STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 12/06/2017

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BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted a follow-up survey December 5, 2017 and December 6, 2017.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls and floors in 4 resident rooms (#13, #27, #37 and #40) were clean and in good repair. The findings are: Observation of resident room #27 on 12/5/17 at 10:10am revealed: -There was a recliner chair approximately 10 inches away from the left wall of the room. -The recliner was not reclined. -The wall behind the recliner had multiple indentations, scrapes and gouges, several of which were missing plaster. Observation of the resident in room #27 on 12/5/17 at 10:12am revealed: -He stood up to repositioned himself in the recliner.	{D 074}		

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{D 074}	Continued From page 1 -When he sat down and elevated his feet, the back of the chair struck the wall, creating a golf ball sized depression. Interview with the resident in room #27 on 12/5/17 at 10:13am revealed it was difficult for him not to "just plop into my chair when I sit down. If I don't sit back far enough, I can't get the footrest up." Observation of resident room #15 on 12/5/17 at 10:35am revealed there was a trail of black spots on the carpet beginning at the door to the bathroom and ending in front of a recliner that was in front of the window on the opposite side of the room. Interview with the resident of room #15 on 12/5/17 at 10:36am revealed: -The carpet is vacuumed weekly. -He "thought" the carpet had been shampooed but did not remember when. -He had no concerns of the condition of his carpet, "it's just worn and spotty". Observation of resident room #7 on 12/5/17 at 10:45am revealed: -There was a brown stain on the carpet between the bed and a chair approximately 8 inches in diameter. -There was what appeared to be cracker crumbs on the carpet under the rocking chair legs. Interview with the resident of room #7 on 12/5/17 at 10:46am revealed: -The carpet "was really worn". -She would like to have a new carpet. -The floor was vacuumed about one time per week. Observation of resident room #37 on 12/5/17 at	{D 074}		

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{D 074}	Continued From page 2 3:50pm revealed -When facing the bathroom door, the lower third of the door frame on the right had black scuff marks and scratches that revealed bare wood, and the bottom of the door had black scuff marks. -On the wall to the left of the bathroom door, near the wall power outlet, there were 2 black scuff marks, on approximately 6 inches in length, the other approximately 4 inches long. Observation on of resident room #40 on 12/5/17 at 4:03pm revealed: -When entering the room, on the wall to the left below the wall power outlet there was a black scuff mark approximately 36 inches long and 2 inches wide along the wall parallel to the floor. In the middle to the scuff mark, the paint had been worn off showing the sheet rock approximately 4 by 2 inches in size. -When entering the room, on the wall to the right there was a black scuff mark approximately 24 inches long and 2 inches wide along the wall parallel to the floor. On one end of the scuff mark, the paint had been worn off showing the sheet rock approximately 3 by 2 inches in size and at the corner of the wall the sheet rock had been broken off exposing approximately 1 by 3 inches of the metal corner protector. Observation of resident room #13 on 12/5/17 at 4:20pm revealed when facing the bathroom door, the bottom third of the right side door frame had numerous scrapes in the wood. Interview with the Maintenance Staff on 12/5/17 at 4:30pm revealed: -All of the touch-up patching and painting work had been completed about 2-3 weeks after the (August 2017) survey. -He had repaired and painted the walls and doors	{D 074}		

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{D 074}	Continued From page 3 in room #37 in mid-August 2017. -The current damage to room #37 was on his list to repair again. -The carpets in rooms #7 and #15 were cleaned by a commercial cleaning company on 9/17/17. The carpets in these two rooms "may need to be replaced". -Every 3 months the commercial cleaning company cleans all the carpets in the common area throughout the facility. -The commercial cleaning company will come to the facility if needed and to date have cleaned the carpets in 29 resident rooms. -He had a small carpet shampoo machine and cleaned the carpets when needed. -He kept a log book in the staff office where any staff could document a maintenance issue. -Every morning he checked the log book and prioritized the repairs to be made. -Frequently he would repair damage to a wall or door from a wheelchair and the next day he would find the same area damaged again. -He was aware of the damage to the wall behind the recliner in room # 27. He pulled the chair away from the wall but when the resident sat in the chair, he would push it back up against the wall. Interview with the Executive Director on 12/6/17 at 11:00am revealed: -She was aware the Maintenance Staff kept a log book in the staff office where any staff could document a maintenance issue. -She was aware that the log was checked on a daily basis. -She and the Maintenance Director communicated on a daily basis regarding the log and any issues needing to be addressed. -She had spoken with the Maintenance Staff regarding the wall in room #27.	{D 074}		

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{D 074}	Continued From page 4 -After the wall has been repaired and painted, a sheet of thick clear plastic will be mounted on the wall behind the recliner. -As resident rooms become vacant, each room will be refurbished from floor to ceiling. -Replacing the carpet throughout the facility would be a major expenditure and that will have to be worked into the budget.	{D 074}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 5 sampled residents (Resident #2) related to Amitiza, Glucosamine/Chrondroitin/MSM, Metoprolol, Prostate supplement, Prozac, Stioloto Respimat Aerosol Solution, Tylenol #3, and Vitamin D3. The findings are: Review of Resident #2's current FL2 dated 7/19/17 revealed: -Diagnoses included primary hypertension, pulmonary hypertension, Abdominal Aortic	{D 358}		

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{D 358}	Continued From page 5 Aneurysm (without rupture), Cardiomegaly (enlarged heart), Chronic Obstructive Pulmonary Disease, chronic kidney disease, hyperglycemia (high blood sugar) and major depressive disorder. -Physician orders for Glucosamine/Chrondroitin 500mg/400mg three times a day (joint supplement), Metoprolol ER 200mg at bedtime (for high blood pressure), Prostate oral one daily (supplement), Prozac 40mg daily (for depression), Stioloto 25 1-2 puffs every day (for breathing), Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 2 every 6 hours as needed for pain and Vitamin D3 1,000 units daily (supplement). Review of Resident #2's Resident Register revealed an admission date of 7/31/17. Review of a subsequent physician's orders revealed: -An order dated 8/29/17 for Prozac 20mg, give 3 tablets (60mg) every morning. -A clarification order dated 9/19/17 for Stioloto 25 1-2 puffs every day (for breathing). Review of Resident #2's November 2017 electronic Medication Administration Record (eMAR) included entries for: -Glucosamine/Chrondroitin 500mg-400mg three times a day. -Metoprolol ER 200mg at bedtime. -Prostate oral one daily. -Prozac 20mg take 3 capsules (60mg) each morning. -Stioloto Respimat Aerosol solution 2.5-2.5mcg/ACT 1 spray inhale orally daily. -Tylenol #3 take 2 every 6 hours as needed for pain. -Vitamin D3 1,000 units daily.	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

Review of Resident #2's record revealed he had been transported to the Emergency Room on 11/29/17 at 3:30pm, admitted to the hospital with a diagnosis of bilateral lower lobe pneumonia and returned to the facility on 12/4/17 at 5:15pm.

Review of Resident #2's hospital discharge medication list dated 12/4/17 revealed physician orders for:
-Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg three times a day.
-Metoprolol ER 50mg daily.
-Prostate oral supplement one daily.
-Prozac 40mg daily.
-Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT take 1-2 puffs by inhalation daily.
-Tylenol #3 take 1 every 6 hours as needed for pain.
-Vitamin D3 1,000 units daily.

Review of Resident #2's December 2017 eMAR included entries for:
-Glucosamine/Chrondroitin 500mg/400mg three times a day. Initialed as administered 12/5/17 at 8:00am.
-There was no entry for Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg three times a day.
-Metoprolol ER 50mg daily. Initialed as administered 12/5/17 at 8:30am.
-Prostate oral supplement one daily. Documented as "Unknown" (not administered) 12/5/17 at 8:00am.
-Prozac 20mg, give 3 tablets each morning. Initialed as administered 12/5/17 at 8:00am.
-There was no entry for Prozac 40mg daily.
-Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale one spray orally daily. Initialed as administered 12/5/17 at 8:00am.
-There was no entry for Stiolto Respimat Aerosol

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{D 358}	Continued From page 7 Solution 2.5-2.5mcg/ACT take 1-2 puffs by inhalation daily. -Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 2 every 6 hours as needed for pain. -There was no entry for Tylenol #3 take 1 every 6 hours as needed for pain. -Vitamin D3 1,000 units daily. Initialed as administered 12/5/17 at 8:00am. Observation of Resident #2's medication on hand with a Medication Aide (MA) on 12/5/17 at 2:45pm revealed: -There was one bottle of Glucosamine/Chrondroitin 500mg/400mg tablets and one bottle of Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg tablets. -There were metoprolol 200mg tablets. -There were no metoprolol 50mg tablets. -There was no prostate supplement. -There was a bubble pack of Prozac 20mg with 3 tablets in each bubble. -There was no Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT. -There was no Tylenol #3. -There were Vitamin D3 2,000 unit tablets. -There were no Vitamin D3 1,000 unit tablets. Interview with a MA on 12/5/17 at 11:30am revealed: -She "usually worked 3:00pm to 11:00pm on the other side of the facility". -Resident #2 had returned from the hospital the evening of 12/4/17. -She had administered his morning medications as directed by the eMAR. -She had administered his medications from the medication cart. -She had administered Glucosamine/Chrondroitin 500mg/400mg tablets. The order had not been discontinued and the new order for	{D 358}		

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{D 358}	Continued From page 8 Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg tablets had not been entered into the eMAR. -She had administered the Metoprolol on the cart which was 200mg instead of 50mg. -She had not administered the Prostate supplement because it was not on the cart. -She had signed as having administered Prozac 20mg, give 3 tablets each morning on 12/5/17 at 8:00am. The order had not been discontinued and the new order for Prozac 40mg daily had not been entered into the eMAR. -She had signed as having administered the Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT but there was none on the cart. -She did not know why there was no Tylenol #3 on the cart. -She had administered the Vitamin D3 on the cart which was 2,000 unit instead of 1,000 units. Interview with a second MA on 12/5/17 at 12:05pm revealed: -When a resident returned to the facility from the hospital, the MA on duty was responsible for entering the new orders into the eMAR, discontinuing medications as indicated, faxing the medication orders to the pharmacy, removing discontinued medications from the medication cart and completing the necessary paperwork to go along with discontinued medications when they are returned to the pharmacy. -A copy of the orders was placed in a book in the medication room, the resident's record and a copy made for the Resident Care Coordinator. Interview with a third MA on 12/6/17 at 3:15pm revealed: -She was the MA on duty when Resident #2 returned from the hospital. -She had entered the physician's orders in the	{D 358}		

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{D 358}	Continued From page 9 e-MAR. -She had faxed the resident's order to the pharmacy. -She had made copies of the orders and placed one copy in the "new tracking book", one copy in the resident's record and the original copy in a book in the medication room for management to review. -She had documented in the resident's record regarding the resident's return to the facility. -The 11:00pm to 7:00am MA was responsible for removing changed/discontinued medications from the cart and medication room, completing the return paperwork and placing medications and paperwork in the tote to be returned to the pharmacy. Interview with the Resident Care Coordinator (RCC) on 12/5/17 at 4:00pm revealed: -The 3:00pm to 11:00pm MA was responsible for entering Resident #2's physician's orders in the e-MAR and faxing the resident's orders to the pharmacy. -She was responsible for making copies of the orders and placing one copy in the "new tracking book", one copy in the Resident's record and placing the original orders in a book in the medication room for nursing management to review the next working day. -She was to remove medications that were changed/discontinued from the medication cart and medication room, complete the return paperwork and place the medications and paperwork in the tote to be returned to the pharmacy. -She would meet with the MA's and review the policy and procedure with them. -The RCC reviewed the orders and eMARs for accuracy the morning of the next working day after admission.	{D 358}		

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{D 358}	Continued From page 10 -The RCC had been unable to review Resident #2's orders and eMAR today due to events occurring in the facility. -She would review the orders, the eMARs and notify the physician today of what had occurred. Attempted telephone interview with Resident #2's physician on 12/6/17 at 3:30pm was not successful.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the	{D 367}		

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{D 367}	Continued From page 11	{D 367}		

accuracy of the Medication Administration Records (MARs) for 2 of 5 sampled residents related to Amitiza, Glucosamine/Chrondroitin/MSM, Metoprolol ER, Prostate oral supplement, Prozac, Stiolto Respimat Aerosol Solution, Vitamin C, Ativan 0.5mg, Lortab, Soma, Tylenol, and Tylenol #3 (Resident #2) and atorvastatin, docusate, gabapentin, latanoprost, alphagan, memantine, Ventolin and divalproex (Resident #1).

The findings are:

A. Review of Resident #2's current FL2 dated 7/19/17 revealed diagnoses included:
-Diagnoses included primary hypertension, pulmonary hypertension, Abdominal Aortic Aneurysm (without rupture), Cardiomegaly (enlarged heart), Chronic Obstructive Pulmonary Disease, chronic kidney disease, hyperglycemia (high blood sugar) and major depressive disorder.
-Physician orders for Amitiza 24mcg twice a day with meals (for constipation), Glucosamine/Chrondroitin 500mg/400mg three times a day (joint supplement), Metoprolol ER 200mg at bedtime (for hypertension), Promethazine HCL 25mg every 8 hours as needed for nausea/vomiting, Vitamin C 500mg twice a day (supplement), Prostate oral one daily (supplement), Prozac 40mg daily (depression), Soma 350mg every 8 hours as needed for muscle spasms and Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale one spray orally daily (for breathing).

Review of Resident #2's Resident Register revealed an admission date of 7/31/17.

Review of subsequent physician orders in

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{D 367}	Continued From page 12 Resident #2's Record revealed: -An order dated 8/3/17 for Tylenol #3 (Tylenol 300mg/Codiene 30mg) take 2 every 6 hours as needed for pain. -An order dated 8/9/17 for Tylenol 325mg give 2 tablets every 6 hours as needed for pain. -An order dated 8/29/17 for Prozac 20mg, give 3 tablets each morning (for depression). -An order dated 9/1/17 for Lortab 7.5mg-325mg every 12 hours as needed for pain. -An order dated 9/6/17 for Ativan 0.5mg every 12 hours as needed for anxiety. -An order dated 10/31/17 for Tizanidine (Zanaflex) HCL 2mg every 8 hours as needed for spasms. Review of Resident #2's November 2017 electronic Medication Administration Record (eMAR) revealed entries for: -Amitiza 24mcg twice a day with meals. -Glucosamine/Chrondroitin 500mg/400mg three times a day. -Metoprolol ER 200mg at bedtime. -Prostate oral supplement one daily. -Prozac 20mg, give 3 tablets each morning. -Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale one spray orally daily. -Vitamin C 500mg twice a day. -Ativan 0.5mg every 12 hours as needed for anxiety. -Lortab 7.5mg-325mg every 12 hours as needed for pain. -Promethazine HCL 25mg every 8 hours as needed for nausea/vomiting. -Soma 350mg every 8 hours as needed for muscle spasms. -Tizanidine HCL 2mg every 8 hours as needed for spasms. -Tylenol 325mg give 2 tablets every 6 hours as needed for pain.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 12/06/2017

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{D 367}	Continued From page 13 -Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 2 every 6 hours as needed for pain. Review of Resident #2's record revealed he had been transported to the Emergency Room on 11/29/17 at 3:30pm, admitted to the hospital with a diagnosis of bilateral lower lobe pneumonia and returned to the facility on 12/4/17 at 5:15pm. Review of Resident #2's hospital discharge medication list dated 12/4/17 revealed physician's orders for: -Amitiza 24mcg twice a day with meals. -Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg three times a day. -Metoprolol ER 50mg daily for 30 days. -Prostate oral supplement one daily. -Prozac 40mg daily -Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale 1-2 puffs by inhalation daily. -Vitamin C 500mg daily. -Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 1 every 6 hours as needed for pain. -Promethazine HCL 25mg every 8 hours as needed for nausea/vomiting to be discontinued. Review of Resident #2's December 2017 eMAR revealed entries for: -Amitiza 24mcg twice a day with meals (8:00am and 8:00pm). -Amitiza at 8:00pm was not at a meal time. -Glucosamine/Chrondroitin 500mg/400mg three times a day. -There was no entry for Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg three times a day. -Metoprolol ER 200mg at bedtime. -Metoprolol ER 50mg daily at 3:00pm for 30 days entered 12/5/17 and discontinued 12/5/17.	{D 367}		

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{D 367}	Continued From page 14 -An entry for Metoprolol ER 50mg daily at 5:00pm. -Prostate oral supplement one daily. -Prozac 20mg, give 3 tablets each morning. -There was no entry for Prozac 40mg daily. -Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale one spray orally daily. -There was no entry for Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT inhale 1-2 puffs by inhalation daily. -Vitamin C 500mg twice a day. -There was no entry for Vitamin C 500mg daily. -Ativan 0.5mg every 12 hours as needed for anxiety. (This order was not on the medication list from the hospital. Medication was not documented as administered.) -Lortab 7.5mg-325mg every 12 hours as needed for pain. (This order was not on the medication list from the hospital. Medication was not documented as administered.) -Promethazine HCL 25mg every 8 hours as needed for nausea/vomiting (This order should have been discontinued 12/4/17.) -Soma 350mg every 8 hours as needed for muscle spasms. (This order was not on the medication list from the hospital. Medication was not documented as administered.) -Tylenol 325mg give 2 tablets every 6 hours as needed for pain. (This order was not on the medication list from the hospital. Medication was not documented as administered.) -Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 2 every 6 hours as needed for pain. -There was no entry for Tylenol #3 (Tylenol 300mg/Codeine 30mg) take 1 every 6 hours as needed for pain. Interview with a MA on 12/5/17 at 11:30am revealed: -She usually worked 3:00pm to 11:00pm on the	{D 367}		

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{D 367}	Continued From page 15	{D 367}		

other side of the facility.
-Resident #2 had returned from the hospital the evening of 12/4/17.
-She had administered his medications as directed by the eMAR using his medications that were in the medication cart.
-She had administered the Metoprolol on the cart which was 200mg instead of 50mg.
-She had not administered the Prostate supplement because it was not on the cart. She had documented it was unavailable.
-She had signed as having administered the Stiolto Respimat Aerosol Solution 2.5-2.5mcg/ACT but there was none on the cart.
-She had administered the Vitamin D3 on the cart which was 2,000 unit instead of 1,000 units.
-She had administered Glucosamine/Chrondroitin 500mg/400mg tablets. The order had not been discontinued and the new order for Glucosamine/Chrondroitin/MSM 500mg-200mg-150mg tablets had not been entered into the eMAR.
-She did not know why the orders for Promethazine HCL 25mg tablets,Soma 350mg tablets, and Tylenol 325mg had not been discontinued on the MAR and the medications removed from the cart.
-She had signed as having administered Prozac 20mg, give 3 tablets each morning on 12/5/17 at 8:00am. The order had not been discontinued and the new order for Prozac 40mg daily had not been entered into the eMAR.

Interview with a second MA on 12/5/17 at 12:05pm revealed:
-When a resident returned to the facility from the hospital, the MA on duty is responsible for entering the new orders into the eMAR, discontinuing medications as indicated, faxing the medication orders to the pharmacy, removing

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{D 367}	Continued From page 16	{D 367}		

discontinued medications from the medication cart and completing the necessary paperwork to go along with discontinued medications when they are returned to the pharmacy.
-A copy of the orders is placed in a book in the medication room, the resident's record and a copy is made for the Resident Care Coordinator.

Interview with a third MA on 12/6/17 at 3:15pm revealed:
-She was the MA on duty when Resident #2 returned from the hospital.
-She had entered the physician's orders in the eMAR.
-She had faxed the resident's order to the pharmacy.
-She had made copies of the orders and placed one copy in the "new tracking book", one copy in the Resident's Record and the original copy in a book in the medication room for management to review.
-She documented in the Resident Record regarding the resident's return to the facility.
-The 11:00pm to 7:00am MA was responsible for removing changed/discontinued medications from the cart and medication room, completing the return paperwork and placing medications and paperwork in the tote to be returned to the pharmacy.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/5/17 at 4:00pm.

Interview with the Executive Director (ED) on 12/6/17 at 2:00pm revealed:
-The Health and Wellness Director (HWD) and the RCC were reviewing the orders and eMARs of Resident #2.
-MA training to address the identified areas of non-compliance would be scheduled.

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{D 367}	Continued From page 17 B. Review of Resident #1's current FL2 dated 5/3/17 revealed: -Diagnoses included Alzheimer's, degenerative hip arthritis, spinal stenosis, hypertension, pre-diabetes, chronic obstructive lung disease, osteoarthritis and chronic lower back pain. -Physician orders for Atorvastatin 40mg 1 tablet at bedtime (used to treat high cholesterol), Docusate 100mg 1 tablet every day (used to treat constipation), Gabapentin 300mg 1 tablet at bedtime (used to treat neuropathic pain), Latanoprost instill 1 drop in both eyes every day (used to treat Glaucoma), Alphagan P instill 1 drop in both eyes twice per day (used to treat dry eyes), Memantine 10mg 1 tablet twice per day (used to treat moderate to severe confusion related to Alzheimer's disease), and Ventolin HFA 90mcg inhale 2 puffs twice per day (used to treat chronic obstructive pulmonary disease). Review of Resident #1's subsequent medication orders revealed an order dated 11/3/17 for divalproex delayed release 125mg 2 tablets at bedtime (used to treat behaviors). Review of the November 2017 electronic Medication Administration Record (eMAR) for Resident #1 revealed there was no documentation on 11/18/17 for the 8:00pm administrations of atorvastatin, docusate, gabapentin, latanoprost, alphagan, memantine, Ventolin and divalproex. Review of the December 2017 eMAR for Resident #1 revealed there was no documentation on 12/4/17 for the 8:00pm administrations of atorvastatin, docusate, gabapentin, latanoprost, alphagan, memantine, Ventolin and divalproex.	{D 367}		

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{D 367}	Continued From page 18 Interview with a Medication Aide (MA) on 12/6/17 at 3:30pm revealed: -She remembered working as the MA for Resident #1 on 11/18/17 and 12/4/17. -She had failed to document Resident #1's 8:00pm medications on the eMAR. -"Most likely what happened" was she had not clicked on the save button on the computer screen after documenting the medications had been administered and the computer screen "timed out". -When she pulled the screen back up it did not automatically return to Resident #1's eMAR and the medications were not saved as administered, thus the reason for the blank space on the eMAR's. Refer to the interview with the Resident Care Coordinator (RCC) on 12/5/17 at 4:00pm. Interview with the Executive Director (ED) on 12/6/17 at 2:00pm revealed: -The Health and Wellness Director (HWD) and the RCC were reviewing the orders and eMARs of Resident #1. -MA training to address the identified areas of non-compliance would be scheduled. _____ Interview with the Resident Care Coordinator (RCC) on 12/5/17 at 4:00pm revealed: -The MA on duty when a resident returned from the hospital was responsible for entering the physician's orders in the e-MAR and faxing the resident's orders to the pharmacy. -The MA was responsible for making copies of the orders and placing one copy in the "new tracking book", one copy in the Resident's record and placing the original orders in a book in the medication room for nursing management to	{D 367}		

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{D 367}	Continued From page 19 review the next working day. -All of the MA's had been trained on this policy and procedure. -The RCC did not know why the MA's had not followed the procedure. -The RCC reviewed the orders and eMARs for accuracy the morning of the next working day after admission. -The RCC had been unable to review new orders and eMAR today due to events occurring in the facility. -She would review the orders, the eMARs and notify the physician today of what had occurred. -She would meet with the MA's and review the policy and procedure with them.	{D 367}		