Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R-C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 and the Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigations from 01/08/25 to 01/09/25. The complaint investigations were initiated by the Mecklenburg County Department of Social Services on 12/09/24 and 12/11/24.	D 000		
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 observations, record review and interviews, the facility failed to ensure referral and follow up to meet the acute health care needs for 1 of 6 resident (Resident #6) related to failure to notify the Primary Care Provider (PCP) that Resident #6 was refusing to eat meals. The findings are: Review of Resident #6's FL2 dated 10/01/24 revealed: -Diagnoses included dementia, anemia, type 2 diabetes, hypertension and hypothyroidism. -She had intermittent disorientation. -She had a written physician's order for a regular diet with thickened liquids. Review of Resident #6's Resident Registered revealed an admission date of 12/22/12. Review of Resident #6's care plan dated 09/20/24	D 273	The Facility Executive Director will in-service Special Care Coordinator and SICs on the rule area listed to be found non-compliance 10A NCAC 13F .0902(b) Health Care Facility Executive Director will coordinate with the Clinical Nurse Consultant to in-service Medication Staff on the following policies and procedures: 1. Healthcare Referral and Follow-up 2. Missed Medications/Refusals 3. Notification to the Provider and documentation of communication 4. Physician/Medical Visits Facility Executive Director and or the designee will review daily progress notes to ensure health care follow-up needs have been reported and a plan is in place to follow up with any healthcare needs from their provider.	Expected compliance: 3/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Caroline Mungo

TITLE: Executive Director

(X6) DATE: 2/25/2025

Reviewed and acknowledged by SSD on 02/28/25 Sharon Dunton RN

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D 273	Continued From page 1 revealed: -She had limited strength in upper extremities. -She required extensive assistance with transfers, dressing, personal hygiene, bathing, and ambulation. -She required limited assistance with eating. Review of Resident #6's record revealed: -There was no documentation of communication between personal care aides (PCA), medication aides (MA), and the Resident Care Coordinator (RCC) that Resident #6 was refusing meals. -There was no documentation that the PCP was notified Resident #6 was refusing meals. Observation of Resident #6 on 01/08/25 at 12:30pm revealed: -She was lying in bed with lights out during the lunch meal. -She declined the lunch meal when the PCA offered to get her out of bed to go to the dining room to eat lunch. Interview with PCAs on 01/08/25 at 12:45pm revealed: -Third shift PCA's were usually responsible for getting Resident #6 up for the day before their shift ended. -Resident #6 was combative at times, often refused breakfast and/or lunch and preferred to stay in bed. -Breakfast and/or lunch trays were not always provided to Resident #6 when she refused to go to the dining room to receive meals. -Resident #6 was not a "morning person" and was not ready to get up for breakfast and was not served a breakfast tray. Interviews with MAs on 01/08/25 at 4:05pm and 01/09/25 at 12:50pm revealed:	D 273		

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D 273	Continued From page 2 -During a meeting, they reported Resident #6 was refusing breakfast and lunch meals. -PCAs were encouraged to assist Resident #6 out of bed and to the dining room for meals. -They did not notify the PCP that Resident #6 was refusing meals. Telephone interview with Resident #6's PCP on 01/09/25 at 1:25pm revealed: -She may have heard Resident #6 may not have been eating well a few weeks ago. -She would have implemented an order for nutritional shakes if she was notified Resident #6 was refusing meals. Interview with the RCC on 01/09/25 at 10:28pm revealed: -She expected staff to inform her that Resident #6's was refusing meals. -If she was made aware Resident #6 was refusing meals, she would have notified the provider, and supplemental shakes would have been recommended or ordered. Interview with the Administrator on 01/09/25 at 1:46pm revealed she expected PCAs, MAs and the RCC to notify the provider of Resident #6's on-going meal refusals, for follow-up.	D 273		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the	D 297		

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D 297	Continued From page 3 community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve a minimum of three nutritionally adequate meals during normal mealtimes for 1 of 6 resident (Resident #6) related to not receiving three meals. The findings are: Review of Resident #6's FL2 dated 10/01/24 revealed: -Diagnoses included dementia, anemia, type 2 diabetes, hypertension and hypothyroidism. -She had intermittent disorientation. -She had a written physician's order for a regular diet, chopped meats and thickened liquids. -Her current level of care was Special Care Unit. Review of Resident #6's Resident Registered revealed an admission date of 12/22/12. Review of Resident #6's care plan dated 09/20/24 revealed: -She had limited strength in upper extremities. -She required extensive assistance with transfers, dressing, personal hygiene, bathing, and ambulation. -She required limited assistance with eating. Observation of Resident #6 on 01/08/25 at 12:30pm revealed: -She was lying in bed with lights out during the	D 297	Facility Executive Director will in service Dietary Manager along with Dietary staff and care staff on the rule area found to be non-compliant 10A NCAC 13F. 0904 Nutrition and Food Service (d)(1) Food Requirements Executive Director and Dietary Manager will in service dietary and care staff on the process for ensuring residents have had 3 minimum nutritionally required adequate meals. The SIC on each shift will review the census report and confirm each resident has had an opportunity to eat. If a resident refuses to eat a meal the community will make 3 attempts to serve the resident in the dining room before putting a plate away for the resident to eat at a later time. The PCA will be responsible for following back up to their assigned resident and offering the plate that is available to them and or alternative options such as snacks or other meal options available in the kitchen to be prepped. At the end of the shift the SIC will be responsible for documenting if the meal was refused and provide that notification to oncoming shifts for next meal preparation	Expected compliance: 3/17/25

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D 297	Continued From page 4 lunch meal. -There was no lunch tray in Resident #6's room. -She declined the lunch meal when the personal care aide (PCA) offered to get her out of bed to go to the dining room to eat lunch. -A lunch tray was not provided until this Surveyor recommended the PCA should do so. Interview with a personal care aide (PCA) on 01/08/25 at 12:45pm revealed: -Third shift PCA's were usually responsible for getting Resident #6 up for the day before their shift ended. -Resident #6 was combative at times. -Resident #6 often refused breakfast and/or lunch and preferred to stay in bed. -She usually got Resident #6 out of bed prior to the end of her day shift (7:00am-3:00pm), if Resident #6 refused to get up earlier in the day. -She did not bring a breakfast or lunch tray to Resident #6's room today because Resident #6 refused to get up and go to the dining room to eat breakfast or lunch. -It was not normal practice to bring meal trays to resident rooms. -Residents were expected to eat meals in the dining room. -Resident #6 usually agreed to get up and eat dinner in the dining room. -She was not aware she was still expected to present Resident #6 with an actual meal tray, if the resident refused. Interview with a medication aide (MA) on 01/08/25 at 4:05pm revealed: -She usually worked on the second shift (3:00pm-11:00pm) and was usually assigned to Resident #6. -Resident #6 required 1-2 person assistance to get out of bed and into the wheel chair.	D 297		

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D 297	Continued From page 5 -She had a special way of interacting with residents who resided in memory care and were combative at times. -When she worked third shift (11:00pm-7:00am) she made sure at least two PCAs got Resident #6 out of bed and to the dining room for breakfast. -If Resident #6 stayed in bed during breakfast and lunch meals, she would miss the meals. -Resident #6 was always up and in the dining room for dinner. Interview with a second PCA on 01/09/25 at 9:55am revealed: -She was the PCA assigned to Resident #6 on 01/08/25 on the day shift. -Resident #6 was not a "morning person" and was not ready to get up for breakfast yesterday and was not served a breakfast tray. -In the past, if PCAs left meal trays in resident rooms beyond the next meal, those left over meal trays attracted insects if they trays were not removed timely. -Resident #6 did not always receive a breakfast or lunch meal tray if she remained in bed during mealtimes. Interview with a second MA on 01/09/25 at 12:50pm revealed: -She administered Resident #6's morning and afternoon medications without difficulty and with applesauce or pudding. -Resident #6 eats meals at her table in her room in the past. -She encouraged PCAs to take Resident #6 to the dining room for breakfast. -She informed the Resident Care Coordinator (RCC) that Resident #6 was refusing meals. -She was not aware Resident #6 was not receiving three meals a day.	D 297		

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D 297	Continued From page 6 Interview with the RCC on 01/09/25 at 10:28am revealed: -She could not recall being told that Resident #6 was refusing meals. -If she had known Resident #6 was refusing meals, she would have informed the Primary Care Provider (PCP). -She expected all residents to receive three nutritious meals each day. Interview with the Administrator on 01/09/25 at 1:46pm revealed: -She expected all residents to be offered and provided three meals and snacks each day. -She did not know that Resident #6 did not receive breakfast or lunch and was refusing meals. -She expected meal refusals to be reported to the PCP.	D 297		
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 record reviews and interviews, the facility failed to administer residents' medications as ordered for 1 of 5 sampled residents (Resident #2) related to topical medications and a vision medication.	D 358		

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D 358	Continued From page 7 The findings are: Review of Resident #2's current FL-2 dated 08/28/24 revealed: -Diagnoses included dementia, schizophrenia, legal blindness, and glaucoma. -The recommended level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 10/11/23. a. Review of Resident #2 record revealed there was an order dated 10/24/24 for ketoconazole 2% shampoo (a medication to treat topical fungal growth), with instructions for applying the shampoo to affected areas before showering, let sit for 3-5 minutes, then wash off as normal, repeat two to three times weekly until clear. Review of Resident #2's October 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for ketoconazole 2% shampoo daily with instructions for applying the shampoo to affected areas before showering, let sit for 3-5 minutes, then wash off as normal, repeat two to three times weekly until clear. -Ketoconazole 2% shampoo was documented as not administered on 10/26/24, 10/27/24, 10/28/24, 10/30/24, and 10/31/24 with an exception reason documented as waiting on pharmacy and/or not administered. Review of Resident #2's October 2024 progress notes revealed there were no entries related to medication refills for ketoconazole 2% shampoo.	D 358	Facility Executive Director will in service Resident Care Coordinator and Medication Aides on the rule area found non-compliant 10A NCAC 13F .1004(a) Medication Administration Facility Executive Director will coordinate with the Clinical Nurse Consultant to in service Resident Care Coordinator and Medication aide staff on the following policies and procedures: 1. Medication Administration/new orders 2. Ordering Process system 3. Medication leaving and returning 4. Medication Labels 5. Medication storage and handling 6. Emergency after hours medication 7. D/C medications 8. Medication errors and documentation 9. Cart Audits 10. Outside Pharmacy and medications Facility Executive Director and or Designees will audit for completion of cart audits weekly Facility Executive Director and or Designees will audit daily missed medication reports to follow up on medication needs and require follow up to medication in house and available to provide as prescribed by Provider.	Expected compliance: 3/17/25

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D 358	Continued From page 8 Review of Resident #2's November 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for ketoconazole 2% shampoo daily with instructions for use once daily as a body wash in shower. -Ketoconazole 2% shampoo was documented as not administered daily from 11/01/24 to 11/27/24 with an exception reason documented as waiting on pharmacy and/or not available. Review of Resident #2's November 2024 progress notes revealed: -An entry dated 11/01/24 at 2:07pm documented a Medication Aide (MA) telephone call to Resident #2's contracted pharmacy requesting a refill status update for ketoconazole 2% shampoo with a message left for Resident #2's in-network physician. -An entry dated 11/14/24 at 11:00am documented a MA telephone call to Resident #2's in-network physician's office requesting a refill status update for ketoconazole 2% shampoo. The MA was instructed to submit the medications orders to Resident #2's in-network physician for approval for Resident #2's contracted pharmacy to fill the medication. -An entry dated 11/27/24 at 11:00pm documented the Administrator telephone call with Resident #2's responsibly party regarding difficulty obtaining Resident #2's medications from Resident #2's in-network pharmacy mailed to the responsible party for delivery to the facility. Review of Resident #2's December 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for ketoconazole 2% shampoo with instructions for use every Monday, Wednesday, and Friday with instructions for applying three	D 358		

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D 358	Continued From page 9 times weekly to the lower back, buttocks and thighs, leave on for 10 minutes and rinse off. -Ketoconazole 2% shampoo was documented as not administered on 12/18/24, 12/23/24, and 12/25/24 with an exception reason documented as shower already taken and/or other. Review of Resident #2's December 2024 progress notes revealed there were no entries related to not administering ketoconazole 2% shampoo. Telephone interview with the facility's contracted pharmacist on 01/08/25 at 2:30pm revealed: -Resident #2 had a physician's order dated 10/24/24 for ketoconazole 2% shampoo with instructions for use every Monday, Wednesday, and Friday with instructions for applying three times weekly to the lower back, buttocks and thighs, leave on for 10 minutes and rinse off. -Ketoconazole 2% shampoo was prescribed to treat fungal growth on skin. -If Resident #2's ketoconazole 2% shampoo was not administered as prescribed, it could allow fungal growth to continue with signs of a fungal skin rash. Telephone interview with a pharmacy technician at Resident #2's contracted pharmacy on 01/09/25 at 9:10am revealed: -Resident #2 had a physician's order dated 10/24/24 for Ketoconazole 2% shampoo from an out-of-network physician which prevented Resident #2's contracted pharmacy from filling the medication. -On 11/14/24, Resident #2's in-network dermatologist prescribed Ketoconazole 2% shampoo for a 30-day supply. -Ketoconazole 2% shampoo was filled on 11/17/24 and mailed to Resident #2's responsible	D 358		

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D 358	Continued From page 10 party on 11/21/24. -On 12/20/24, Resident #2's responsible party requested a refill of Resident #2's Ketoconazole 2% shampoo. -Ketoconazole 2% shampoo was refilled on 12/20/24 for a 30-day supply and mailed to Resident #2's responsible party. Attempted telephone interview with Resident #2's facility contracted dermatologist on 01/09/25 at 2:34pm was unsuccessful. Interview with a first shift Medication Aide (MA) on 01/09/25 at 12:50pm revealed: -Resident #2 had been prescribed ketoconazole 2% shampoo at the end of October 2024 and she faxed the order to Resident #2's contracted pharmacy. -On 11/14/24, she contacted Resident #2's contracted pharmacy and was notified the pharmacy needed Resident #2's ketoconazole 2% shampoo to be authorized by Resident #2's in-network PCP or clinical specialists before the pharmacy filled and mailed the medications to Resident #2's responsible party. Interview with the Special Care Coordinator (SCC) on 01/09/25 at 2:00pm revealed: -She was unaware Resident #2's ketoconazole 2% shampoo prescribed on 10/24/24 was unavailable until the end of November 2024 when a MA notified her. -Resident #2's responsible party delivered Resident #2's ketoconazole 2% shampoo to the facility on or about 12/01/24. Telephone interview with the facility's contracted Nurse Practitioner on 01/09/25 at 1:20pm revealed: -Resident #2's ketoconazole 2% shampoo had	D 358		

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D 358	Continued From page 11 been prescribed by the facility's contracted dermatologist at the end of October 2024. -Ketoconazole 2% shampoo was usually prescribed to treat fungal growth on skin. -If Ketoconazole 2% shampoo was not administered as prescribed, it could result in continued fungal growth to the scalp. b. Review of Resident #2 record revealed there was an order dated 10/24/24 for triamcinolone acetonide 0.1% topical cream (a medication used to treat topical fungal growth), with instructions for applying to rash twice daily for two weeks, then one week off, repeating cycle as needed. Review of Resident #2's October 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for triamcinolone acetonide 0.1% cream with instructions for applying to affected areas twice daily. -Triamcinolone acetonide 0.1% cream was documented as not administered at 8:00am on 10/26/24, 10/27/24, 10/28/24, 10/29/24, 10/30/24, and 10/31/24 with an exception reason documented as waiting on pharmacy and/or needed to be ordered. -Triamcinolone acetonide 0.1% cream was documented as not administered at 8:00pm on 10/25/24, 10/26/24, 10/27/24, 10/28/24, 10/29/24, and 10/31/24 with an exception reason documented as waiting on pharmacy and/or needed to be ordered. Review of Resident #2's October 2024 progress notes revealed there were no entries related to medication refills for triamcinolone acetonide 0.1% topical cream. Review of Resident #2's November 2024	D 358		

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D 358	Continued From page 12 electronic Medication Administration Record (eMAR) revealed: -An entry for triamcinolone acetonide 0.1% cream with instructions for applying to affected areas twice daily. -Triamcinolone acetonide 0.1% cream was documented as not administered daily at 8:00am from 11/01/24 to 11/27/24 and on 11/30/24 with an exception reason documented as waiting on pharmacy and/or needed to be ordered. -Triamcinolone acetonide 0.1% cream was documented as not administered at 8:00pm from 11/01/24 to 11/02/24, 11/04/24 to 11/10/24, 11/12/24 to 11/24/24, 11/26/24 to 11/27/24, and from 11/29/24 to 11/30/24 with an exception reason documented as waiting on pharmacy and/or needed to be ordered. Review of Resident #2's November 2024 progress notes revealed: -An entry dated 11/01/24 at 2:07pm documented a Medication Aide (MA) telephone call to Resident #2's contracted pharmacy requesting a refill status update for triamcinolone 0.1% cream with a message left for Resident #2's in-network physician. -An entry dated 11/14/24 at 11:00am documented a MA telephone call to Resident #2's in-network physician's office requesting a refill status update for triamcinolone 0.1% cream. The MA was instructed to submit the medications orders to Resident #2's in-network physician for approval for Resident #2's contracted pharmacy to fill the medication. -An entry dated 11/27/24 at 11:00pm documented the Administrator telephone call with Resident #2's responsibly party regarding difficulty obtaining Resident #2's medication from Resident #2's contracted pharmacy mailed to the responsible party for delivery to the facility.	D 358		

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	HAL060125	A. BUILDING: _____ B. WING _____	R-C 01/09/2025

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D 358	Continued From page 13 Review of Resident #2's December 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for triamcinolone acetonide 0.1% cream with instructions for applying to affected areas twice daily. -Triamcinolone acetonide 0.1% cream was documented as not administered at 8:00am on 12/01/24 an exception reason documented as waiting on pharmacy. -Triamcinolone acetonide 0.1% cream was documented as not administered at 8:00pm on 12/01/24 an exception reason documented as waiting on pharmacy. Review of Resident #2's December 2024 progress notes revealed there were no entries related to not administering triamcinolone acetonide 0.1% cream. Telephone interview with the facility's contracted pharmacist on 01/08/25 at 2:30pm revealed: -Resident #2 had a physician's order dated 10/24/24 for triamcinolone acetonide 0.1% cream with instructions for applying to affected areas twice daily. -Triamcinolone acetonide 0.1% cream was prescribed to treat fungal growth on skin. -If Resident #2's triamcinolone acetonide 0.1% cream was not administered as prescribed, it could allow fungal growth to continue with signs of a fungal skin rash. Telephone interview with a pharmacy technician at Resident #2's contracted pharmacy on 01/09/25 at 9:10am revealed: -On 11/14/24, Resident #2's in-network dermatologist prescribed triamcinolone acetonide 0.1% cream twice daily.	D 358		

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D 358	Continued From page 14 -A 30-day supply of Resident #2's triamcinolone acetonide 0.1% cream was mailed to Resident #2's responsible party on 11/19/24 and 12/26/24. Telephone interview with Resident #2's facility contracted dermatologist on 01/09/25 at 2:34pm was unsuccessful. Interview with a first shift Medication Aide (MA) on 01/09/25 at 12:50pm revealed: -Resident #2 had been prescribed triamcinolone acetonide 0.1% cream at the end of October 2024 and she faxed the orders to Resident #2's contracted pharmacy. -On 11/14/24, she contacted Resident #2's contracted pharmacy and was notified the pharmacy needed Resident #2's triamcinolone acetonide 0.1% cream to be authorized by Resident #2's in-network PCP and clinical specialists before the pharmacy filled and mailed the medication to Resident #2's responsible party. Interview with the Special Care Coordinator (SCC) on 01/09/25 at 2:00pm revealed: -She was unaware Resident #2's triamcinolone acetonide 0.1% cream prescribed on 10/24/24 was unavailable until the end of November 2024 when a MA notified her. -Resident #2's responsible party delivered Resident #2's triamcinolone acetonide 0.1% cream to the facility on or about 12/01/24. Telephone interview with the facility's contracted Nurse Practitioner on 01/09/25 at 1:20pm revealed: -Resident #2's Triamcinolone acetonide 0.1% cream had been prescribed by the facility's contracted dermatologist. -Triamcinolone acetonide 0.1% cream was usually prescribed to treat fungal growth on skin.	D 358		

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D 358	Continued From page 15 -If Triamcinolone acetonide 0.1% cream was not administered as prescribed, it could allow continued fungal growth on skin. c. Review of Resident #2 record revealed there was an order dated 06/24/24 for dorzolamide-timolol 22.3-6.8mg/ml eyedrops (a medication used to treat eye pressure) with instructions for applying one drop in both eyes twice daily. Review of Resident #2's October 2024 electronic Medication Administration Record (eMAR) revealed: -An entry for dorzolamide-timolol 22.3-6.8mg/ml eyedrops with instructions for applying one drop in both eyes twice daily. -Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were documented as not administered at 8:00am from 10/10/24 to 10/16/24 with an exception reason documented as waiting on pharmacy and/or unavailable. -Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were documented as not administered at 8:00pm from 10/11/24 to 10/15/24 with an exception reason documented as waiting on pharmacy and/or unavailable. Review of Resident #2's October 2024 progress notes revealed there were no entries related to medication refill requests for dorzolamide-timolol 22.3-6.8mg/ml eyedrops. Telephone interview with the facility's contracted pharmacist on 01/08/25 at 2:30pm revealed: -The pharmacy was responsible for transcribing all of Resident #2's medication orders for the facility's eMAR system. -Resident #2 did not use the facility's contracted pharmacy for medication refills.	D 358		

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D 358	Continued From page 16 -Resident #2 had a physician's order dated 06/24/24 for dorzolamide-timolol 22.3-6.8mg/ml eyedrops, instill one drop in each eye twice daily. -On 10/16/24, the facility requested a refill for dorzolamide-timolol 22.3-6.8mg/ml eyedrops, billed to the facility and delivered on 10/16/24. -Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were prescribed to treat pressure in the eye. -If Resident #2's dorzolamide-timolol 22.3-6.8mg/ml eyedrops was not administered as prescribed, it could increase inter-ocular eye pressure after a few months of not being administered. Telephone interview with a pharmacy technician at Resident #2's contracted pharmacy on 01/09/25 at 9:10am revealed: -Resident #2's medications were filled by the pharmacy only if prescribed by Resident #2's in-network physicians. -Resident #2's medication orders prescribed by out-of-network physicians required approval by Resident #2's in-network physicians before medications would be filled. -Medications dispensed from the pharmacy could take up to 7-10 calendar days for mail delivery. -Resident #2's medications refills were requested by the facility and Resident #2's responsible party. -Resident #2's medication refills were to be mailed to Resident #2's responsible party. -Resident #2 had a physician order dated 06/24/24 for dorzolamide-timolol 22.3-6.8mg/ml eyedrops, instill one drop in each eye twice daily for a 90-day supply. -On 06/24/24 the facility requested the pharmacy dispense Dorzolamide-timolol 22.3-6.8mg/ml eyedrops and a 90-day supply (2-vials) was dispensed on 06/24/24 to the pharmacy's customer pickup window.	D 358		

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D 358	Continued From page 17 -On 11/24/24 the facility requested the pharmacy dispense Dorzolamide-timolol 22.3-6.8mg/ml eyedrops and a 90-day supply was dispensed on 11/14/24 to Resident #2's responsible party's mailing address. Telephone interview with Resident #2's responsible party on 01/08/25 at 3:30pm revealed: -Resident #2 was admitted to the facility in October 2023. -Resident #2 primarily utilized Resident #2's contracted Primary Care Physician (PCP) and in-network clinical specialists and utilized the facility's contracted Nurse Practitioner and clinical specialists as needed. -Resident #2 utilized his contracted pharmacy associated with Resident #2's contracted PCP and in-network clinical specialists for all medication orders and refills. -Resident #2's pharmacy only filled medications prescribed by Resident #2's in-network PCP and specialists. -If Resident #2 was prescribed medications from an out-of-network provider, the pharmacy required authorization from Resident #2's in-network PCP or clinical specialist to fill the medication. -She expected the facility to ensure the prior authorization was sent from the prescribing physician. -All of Resident #2's medications filled by Resident #2's contracted pharmacy was to be mailed to her, upon receipt she brought them to the facility as soon as possible. -Since June 2024 or July 2024, the facility had frequently communicated with her concerning Resident #2's medications requiring refill from Resident #2's contracted pharmacy. -She did not know why the facility was running out	D 358		

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D 358	Continued From page 18 of Resident #2's medications too soon before the next medication refill supply was due. -If Resident #2's medications were filled by the facility's contracted pharmacy, she was billed. -She did not want to pay for Resident #2's medications filled by the facility's contracted pharmacy if the medications could be filled by Resident #2's contracted pharmacy. Interview with a first shift Medication Aide (MA) on 01/09/25 at 12:50pm revealed: -The facility was responsible for ordering Resident #2's medications from Resident #2's contracted pharmacy and wait for Resident #2's responsible party to bring the medications to the facility. -Between October 2024 and November 2024, the SCC and Administrator assigned her responsible for all of Resident #2's weekly medication cart audits, medication ordering, and refill requests due to the complexity of Resident #2's medication ordering and refill needs. -Resident #2 had been prescribed Dorzolamide-timolol 22.3-6.8mg/ml eyedrops. -Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were filled for a 90-day supply by Resident #2's contracted pharmacy. -In October 2024, she notified the SCC and Administrator that Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops had run out. -In October 2024, the Administrator approved a re-supply of Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops from the facility's contracted pharmacy. -Facility staff discard residents eyedrops 30-days after opening. -In October 2024, she determined Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were discarded earlier than Resident #2's	D 358		

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D 358	Continued From page 19	D 358		

contracted pharmacy refill was authorized.
-Facility staff were instructed to keep Resident #2's opened eyedrops on the medication cart for 45 days from the date opened, for ensuring Resident #2's 90-day supply of eyedrop vials lasted until a refill was scheduled to be dispensed.
-After waiting two to three weeks for receipt of Resident #2's medications, she was responsibly for notifying the Special Care Coordinator (SCC) or Administrator.
-The Administrator was responsible for determining if the facility's contracted pharmacy filled Resident #2's medications as needed if the facility did not have Resident #2's medications available for administration.

Interview with the Special Care Coordinator (SCC) on 01/09/25 at 2:00pm revealed:
-Resident #2 utilized the facility's contracted Nurse Practitioner and clinical specialists and his in-network PCP and clinical specialists for medication orders.
-All of Resident #2's medications filled by his contracted pharmacy were mailed to Resident #2's responsible party.
-Resident #2's responsible party was responsible for delivering Resident #2's medications as soon as possible.
-Resident #2 was prescribed Dorzolamide-timolol 22.3-6.8mg/ml eyedrops twice daily.
-On 10/16/24, a MA notified her Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were unavailable for administration since 10/10/24.
-On 10/16/24, the Administrator immediately ordered Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops from the facility's contracted pharmacy, billed to the facility.
-In November 2024, she assigned a first shift MA

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D 358	Continued From page 20 for Resident #2's medication ordering, refills, and weekly cart audit due to ongoing difficulties with ensuring Resident #2's medications were available for administration. Interview with the Administrator on 01/09/25 at 2:25pm revealed: -The facility was responsible for administering Resident #2's medications as prescribed. -Resident #2 utilized his in-network PCP and Resident #2's contracted pharmacy for all medication orders and refills. -Resident #2's responsible party also utilized the facility's contracted Nurse Practitioner (NP) and clinical specialists for wellness needs. -All of Resident #2's medications filled by his contracted pharmacy were mailed to Resident #2's responsible party. -Resident #2's responsible party was responsible for delivering Resident #2's medications as soon as possible. -The facility had difficulty obtaining Resident #2's medications prescribed by the facility contracted NP or clinical specialists filled by Resident #2's contracted pharmacy because Resident #2's pharmacy required medication order authorization from Resident #2's in-network PCP and clinical specialists before dispensing medications. -On 10/16/24, the SCC notified her Resident #2's Dorzolamide-timolol 22.3-6.8mg/ml eyedrops were unavailable for administration and she requested the facility's contracted pharmacy refill the medication immediately. -In late November 2024, she was aware some of Resident #2's topical medications had been unavailable for administration since 10/24/24 and she requested Resident #2's responsible party bring the medications to the facility. -Between November 2024 and December 2024, she had notified Resident #2's responsible party	D 358		

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D 358	Continued From page 21 concerning the facility's medication ordering, refill, and physician's orders requirements for preventing interruption of Resident #2's medication administration needs. Telephone interview with the facility's contracted Nurse Practitioner on 01/09/25 at 1:20pm revealed: -Resident #2 utilized her and another primary care provider for clinical services. -Resident #2 utilized his contracted pharmacy for all medication refills. -Resident #2's dorzolamide-timolol 22.3-6.8mg/ml eyedrops twice daily was prescribed to treat eye pressure. -If Dorzolamide-timolol 22.3-6.8mg/ml eyedrop was not administered as prescribed, eye pressure could continue.	D 358		