resident #5 had trazodone at night to help him sleep but he would refuse it sometimes. -She worked evenings occasionally and gave him his trazodone and documented administration. -When MAs prepared medications from the blister pack, they select the time frame in the eMAR, for example 8:00pm. -If the trazadone was scheduled at 9:00pm, it would not populate to document on if 8:00pm was selected. -Medications are in blister pack rolls in line according to their administration time; morning medications first, then afternoon medications, then evening medications and then night medications. -MAs usually administer 8:00pm and 9:00pm	D 367		

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medications from the roll at the same time.
-MAs could get busy and forget to go back and pull up the 9:00pm medications on the eMAR to document administration.

Interview with a second MA on 09/19/24 at 1:55pm revealed:
-She worked evening, 3:00pm-11:00pm, and gave Resident #5 his trazodone and documented administration.
-Medications were in blister pack rolls and his night time trazodone had been in the roll each night.
-MAs usually administered 8:00pm and 9:00pm medications from the roll at the same time.
-MAs could forget to go back and pull up the 9:00pm medications on the eMAR to document administration.

Telephone interview with Resident #5's primary care provider (PCP) on 09/19/24 at 1:00pm revealed:
-Resident #5 had an order for trazodone from his Mental Health Provider (MHP).
-He had reported resting well and had not reported any difficulty sleeping.

Telephone interview with Resident #5's MHP on 09/19/24 at 1:49pm revealed:
-Resident #5 had a current order for trazodone 100mg at night for insomnia.
-He had no recent complaints and reported that he rested well while taking trazodone.
-He was familiar with his pills and would refuse the trazodone if he felt he did not need it that night.
-She asked for refusals but did not routinely look at the eMARs when she visited.
-She was confident Resident #5 did receive trazodone most of the time.

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D 367	Continued From page 20 Interview with the Resident Care Coordinator (RCC) on 09/18/24 at 2:20pm revealed: -She started working as the RCC approximately 3 weeks prior but was still in training with the Administrator. -She would be responsible to audit the medications on the medication carts and the eMAR documentation but had not set up a process to audit eMARs -She did not see the missing trazodone documentation on Resident #5's eMAR. Interview with the Administrator on 09/19/24 at 3:00pm revealed: -The RCC and/or the Administrator were responsible for medication administrations were documented. -The facility had been without an RCC and had staff turnover and she would occasionally administer medications to residents. She randomly audited the eMARs compared to available medications but she had not audited eMARs for missing documentation. -She administered medications to Resident #5 on 09/14/24 and saw that his trazodone was in the blister packs but were not on the eMAR. -She called the pharmacy and had the entry added and found that the previous RCC had inadvertently discontinued Resident #5's trazodone on the eMAR. -She interviewed MAs and determined that all had still administered Resident #5's trazodone but had not reported to her that it was not on the eMAR. -She expected all MAs to document all medication administration on the eMAR.	D 367		