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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 02/25/25 through 02/27/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 5 sampled residents (#1 ,#3 ,#4 ,and #5) were tested for Tuberculosis (TB) disease upon admission. The findings are: 1. Review of Resident #1's current FL2 dated 01/12/25 revealed: -Diagnoses included acute & chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, hypertension, diabetes mellitus type 2, bipolar disorder, anxiety, end stage renal disease, renal dialysis, and hyperlipidemia.	D 234		

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-Recommended level of care was documented as assisted living facility.

Review of Resident #1's Resident Register revealed an admission date on 01/06/25.

Review of Resident #1's record revealed:
-There was no documentation a tuberculosis (TB) test was completed since Resident #1 was admitted to the facility.
-There was a chest x-ray completed for Resident #1 on 12/29/24 at a local hospital emergency department (ED) for shortness of breath and diagnosed with multifocal airspace disease and emphysema.
-There was no documentation on Resident #1's chest x-ray to confirm or deny the presence of TB.

Interview with Resident #1 on 02/26/25 at 10:54am revealed she could not remember anyone completing a TB skin test on her when she was admitted.

Interview with the Health and Wellness Director (HWD) on 02/25/25 at 3:00pm revealed:
-Resident #1 had an "expedited" admission on 01/06/25 from a local hospital.
-Resident #1 had a chest x-ray completed in the hospital and she called the case manager from the hospital after Resident #1 was admitted to see if an attestation could be added to the chest x-ray documenting Resident #1 did not have TB.
-The attestation documenting Resident #1 did not have TB was never faxed to the facility.
-She did not follow up with the hospital case manager.
-The Sales Director was responsible for administering the 1st step TB skin test on admission.

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-She was responsible for administering a 2nd step TB skin test to residents after admission but missed completing Resident #1's TB skin test because the previous Administrator assembled Resident #1's record and did not let anyone know the TB test was not completed.

Interview with the Administrator on 02/27/25 at 11:57am revealed:
-She expected TB tests to be completed upon admission to the facility and a second step should be completed and documented within the allotted time frame.
-The Sales Director and HWD were responsible for administering a 2 step TB skin test to residents.
-She and the HWD were responsible for ensuring TB tests were completed.
-The Resident Care Coordinator (RCC) and the HWD should audit records to make sure there were no missed TB skin tests.

2. Review of Resident #3's current FL2 dated 01/25/24 revealed:
-There were no diagnoses listed on the FL2.
-The FL2 was illegible.

Review of a physician's order dated 08/29/24 revealed diagnoses included type 2 diabetes, epilepsy, sleep apnea, liver disease, lower back pain, and pain unspecified hip.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 01/30/24.

Review of Resident #3's record revealed:
-There was a report of a tuberculosis (TB) screening evaluation dated 01/22/24.
-The report showed the first TB test was

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completed 01/25/24.
-There was no record of the second step TB test being completed.

Interview with the Health and Wellness Director (HWD) on 02/27/25 at 10:34am revealed:
-Resident #3 was admitted toward the end of January 2024 and she had just started at that time and was in training.
-She was never told a second step TB test needed to be completed on Resident #3.

Interview with the Administrator on 02/27/25 at 11:57am revealed:
-She expected TB tests to be completed upon admission to the facility and a second step should be completed and documented within the allotted time frame.
-She and the HWD were responsible for ensuring TB tests were completed.
-She was not sure why Resident #3 did not have a second step TB test completed because she came in March 2024 and Resident #3 was admitted in January 2024.
-The Resident Care Coordinator (RCC) and the HWD should be looking at records and catching missed TB tests.

3. Review of Resident #4's current FL2 dated 08/01/24 revealed diagnoses included vascular dementia, anemia, atrial fibrillation, failure to thrive, and malnutrition.

Review of Resident #4's Resident Register revealed an admission date on 08/07/24.

Review of Resident #4's record revealed:
-The 1st step tuberculosis (TB) skin test was administered on 09/03/24 and read as 0mm (negative) on 09/05/24.

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D 234	Continued From page 4 -There was no documentation of a 2nd step TB skin test completed for Resident #4. Interview with the Health and Wellness Director (HWD) on 02/27/25 at 9:05am revealed: -The Sales Director was responsible for administering the 1st step TB skin test on admission. -She administered the 2nd step TB skin test to the residents. -She was responsible for making sure all the residents' TB tests were completed. -She started working at the facility in February 2024 and had not checked all the residents' records to make sure TB skin tests were completed. -She started a new tracking system in the computer system in January 2025 to make sure residents' records were up to date including checking to make sure all the residents had either a chest x-ray or 2 step TB skin test completed upon admission. -She had not had time since she started the tracking system to check and see if Resident #4 had both TB skin test completed on admission. Interview with the Administrator on 02/27/25 at 11:57am revealed: -She expected TB tests to be completed upon admission to the facility and a second step should be completed and documented within the allotted time frame. -The Sales Director and HWD were responsible for administering a 2 step TB skin test to residents. -She and the HWD were responsible for ensuring TB tests were completed. -The Resident Care Coordinator (RCC) and the HWD should audit records to make sure there were no missed TB skin tests.	D 234		

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D 234	Continued From page 5 Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable. 4. Review of Resident #5's current FL2 dated 12/05/24 revealed: -Diagnoses included diabetes mellitus type 2, neoplasm of the prostate, chronic gout, and abnormalities of gait and mobility. -Recommended level of care was documented as domiciliary. Review of Resident #5's Resident Register revealed: -There was no admission date documented on the register. -Resident #5 signed and dated the document on 06/30/23. Review of Resident #5's record revealed: -The 1st step tuberculosis (TB) skin test was administered on 07/05/23 and read as 0mm (negative) and no read date documented. -There was no documentation of a 2nd step TB skin test completed for Resident #5. Interview with Resident #5 on 02/27/25 at 9:18am revealed: -He was admitted to the facility after he fell at home a couple of years ago and hurt his back. -He could not remember if he had a 2-step TB skin test completed when he was admitted. Interview with the Health and Wellness Director (HWD) on 02/27/25 at 9:05am revealed: -The Sales Director was responsible for administering the 1st step TB skin test on admission. -She administered the 2nd step TB skin test to	D 234		

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D 234	Continued From page 6 the residents. -She was responsible for making sure all the residents' TB tests were completed. -She started working at the facility in February 2024 and had not checked all the residents' records to make sure TB skin tests were completed. -She started a new tracking system in the computer system in January 2025 to make sure residents' records were up to date including checking to make sure all the residents had either a chest x-ray or 2 step TB skin test completed upon admission. -She had not had time since she started the tracking system to check and see if Resident #5 had both TB skin tests completed on admission. Interview with the Administrator on 02/27/25 at 11:57am revealed: -She expected TB tests to be completed upon admission to the facility and a second step should be completed and documented within the allotted time frame. -The Sales Director and HWD were responsible for administering 2-step TB skin tests to residents. -She and the HWD were responsible for ensuring TB tests were completed. -The Resident Care Coordinator (RCC) and the HWD should audit records to make sure there were no missed TB skin tests.	D 234		
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.	D 273		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#7) related to failing to inform a primary care provider (PCP) of verbal aggression directed toward other residents and a psychiatric nurse practitioner (NP) of verbal aggression and intoxication.

The findings are:

Review of Resident #7's current FL2 dated 04/01/24 revealed diagnoses included hypertension, anemia, transient cerebral ischemic attack, type 2 diabetes, substance abuse, aphasia, and atherosclerotic heart disease.

Review of progress notes dated 06/16/24 through 12/24/24 revealed:
-On 06/16/24, Resident #7 had been aggravating other residents, going to other resident rooms, and another resident complained of Resident #7 and stated he felt threatened by Resident #7.
-On 07/14/24, Resident #7 was harassing other residents, calling them racial names.
-On 07/19/24, Resident #7 was harassing other residents, calling them racial names and threatening to hit other residents with his cane.
-On 08/06/24, Resident #7 stole snacks from his roommate and was displaying bullying behaviors and attempted to start arguments.
On 08/06/24, Resident #7's roommate complained of being afraid to go to sleep.
-On 08/25/24, Resident #7 had gone out with a friend and when he returned to facility, he had a strong alcohol smell.
-On 09/08/24, Resident #7 left facility with a friend

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and when he returned he smelled like alcohol.
-On 10/20/24, Resident #7 started displaying more aggression.
-On 10/21/24, Resident #7 had increased aggression and agitation and got in another resident's face and yelled.
-On 11/05/24, Resident #7 was intoxicated and was verbally abusive toward roommate, police were called.
-On 11/16/24, Resident #7 was intoxicated and threatening roommate, police were called.
-On 11/29/24, Resident #7 attempted to get into another resident's room.
-On 12/24/24, Resident #7 passed out due to intoxication.

Review of Psychiatry Initial Visit note dated 11/21/24 revealed:
-Resident #7 was initially evaluated for chronic mood disorder.
-Resident #7 denied any problems or issues.
-Resident #7 had been compliant with medications and staff requests.
-Resident #7 had a past history of illegal drug use.
-Resident #7 denied any new or acute psychiatric complaints during the examination.
-Interventions included continuing Depakote Sprinkles 125 mg, BID, monitor and document any associated side effects, evidence of psychosis and/or changes in mental status, mood, behavior, sleep, or appetite, continue psychotherapy services, continue to encourage participation in recreational activities, and continue ongoing supportive/behavioral strategies currently implemented by staff.

Review of a Psychiatry follow-up note dated 02/13/25 revealed:
-Resident #7 had a follow-up for chronic mood

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disorder.
-Resident #7 denied any problems or issues.
-Resident #7 had been compliant with medications and staff requests.
-Resident #7 had a history of illegal drug use.
-Resident #7 denied any new or acute psychiatric complaints during the examination.
-No emotional or behavioral outbursts have been noted since prior encounter.
-Interventions included continuing Depakote Sprinkles 125 mg, BID, monitor and document any associated side effects, evidence of psychosis and/or changes in mental status, mood, behavior, sleep, or appetite, continue psychotherapy services, continue to encourage participation in recreational activities, and continue ongoing supportive/behavioral strategies currently implemented by staff.

Interview with a resident on 02/26/25 at 8:43am revealed:
-He reported verbal threats from Resident #7 that had been going on for 4 months.
-Resident #7 told him he was going to beat his head open "to the white meat."
-He had heard him threaten other residents and police had been called.
-He has had verbal threats from Resident #7 for around 4 months.
-Resident #7 lifted his cane at him, but had never hit him.
-He had been unable to sleep at night sometimes.
-He reported Resident #7's behavior to the Administrator and Health and Wellness Director (HWD).

Interview with another resident on 02/26/25 at 9:46am revealed:
-He had gotten into verbal arguments with Resident #7 3 to 4 times in the last 3 months.

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D 273	Continued From page 10 -When Resident #7 first arrived at the facility, he grabbed his wrists and when he asked him why he grabbed his wrist, Resident #7 said he thought he had his fists balled up and he grabbed his wrists so he would not hit him. Interview with the Primary Care Provider (PCP) on 02/27/25 at 2:32pm revealed: -She was not aware Resident #7 had been verbally threatening toward other residents. -She was aware Resident #7 had left the facility and drank alcohol and had come back to the facility intoxicated on several occasions. -She was aware he was seeing psychiatric services. -Psychiatric services prescribed Depakote for mood stabilization. -She did not think he should be taking Depakote and mixing with alcohol. -She expected staff to notify her of any verbal threats made by residents to other residents. Interview with the Psychiatric Nurse Practitioner (NP) on 02/27/25 at 2:41pm revealed: -He had seen Resident #7 twice with his initial assessment completed on 11/21/2024 and a follow-up visit on 02/13/25. -He once overheard a housekeeping staff member say Resident #7 had been verbally aggressive but had not been told by anyone directly and did not ask the housekeeping staff about what he overheard. -He was not aware Resident #7 would leave the facility and return intoxicated. -He received no reports of verbal aggression/threats to other residents. -He had no knowledge of police being called to the facility for Resident #7. -He did not think alcohol and Depakote should be taken together.	D 273		

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-He would need to have labs done to check Resident #7's liver functioning to assess if he needed to stop any of the medications.
-He would have put Resident #7 on an antipsychotic medication if he had known about his behavior.
-He expected staff to notify him of any behaviors of verbal threats or aggression and intoxication.

Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 9:19am revealed:
-She was aware Resident #7 had made verbal threats to other residents, had come back to the facility intoxicated on several occasions, and the police had been called out a couple times for threatening behaviors.
-She did not know if the physician was informed of Resident #7's behaviors.
-The physician's "sometimes" were notified about incidents with verbal aggression.
-Physician's usually not notified unless the resident becomes physically aggressive.

Interview with the Health and Wellness Director (HWD) on 02/27/25 at 10:34pm revealed:
-She was aware that Resident #7 had made verbal threats to other residents.
-She did not report any of Resident #7's behaviors to the physician because she did not think she needed to for verbal threats or when police were called.
-She had only been told to notify physicians about falls, elopements, and injuries.

Interview with the Administrator on 02/27/25 at 11:57am revealed:
-She was aware of Resident #7 returning to the facility intoxicated after leaving facility with friends/family.
-She was aware the police were called out one

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D 273	Continued From page 12 time for Resident #7 when he was verbalizing threats. -She was not aware of police being called out more than once. -She was aware Resident #7 had made threats to another resident, threatening to hit him with his cane. -She expected the HWD and the RCC to inform the physicians of any behavior's residents have including verbal threats, intoxication, and when police were called out.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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 observations, interviews, and record reviews, the facility failed to ensure clarification or verification of medication orders for 1 of 5 sampled residents (#5) for an anticoagulant, a medication to treat elevated blood sugar levels, iron supplement, a stool softener, a medication to treat acid reflux, and an opioid pain medication.	D 344		

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D 344	Continued From page 13 The findings are: Review of the facility's policy and procedures for self-administration of medications dated 08/2023 revealed: -Any resident desiring to self-administer medications would be evaluated by a nurse who would complete an initial, quarterly, or with a change of condition self-administration of medications assessment form. -An order for self-administration from the resident's primary care provider (PCP) would be obtained. Review of Resident #5's current FL2 dated 12/05/24 revealed: -Diagnoses included atrial fibrillation, diabetes mellitus type 2, anemia, constipation, gastroesophageal reflux disease, and neoplasm of the prostate. -There was an order for warfarin (used to treat an irregular heart rate causing poor blood flow) 2.5mg take 1 tablet every evening on Mondays, Wednesdays, and Fridays. -There was an order for warfarin 5mg take 1 tablet every evening on Tuesdays, Thursdays, Saturdays, and Sundays. -There was an order for metformin (used to treat elevated blood glucose levels) 500mg take 1 tablet daily. -There was an order for Poly-iron (used to treat anemia) 150mg take 1 tablet twice daily. -There was an order for Colace (used to soften the stool) 100mg take 1 capsule twice daily. -There was an order for pantoprazole (used to treat acid reflux) 40mg take 1 tablet twice daily. -There was no order to self-administer medications.	D 344		

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Review of Resident #5's physician's order dated 10/09/23 revealed there was an order for Resident #5 to self-administer medications.

Review of Resident #5's quarterly self-administration of medications review and assessment dated 12/03/24 revealed:
-There was documentation of no change in medications since the previous self-administration medication review and assessment.
-There was documentation that there was an order for Resident #5 to self-administer medications.
-There was documentation that Resident #5 was approved to self-administer medications.
-The review and assessment were completed by the Resident Care Coordinator (RCC).

Observation of Resident #5's medications on hand in Resident #5's room on 02/27/25 at 9:15am revealed:
-There was a bottle containing warfarin 5mg tablets take 1 tablet daily with a dispense date on 02/02/25.
-There was no metformin available for administration.
-There was no Poly-iron available for administration.
-There was no Colace available for administration.
-There was no pantoprazole available for administration.
-There was a bottle containing acetaminophen with codeine #3 (an opioid pain medication to treat pain) 300mg-30mg take 1 tablet every 4-6 hours as needed for pain with a dispense date on 02/14/25 in the quantity of 16 tablets with 14 tablets remaining in the bottle (there was no order for acetaminophen with codeine #3 in Resident

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D 344	Continued From page 15 #5's record). Interview with Resident #5 on 02/27/25 at 9:15am revealed: -He self-administered his own medications every day. -The order for the warfarin regimen dated 12/05/24 was "old news" and he took warfarin 5mg daily. -His metformin, Poly-iron, Colace, and pantoprazole were discontinued by his PCP, and he no longer took those medications. -His PCP told him at his office appointments what medications to take every day. -He was recently prescribed the acetaminophen with codeine #3 for tooth pain. Review of Resident #5's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin 2.5mg take 1 tablet every Sunday at 7:00am with no documentation of administration and the reason was documented as unknown, self-administered on 01/05/25, 01/12/25, 01/19/25, and 01/26/25 at 7:00am. -There was an entry for warfarin 2.5mg take 2 tablets every Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday at 5:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 01/01/25-01/04/25, 01/06/25-01/11/25, 01/13/25-01/18/25, 01/20/25-01/25/25, and 01/27/25-01/31/25. -There was an entry for metformin 500mg take 1 tablet daily at 7:00am with no documentation of administration and the reason was documented as unknown, self-administered from 01/01/25-01/31/25. -There was an entry for Poly-Iron 150mg take 1	D 344		

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tablet twice daily at 7:00am and 7:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 01/01/25-01/31/25 at 7:00am and 7:00pm.
-There was an entry for Colace 100mg take 1 capsule twice daily at 7:00am and 7:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 01/01/25-01/31/25 at 7:00am and 7:00pm.
-There was an entry for pantoprazole 40mg take 1 tablet twice daily at 7:00am and 7:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 01/01/25-01/31/25 at 7:00am and 7:00pm.

Review of Resident #5's 02/01/25-02/25/25 eMAR revealed:
-There was an entry for warfarin 2.5mg take 1 tablet every Sunday at 7:00am with no documentation of administration and the reason was documented as unknown, self-administered on 02/02/25, 02/09/25, 02/16/25, and 02/23/25 at 7:00am.
-There was an entry for warfarin 2.5mg take 2 tablets every Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday at 5:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 02/01/25, 02/03/25-02/08/25, 02/10/25-02/15/25, 02/17/25-02/22/25, and 02/24/25-02/25/25 at 5:00pm.
-There was an entry for metformin 500mg take 1 tablet daily at 7:00am with no documentation of administration and the reason was documented as unknown, self-administered from 02/01/25-02/25/25 at 7:00am.
-There was an entry for Poly-Iron 150mg take 1 tablet twice daily at 7:00am and 7:00pm with no documentation of administration and the reason

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was documented as unknown, self-administered from 02/01/25-02/25/25 at 7:00am and 7:00pm.
-There was an entry for Colace 100mg take 1 capsule twice daily at 7:00am and 7:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 02/01/25-02/25/25 at 7:00am and 7:00pm.
-There was an entry for pantoprazole 40mg take 1 tablet twice daily at 7:00am and 7:00pm with no documentation of administration and the reason was documented as unknown, self-administered from 02/01/25-02/25/25 at 7:00am and 7:00pm.
-There was no entry for acetaminophen with codeine #3 (300mg-30mg) take 1 tablet every 4-6 hours as needed for pain.

Review of Resident #5's physician's orders revealed there was no documentation or orders to indicate Resident #5's warfarin, metformin, Poly-iron, Colace, pantoprazole, or acetaminophen with codeine #3 was clarified with the PCP.

Interview with a medication aide (MA) on 02/27/25 at 9:38am revealed:
-She never asked Resident #5 what medications he self-administered.
-She did not document Resident #5's medications as self-administered on the eMAR because the system would not allow the user to document any medications for Resident #5.
-She was trained that she did not have to verify that the resident took their medications or what medications the resident self-administered when a resident had an order to self-administer.

Interview with the RCC on 02/27/25 at 9:10am and 9:47am revealed:
-Resident #5 drove himself to all his appointments and did not bring any paperwork

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back to the facility with orders when he went to the PCP.
-She was responsible for contacting a PCP to get copies of the PCP office visits and new or changed medication orders to file in resident records.
-Resident #5's PCP told Resident #5 what dosage of warfarin to take and when to have the next blood lab value drawn to manage the warfarin.
-She and/or the Health and Wellness Director (HWD) were responsible for entering or changing the medication orders on the eMAR but she did not update Resident #5's eMAR because she did not get copies of the orders from Resident #5's PCP.
-She and/or the HWD were responsible for making sure the eMARs were accurate.
-She did not know Resident #5's warfarin dosage was changed by the PCP or that Resident #5 was not self-administering some of his medications.
-She did not know Resident #5 was dispensed acetaminophen with codeine #3 for tooth pain.
-She did not contact Resident #5's PCP to get copies of the medication orders because she thought she did not have to because Resident #5 self-administered his own medications.

Interview with the HWD on 02/27/25 at 10:45am revealed:
-The RCC was responsible for adding new orders to Resident #5's eMAR when new orders were received.
-The RCC made sure Resident #5 knew what medications to self-administer because Resident #5 had an order to self-administer medications.
-Resident #5 was alert and oriented most of the time but had forgetful moments.
-The eMAR system would not let a MA document on the eMAR for any residents with an order to

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self-administer medications.
-She or the RCC contacted Resident #5's PCP to clarify any medication orders.
-She did not contact Resident #5's PCP to clarify medication orders because she did not know that Resident #5 was taking a different dosage of warfarin than what was entered on the eMAR and not taking Poly-iron, Colace, metformin, and pantoprazole.

Telephone interview with a pharmacist from Resident #5's local pharmacy on 02/27/25 at 11:13am revealed:
-Resident #5's warfarin 5mg was last dispensed on 02/02/25 in the quantity of 90 tablets.
-The pharmacy did not dispense Resident #5's warfarin 2.5mg during 2024 or 2025.
-The last order received for Resident #5's warfarin dated 08/16/24 was for 5mg take 1 tablet every evening.
-The pharmacy never received an order for Resident #5's Poly-iron, Colace, or pantoprazole and had never dispensed it to Resident #5.
-The last prescription for Resident #5's metformin was received in April 2024 and the medication was never picked up.
-The pharmacy never dispensed acetaminophen with codeine #3 to Resident #5.

Telephone interview with a medical assistant from Resident #5's PCP office on 02/27/25 at 11:58am revealed:
-Resident #5's current medication orders included warfarin 5mg take 1 tablet daily, Poly-iron 150mg take 1 tablet twice daily, metformin 500mg daily, Colace 100mg take 1 capsule twice daily, and pantoprazole 40mg take 1 tablet twice daily.
-They were not aware Resident #5 was not taking Poly-iron, metformin, Colace, or pantoprazole as ordered.

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-Resident #5's last visit with the PCP was February 2024 and was due for an annual visit.
-Resident #5 had bloodwork drawn at the office to make sure the warfarin was therapeutic, and warfarin was increased to 5mg daily on 11/05/24.
-The office sent all of Resident #5's PCP progress notes including medication orders with Resident #5 after each office visit.
-There was no documentation in the computer system that the facility called to clarify any medication orders or get a copy of the PCP notes faxed to the facility since February 2024.

Interview with the Administrator on 02/27/25 at 12:25pm revealed:
-The RCC and HWD were responsible for completing chart audits to make sure all medication orders and PCP notes with orders were filed in Resident #5's chart.
-The RCC and HWD entered all medication orders into the eMAR system and were responsible for calling Resident #5's PCP to clarify medication orders.
-Resident #5 was assessed quarterly and allowed to self-administer his own medications.
-She was not aware that Resident #5 was taking a different dosage of warfarin than what was entered on the eMAR.
-She was not aware that Resident #5 had stopped self-administering Poly-iron, metformin, Colace, and pantoprazole to himself.
-The MAs did not have to ask Resident #5 if he took his medications since he had orders to self-administer.
-The eMAR system would not allow the MAs to document on Resident #5's eMAR since he self-administered his medications.
-She did not know how the RCC or HWD would know to call and clarify Resident #5's medication orders if the facility did not get a copy from

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D 344	Continued From page 21 Resident #5 when he returned from an office visit and the MAs did not ask Resident #5 if he took the medications scheduled on the eMAR.	D 344		