

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL 025044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2024
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NAME OF PROVIDER OR SUPPLIER THE VIRIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 3003 WATERSCAPE WAY NEW BERN, NC 28562
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 09/18/24 through 09/20/24.	D 000		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#3,#4,#5) related to a medication for tremors and anxiety (#3) a medication used to control pain (#5) and a medication used to treat infection (#4).</p> <p>The findings are:</p> <p>1. Review of Resident #3's current FL-2 dated 02/20/24 revealed diagnoses included anxiety disorder, fibromyalgia, and hyperlipidemia.</p> <p>Review of Resident #3's physician order sheet dated 08/29/24 revealed there was an order for Alprazolam 0.25mg five times a day for tremors at 7:00am, 11:00am, 3:00pm, 7:00pm, and 9:00pm, hold for sedation (Alprazolam is used to treat anxiety and tremors).</p>	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 358	<p>Continued From page 1</p> <p>Observation of Resident #3's medications on hand on 09/19/24 at 5:22pm revealed: -There was a prescription bottle of Alprazolam 0.25mg tablet with instructions to take 1 tablet five times a day. -150 tablets of Alprazolam 0.25mg were dispensed on 08/20/24 for a 30 day supply. -There was one tablet of Alprazolam 0.25mg in the prescription bottle.</p> <p>Observation of Resident #3's medications on hand on 09/20/24 at 4:23pm revealed: -There were two bubble cards with 75 tablets of Alprazolam 0.25mg for Resident #3 with a dispense date of 09/19/24 for a quantity of 150 tablets. -There was a bubble card with 6 tablets of Alprazolam 0.25mg for Resident #3 with a dispense date of 09/19/24 for a quantity of 10 tablets.</p> <p>Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/20/24 at 2:15pm revealed: -The pharmacy dispensed 60 tablets of Alprazolam 0.25mg for Resident #3 on 06/24/24 for a 12 day supply. -The pharmacy dispensed 150 tablets of Alprazolam 0.25mg for Resident #3 on 07/11/24 for a 30 day supply. -The pharmacy dispensed 150 tablets of Alprazolam 0.25mg for Resident #3 on 07/17/24 for a 30 day supply. -The pharmacy dispensed 150 tablets of Alprazolam 0.25mg for Resident #3 on 09/19/24 for a 30 day supply.</p> <p>Telephone interview with a pharmacist with the facility's contracted back up pharmacy on 09/20/24 at 10:18am revealed:</p>	D 358		

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D 358	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The pharmacy dispensed 25 of Alprazolam 0.25mg for Resident #3 on 07/10/24 for a 5 day supply. -The pharmacy dispensed 150 tablets of Alprazolam 0.25mg for Resident #3 on 08/20/24 for a 30 day supply. -The pharmacy dispensed 10 tablets of Alprazolam 0.25mg for Resident #3 on 09/19/24 for a 2 day supply. <p>Review of Resident #3's July 2024 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Alprazolam 0.25mg, take one tablet five times a day for essential tremor at 7:00am, 11:00am, 3:00pm, 7:00pm, and 9:00pm, hold for sedation. -Alprazolam 0.25mg was documented as not administered on 07/09/24 at 9:00pm. -Alprazolam 0.25mg was documented with a medication aide's (MAs) initials with parenthesis around the initials on 07/09/24 at 9:00pm. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered; waiting on pharmacy. -Alprazolam 0.25mg was documented as not administered on 07/10/24 at 7:00am, 11:00am, 3:00pm, 7:00pm, and 9:00pm. -Alprazolam 0.25mg was documented with a MA initials in parenthesis around the initials on 07/10/24 at 7:00am, 11:00am, 3:00pm, 7:00pm, and 9:00pm. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 07/10/24 at 7:00am; waiting on pharmacy. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 07/10/24 at 11:00am; pharmacy will deliver. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 	D 358		

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D 358	<p>Continued From page 3</p> <p>07/10/24 at 3:00pm; waiting on pharmacy. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 07/10/24 at 7:00pm; waiting. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 07/10/24 at 9:00pm, waiting. -Alprazolam 0.25mg was documented as not administered on 07/11/24 at 7:00am and 11:00am. -Alprazolam 0.25mg was documented with a MA initials in parenthesis around the initials on 07/11/24 at 7:00am and 11:00am. -There was an entry on the eMAR exceptions that Alprazolam 0.25mg was not administered on 07/11/24 at 7:00am; waiting on pharmacy. -Alprazolam 0.25mg was documented as not administered on 07/11/24 at 11:00am; waiting on pharmacy.</p> <p>Review of Resident #3's controlled substance log for July 2024 revealed there was an entry on 07/10/24 at 4:39pm that 25 tablets of Alprazolam 0.25mg for Resident #3 were received by the facility.</p> <p>Interview with Resident #3 on 09/20/24 at 9:10am revealed: -She had not noticed that she missed any doses of anxiety medication. -Her anxiety and tremors were doing better. -If she had any concerns about her medication not being administered as ordered she would ask a MA, the Resident Care Director(RCD) or her PCP, and she would report her concerns to them.</p> <p>Interview with the RCD on 09/20/24 at 3:20pm revealed: -The MAs should have notified her that Resident #3 missed several doses of Alprazolam due to</p>	D 358		

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D 358	<p>Continued From page 4</p> <p>waiting on the pharmacy.</p> <ul style="list-style-type: none"> -She was not aware the resident had missed several doses until yesterday (09/19/24). -MAs should triple check the physician's order, with the eMAR, and prescribing information on the multidose pack of medications or on the prescription bottle. -When Resident #3 was out of Alprazolam due to waiting on pharmacy, she or the MA should have contacted the facility's contracted back up pharmacy to ensure the resident had her medication. <p>Interview with the Administrator on 09/20/24 at 3:40pm revealed:</p> <ul style="list-style-type: none"> -The MAs should have notified the facility's contracted back up pharmacy to request the Resident #3's medication. -The MAs should have notified the RCD and the Administrator that the facilities contracted pharmacy had not delivered the resident's medication. -She expected the MAs to ensure residents received their medications as ordered. <p>Interview with Resident #3's primary care provider (PCP) on 09/20/24 at 11:38am revealed:</p> <ul style="list-style-type: none"> -Resident #3 was prescribed Alprazolam 0.25mg, take 5 times a day for anxiety and tremors. -She had prescribed a small dosage to help with the resident's anxiety and tremors. -Resident #3 should not miss any doses of her Alprazolam to prevent anxiety. -The resident's had more frequent and more intense anxiety when she did not receive her Alprazolam. -She knew that Resident #3 missed several doses of Alprazolam due to an issue with the facility's contracted pharmacy but was not aware of the specifics. 	D 358		

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D 358	<p>Continued From page 5</p> <p>2. Review of Resident #5's current FL-2 dated 08/13/24 revealed diagnoses included atrial fibrillation, urinary incontinence and congestive heart failure.</p> <p>Review of Resident #5's current assessment and care plan dated 09/09/24 revealed: -She required extensive assistance from staff for toileting and dressing. -She was totally dependant on staff for eating, ambulation, bathing grooming and transfer.</p> <p>Review of a physician's order for Resident #5 dated 08/29/24 revealed acetaminophen 325mg, 2 tablets were to be administered every 8 hours for pain and may hold if asleep. (Acetaminophen is a medication used to treat pain.)</p> <p>Observation of the 8:00am medication pass on 09/18/24 revealed: -A multidose pack of 13 tablets which included 4 acetaminophen 325mg tablets was crushed and placed in pudding at 8:42am for Resident #5. -The medication attempted to administer the medication to Resident #5 at 8:50am however Resident #5 took a small bite and refused her the rest of the medication.</p> <p>Review of Resident #5's electronic medication administration record (eMAR) for August 2024 revealed: -There was a computerized entry for acetaminophen 325mg, 2 tablets to be administered every 8 hours for pain and may hold while asleep which began on 08/29/24. -The acetaminophen was scheduled scheduled for 8:00am, 8:00am and 2:00pm. -There was documentation acetaminophen 325mg, 2 tablets was administered on 08/30/24</p>	D 358		

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D 358	<p>Continued From page 6</p> <p>at 8:00am.</p> <p>-There was documentation acetaminophen 325mg, 2 tablets was not administered on 08/31/24 at 8:00am because Resident #5 refused the medication.</p> <p>Review of Resident #5's eMAR for September 2024 revealed:</p> <p>-There was a computerized entry for acetaminophen 325mg, 2 tablets to be administered every 8 hours for pain and may hold while asleep.</p> <p>-The acetaminophen was scheduled scheduled for 8:00am, 8:00am and 2:00pm.</p> <p>-There was documentation acetaminophen 325mg, 2 tablets was administered at 8:00am on 09/01/24, 09/03/24, 09/05/24 through 09/07/24, 09/11/24 and on 09/13/24.</p> <p>-There was documentation acetaminophen 325mg, 2 tablets was not administered at 8:00am on 09/02/24, 09/04/24, 09/08/24, through 09/10/24 and on 09/12/24 because Resident #5 refused the medication.</p> <p>-There was an "x" in the block for administration for each dose from 2:00pm on 09/13/24 through 09/18/24.</p> <p>Observation of medications on hand for Resident #5 on 09/18/24 at 1:17pm revealed:</p> <p>-Resident #5's medications were dispensed in a multi-dose package.</p> <p>-There were instructions for each medication that was dispensed in the individual dose packs attached to the instructions; There were instructions for acetaminophen 325mg, 2 tablets to be administered every 8 hours for pain and may hold while asleep.</p> <p>-There were individual dose packs labeled to be administered in the morning, midday and evening , the name of the medication, dosage and</p>	D 358		

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D 358	<p>Continued From page 7</p> <p>number of tablets for each medication within the packet; there were 4 tablets of acetaminophen 325mg in the morning dose pack and 2 tablets of acetaminophen 325mg in the midday dose pack.</p> <p>Interview with the medication aide (MA) on 09/18/24 at 1:17pm revealed: -She knew there were 4 tablets of acetaminophen in the dose pack to be administered to Resident #5 in the mornings. -Four acetaminophen tablets were crushed to be administered that morning for Resident #5. -She compared the multidose pack to the eMAR prior to administering the medications but she missed seeing the difference in the quantity to be administered.</p> <p>Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/20/24 at 1:48pm revealed: -Medication orders and administration times are entered onto the eMAR by the pharmacy. -Administration times for an every 8 hour dosing schedule was 12:00am, 8:00am and 2:00pm and she did not know how the times were on the eMAR for 8:00am twice and 2:00pm for Resident #5's acetaminophen. -Once medications were entered onto the eMAR by the pharmacy, the facility was responsible for verifying the order and approving the order so the medication could be administered. -Medication orders should not be approved by the facility if it is not correct including scheduled times. -The scheduled administration times were corrected on 09/19/24 after receiving a call from the facility. -The maximum daily dose of acetaminophen is 4gm (4,000mg) daily but is typically lower for elderly people.</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>-Too much acetaminophen can impact liver function.</p> <p>Interview with Resident #5's primary care provider (PCP) on 09/20/24 at 11:38am revealed: -She expected acetaminophen 650mg to be administered to Resident #5 every 8 hours to adequately control her pain. -1300mg of acetaminophen should not be administered in one dose because it could cause liver damage.</p> <p>Interview with the Resident Care Director (RCD) on 09/18/24 at 1:30pm revealed: -A MA brought it to her attention the previous week that there was a discrepancy in the the dispensing of Resident #5's acetaminophen. -She placed an alert sticker on the multi-dose pack and called the pharmacy about the issue. -Medication batches were sent weekly and the current medications on hand were a new batch from the previous week so there was no alert sticker.</p> <p>Second interview with the RCD on 09/20/24 at 3:14pm revealed: -New orders were faxed to the pharmacy to be entered onto the eMAR. -She was responsible for approving the medications once they were entered by pharmacy so they could be administered. -She thought the pharmacy corrected the problem when she called them the previous week so she did not check the new batch to ensure the medication was dispensed correctly.</p> <p>Interview with the Administrator on 09/20/24 at 3:14pm revealed: -Resident #5 complained of pain typically during incontinence care.</p>	D 358		

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D 358	<p>Continued From page 9</p> <p>-MAs were expected to compare the medication to be administered with the eMAR prior to administration of a medications and medications should be administered as ordered.</p> <p>-MAs should catch any dispensing issues prior to the administration of medications and report the issue to the RCD.</p> <p>3. Review of Resident #4's current FL-2 dated 05/29/24 revealed diagnoses included chronic kidney disease edema and venous insufficiency.</p> <p>Review of Resident #4's current care plan dated 05/20/24 revealed:</p> <p>-She required limited assistance from staff for eating and toileting.</p> <p>-She required extensive assistance from staff for grooming and transfers.</p> <p>-She was totally dependant on staff for ambulation, bathing and dressing.</p> <p>Review of Resident #4's electronic medication administration record (eMAR) for August 2024 revealed:</p> <p>-There was a computerized entry for linezolid 600mg to be administered every 12 hours for 14 days and was scheduled for 8:00am and 8:00pm beginning at 8:00pm on 08/21/24.</p> <p>-There was documentation linezolid 600mg was administered at 8:00am on 08/22/24 through 08/29/24 and at 8:00pm on 08/21/24, 08/23/24 through 08/26/24.</p> <p>-There was documentation linezolid 600mg was not administered 8:00pm on 08/22/24 and on 08/27/24 through 08/28/24 because the resident was asleep.</p> <p>-The administration times changed to 7:00am and 7:00pm on 08/29/24.</p> <p>-There was documentation linezolid 600mg was administered at 7:00am on 08/30/24 and at</p>	D 358		

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D 358	<p>Continued From page 10</p> <p>7:00pm on 08/29/24 through 08/30/24. -There were a total of 16 doses administered out of 19 possible doses for the month of August 2024.</p> <p>Review of Resident #4's eMAR for September 2024 revealed: -There was a computerized entry for linezolid 600mg to be administered every 12 hours for 14 days and was scheduled for 7:00am and 7:00pm -There was documentation linezolid 600mg was administered at 7:00am and 7:00pm on 09/01/24 through 09/04/24 for a total of 8 doses. -There was an "x" in each block beginning 09/05/24 at 7:00am. -There was a total of 24 out of 28 scheduled doses documented as administered to Resident #4 in August and September.</p> <p>Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/20/24 at 1:48pm revealed: -They received an order for Resident #4 to administered linezolid 600mg to be administered every 12 hours for 14 days on 08/20/24. - Linezolid 600mg, 8 tablets were dispensed on 08/20/24 and 20 tablets were dispensed on 08/22/24. - Linezolid was an antibiotic that treats infection but it was rarely used because it was very expensive and typically reserved for treatment of bacteria that was resistant to other antibiotics treatments.</p> <p>Telephone interview with Resident #4's primary care provider (PCP) on 09/20/24 at 11:38am revealed: -Resident #4 had a urine analysis with abnormal values and a urine culture was performed. -She was surprised when the urine culture</p>	D 358		

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D 358	<p>Continued From page 11</p> <p>showed VRE and she began treatment with linezolid 600mg for 14 days.</p> <p>Interview with the RCD on 09/20/24 at 3:14pm revealed there were extra doses left after the linezolid 600mg was completed on the eMAR because the MA did not administer the medication when Resident #4 was asleep.</p> <p>Interview with the Administrator on 09/20/24 at 3:14pm revealed: -She was not aware Resident #4 was not administered linezolid as ordered. -Some of the MAs thought it was a resident rights concern to wake a resident up to administer medications when they were sleeping. -Residents should be administered medications as ordered even if they are asleep.</p>	D 358		
D 367	<p>10A NCAC 13F .1004(j) Medication Administration</p> <p>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,</p>	D 367		

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NAME OF PROVIDER OR SUPPLIER THE VIRIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 3003 WATERSCAPE WAY NEW BERN, NC 28562
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D 367	<p>Continued From page 12</p> <p>(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).</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 2 of 5 sampled residents (#4, #5) related to a medication used to treat infection (#4) and a medication used to control pain (#5).</p> <p>The findings are:</p> <p>1. Review of Resident #4's current FL-2 dated 05/29/24 revealed diagnoses included chronic kidney disease edema and venous insufficiency.</p> <p>Review of Resident #4's current care plan dated 05/20/24 revealed: -She required limited assistance from staff for eating and toileting. -She required extensive assistance from staff for grooming and transfers. -She was totally dependant on staff for ambulation, bathing and dressing.</p> <p>Review of Resident #4's electronic medication administration record (eMAR) for August 2024 revealed: -There was a computerized entry for linezolid 600mg to be administered every 12 hours for 14 days and was scheduled for 8:00am and 8:00pm beginning at 8:00pm on 08/21/24. -There was documentation linezolid 600mg was administered at 8:00am on 08/22/24 through 08/29/24 and at 8:00pm on 08/21/24, 08/23/24 through 08/26/24.</p>	D 367		

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D 367	<p>Continued From page 13</p> <ul style="list-style-type: none"> -There was documentation linezolid 600mg was not administered 8:00pm on 08/22/24 and on 08/27/24 through 08/28/24 because the resident was asleep. -The administration times changed to 7:00am and 7:00pm on 08/29/24. -There was documentation linezolid 600mg was administered at 7:00am on 08/30/24 and at 7:00pm on 08/29/24 through 08/30/24. -There were a total of 16 doses administered out of 19 possible doses for the month of August 2024. <p>Review of Resident #4's eMAR for September 2024 revealed:</p> <ul style="list-style-type: none"> -There was a computerized entry for linezolid 600mg to be administered every 12 hours for 14 days and was scheduled for 7:00am and 7:00pm -There was documentation linezolid 600mg was administered at 7:00am and 7:00pm on 09/01/24 through 09/04/24 for a total of 8 doses. -There was an "x" in each block beginning 09/05/24 at 7:00am. -There was a total of 24 out of 28 scheduled doses documented as administered to Resident #4 in August and September. <p>Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/20/24 at 1:48pm revealed:</p> <ul style="list-style-type: none"> -They received an order for Resident #4 to administered linezolid 600mg to be administered every 12 hours for 14 days on 08/20/24. - Linezolid 600mg, 8 tablets were dispensed on 08/20/24 and 20 tablets were dispensed on 08/22/24. - Linezolid was an antibiotic that treats infection but it was rarely used because it was very expensive and typically reserved for treatment of bacteria that was resistant to other antibiotics 	D 367		

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D 367	<p>Continued From page 14</p> <p>treatments.</p> <p>Telephone interview with Resident #4's primary care provider (PCP) on 09/20/24 at 11:38am revealed:</p> <ul style="list-style-type: none"> -Resident #4 had a urine analysis with abnormal values and a urine culture was performed. -She was surprised when the urine culture showed VRE and she began treatment with linezolid 600mg for 14 days with good results according to a follow-up urinalysis. <p>Interview with the RCD on 09/20/24 at 3:14pm revealed:</p> <ul style="list-style-type: none"> -There were extra doses left after the linezolid 600mg was completed on the eMAR. -She took the doses of the medication to the medication aide each day so it could be administered. -She ensured all 28 doses of linezolid 600mg were administered to Resident #4. -She should have called Resident #4's PCP but it was easier just to have the medication administered until it was completed. <p>Refer to interview with the Administrator on 09/20/24 at 3:14pm.</p> <p>2. Review of Resident #5's current FL-2 dated 08/13/24 revealed diagnoses included atrial fibrillation, urinary incontinence and congestive heart failure.</p> <p>Review of a physician's order for Resident #5 dated 08/29/24 revealed acetaminophen 325mg, 2 tablets were to be administered every 8 hours for pain and may hold if asleep. (Acetaminophen is a medication used to treat pain.)</p> <p>Observation of the 8:00am medication pass on</p>	D 367		

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D 367	<p>Continued From page 15</p> <p>09/18/24 revealed: -A multidose pack of 13 tablets which included 4 acetaminophen 325mg tablets was crushed and placed in pudding at 8:42am for Resident #5. -The medication attempted to administer the medication to Resident #5 at 8:50am however Resident #5 took a small bite and refused her the rest of the medication.</p> <p>Review of Resident #5's electronic medication administration record (eMAR) for August 2024 revealed: -There was a computerized entry for acetaminophen 325mg, 2 tablets to be administered every 8 hours for pain and may hold while asleep which began on 08/29/24. -The acetaminophen was scheduled scheduled for 8:00am, 8:00am and 2:00pm. -There was documentation acetaminophen 325mg, 2 tablets was administered on 08/30/24 at 8:00am. -There was documentation acetaminophen 325mg, 2 tablets was not administered on 08/31/24 at 8:00am because Resident #5 refused the medication.</p> <p>Review of Resident #5's eMAR for September 2024 revealed: -There was a computerized entry for acetaminophen 325mg, 2 tablets to be administered every 8 hours for pain and may hold while asleep. -The acetaminophen was scheduled scheduled for 8:00am, 8:00am and 2:00pm. -There was documentation acetaminophen 325mg, 2 tablets was administered at 8:00am on 09/01/24, 09/03/24, 09/05/24 through 09/07/24, 09/11/24 and on 09/13/24. -There was documentation acetaminophen 325mg, 2 tablets was not administered at 8:00am</p>	D 367		

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D 367	<p>Continued From page 16</p> <p>on 09/02/24, 09/04/24, 09/08/24, through 09/10/24 and on 09/12/24 because Resident #5 refused the medication.</p> <p>-There was an "x" in the block for administration for each dose from 2:00pm on 09/13/24 through 09/18/24 and no documentation of administration.</p> <p>-There was no documentation Resident #5 refused her acetaminophen on 09/18/24 at 8:00am.</p> <p>Interview with the medication aide (MA) on 09/18/24 at 1:17pm revealed:</p> <p>-She knew there were 4 tablets of acetaminophen in the dose pack to be administered to Resident #5 in the mornings.</p> <p>-Four acetaminophen tablets were crushed to be administered that morning for Resident #5.</p> <p>-She compared the multidose pack to the eMAR prior to administering the medications but she missed seeing the difference in the quantity to be administered.</p> <p>-She thought she documented all medications as refused that morning including the acetaminophen.</p> <p>Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/20/24 at 1:48pm revealed:</p> <p>-Medication orders and administration times are entered onto the eMAR by the pharmacy.</p> <p>-Administration times for an every 8 hour dosing schedule was 12:00am, 8:00am and 2:00pm and she did not know how the times were on the eMAR for 8:00am twice and 2:00pm for Resident #5's acetaminophen.</p> <p>-Once medications were entered onto the eMAR by the pharmacy, the facility was responsible for verifying the order and approving the order so the medication could be administered.</p> <p>-An "x" in the documentation box does not allow</p>	D 367		

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D 367	<p>Continued From page 17</p> <p>for the documentation of medication administration; Either the medication is discontinued or is waiting for the facility to take action such as verification.</p> <p>Telephone interview with Resident #5's primary care provider (PCP) on 09/20/24 at 11:38am revealed: -She expected acetaminophen 650mg to be administered to Resident #5 every 8 hours to adequately control her pain. -eMARs needed to accurately reflect what medications are being administered and when in case she needed to adjust treatment for a resident.</p> <p>Interview with the Resident Care Director (RCD) on 09/18/24 at 1:30pm revealed: -A MA brought it to her attention the previous week that there was a discrepancy in the the dispensing of Resident #5's acetaminophen and she called the pharmacy. -She placed an alert sticker on the multi-dose pack and called the pharmacy about the issue. -Medication batches were sent weekly and the current medications on hand were a new batch from the previous week so there was no alert sticker.</p> <p>Second interview with the RCD on 09/20/24 at 3:14pm revealed: -New orders were faxed to the pharmacy to be entered onto the eMAR. -She was responsible for approving the medications once they were entered by pharmacy so they could be administered. -She thought the pharmacy corrected the problem when she called them the previous week so she did not check the new batch to ensure the mediation was dispensed correctly.</p>	D 367		

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D 367	<p>Continued From page 18</p> <p>-She had not had an opportunity to look for medications that needed to be verified since calling the pharmacy regarding Resident #5's acetaminophen order so it was still showing that it was awaiting verification on the eMAR and could not be documented as administered.</p> <p>Refer to interview with the Administrator on 09/20/24 at 3:14pm.</p> <p>Interview with the Administrator on 09/20/24 at 3:14pm revealed:</p> <p>-MAs were expected to compare the medication to be administered with the eMAR prior to administration of a medications and medications should be administered as ordered.</p> <p>-Medications that required verification could not be documented as administered on the eMAR.</p> <p>-It was important for the eMAR to reflect a clear picture of what medications are administered to help guide providers when changes to treatment were needed.</p>	D 367		