

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL046013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/19/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WEAVER'S PINEVIEW HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>142 WEST LEWISTOWN ROAD</b> <b>MURFREESBORO, NC 27855</b>
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{C 000}	Initial Comments	{C 000}		
{C 257}	<p>10A NCAC 13G .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A2 VIOLATION.</p> <p>The Type A2 Violation is abated. Non-compliance continues.</p> <p>THIS IS A TYPE B VIOLATION</p> <p>Based on observations, record review and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to observations of live and dead roaches in the cabinets, on the countertops, in the door of the freezer, on the kitchen floor and on the dining room table.</p>	{C 257}		

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

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{C 257}	<p>Continued From page 1</p> <p>The findings are:</p> <p>Review of an Environmental Health report dated 08/30/23 for the facility revealed:</p> <ul style="list-style-type: none"> <li>-There were a total of 10 demerits with documentation of approved status.</li> <li>-There were 2 demerits for live and dead bugs present.</li> <li>-There were mouse droppings observed in the kitchen cabinets.</li> <li>-There was documentation an exterminator was scheduled to provide services in the home multiple times a month until vermin issue was completely cleared up.</li> </ul> <p>Observation of the kitchen on 10/18/23 at 8:40am revealed there was a live roach, 2 dead roaches and excrement in a lower cabinet to the left of the stove that contained canned goods.</p> <p>Observation of the kitchen on 10/18/23 at 9:36am revealed:</p> <ul style="list-style-type: none"> <li>-There was a live roach crawling on an envelope on the counter to the left of the stove.</li> <li>-There were plastic and styrofoam drinking cups beside the envelope.</li> </ul> <p>Observation of the kitchen on 10/18/23 at 9:39am revealed there was a roach crawling in the door of the upper cabinet to the right of the stove where some drinking glasses and home canning jar of food was stored.</p> <p>Observation of the kitchen on 10/18/23 at 9:40am revealed there was a live roach and several dead roaches in the cabinet under the sink.</p> <p>Observation of the dining room on 10/18/23 at 1:40pm revealed there was a small roach</p>	{C 257}		

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{C 257}	<p>Continued From page 2</p> <p>crawling across the dining room table.</p> <p>Observation of the side by side refrigerator-freezer in the kitchen on 10/18/23 at 3:21pm revealed: -There were 3 dead and 1 live roach under the freezer door when the door was opened. -There was excrement on the bottom, sides and in the seal of the freezer door.</p> <p>Observation of kitchen on 10/19/23 at 9:37am revealed there was a live roach in the drawer that was used to store clean eating utensils.</p> <p>Observation of the dining room on 10/19/23 at 10:18am revealed: -There was a glue trap on the floor under a buffet that had an undetermined amount of roaches trapped inside. -There was a second glue trap with numerous roaches trapped on top. -There were dead bugs and excrement on the floor and baseboards.</p> <p>Interview with a resident on 10/18/23 at 9:00am revealed: -The Administrator had people to come in the the facility and clean really well. -He had not seen any roaches for a couple of weeks.</p> <p>Interview with a second resident on 10/18/23 at 9:15am revealed it had been a few weeks since an exterminator came to the facility and he had not seen any roaches since then.</p> <p>Interview with the receptionist for the facility's contracted pest control company on 10/18/23 at 1:43pm revealed: -The facility had a contract for standard pest</p>	{C 257}		

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{C 257}	<p>Continued From page 3</p> <p>control that began August 2023.</p> <ul style="list-style-type: none"> <li>-Services were to be provided every other month and the next treatment for common pests was scheduled for November 1, 2023.</li> <li>-Standard pest control services treated for common pests such as roaches, mice and ants.</li> </ul> <p>A second interview with the receptionist for the facility's contracted pest control company on 10/19/23 at 11:25am revealed:</p> <ul style="list-style-type: none"> <li>-A pest control technician was last out to treat the facility for roaches on 09/07/23.</li> <li>-A pest control technician serviced the facility for mosquitos on 10/07/23.</li> </ul> <p>Telephone interview with a pest control technician for the the facility's contracted pest control company on 10/19/23 at 2:52pm revealed:</p> <ul style="list-style-type: none"> <li>-Roaches were a public safety health concern which meant they carry bacteria and disease, such as E. Coli, that could be transmitted to humans if not properly treated. (E. Coli is a bacteria that normally lives in the intestinal tract but can cause food poisoning if it is ingested.)</li> <li>-When roaches were observed moving during the day, it was an indication of heavy infestation.</li> </ul> <p>Interview with the Administrator on 10/18/23 at 9:30am revealed:</p> <ul style="list-style-type: none"> <li>-New cabinets and a new stove had been installed.</li> <li>-She used a hot water steamer inside the cabinets and cleaned everyday at the recommendation of the cleaning service she hired.</li> <li>-She hired people to come to the facility and do a total cleaning every 3 months; they had been once and were scheduled to return in November 2023 (dates unknown).</li> </ul>	{C 257}		

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{C 257}	<p>Continued From page 4</p> <p>A second interview with the Administrator on 10/19/23 at 2:21pm revealed:</p> <ul style="list-style-type: none"> <li>-She thought the pest control technician treated the facility for roaches on 10/07/23.</li> <li>-She thought the treatment was "weak" because it did not kill the roaches they way the previous treatment had and she continued to see them crawling around.</li> <li>-She had not contacted the pest control company about the concern but had meant to.</li> <li>-Roaches multiplied quickly and dropped bags of eggs around.</li> <li>-Roaches were pests and could get into food and leave bacteria where ever they were.</li> </ul> <p>_____</p> <p>The facility failed to ensure all residents were protected from illness from foods exposed to live and dead roaches. Living and dead roaches were observed in areas used to store food and clean utensils used by residents for eating and drinking. The facility's failure to control pests was detrimental to the health and safety of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/23 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 3, 2023.</p>	{C 257}		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments</p>	C 330		

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C 330	<p>Continued From page 5</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents that was prescribed a medication to treat anxiety (#2).</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 06/09/23 revealed: -Diagnoses included schizoaffective disorder; depressed type with multiple episodes severe with catatonic features and anxiety disorder. -There was an order for lorazepam 1mg to be administered three times each day. (Lorazepam is a medication used to treat anxiety.)</p> <p>Review of Resident #2's discharge summary from the local hospital revealed: -Resident #2 was admitted from the emergency department (ED) on 09/27/23 and discharged on 09/30/23. -He was diagnosed with acute metabolic encephalopathy. -He was previously seen on 09/25/23 for chest pain, was evaluated and sent back to the facility. -Resident #2 had not eaten or drank anything since he returned home. -Resident #2 would only answer yes or no questions while in the ED upon return. -He was discharged with instructions to continue his current medications.</p>	C 330		

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C 330	<p>Continued From page 6</p> <p>-Resident #2 had an episode of catatonia in May 2023 which required hospitalization.</p> <p>Review of Resident #2's medication administration record (MAR) for August 2023 revealed:</p> <p>-There was an electronic entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm.</p> <p>-There was documentation lorazepam 1mg was administered each day from 08/01/23 through 08/31/23.</p> <p>Review of Resident #2's controlled substances (CS) log for August 2023 revealed:</p> <p>-There was a label for a quantity of 93 lorazepam 1mg to be administered three times each day with at dispense date of 08/14/23.</p> <p>-There was documentation lorazepam 1mg was administered three times each day on 08/14/23 through 08/16/23 with 3 doses remaining.</p> <p>-There was no documentation the medication was administered before 08/14/23 or after 08/16/23.</p> <p>Review of Resident #2's MAR for September 2023 revealed:</p> <p>-There was an electronic entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm.</p> <p>-There was documentation lorazepam 1mg was administered three times each day on 09/01/23 through 09/24/23 and on 09/30/23.</p> <p>-There was an "X" documented for each dose on 09/25/23 and an "R" documented for each dose on 09/26/23.</p> <p>-There were lines drawn through the dates on 09/27/23 through 09/29/23 with a hand written notation that read "hospital".</p>	C 330		

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C 330	<p>Continued From page 7</p> <p>Attempted review of Resident #2's CS log for September 2023 revealed there was no CS log available for review.</p> <p>Review of Resident #2's MAR for October 2023 revealed: -There was an entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered three times each day on 10/01/23 through 10/17/23 and at 8:00am on 10/18/23.</p> <p>Review of Resident #2's CS log for October 2023 revealed: -There was a label for a quantity of 90 lorazepam 1mg to be administered three times each day with at dispense date of 10/03/23. -There was documentation lorazepam 1mg was administered three times each on 10/04/23 through 10/18/23 and at 7:00am on 10/19/23 with 44 doses remaining.</p> <p>Observation of medications on hand for Resident #2 on 10/19/23 at 10:40am revealed: -There was 1 medication bubble pack labeled lorazepam 1mg to be administered three times each day. -A quantity of 90 tablets was dispensed on 10/03/23. -There were 63 tablets remaining; 19 more doses available for administration than was indicated on the CS log.</p> <p>Interview with Resident #2 on 10/19/23 at 9:26am revealed: -He was in the hospital but he did not remember being there. -He thought his "liver backed up" and made him catatonic.</p>	C 330		



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C 330	<p>Continued From page 8</p> <p>Second interview with the Resident #2 on 10/19/23 at 2:00pm revealed: -He received medication twice each day: in the morning and evening. -He became catatonic twice since he was admitted to the facility. -He got anxious and depressed prior to his episodes of catatonia. -He was depressed prior to his hospitalization a few weeks prior because his family member did not visit as he promised.</p> <p>Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 2:29pm revealed: -A 30 day supply of lorazepam 1mg was filled on 08/07/23 and 10/03/23 for Resident #2. -There was no refill in September 2023 for Resident #2.</p> <p>Interview with the pharmacist for the facility's contracted pharmacy on 10/19/23 at 1:15pm revealed: -Lorazepam was an anti-anxiety medication and had a relaxant effect. -Resident #2 was ordered lorazepam 1 mg to be administered three times each day on 08/07/23. -A 30 day supply of lorazepam 1mg to be administered three times each day was filled and dispensed on 08/07/23 that would begin 08/14/23. -There was no refill in September 2023 for Resident #2 because they needed a refill from the provider. -Resident #2 should have ran out of medication on 09/13/23 if he was administered the medication three times each day as ordered. -They received a refill order for Lorazepam 1mg to be administered three times each day on 10/03/23 and dispensed a 30 day supply to begin</p>	C 330		

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C 330	<p>Continued From page 9 on 10/04/23.</p> <p>Telephone interview with the Registered Nurse for Resident #2's mental health provider on 10/19/23 at 11:29am revealed:</p> <ul style="list-style-type: none"> <li>-Catatonia was a vegetative state but the person remained awake but not eating, speaking or moving.</li> <li>-Catatonia to progress to stiffness or amnesia and cause dehydration if the person is not eating or drinking.</li> <li>-There was visit note dated 08/11/23 that said to continue lorazepam 1mg three times each day.</li> <li>-The provider had attempted to decrease Resident #2's dose of lorazepam in May 2023 and Resident #2 became catatonic requiring hospitalization.</li> <li>-There was a refill order for lorazepam 1mg three times each day on 08/07/23 and on 10/03/23.</li> <li>-There was no refill order in September 2023 and they did not receive a request from the facility in September 2023.</li> <li>-Lorazepam required a new order each month and the facility was responsible for contacting the provider.</li> <li>-Running out of Lorazepam could cause withdrawal symptoms within 7 days and increased anxiety.</li> </ul> <p>Interview with the Administrator on 10/19/23 at 1:50pm and 3:07pm revealed:</p> <ul style="list-style-type: none"> <li>-The "X" and "R" was documented on 09/25/23 and 09/26/23 on the September 2023 MAR when Resident #2 was at the local hospital and was not available.</li> <li>-Resident #2 went into "spells" where he did not eat, drink or talk.</li> <li>-This happened a few days after he was admitted and again on 09/26/23.</li> <li>-On 09/25/23 he was sent to the hospital because</li> </ul>	C 330		

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C 330	<p>Continued From page 10</p> <p>he said he thought he was having a heart attack but testing showed nothing was wrong and he was sent back to the facility.</p> <p>-On 09/26/23 he woke up and was stiff and would not talk or eat and he was sent back to the hospital were he stayed for a few days.</p> <p>-There was no refill requested in September 2023 but she had medication left over from a previous pack that was sent.</p> <p>-She and the pharmacy were responsible for calling the provider for refill on medication.</p> <p>-She called the pharmacy for a refill in September but did not call the provider.</p> <p>-She did not know why there were 19 more pills available for administration than were on the CS log.</p> <p>-She did forget to administer Resident #2's 2:00pm dose sometimes because he was the only resident that received medication throughout the day.</p> <p>-She always administered the missed dose later in the day and would sign out medication on the CS log each time it was administered.</p> <p>Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/18/23 at 12:32pm and on 10/19/23 at 9:38am and 10:06am was unsuccessful.</p> <p>Attempted telephone interview with Resident #2's mental health provider on 10/19/23 at 11:14am and 11:30am were unsuccessful.</p> <p>_____</p> <p>The facility failed to administer an anti-anxiety medication as prescribed to a resident which lead to poor control of his anxiety and caused the resident to stop eating and drinking, requiring 2 ED visits and being hospitalized for 3 days. The failure placed the resident at substantial risk for serious physical harm and constitutes a Type A2</p>	C 330		

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C 330	Continued From page 11 violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/23 with addendum on 10/27/23 for this violation.  THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 18, 2023.	C 330		
{C 342}	10A NCAC 13G .1004(j) Medication Administration  10A NCAC 13G .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, interviews, and record reviews, the facility failed to ensure the	{C 342}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL046013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/19/2023</b>
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{C 342}	<p>Continued From page 12</p> <p>medication administration records were accurate for 1 of 3 sampled residents including medications for anxiety (#2).</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 06/09/23 revealed: -Diagnoses included schizoaffective disorder; depressed type with multiple episodes, severe with catatonic features and anxiety disorder. -There was an order for lorazepam 1mg to be administered three times each day. (Lorazepam is a medication used to treat anxiety.)</p> <p>Review of Resident #2's medication administration record (MAR) for August 2023 revealed: -There was an electronic entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered each day from 08/01/23 through 08/31/23.</p> <p>Review of Resident #2's controlled substances (CS) log for August 2023 revealed: -There was a label for a quantity of 93 lorazepam 1mg to be administered three times each day with at dispense date of 08/14/23. -There was documentation lorazepam 1mg was administered three times each day on 08/14/23 through 08/16/23 with 3 doses remaining. -There was no documentation the medication was administered after 08/16/23.</p> <p>Review of Resident #2's MAR for September 2023 revealed: -There was an electronic entry for lorazepam 1mg to be administered three times each day and</p>	{C 342}		

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{C 342}	<p>Continued From page 13</p> <p>scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered three times each day on 09/01/23 through 09/24/23 and on 09/30/23. -There was an "X" documented for each dose on 09/25/23 and an "R" documented for each dose on 09/26/23. -There were lines drawn through the dates on 09/27/23 through 09/29/23 with a hand written notation that read "hospital".</p> <p>Attempted review of Resident #2's CS log for September 2023 revealed there was no CS log available for review.</p> <p>Review of Resident #2's MAR for October 2023 revealed: -There was an entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered three times each day on 10/01/23 through 10/17/23 and at 8:00am on 10/18/23.</p> <p>Review of Resident #2's CS log for October 2023 revealed: -There was a label for a quantity of 90 lorazepam 1mg to be administered three times each day with at dispense date of 10/03/23. -There was documentation lorazepam 1mg was administered three times each day on 10/04/23 through 10/18/23 and at 7:00am on 10/19/23 with 44 doses remaining.</p> <p>Observation of medications on hand for Resident #2 on 10/19/23 at 10:40am revealed: -There was 1 medication bubble pack labeled lorazepam 1mg to be administered three times each day. -A quantity of 90 tablets was dispensed on</p>	{C 342}		

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{C 342}	<p>Continued From page 14</p> <p>10/03/23.</p> <p>-There were 63 tablets remaining; 19 more doses available for administration than was indicated on the CS log.</p> <p>Interview with the Resident #2 on 10/19/23 at 2:00pm revealed he received medication twice each day; in the morning and evening.</p> <p>Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 2:29pm revealed:</p> <p>-A 30 day supply of lorazepam 1mg was filled on 08/07/23 and 10/03/23 for Resident #2.</p> <p>-There was no refill in September 2023 for Resident #2.</p> <p>Interview with the pharmacist for the facility's contracted pharmacy on 10/19/23 at 1:15pm revealed:</p> <p>-Lorazepam was an anti-anxiety medication and had a relaxant effect.</p> <p>-A 30 day supply of lorazepam 1mg was filled and dispensed on 08/07/23 to begin administration on 08/14/23.</p> <p>-There was no refill in September 2023 for Resident #2 because they needed a refill from the provider.</p> <p>-Resident #2 would have ran out of medication on 09/13/23.</p> <p>-They received a refill order on 10/03/23 and dispensed a 30 day supply to begin on 10/04/23.</p> <p>Interview with the Administrator on 10/19/23 at 1:50pm and 3:07pm revealed:</p> <p>-There was no refill requested in September 2023 Resident #2 but she had medication left over from a previous pack that was sent.</p> <p>-She called the pharmacy for a refill in September but did not call the provider.</p>	{C 342}		

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{C 342}	<p>Continued From page 15</p> <p>-She did not know why there were 19 more pills available for administration than were on the CS log.</p> <p>-She always administered the missed dose later in the day and would sign out medication on the CS log each time it was administered.</p> <p>Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/18/23 at 12:32pm and on 10/19/23 at 9:38am and 10:06am was unsuccessful.</p> <p>Attempted telephone interview with Resident #2's mental health provider on 10/19/23 at 11:14am and 11:30am were unsuccessful.</p>	{C 342}		
{C 367}	<p>10A NCAC 13G .1008(a) Controlled Substances</p> <p>10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 1 of 1 sampled resident ( #3) with an order for a medication used to treat anxiety.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 06/09/23 revealed:</p>	{C 367}		



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{C 367}	<p>Continued From page 16</p> <p>-Diagnoses included schizoaffective disorder; depressed type with multiple episodes, severe with catatonic features and anxiety disorder. -There was an order for lorazepam 1mg to be administered three times each day. (Lorazepam is a medication used to treat anxiety.)</p> <p>Review of Resident #2's medication administration record (MAR) for August 2023 revealed: -There was an electronic entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered each day from 08/01/23 through 08/31/23.</p> <p>Review of Resident #2's controlled substances (CS) log for August 2023 revealed: -There was a label for a quantity of 93 lorazepam 1mg to be administered three times each day with at dispense date of 08/14/23. -There was documentation lorazepam 1mg was administered three times each day on 08/14/23 through 08/16/23 with 3 doses remaining. -There was no documentation the medication was administered after 08/16/23.</p> <p>Review of Resident #2's MAR for September 2023 revealed: -There was an electronic entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered three times each day on 09/01/23 through 09/24/23 and on 09/30/23. -There was an "X" documented for each dose on 09/25/23 and an "R" documented for each dose on 09/26/23. -There were lines drawn through the dates on</p>	{C 367}		

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{C 367}	<p>Continued From page 17</p> <p>09/27/23 through 09/29/23 with a hand written notation that read "hospital".</p> <p>Attempted review of Resident #2's CS log for September 2023 revealed there was no CS log available for review.</p> <p>Review of Resident #2's MAR for October 2023 revealed: -There was an entry for lorazepam 1mg to be administered three times each day and scheduled for 8:00am, 2:00pm and 8:00pm. -There was documentation lorazepam 1mg was administered three times each day on 10/01/23 through 10/17/23 and at 8:00am on 10/18/23.</p> <p>Review of Resident #2's CS log for October 2023 revealed: -There was a label for a quantity of 90 lorazepam 1mg to be administered three times each day with at dispense date of 10/03/23. -There was documentation lorazepam 1mg was administered three times each day on 10/04/23 through 10/18/23 and at 7:00am on 10/19/23 with 44 doses remaining.</p> <p>Observation of medications on hand for Resident #2 on 10/19/23 at 10:40am revealed: -There was 1 medication bubble pack labeled lorazepam 1mg to be administered three times each day. -A quantity of 90 tablets was dispensed on 10/03/23. -There were 63 tablets remaining; 19 more doses available for administration than was indicated on the CS log.</p> <p>Interview with the Resident #2 on 10/19/23 at 2:00pm revealed he received medication twice each day; in the morning and evening.</p>	{C 367}		

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{C 367}	<p>Continued From page 18</p> <p>Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 10/18/23 at 2:29pm revealed: -A 30 day supply of lorazepam 1mg was filled on 08/07/23 and 10/03/23 for Resident #2. -There was no refill in September 2023 for Resident #2.</p> <p>Interview with the pharmacist for the facility's contracted pharmacy on 10/19/23 at 1:15pm revealed: -Lorazepam was an anti-anxiety medication and had a relaxant effect. -A 30 day supply of lorazepam 1mg was filled and dispensed on 08/07/23 to begin administration on 08/14/23. -There was no refill in September 2023 for Resident #2 because they needed a refill from the provider. -Resident #2 would have ran out of medication on 09/13/23. -They received a refill order on 10/03/23 and dispensed a 30 day supply to begin on 10/04/23.</p> <p>Interview with the Administrator on 10/19/23 at 11:01am, 1:50pm and 3:07pm revealed: -There was no refill requested in September 2023 but she had medication left over from a previous pack that was sent. -She did not know why there were 19 more pills available for administration than were on the CS log. -She always administered the missed dose later in the day and would sign out medication on the CS log each time it was administered. -It did not matter which CS log she signed the medication out on as long as Resident #2 received his medication.</p>	{C 367}		

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{C 367}	<p>Continued From page 19</p> <p>Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/18/23 at 12:32pm and on 10/19/23 at 9:38am and 10:06am was unsuccessful.</p> <p>Attempted telephone interview with Resident #2's mental health provider on 10/19/23 at 11:14am and 11:30am were unsuccessful.</p>	{C 367}		