Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068020	A. BUILDING: _____ B. WING _____	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAROL WOODS RETIREMENT COMMUNI	750 WEAVER DAIRY ROAD CHAPEL HILL, NC 27514

(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 survey on September 12, 2023.	D 000		
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, interview, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) for two blood pressure medications, a cholesterol medication, a blood thinner and a supplement. The findings are: Review of Resident #3's current FL-2 dated 12/07/22 revealed diagnoses included heart disease, chest pain, heart failure, hypertension, and hyperlipidemia. 1. Review of Resident #3's current FL-2 dated 12/07/22 revealed there was an order for amlodipine 5mg (used to treat elevated blood pressure) daily.	D 344	Following is the facility's Plan of Correction for the deficiencies cited. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. What corrective action will be accomplished for residents affected? a. As of 9/12/2023, all current residents of Building 6 have accurate Physician Order Sheets. All current residents Physician Order Sheets were reviewed for accuracy by the Director of Nursing/Designee. All corrected order sheets resubmitted for Provider signature. How will the facility identify other residents having the potential to be affected by this same practice? a. All residents have the potential to be affected by this practice. The Nurse Coordinator and Staff Nurses were educated regarding the steps to take to ensure the Physician Orders Sheets are accurate by 9/29/2023	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

9-29-2023

Received and Acknowledged on 10/02/23

Janet Thornburg

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D 344	Continued From page 1 Review of Resident #3's signed physicians' orders dated 07/14/23 revealed: -There was an order for amlodipine 5mg ½ tablet daily. -There was an order for amlodipine 5mg daily. Review of Resident #3's signed physicians' orders dated 08/04/23 revealed: -There was an order for amlodipine 5mg ½ tablet daily. -There was an order for amlodipine 5mg daily. Review of Resident #3's signed physicians' orders dated 09/08/23 revealed: -There was an order for amlodipine 5mg ½ tablet daily. -There was an order for amlodipine 5mg daily. Review of Resident #3's July 2023 electronic medication administration record (eMAR) from 07/14/23 to 07/31/23 revealed: -There was an entry for amlodipine 5mg daily. -There was documentation that amlodipine 5mg was administered daily. -There was no entry for amlodipine 5mg ½ tablet daily. Review of Resident #3's August 2023 eMAR revealed: -There was an entry for amlodipine 5mg daily. -There was documentation that amlodipine 5mg was administered daily. -There was no entry for amlodipine 5mg ½ tablet daily. Review of Resident #3's September eMAR from 09/01/23 to 09/12/23 revealed: -There was an entry for amlodipine 5mg daily. -There was documentation that amlodipine 5mg	D 344	Measures to be put into place to ensure this practice does not reoccur. a. Nursing staff educated on steps to take to eliminate inaccurate medication orders by 9/29/2023 b. All new admission orders will be audited by the Nurse Coordinator/ Designee to ensure accuracy of active medications. c. Prior to monthly recapitulation of resident orders for physician signatures, the Physician Order Sheets will be printed and compared to active medication orders in the Electronic Health Record, by the Nurse Coordinator, as follows: Monthly x 3 month How corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. a. Findings of these audits will be reported to the facility's QAPI Committee by the Director of Nursing/Designee for identification of trends and determination of need for further corrective action, monthly x3.	

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was administered daily.
-There was no entry for amlodipine 5mg ½ tablet daily.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed:
-The pharmacy had an order for amlodipine 5mg daily dated 12/06/22.
-The pharmacy had no other order for amlodipine.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/12/23 at 4:39pm revealed:
-Resident #3 had an order for amlodipine 5mg daily.
-Amlodipine 5mg ½ tablet was discontinued a few months ago.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm.

Refer to the interview with the Nurse Coordinator on 09/12/23 at 1:30pm.

Refer to the telephone interview with the DON on 09/12/23 at 4:13pm.

Refer to the interview with the Administrator on 09/12/23 at 5:25pm.

2. Review of Resident #3's signed physicians' orders dated 07/14/23 revealed there was an order for metoprolol tartrate 25mg (used to treat elevated blood pressure) ½ tablet daily.

Review of Resident #3's signed physicians' orders dated 08/04/23 revealed there was an

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D 344	Continued From page 3 order for metoprolol tartrate 25mg ½ tablet daily. Review of Resident #3's signed physicians' orders dated 09/08/23 revealed there was an order for metoprolol tartrate 25mg ½ tablet daily. Review of Resident #3's July 2023 electronic medication administration record (eMAR) from 07/14/23 to 07/31/23 revealed: -There was no entry for metoprolol tartrate 25mg ½ tablet daily to be administered. -There was no documentation metoprolol tartrate 25mg ½ tablet was administered. Review of Resident #3's August 2023 eMAR revealed: -There was no entry for metoprolol tartrate 25mg ½ tablet to be administered daily. -There was no documentation metoprolol tartrate 25mg ½ tablet was administered. Review of Resident #3's September eMAR from 09/01/23 to 09/12/23 revealed: -There was no entry for metoprolol tartrate 25mg ½ tablet to be administered daily. -There was no documentation metoprolol tartrate 25mg ½ tablet was administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed: -The pharmacy did not have a current order for metoprolol tartrate 25mg ½ tablet daily. -Metoprolol was discontinued on 12/06/22. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed: -Resident #3 did not have a current order for metoprolol tartrate 25mg ½ tablet.	D 344		

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-She discontinued metoprolol because Resident #3's heart rate was consistently low.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm.

Refer to the interview with the Nurse Coordinator on 09/12/23 at 1:30pm.

Refer to the telephone interview with the DON on 09/12/23 at 4:13pm.

Refer to the interview with the Administrator on 09/12/23 at 5:25pm.

3. Review of Resident #3's signed physicians' orders dated 07/14/23 revealed there was an order for atorvastatin 10mg (used to treat elevated cholesterol levels) daily.

Review of Resident #3's signed physicians' orders dated 08/04/23 revealed there was an order for atorvastatin 10mg daily.

Review of Resident #3's signed physicians' orders dated 09/08/23 revealed there was an order for atorvastatin 10mg daily.

Review of Resident #3's July 2023 electronic medication administration record (eMAR) from 07/14/23 to 07/31/23 revealed:
-There was no entry for atorvastatin 10mg daily to be administered.
-There was no documentation that atorvastatin 10mg was administered.

Review of Resident #3's August 2023 eMAR revealed:
-There was no entry for atorvastatin 10mg daily to

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be administered.
-There was no documentation that atorvastatin 10mg was administered.

Review of Resident #3's September eMAR from 09/01/23 to 09/12/23 revealed:
-There was no entry for atorvastatin 10mg daily to be administered.
-There was no documentation that atorvastatin 10mg was administered.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed the pharmacy did not have a current order for atorvastatin 10mg daily for Resident #3.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/12/23 at 4:39pm revealed Resident #3 did not have a current order for atorvastatin.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm.

Refer to the interview with the Nurse Coordinator on 09/12/23 at 1:30pm.

Refer to the telephone interview with the DON on 09/12/23 at 4:13pm.

Refer to the interview with the Administrator on 09/12/23 at 5:25pm.

4. Review of Resident #3's signed physicians' orders dated 07/14/23 revealed there was an order for fish oil 1000mg (used to treat elevated cholesterol levels) daily.

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Review of Resident #3's signed physicians' orders dated 08/04/23 revealed there was an order for fish oil 1000mg daily.

Review of Resident #3's July 2023 electronic medication administration record (eMAR) from 07/14/23 to 07/31/23 revealed:
-There was no entry for fish oil 1000mg daily to be administered.
-There was no documentation fish oil 1000mg was administered.

Review of Resident #3's August 2023 eMAR revealed:
-There was no entry for fish oil 1000mg daily to be administered.
-There was no documentation fish oil 1000mg was administered.

Review of Resident #3's September eMAR from 09/01/23 to 09/12/23 revealed:
-There was no entry for fish oil 1000mg daily to be administered.
-There was no documentation fish oil 1000mg was administered.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed the pharmacy did not have an order for fish oil 1000mg daily for Resident #3.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/12/23 at 4:39pm revealed Resident #3 did not have a current order for fish oil 1000mg daily.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm.

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Refer to the interview with the Nurse Coordinator on 09/12/23 at 1:30pm.

Refer to the telephone interview with the DON on 09/12/23 at 4:13pm.

Refer to the interview with the Administrator on 09/12/23 at 5:25pm.

5. Review of Resident #3's signed physicians' orders dated 07/14/23 revealed there was an order for aspirin 81mg (used to thin the blood) every morning.

Review of Resident #3's signed physicians' orders dated 08/04/23 revealed there was an order for aspirin 81mg (used to thin the blood) every morning.

Review of Resident #3's signed physicians' orders dated 09/08/23 revealed there was an order for aspirin 81mg (used to thin the blood) every morning.

Review of Resident #3's July 2023 electronic medication administration record (eMAR) from 07/14/23 to 07/31/23 revealed:
-There was no entry for aspirin 81mg daily to be administered.
-There was no documentation aspiring 81mg was administered.

Review of Resident #3's August 2023 eMAR revealed:
-There was no entry for aspirin 81mg daily to be administered.
-There was no documentation aspirin 81mg was administered.

Review of Resident #3's September eMAR from

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D 344	Continued From page 8 09/01/23 to 09/12/23 revealed: -There was no entry for aspirin 81mg daily to be administered. -There was no documentation aspirin 81mg was administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed the pharmacy did not have a current order for aspirin 81mg for Resident #3. Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/12/23 at 4:39pm revealed: -Resident #3 did not have a current order for aspirin 81mg. -Resident #3 was currently taking Eliquis 5mg twice daily. Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm. Refer to the interview with the Nurse Coordinator on 09/12/23 at 1:30pm. Refer to the telephone interview with the DON on 09/12/23 at 4:13pm. Refer to the interview with the Administrator on 09/12/23 at 5:25pm. _____ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed: -Someone at the facility created the physician's orders and sent them to her. -She or her assistant would review the orders, then she would sign the physician's orders.	D 344		

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-She did not notice any medications listed on the physician's orders that Resident #3 was not being administered.
-She would expect the physician's orders to be correct when they were sent to her for her signature.

Interview with the Nurse Coordinator on 09/12/23 at 1:30pm revealed:
-The facility staff would enter new orders into the eMAR.
-The Director of Nursing (DON) sent the physician orders to the PCP for signature.

Telephone interview with the DON on 09/12/23 at 4:13pm revealed:
-She was responsible for running the report and sending the physicians' orders to the PCP for signature.
-Resident #3 was admitted to the Assisted Living Facility from Independent Living.
-Resident #3's record was closed when she was discharged from Independent Living, but the medications were not ended when Resident #3's record was closed.
-There seemed to be a glitch in the computer system since it was "pulling" medications over onto the current physician's order from when Resident #3 lived independently.
-The staff looked to see that the physician orders came back signed but did not review the signed physician orders.
-In theory the active orders for the Assisted Living facility should be the only orders that "pull" over to the physician's orders.

Interview with the Administrator on 09/12/23 at 5:25pm revealed:
-The facility wanted an accurate medication list.
-The computer system should print the active

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D 344	Continued From page 10 medications on the physician orders to be signed. -The DON designates which orders were sent to the PCP for signature. -The computer system had a glitch where it was sending medications orders that were no longer active to the PCP for signature. -There should be auditing of the physician orders for accuracy.	D 344		
D 388	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to destroy or return a discontinued medication for 1 of 1 sampled resident (#3) to the pharmacy within 90 days. The findings are: Review of Resident #3's current FL-2 dated 12/07/22 revealed diagnoses included heartburn, gastro-esophageal reflux disease, and diaphragmatic hernia. Review of Resident #3's physicians' order dated 01/31/23 revealed there was an order for calcium carbonate chewable 500mg 4 times daily as needed for 48 hours.	D 388	Following is the facility's Plan of Correction for the deficiencies cited. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. What corrective action will be accomplished for residents affected? a. All current resident medication orders reviewed and compared with available medications in the Med Cart. No other discontinued medications noted. Completed 9/13/2023. b. Nurse Coordinator, Staff Nurses and Medication Techs educated regarding the need to return all discontinued medications to pharmacy with next pharmacy delivery/pickup by 9/29/2023.	

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D 388	Continued From page 11 Observation of Resident #3's medications on hand on 09/12/23 revealed: -There was a bubble pack labeled calcium carbonate chewable tablets four times daily as needed for 48 hours. -There were 8 calcium carbonate chewable tablets dispensed on 02/01/23. -There were 8 of 8 calcium carbonate chewable tablets remaining. Interview with a medication aide (MA) on 09/12/23 at 5:09pm revealed: -The MAs did not do medication cart audits; they were completed by the nurses. -When a medication was discontinued when she worked pull the discontinued medication from the residents drawer and place it in the bottom of the medication cart to be returned to the pharmacy. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed: -The pharmacy did not have a current order for calcium carbonate chewable tablets. -The order was written for 48 hours and was automatically discontinued after 48 hours. -Discontinued medications could be picked up by the pharmacy personnel who delivered the medications. -The discontinued medications would be destroyed at the pharmacy. Interview with the Nurse Coordinator on 09/12/23 at 1:30pm revealed: -She did not know Resident #3 had discontinued medication on the medication cart since February 2023. -She audited the medication carts, but she had not noticed the medication on the carts. -Discontinued medications should be removed	D 388	How will the facility identify other residents having the potential to be affected by this same practice? a. All residents have the potential to be affected by this practice. The Nurse Coordinator, Staff Nurses and Medication Techs educated regarding the steps to take to ensure discontinued medications are removed from the med cart and returned to the pharmacy timely by 9/29/2023. Measures to be put into place to ensure this practice does not reoccur. a. Nursing staff educated regarding proper steps to take to ensure timely return of discontinued medications to the pharmacy by 9/29/2023. b. Nurse Coordinator will audit all resident medications as follows i. Two times per week x 2 months ii. One time per week x 1 month How corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. b. Findings of these audits will be reported to the facility's QAPI Committee by the Director of Nursing/Designee for identification of trends and determination of need for further corrective action, monthly x3.	

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D 388	Continued From page 12 from the medication cart when the order was written to discontinue the medication. -The MAs were responsible for removing the discontinued medications and sending them back to the pharmacy. Telephone interview with the Director of Nursing on 09/12/23 at 4:13pm revealed: -Discontinued medication should be removed from the medication cart and returned to the pharmacy to be destroyed. -It was the responsibility of the MAs to see that all discontinued medications were removed from the medication cart and returned to the pharmacy to be destroyed. Interview with the Administrator on 09/12/23 at 5:25pm revealed: -The Nurse and the MA should identify the medications that have been discontinued, remove the medication from the medication cart and send the medication back to the pharmacy. -She expected all discontinued medications to be removed from the medication cart in a timely manner.	D 388		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount	D 394	Following is the facility's Plan of Correction for the deficiencies cited. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068020	A. BUILDING: _____ B. WING _____	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 394	Continued From page 13 returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to destroy or return a discontinued controlled substance for 1 of 1	D 394	What corrective action will be accomplished for residents affected? a. All current resident medication orders reviewed and compared with available medications in the Med Cart. No other discontinued medications noted. Completed 9/13/2023. b. Nurse Coordinator, Staff Nurses and Medication Techs educated regarding the need to return all discontinued medications to pharmacy with next pharmacy delivery/pickup by 9/29/2023. How will the facility identify other residents having the potential to be affected by this same practice? a. All residents have the potential to be affected by this practice. The Nurse Coordinator, Staff Nurses and Medication Techs educated regarding the steps to take to ensure discontinued medications are removed from the med cart and returned to the pharmacy timely by 9/29/2023. Measures to be put into place to ensure this practice does not reoccur. a. Nursing staff educated regarding proper steps to take to ensure timely return of discontinued medications to the pharmacy by 9/29/2023. b. Nurse Coordinator will audit all resident medications as follows: i. Two times per week x 2 months ii. One time per week x 1 month	

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D 394	Continued From page 14 sampled residents (#3) to the pharmacy within 90 days. The findings are: Review of Resident #3's current FL-2 dated 12/07/22 revealed: -Diagnoses included heart disease, chest pain, heart failure, hypertension, and hyperlipidemia. -There was an order for lorazepam 0.5mg ½ tablet every 8 hours as needed for anxiety with a stop date of 03/04/23. Observation of Resident #3's medications on hand on 09/12/23 revealed: -There was a bubble pack labeled lorazepam 0.5mg ½ tablet every 8 hours as needed for anxiety. -There were 30 ½ tablets of lorazepam 0.5mg dispensed on 01/01/23. -There were 18 of 30 ½ tablets remaining. Interview with a medication aide (MA) on 09/12/23 at 5:09pm revealed: -The MAs did not do medication cart audits; they were completed by the nurses. -When a controlled substance was discontinued, she would leave the controlled substance in the locked box and would send it to the pharmacy to be destroyed by the pharmacy delivery personnel. -If the pharmacy delivery came later, she would inform the third shift staff there was a controlled substance to be returned to the pharmacy to be destroyed. -She had not returned any of Resident #3's controlled substance to the pharmacy. -She did not know Resident #3 had a discontinued controlled substance on the medication cart.	D 394	How corrective action(s) will be monitored to ensure the alleged deficient practice will not recur. a. Findings of these audits will be reported to the facility's QAPI Committee by the Director of Nursing/Designee for identification of trends and determination of need for further corrective action, monthly x3.	

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D 394	Continued From page 15	D 394		

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/12/23 at 3:55pm revealed:
-The pharmacy did not have a current order for lorazepam 0.5mg.
-The last order the pharmacy had for lorazepam 0.5mg ½ tablet every 8 hours as needed was dated 12/07/22 with a stop date of 03/04/23.
-Controlled substances could be returned to the pharmacy by the delivery driver or the facility could destroy the controlled substance in house.

Interview with the Nurse Coordinator on 09/12/23 at 1:30pm revealed:
-She did not see a current order for lorazepam 0.5mg in the computer.
-She did not realize lorazepam had been discontinued but the medication remained on the medication cart.
-She did not know why lorazepam was not removed from the medication cart and returned to the pharmacy to be destroyed.
-The nurse working when the medications were delivered from the pharmacy was responsible for sending discontinued narcotics back to the pharmacy with the delivery personnel.
-She audited medication carts every 1 to 2 months.
-She compared the eMAR with the medications in the medication cart to ensure all medications on the eMAR were available for administration.
-She did not notice the discontinued medication on the medication cart during the audits.

Telephone interview with the Director of Nursing on 09/12/23 at 4:13pm revealed:
-Discontinued controlled substances should be removed from the medication cart and returned to the pharmacy to be destroyed.
-It was the responsibility of the MAs to see that all

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D 394	Continued From page 16 discontinued medications were removed from the medication cart and returned to the pharmacy to be destroyed. Interview with the Administrator on 09/12/23 at 5:25pm revealed: -The Nurse and the MA should identify the medication that had been discontinued and send the medication back to the pharmacy to be destroyed. -She expected all discontinued medications to be removed from the medication cart.	D 394		