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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 12/10/24 to 12/12/24.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were provided non-disposable place settings including plates, forks, knives, spoons, and cups during meal service when eating in their rooms. The findings are: Observation of a resident's breakfast service on 12/10/24 at 9:20am revealed: -The resident was eating breakfast in his room. -The resident's breakfast meal was served on a disposable plate. -The resident's drink was in a disposable cup. -Plastic utensils were provided.	D 286		

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Observation of the resident's lunch service on 12/10/24 at 12:47pm revealed:
-The resident's lunch meal was served on a disposable plate.
-The resident's drink was in a disposable cup.
-Plastic utensils were provided.

Observation of resident's breakfast service on 12/11/24 at 8:32am revealed:
-The resident's breakfast meal was served on a disposable plate.
-The resident's drink was in a disposable cup.
-Plastic utensils were provided.

Interview with the resident on 12/10/24 at 9:20am revealed:
-He ate all meals in his room.
-His meals were served on disposable plates.

Observation of a second resident's breakfast service on 12/11/24 at 9:00am revealed:
-The resident was eating breakfast in her room.
-The resident's breakfast meal was served on disposable plate.
-The resident's drink was served in a disposable cup.
-The resident was provided plastic utensils.

Interview with the second resident on 12/11/24 at 9:00am revealed:
-She ate all meals in her room.
-Her meals were served on disposable plates, paper cups, and plastic utensils.
-She would prefer that her meals were served on regular place settings.

Interview with the Dining Service Coordinator (DSC) on 12/11/24 at 2:15pm revealed:
-Disposable place settings were not supposed to be used for residents who ate meals in their

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D 286	Continued From page 2 rooms. -Disposable place settings were only used if a resident was quarantined. -She did not know that the residents who ate in their rooms were served their meals on disposable place settings with disposable cups and plastic utensils. -The facility had enough non-disposable place settings, cups, and utensils to serve all residents who ate their meals in their rooms. Interview with the Executive Director (ED) on 12/11/24 at 2:30pm revealed: -Disposable place settings were not supposed to be used for residents who ate their meals in their rooms. -Disposable place settings were only used if a resident was quarantined. -She did not know that the residents who ate their meals in their rooms were served on disposable place settings with disposable cups and plastic utensils. -The facility had enough non-disposable place settings, cups, and utensils to serve all residents who ate their meals in their rooms. -The clinical staff were educated on room tray guidelines on 11/25/24.	D 286		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility	D 345		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were maintained in the resident's record for 1 of 7 sampled residents (#1) related to orders for a medication used to treat high blood sugar, a medication used to treat high blood pressure, and a medication used to treat shortness of breath.

The findings are:

Review of the facility's medication oversight program policy dated April 2023 revealed:
-Residents who self-administer medications are assessed upon move-in and monthly thereafter by a licensed nurse.
-For a resident to self-administer medications, the resident must alert a licensed nurse of any changes in the medication regimen.

Review of Resident #1's current FL2 dated 05/30/24 revealed:
-Diagnoses included chronic kidney disease, type 2 diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and hypothyroidism.
-There was an order for Albuterol inhaler inhale 2 puffs by mouth every 8 hours as needed (Albuterol is a medication used to treat shortness of breath).
-There was an order for Novolog 70/30 insulin inject 7 units subcutaneously every morning (Novolog is a medication used to lower blood sugar levels).

Review of Resident#1's primary care provider's (PCP) order dated 02/23/24 revealed there was an order for Resident #1 to self-administer medications.

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Review of Resident #1's facility monthly wellness visit dated 11/13/24 revealed:
-Resident #1 currently self-administered medications.
-Resident #1 was able to manage medication changes, ordering/reordering, and alerted nurse to any changes in medication regimen.

Review of Resident #1's PCP visit summary dated 09/03/24 revealed:
-There was no order for Albuterol inhaler inhale 2 puffs by mouth every 8 hours as needed on the current medications list.
-There was an order for Novolog 70/30 twice daily, if fingerstick blood sugar (FSBS) greater than 100, inject 5 units before breakfast, if FSBS less than 100, inject 3 units after breakfast, if greater than 200, inject 4 units with supper, if less than 200, zero units on the current medications list.
-There was an order to start Clonidine 0.1mg take 1 tablet by mouth once a day if systolic blood pressure is greater than 170 (Clonidine is a medication used to lower blood pressure).

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed.
-There was no documentation of Albuterol being administered from 10/01/24 to 10/31/24.
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 10/01/24 to 10/31/24

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-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for 4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 10/01/24 to 10/31/24
-There was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed.
-There was no documentation of Albuterol being administered from 11/01/24 to 11/30/24.
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 11/01/24 to 11/30/24
-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for 4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 11/01/24 to 11/30/24
-There was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170.

Review of Resident #1's December 2024 eMAR revealed:
-There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed.

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-There was no documentation of Albuterol being administered from 12/01/24 to 12/10/24.
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 12/01/24 to 12/10/24
-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for 4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 12/01/24 to 12/09/24
-There was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170.

Observation of Resident #1's recorded FSBS results on 12/10/24 at 3:36pm revealed Resident #1's FSBS readings for November 2024 to 12/10/24 ranged from 82-318.

Observation of Resident #1's room on 12/11/24 at 12:00pm revealed Resident #1 had a wrist blood pressure monitoring device.

Observation of Resident #1's medications on hand on 12/10/24 at 3:36pm revealed:
-There was no Albuterol inhaler.
-There was a plastic bag containing 1 Novolog 70/30 pen with a label from a local pharmacy.
-The label on the plastic bag containing 1 Novolog 70/30 pen indicated the medication was last filled 10/24/24 for a quantity of 3 Novolog 70/30 pens.

Second observation of Resident #1's medications on hand on 12/11/24 at 12:00pm revealed there was a bottle of Clonidine 0.1mg filled 09/03/24.

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D 345	Continued From page 7 Interview with Resident #1 on 12/10/24 at 3:35pm revealed: -She had self-administered her medications since she moved into the facility last year. -She took her FSBS twice daily and recorded the results on her electronic tablet. -She administered her insulin before or after breakfast and with dinner as instructed by her PCP. -She was no longer taking Albuterol inhaler as needed. -She did not have an Albuterol inhaler and had not experienced any shortness of breath in a long time. -She last saw her PCP on 09/03/24. -She kept a copy of all of the documentation she received from her PCP and specialists. -She did not usually give the facility staff a copy of the paperwork from her PCP visits. -The facility staff had not asked her for any of the paperwork or new orders after her PCP visits. Second interview with Resident #1 on 12/11/24 at 12:00pm revealed: -Her PCP prescribed Clonidine 0.1mg at her last PCP visit 09/03/24. -She had a wrist blood pressure monitoring device and checked her blood pressure often. -She did not check her blood pressure every day, but she checked her blood pressure if she felt dizzy, light-headed, or did not feel well. -She had taken Clonidine 0.1mg 1-2 times since the medication was filled. -The facility had a few nurses on staff and the nurses stopped by occasionally to see how she was doing and asked how she felt. -The nurses did not usually review her medications with her or ask to see her medications or current medication list from her	D 345		

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D 345	Continued From page 8 PCP. Interview with a medication aide (MA) on 12/11/24 revealed: -Resident #1 self-administered her medications. -MAs were not responsible for checking medications for residents who self-administered their medications. -MAs were not responsible for processing new or changed medication orders for residents who self-administered medications or needed assistance with medication administration. -Residents who self-administered their medications would sometimes have paperwork from their PCP visits. -The wellness nurses handled all new or changed medication orders for all of the residents. -The facility's contracted pharmacy entered all new medication orders in the eMAR system. Interview with a Licensed Practical Nurse (LPN) on 12/12/24 at 9:38am revealed: -She was 1 of the 2 wellness nurses employed at the facility. -LPNs were responsible for ensuring all the residents' medication orders were sent to the pharmacy and added to the eMAR. -The residents' medication orders should be verified and updated every 6 months. -LPNs did monthly wellness checks with each resident. -If the residents self-administered their medications, the LPN reviewed their medications and did a medication assessment with them during their monthly wellness visit. -During the wellness visit, she asked the residents what medications they were taking and if the resident knew side effects of the medication and observed for any loose pills and medications in the resident's room.	D 345		

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-Residents who self-administered medications were supposed to inform the facility staff if they had new medication orders.
-She was not aware Resident #1 had medication changes to Novolog 70/30, Clonidine 0.1mg, and was no longer using her Albuterol inhaler.
-Sometimes residents who self-administered medications stopped or started medications and did not inform the facility staff.

Interview with the Resident Care Director (RCD) on 12/12/24 at 10:10am revealed:
-She was a registered nurse (RN).
-LPNs were responsible for ensuring all residents' medication orders were accurate.
-LPNs were responsible for completing a monthly wellness visit with each resident.
-She did not usually complete the monthly wellness visits but completed the visits if the LPNs were out of the office.
-If a resident self-administered medication, the LPN did an assessment with them during the monthly wellness visits.
-The LPNs assessed to determine if the resident could safely administer their medications.
-In order to self-administer medications, residents should know what medications they were taking and the side effects of the medications.
-LPNs should check to see if residents had new medication orders or dosage changes during each monthly medication assessment.
-Residents who self-administered medications should inform the facility staff when they had appointments with their PCP or other medical providers.
-She was not aware Resident #1 had medication changes to Novolog 70/30, Clonidine 0.1mg, and Albuterol inhaler.
-Sometimes residents who self-administered their medication had medication changes and did not

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communicate the changes to facility staff.
-She was unsure how Resident #1's medication changes were missed during the monthly wellness visit.
-It was her responsibility to follow-up and ensure the residents' medication orders were accurate.

Interview with the Administrator on 12/12/24 at 10:51am revealed:
-The LPNs and the RCD were responsible for receiving new medication orders and ensuring the orders were sent to the pharmacy to be added to the eMARs.
-The RCD was responsible for completing an assessment for residents who self-administered medications.
-LPNs completed monthly wellness visits with each resident and reported any concerns to the RCD.
-Any new medication orders or changes should be identified during the monthly wellness visits.
-Residents who self-administered medications should notify facility staff of any changes in the medications.
-The LPNs and RCD should follow-up with residents who self-administered medications after their medical appointments to determine if there were new medication orders.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/12/24 at 11:49am revealed:
-The pharmacy had not received any updated medication orders for Resident #1's Novolog 70/30, Clonidine 0.1mg, or Albuterol inhaler.
-The facility should have all medication orders updated in the resident's record so the correct and most recent medication orders could be determined.

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D 345	Continued From page 11 Attempted telephone interviews with Resident #1's PCP on 12/12/24 at 10:14am and 3:25pm were unsuccessful.	D 345		
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 reviews, the facility failed to ensure the medication administration record was accurate for 1 of 7 sampled residents (#1) related to a medication used to treat high blood sugar, a medication used to treat high blood pressure, and a medication used to treat shortness of breath.	D 367		

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The findings are:

Review of Resident #1's current FL2 dated 05/30/24 revealed diagnoses included chronic kidney disease, type 2 diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and hypothyroidism.

Review of Resident#1's primary care provider's (PCP) order dated 02/23/24 revealed there was an order for Resident #1 to self-administer medications.

a. Review of Resident #1's current FL2 dated 05/30/24 revealed there was an order for Novolog 70/30 insulin inject 7 units subcutaneously every morning (Novolog is a medication used to treat high blood sugar levels).

Review of Resident #1's PCP visit summary dated 09/03/24 revealed there was an order for Novolog 70/30 twice daily, if fingerstick blood sugar (FSBS) greater than 100, inject 5 units before breakfast, if FSBS less than 100, inject 3 units after breakfast, if greater than 200, inject 4 units with supper, if less than 200, zero units on the current medications list.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 10/01/24 to 10/31/24
-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for

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4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 10/01/24 to 10/31/24

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 11/01/24 to 11/30/24
-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for 4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 11/01/24 to 11/30/24

Review of Resident #1's December 2024 eMAR revealed:
-There was an entry for Novolog 70/30 inject 7 units subcutaneously every morning with breakfast scheduled for 7:00am to 9:00am.
-Novolog 70/30 7 units was documented as unknown, self-administers (U-SA) from 12/01/24 to 12/10/24
-There was an entry for Novolog 70/30 inject 5 units every evening with dinner scheduled for 4:00pm to 6:00pm.
-Novolog 70/30 5 units was documented as unknown, self-administers (U-SA) from 12/01/24 to 12/09/24

Observation of Resident #1's recorded FSBS results on 12/10/24 at 3:36pm revealed Resident #1's FSBS for November 2024 to 12/10/24 ranged from 82-318.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT NORTH HILLS	615 SPRING FOREST ROAD RALEIGH, NC 27609

(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 367	Continued From page 14 Observation of Resident #1's medications on hand on 12/10/24 at 3:36pm revealed: -There was a plastic bag containing 1 Novolog 70/30 pen with a label from a local pharmacy. -The label on the plastic bag containing the Novolog 70/30 pen indicated the medication was last filled on 10/24/24 for a quantity of 3 Novolog 70/30 pens. Refer to interview with Resident #1 on 12/10/24 at 3:35pm. Refer to second interview with Resident #1 on 12/11/24 at 12:00pm. Refer to interview with a medication aide (MA) on 12/11/24 at 3:02pm. Refer to interview with a Licensed Practical Nurse (LPN) on 12/12/24 at 9:38am. Refer to interview with the Resident Care Director (RCD) on 12/12/24 at 10:10am. Refer to interview with the Administrator on 12/12/24 at 10:51am. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/12/24 at 11:49am. Attempted telephone interviews with Resident #1's PCP on 12/12/24 at 10:14am and 3:25pm were unsuccessful. b. Review of Resident #1's PCP visit summary dated 09/03/24 revealed there was an order to start Clonidine 0.1mg take 1 tablet by mouth once a day if systolic blood pressure is greater than 170 (Clonidine is a medication used to lower	D 367		

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D 367	Continued From page 15 blood pressure). Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed there was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170. Review of Resident #1's November 2024 eMAR revealed there was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170. Review of Resident #1's December 2024 eMAR revealed there was no entry for Clonidine 0.1mg 1 tablet by mouth once daily if systolic blood pressure greater than 170. Observation of Resident #1's room on 12/11/24 at 12:00pm revealed Resident #1 had a wrist blood pressure monitoring device. Observation of Resident #1's medications on hand on 12/11/24 at 12:00pm revealed there was a bottle of Clonidine 0.1mg filled 09/03/24. Refer to interview with Resident #1 on 12/10/24 at 3:35pm. Refer to second interview with Resident #1 on 12/11/24 at 12:00pm. Refer to interview with a medication aide (MA) on 12/11/24 at 3:02pm. Refer to interview with a Licensed Practical Nurse (LPN) on 12/12/24 at 9:38am. Refer to interview with the Resident Care Director (RCD) on 12/12/24 at 10:10am.	D 367		

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Refer to interview with the Administrator on 12/12/24 at 10:51am.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/12/24 at 11:49am.

Attempted telephone interviews with Resident #1's PCP on 12/12/24 at 10:14am and 3:25pm were unsuccessful.

c. Review of Resident #1's current FL2 dated 05/30/24 revealed there was an order for Albuterol inhaler inhale 2 puffs by mouth every 8 hours as needed (Albuterol is a medication used to treat shortness of breath).

Review of Resident #1's PCP visit summary dated 09/03/24 revealed there was no order for Albuterol inhaler inhale 2 puffs by mouth every 8 hours as needed on the current medications list.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed.
-There was no documentation of Albuterol being administered from 10/01/24 to 10/31/24.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed.
-There was no documentation of Albuterol being

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D 367	Continued From page 17 administered from 11/01/24 to 11/30/24. Review of Resident #1's December 2024 eMAR revealed: -There was an entry for Albuterol inhaler inhale 2 puffs every 8 hours as needed for wheezing/shortness of breath scheduled as needed. -There was no documentation of Albuterol being administered from 12/01/24 to 12/10/24. Observation of Resident #1's medications on hand on 12/10/24 at 3:36pm revealed there was no Albuterol inhaler. Refer to interview with Resident #1 on 12/10/24 at 3:35pm. Refer to second interview with Resident #1 on 12/11/24 at 12:00pm. Refer to interview with a medication aide (MA) on 12/11/24 at 3:02pm. Refer to interview with a Licensed Practical Nurse (LPN) on 12/12/24 at 9:38am. Refer to interview with the Resident Care Director (RCD) on 12/12/24 at 10:10am. Refer to interview with the Administrator on 12/12/24 at 10:51am. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/12/24 at 11:49am. Attempted telephone interviews with Resident #1's PCP on 12/12/24 at 10:14am and 3:25pm were unsuccessful.	D 367		

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D 367	Continued From page 18 Interview with Resident #1 on 12/10/24 at 3:35pm revealed: -She had self-administered her medications since she moved into the facility last year. -She took her fingerstick blood sugar (FSBS) twice daily and recorded the results on her electronic tablet. -She administered her insulin before or after breakfast and with dinner as instructed by her primary care provider (PCP). -She was no longer taking Albuterol inhaler as needed. -She did not have an Albuterol inhaler and had not experienced any shortness of breath in a long time. -She last saw her PCP on 09/03/24. -The facility staff had not asked her for any of the paperwork or new orders after her PCP visits. Second interview with Resident #1 on 12/11/24 at 12:00pm revealed: -Her PCP prescribed Clonidine 0.1mg at her last PCP visit 09/03/24. -She had a wrist blood pressure monitoring device and checked her blood pressure often. -She did not check her blood pressure every day, but she checked her blood pressure if she felt dizzy, light-headed, or did not feel well. -She had taken the Clonidine 0.1mg 1-2 times since the medication was filled. -The nurses at the facility did not usually review her medications with her or ask to see her medications. Interview with a medication aide (MA) on 12/11/24 at 3:02pm revealed: -Resident #1 self-administered her medications. -MAs were not responsible for processing new or changed medication orders.	D 367		

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-The wellness nurses handled all new or changed medication orders for the residents.
-The facility's contracted pharmacy entered all new medication orders in the electronic medication administration record (eMAR) system.

Interview with a Licensed Practical Nurse (LPN) on 12/12/24 at 9:38am revealed:
-She was 1 of the 2 wellness nurses employed at the facility.
-LPNs were responsible for ensuring all the residents' medication orders were sent to the pharmacy and added to the eMAR.
-LPNs did monthly wellness checks with each resident.
-If the residents self-administered their medications, the LPN reviewed their medications and did a medication assessment with them during their monthly wellness visit.
-Residents who self-administered medications were supposed to inform the facility staff if they had new medication orders.
-She was not aware Resident #1 had medication changes to Novolog 70/30, Clonidine 0.1mg, and was no longer using her Albuterol inhaler.
-Sometimes residents who self-administered medications stopped or started medications and did not inform the facility staff.
-The residents' eMAR should match the residents' current medication orders.

Interview with the Resident Care Director (RCD) on 12/12/24 at 10:10am revealed:
-She was a registered nurse (RN) and had been employed at the facility for 2 years.
-The LPNs were responsible for ensuring all residents' medication orders were accurate.
-MAs should check the residents' eMARs weekly for accuracy.
-LPNS should check the residents' eMARs

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monthly for accuracy.
-LPNs were responsible for completing a monthly wellness visit with each resident.
-She did not usually complete the monthly wellness visits but had completed the visits if the LPNs were out of the office.
-If a resident self-administered medication, the LPN did an assessment with them during the monthly wellness visits.
- LPNs should check to see if residents had new medication orders or dosage changes during each monthly medication assessment.
-Residents who self-administered medications should inform the facility staff when they had appointments with their PCP or other medical providers.
-She was not aware Resident #1 had medication changes to Novolog 70/30, Clonidine, and Albuterol inhaler.
-Sometimes residents who self-administered their medication had medication changes and did not communicate the changes to facility staff.
-She was unsure how Resident #1's medication changes were missed during the monthly wellness visit.
-The residents' eMAR should match the medications the resident was currently taking.
-It was her responsibility to follow-up and ensure the residents' medication orders were accurate.

Interview with the Administrator on 12/12/24 at 10:51am revealed:
-The LPNs and the RCD were responsible for receiving new medication orders and ensuring the orders were sent to the pharmacy to be added to the eMARs.
-The RCD was responsible for completing an assessment for residents who self-administered medications.
-LPNs completed monthly wellness visits with

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each resident and reported any concerns to the RCD.
-Any new medication orders or changes should be identified during the monthly wellness visits.
-Residents who self-administered medications should notify facility staff of any changes in the medications.
-The residents' medication list should be sent to each PCP visit.
-The LPNs and RCD should follow-up with residents who self-administered medications after their medical appointments to determine if there were new medication orders.
-The residents' medication orders should be verified with the residents' PCPs, then sent to the pharmacy to be entered on their eMAR.
-The residents' eMAR should reflect their current medication orders.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/12/24 at 11:49am revealed:
-The pharmacy had not received any updated medication orders for Resident #1's Novolog 70/30, Clonidine 0.1mg, or Albuterol inhaler.
-The facility should send all residents' medication orders so the pharmacy could update the eMARs.
-The eMAR should reflect what medications the resident was currently taking, whether the resident self-administered their medications or if the staff administered their medications.