STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051069	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SILKGRASS	118 SILKGRASS WAY CLAYTON, NC 27527

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up on 02/26/25.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had signed medication orders from a provider upon admission. The findings are: Review of the Resident #2's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, hyperlipidemia, depression, osteoarthritis, and chronic kidney disease. -There was an order for Oxycodone 5mg, ½ tab every day. (Oxycodone is used to relieve pain). -There was an order for Oxycodone 5mg, ½ tab every 4 hours as needed (PRN) for pain. -There was an order for Sertraline 50mg, 1 tab	C 315		

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C 315	Continued From page 1	C 315		

every day. (Sertraline is used to treat depression).
-There was an order for Trazodone 50mg, 1 ½ tabs every evening. (Trazodone is used to treat depression).
-There was an order for Trimethoprim 100mg, 1 tab every day. (Trimethoprim is used to treat infections).
-There was an order for Verapamil 180mg, 1 tab twice per day. (Verapamil is used to treat high blood pressure).
-There was an order for Diclofenac sodium gel, apply 4grams to back every day. (Diclofenac sodium gel is used to reduce pain and swelling).
-There was an order for Divalproex 125mg, 1 tab every evening. (Divalproex is used to treat seizures).
-There was an order for Olanzapine 5mg, 1 tab twice per day. (Olanzapine is used to treat mental disorders).
-There was an order for Melatonin 3mg, 1 tab every day. (Melatonin is used to treat insomnia).
-There was an order for Protonix 20mg, 1 tab every day, discontinue 02/24/25. (Protonix is used to treat gastroesophageal reflux disease).
-There was an order for Aspirin 81mg tablet, 1 tab twice per day, discontinue 02/23/25. (Aspirin is used to treat pain and reduce the risk of heart attack).
-There was an order for Multivitamin, 1 tab every day. (Multivitamin is used to treat vitamin deficiency).
-There was an order for One a day vitamin, 1 tab every day. (One a day vitamin is used to treat vitamin deficiency).
-There was an order for Refresh plus 0.5%, 1 drop in both eyes twice per day. (Refresh is used to treat dry, burning, and irritated eyes).

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed:

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C 315	Continued From page 2 -There was a bottle of Sertraline 50mg available for administration. -There was a bottle of Trazodone 50mg available for administration. -There was a bottle of Trimethoprim 100mg available administration. -There was a bottle of Verapamil 180mg available administration. -There was a bottle of Divalproex 125mg available for administration. -There was a bottle of Olanzapine 5mg available for administration. -There was a bottle of Protonix 20mg available for administration. Interview with a medication aide (MA) on 02/26/25 at 10:33am revealed: -Resident #2's medications were brought into the facility in a bag. -Someone marked the medication bottles with an M for morning and N for night to let the MAs know when to administer the medications. -She administered Resident #2's medications based on the labels. -She did not know if the medication orders for Resident #2 were accurate on the medication label. Interview with the House Manager on 02/26/25 at 10:48 am and 2:38pm revealed: -Resident #2 was admitted to the facility on 02/14/25. -Resident #2's family member brought in her medications. -She knew the MAs could not administer medications without orders. -She received Resident #2's FL-2 dated 02/11/25 on 02/21/25. -She sent the FL-2 dated 02/11/25 to the pharmacy on 02/26/25.	C 315		

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C 315	Continued From page 3 -After the pharmacy received the FL-2 they put the orders in the eMAR system and flagged it for approval. -The facility approved the physician's orders and the medications were sent out. -She made a mistake and should have made it a priority to ensure Resident #2 had medication orders. Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 12:38pm revealed: -She should have checked to ensure when Resident #2 was admitted there were physician orders. -The process would have been for the facility to fax orders to their contracted pharmacy. -The contracted pharmacy would input the orders into the system. -The orders were then approved by the facility. -She was not aware Resident #2 did not have medication orders. Interview with the Administrator on 02/26/25 at 1:51pm revealed: -Physician orders should have been included in the Resident #2's admission packet. -The House Manager should have called the RCC to inform them Resident #2 did not have physician's orders. -Physician orders were important to ensure the safety of the residents and ensure they were receiving the accurate medications. -The MAs should not have administered medications to Resident #2 without medication orders. Interview with the facility's contracted pharmacy on 02/26/25 at 12:31pm revealed there was not a profile or active orders for Resident #2 in their system.	C 315		

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C 315	Continued From page 4 Based on observations, interviews, and record review it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's hospice nurse on 02/26/25 at 12:15pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/26/25 at 1:08pm was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) including medications use to treat seizures, moderate to severe pain, depression, insomnia, dry, burning, irritated eyes and medication used to reduce swelling and pain, a medication used to treat gastroesophageal reflux and a vitamin supplement.	C 330		

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C 330	Continued From page 5 The findings are: Review of the Resident #2's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, hyperlipidemia, depression, osteoarthritis, chronic kidney disease, and right femur fracture. -There was no admission date documented. Review of Resident #2's Resident Register dated 02/14/25 revealed there was no admission date documented. Interview with a medication aide (MA) on 02/26/25 at 10:33am revealed there was no electronic medication administration record (eMAR) for Resident #2. Interview with the House Manager on 02/26/25 at 10:48 am and 2:38pm revealed: -Resident #2 was admitted to the facility on 02/14/25. -She notified the Administrator on 02/20/25 she did not have an FL-2 or orders for Resident #2. -She received Resident #2's FL-2 dated 02/11/25 on 02/21/25. -She sent the FL-2 dated 02/11/25 to the pharmacy on 02/26/25. a. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Oxycodone 5mg, ½ tab every day and Oxycodone 5mg, ½ tab every 4 hours as needed (PRN) for pain. (Oxycodone is used to treat moderate to severe pain). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed:	C 330		

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C 330	Continued From page 6 -There was not an entry for Oxycodone 5mg, ½ tab every day. -There was not an entry for Oxycodone 5mg, ½ tab every 4 hours PRN for pain Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Oxycodone 5mg was not available for administration. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am and 1:30pm revealed: -Resident #2's Oxycodone was not dispensed upon discharge from the rehab center because they did not dispense it for patients discharging. -The Oxycodone order was due to Resident #2 having a healing hip fracture. -She was not sure if Resident #2 needed the Oxycodone because she did not know her pain level. -She was concerned the resident may have been in pain if she was not receiving the Oxycodone as ordered. -Resident #2 would have to be assessed by her primary care provider (PCP)to determine her pain level. b. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Sertraline 50mg, 1 tab every day. (Sertraline is used to treat depression). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Sertraline 50mg, 1 tab every day. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was	C 330		

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C 330	Continued From page 7 a bottle of Sertraline 50mg available. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Sertraline 50mg, 1 tablet every day on 02/14/25 for 15 days for Resident #2 until she established care with a new provider. c. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Trazodone 50mg, 1 ½ tabs every evening. (Trazodone is used to treat depression). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Trazodone 50mg, 1 ½ tabs every evening. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was a bottle of Trazodone 50mg available. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Trazodone 50mg, 1 ½ tablet at bedtime on 02/14/25 for 15 days for Resident #2 until she established care with a new provider. d. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Trimethoprim 100mg, 1 tab every day. (Trimethoprim is used to treat infections). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Trimethoprim 100mg, 1 tab every day.	C 330		

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C 330	Continued From page 8 Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was a bottle of Trimethoprim 100mg available. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Trimethoprim 100mg, 1 tablet every day on 02/14/25 for 15 days for Resident #2 until she established care with a new provider. e. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Verapamil 180mg, 1 tab twice per day. (Verapamil is used to treat high blood pressure). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Verapamil 180mg, 1 tab twice per day. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was a bottle of Verapamil 180mg available. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Verapamil 180mg, 1 tablet twice per day on 02/14/25 for 15 days for Resident #2 until she established care with a new provider. f. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Diclofenac sodium gel, apply 4grams to back every day. (Diclofenac sodium gel is used to reduce pain and swelling). Review of Resident #2's February 2025 eMAR	C 330		

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that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Diclofenac sodium gel, apply 4grams to back every day.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Diclofenac sodium gel was not available.

g. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Divalproex 125mg, 1 tab every evening. (Divalproex is used to treat seizures and mood disorders).

Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed:
-There was an entry for Divalproex 125mg, 1 tab twice per day scheduled for 8:00am and 8:00pm.
-Divalproex 125mg tablet was not documented as administered from 02/01/25 to 02/26/25.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed:
-There was a bottle of Divalproex 125mg available.
-The medication label stated to take 2 capsules in the morning and 1 capsule every evening.

Interview with a medication aide (MA) on 02/26/25 at 10:33am revealed:
-She administered Resident #2's medications based on the labels.
-She administered all the medications in the bag to Resident #2 that were labeled for morning.

Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am and 1:30pm revealed:

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C 330	Continued From page 10 -The pharmacist dispensed Divalproex 125mg, 2 tablets every morning and 1 tablet every evening on 02/14/25 for 15 days for Resident #2 until she established care with a new provider. -Divaloproex could cause dizziness, drowsiness, headaches, nervousness, and abdominal pain if taking too much. -Divaloprex could cause nausea and abdominal pain if the resident was nonambulatory and refusing meals. Observation of Resident #2 during the breakfast meal observation on 02/26/25 at 9:50am revealed she refused her meal. h. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Olanzapine 5mg, 1 tab twice per day. (Olanzapine is used to treat mental disorders). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed: -There was an entry for Olanzapine 5mg, 1 tab twice per day scheduled for 8:00am and 8:00pm. -Olanzapine 5mg was not documented as administered from 02/01/25 to 02/26/25. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was a bottle of Olanzapine 5mg available for administration. Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Olanzapine 5mg on 02/14/25 for 15 days for Resident #2 until she established care with a new provider.	C 330		

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i. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Melatonin 3mg, 1 tab every day. (Melatonin is used to treat insomnia).

Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed:
-There was an entry for Melatonin 3mg, 1 tab every day.
- Melatonin 3mg tablet was not documented as administered from 02/01/25 to 02/26/25.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Melatonin 3mg was not available for administration.

j. Review of Resident #2's current FL-2 dated 02/11/25 revealed:
-There was an order for Protonix 20mg, 1 tablet every day. (Protonix is used to treat gastroesophageal reflux).
-There was an order to discontinue Protonix on 02/24/25.

Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Protonix 20mg tablet, 1 tablet every day.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed there was a bottle of Protonix 20mg available for administration.

Telephone interview with Resident #2's pharmacist at their previous pharmacy on 02/26/25 at 11:33am revealed the pharmacist dispensed Protonix 20mg on 02/14/25 for 15 days for Resident #2 until she established care with a

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new provider.

k. Review of Resident #2's current FL-2 dated 02/11/25 revealed:
-There was an order for Aspirin 81mg, 1 tablet twice per day. (Aspirin is used to treat pain, fever, headache and inflammation or to thin the blood).
-There was an order to discontinue Aspirin on 02/23/25.

Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed:
-There was an entry for Aspirin 81mg tablet, 1 tablet twice per day scheduled for 8:00am and 8:00pm.
-Aspirin 81mg tablet was not documented as administered from 02/01/25 to 02/26/25.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Aspirin 81mg was not available for administration.

l. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Multivitamin, 1 tab every day. (Multivitamin is used to treat vitamin deficiency).

Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Multivitamin, 1 tablet every day.

Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Multivitamin tablets were not available for administration.

m. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for

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	FCL051069	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SILKGRASS	118 SILKGRASS WAY CLAYTON, NC 27527

(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
C 330	Continued From page 13 One a day vitamin, 1 tab every day. (One a day vitamin is used to treat vitamin deficiency). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for One a day vitamin, 1 tab every day. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed One a day vitamin tablets were not available for administration. n. Review of the Resident #2's current FL-2 dated 02/11/25 revealed there was an order for Refresh plus 0.5%, 1 drop in both eyes twice per day. (Refresh plus is used to treat dry, burning, and irritated eyes). Review of Resident #2's February 2025 eMAR that was created by the facility on 02/26/25 and provided at 10:48am revealed there was not an entry for Refresh plus 0.5%, 1 drop in both eyes twice per day. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed Refresh plus 0.5% was not available for administration. Interview with a MA on 02/26/25 at 10:33am revealed: -Resident #2's medications were brought into the facility in a bag when she was admitted. -Someone marked the medication bottles with an M for morning and N for night to let the MAs know when to administer the medications. -She administered all the medications in the bag to Resident #2 that were labeled for morning. Interview with the House Manager on 02/26/25 at	C 330		

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C 330	Continued From page 14 10:48 am and 2:38pm revealed: -When Resident #2 was admitted she used the medication list that came for the resident as her orders. -She no longer had a copy of the medication list because she gave it to the hospice nurse on 02/25/25. -Someone she spoke to from the rehab center told her some of Resident #2's medication did not match her orders and she needed to check the medications. -She made a mistake and should have made it a priority to ensure Resident #2 had medication orders. -She told the MAs Resident #2 was not to receive all the medications in the bag that was provided by the family. -She did not have time to go through the medications and ensure they were correct. -There was no eMAR in the system for Resident #2 until today, 02/26/25. -Resident #2's family member brought in the medication. -She knew the MAs could not administer medications without orders and an eMAR. -She attempted to contact the rehab center where Resident #2 came from to obtain physician's orders but they would not send them. -She asked the family member to bring in signed physician orders. -After the pharmacy received the FL-2 they put the orders in the eMAR system and flagged it for approval. -The facility approved the physician's orders and the medications were sent out. -She knew medications should not have been administered without an eMAR. -She compared the medications on hand and the medications on the FL-2 and realized some of them did not match the orders.	C 330		

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C 330	Continued From page 15 Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 12:38pm revealed: -She was responsible for the admission paperwork for residents. -She was not available the date Resident #2 was admitted to the facility. -She should have checked to ensure when Resident #2 was admitted there were physician orders. -The MAs should not have administered Resident #2's medications without an MAR. -The process would have been for the facility to fax orders to their contracted pharmacy. -The contracted pharmacy would input the orders into the eMAR system. -The orders were then approved by the facility. -Staff should have used a paper medication administration record if there was not an eMAR for Resident #2. -She was not aware Resident #2 did not have an eMAR. Interview with the Administrator on 02/26/25 at 1:51pm revealed: -Physician orders should have been included in the Resident #2's admission packet. -He was not aware staff did not have an eMAR for Resident #2. -The House Manager should have called the RCC to inform them Resident #2 did not have physician's orders. -Physician orders were important to ensure the safety of the residents and ensure they were receiving the accurate medications. -The MAs should not have administered medications to Resident #2 without medication orders. -He was not aware Resident #2 did not have an FL-2 upon admission.	C 330		

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C 330	Continued From page 16 -He never contacted the rehab center where Resident #2 was admitted prior to her admission to the facility. Telephone interview with the facility's contracted pharmacy on 02/26/25 at 12:31pm revealed: -There was not a profile or active orders for Resident #2 in their system. -Without a profile or active orders there would not be an eMAR generated for Resident #2. -The facility must have entered the orders in the system for there to be an MAR available. Based on observations and interviews, it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's hospice nurse on 02/26/25 at 12:15pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider on 02/26/25 at 1:08pm was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for Resident #2 including medications used to treat moderate to severe pain for a healing hip fracture, depression, insomnia, dry, burning, irritated eyes and medication used to reduce swelling and pain, and a used to treat gastroesophageal reflux, a medication that was discontinued and the resident continued to receive and a medication used to treat seizures or mood disorders that had been decreased and the resident received a triple dose of the medication which could cause dizziness, drowsiness, headache, nervousness, and abdominal pain. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of	C 330		

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C 330	Continued From page 17 the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/26/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2025.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to document medications that were administered to 1 of 3 sampled residents (#2) in the electronic medication administration record (eMAR) system immediately following administration. The findings are: Review of the Resident #2's current FL-2 dated 02/11/25 revealed:	C 341		

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C 341	Continued From page 18 -Diagnoses included dementia, hyperlipidemia, depression, osteoarthritis, and chronic kidney disease. -There was no admission date documented. -There was an order for Sertraline 50mg, 1 tab every day. (Sertraline is used to treat depression). -There was an order for Trazodone 50mg, 1 ½ tabs every evening. (Trazodone is used to treat depression). -There was an order for Trimethoprim 100mg, 1 tab every day. (Trimethoprim is used to treat infections). -There was an order for Verapamil 180mg, 1 tab twice per day. (Verapamil is used to treat high blood pressure). -There was an order for Divalproex 125mg, 1 tab every evening. (Divalproex is used to treat seizures). -There was an order for Olanzapine 5mg, 1 tab twice per day. (Olanzapine is used to treat mental disorders). -There was an order for Protonix 20mg, 1 tab every day, discontinue 02/24/25. (Protonix is used to treat gastroesophageal reflux disease). Review of Resident #2's Resident Register dated 02/14/25 revealed there was no admission date documented. Observation of Resident #2's medications on hand on 02/26/25 at 10:33am revealed: -There was a bottle of Sertraline 50mg available for administration. -There was a bottle of Trazodone 50mg available for administration. -There was a bottle of Trimethoprim 100mg available for administration. -There was a bottle of Verapamil 180mg available for administration. -There was a bottle of Divalproex 125mg	C 341		

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C 341	Continued From page 19	C 341		

available administration.
-There was a bottle of Olanzapine 5mg available fro administration.
-There was a bottle of Protonix 20mg available for administration.

Interview with a medication aide (MA) on 02/26/25 at 10:33am revealed:
-There was no electronic medication administration record (eMAR) for Resident #2.
-She did not contact the pharmacy to let them know she needed an eMAR for Resident #2.
-She administered all the medications in the bag to Resident #2 that were labeled for morning.
-Someone marked the medication bottles with an M for morning and N for night to let the MAs know when to administer the medications.
-She administered Resident #2's medications based on the labels.
-She should have an eMAR to administer medications.

Interview with the House Manager on 02/26/25 at 10:48 am and 2:38pm revealed:
-Resident #2 was admitted to the facility on 02/14/25.
-Resident #2's family member brought in the medication.
-She received Resident #2's FL-2 dated 02/11/25 on 02/21/25.
-The MAs were expected to administer medications using an eMAR.
-Resident #2 did not have an eMAR until today, 02/26/25.
-She knew the MAs could not administer medications without an eMAR.

Interview with the Resident Care Coordinator (RCC)on 02/26/25 at 12:38pm revealed:
-The MAs should not have administered Resident

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#2's medications without a MAR.
-Staff should have used a paper medication administration record if there was not an eMAR for Resident #2.
-She was not aware Resident #2 did not have an eMAR.
-She was responsible for the admission paperwork for residents.
-She was not available the date Resident #2 was admitted to the facility.

Interview with the Administrator on 02/26/25 at 1:51pm revealed:
-He was not aware staff did not have an eMAR for Resident #2.
-The House Manager should have called the RCC to inform them Resident #2 did not have physician's orders.
-The MAs should not have administered medications to Resident #2 without medication orders and an eMAR.

Interview with the facility's contracted pharmacy on 02/26/25 at 12:31pm revealed:
-There was not a profile or active orders for Resident #2 in their system.
-Without a profile or active orders there would not be an eMAR generated for Resident #2.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's hospice nurse on 02/26/25 at 12:15pm was unsuccessful.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/26/25 at 1:08pm was unsuccessful.

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