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
	HAL086014	A. BUILDING: ______ B. WING ______	R 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWOOD ALF	711 W ATKINS DR DOBSON, NC 27017

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 12/06/23 through 12/07/23.	{D 000}		
{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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B violation is abated. Non-compliance continues. Based on record reviews, and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#1) related to medication refusals of antipsychotic and a psychotropic medication. The findings are: Review of Resident #1's current FL-2 dated 10/30/23 revealed diagnoses included mild intellectual disability and schizoaffective disorder. a. Review of Resident #1's signed physician's orders dated 10/30/23 revealed there was an order for mirtazapine (used to treat depression) 30mg at bedtime. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for mirtazapine 30 mg at bedtime scheduled for administration at 7:00pm daily.	{D 273}		

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

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{D 273}	Continued From page 1 -There was no documentation of administration of mirtazapine for 7:00pm for 31 of 31 opportunities from 10/01/23 to 10/31/23. -There was an entry for mirtazapine 30 mg at bedtime scheduled for administration at 8:00pm daily. -Mirtazapine 30mg was documented as "resident refused" at 8:00pm for 11 of 31 opportunities on 10/01/23, 10/07/23, 10/08/23, 10/10/23-10/12/23, 10/17/23, 10/23/23-10/25/23 and 10/30/23. Review of Resident #1's November 2023 eMAR revealed: -There was an entry for mirtazapine 30 mg at bedtime scheduled for administration at 7:00pm daily. -Mirtazapine 30mg was documented as "resident refused" at 7:00pm for 2 of 14 opportunities on 11/18/23 and 11/26/23. -There was an entry for mirtazapine 30 mg at bedtime scheduled for administration at 8:00pm daily. -Mirtazapine 30mg was documented as "resident refused" at 8:00pm for 6 of 16 opportunities on 11/01/23, 11/03/23, 11/06/23, 11/09/23, 11/12/23 and 11/14/23. Review of Resident #1's progress notes revealed: -There was no documentation Resident #1 had experienced any episodes of depression, sleep disturbance, or decreased appetite. -There was no documentation the Mental Health Provider was notified for refused medications. Refer to the interview with Resident #1 on 12/07/23 at 9:44am. Refer to the interview with a medication aide (MA) on 12/06/23 at 11:40am.	{D 273}		

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Refer to the interview with a second MA on 12/07/23 at 7:50am.

Refer to the telephone interview with Resident #1's Mental Health Provider on 12/06/23 at 3:19pm.

Refer to the interview with the Resident Care Coordinator on 12/07/23 at 11:40am.

Refer to the interview with the Administrator on 12/07/23 at 12:10pm.

b. Review of Resident #1's signed physician's orders dated 10/30/23 revealed there was an order for risperidone (an antipsychotic used to treat schizoaffective disorder) 0.5 mg take one tablet 2 times a day with a 2mg dose.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for risperidone 0.5 mg take one tablet 2 times a day with a 2mg dose scheduled for administration at 8:00am, with entries for 7:00pm and 8:00pm daily.
-There was no documentation of administration at 7:00pm for 31 of 31 opportunities.
-Risperidone 0.5mg was documented as "resident refused" at 8:00pm for 11 of 31 opportunities on 10/01/23, 10/07/23, 10/08/23, 10/10/23-10/12/23, 10/17/23, 10/23/23-10/25/23 and 10/30/23.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for risperidone 0.5 mg take one tablet 2 times a day with a 2mg dose scheduled for administration at 8:00am, and with entries for 7:00pm and 8:00pm daily.
- Risperidone 0.5 mg was documented as

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"resident refused" at 7:00pm for 2 of 14 opportunities on 11/18/23 and 11/26/23.
-Risperidone 0.5 mg was documented as "resident refused" at 8:00pm for 6 of 16 opportunities on 11/01/23, 11/03/23, 11/06/23, 11/09/23, 11/12/23 and 11/14/23.

Review of Resident #1's progress notes revealed:
-There was no documentation Resident #1 had experienced incidents related to behaviors.
-There was no documentation the Mental Health Provider was notified for refused medications.

Refer to the interview with Resident #1 on 12/07/23 at 9:44am.

Refer to the interview with a medication aide (MA) on 12/06/23 at 11:40am.

Refer to the interview with a second MA on 12/07/23 at 7:50am.

Refer to the telephone interview with Resident #1's Mental Health Provider on 12/06/23 at 3:19pm.

Refer to the interview with the Resident Care Coordinator on 12/07/23 at 11:40am.

Refer to the interview with the Administrator on 12/07/23 at 12:10pm.

c. Review of Resident #1's signed physician's orders dated 10/30/23 revealed there was an order for risperidone (used to treat schizoaffective disorder) 2.0 mg take one tablet 2 times a day.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for risperidone 2.0 mg take

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one tablet 2 times a day with a 2mg dose scheduled for administration at 8:00am, with entries for 7:00pm and 8:00pm daily.
-There was no documentation of administration at 7:00pm for 31 of 31 opportunities.
-Risperidone 2.0 mg was documented as "resident refused" at 8:00pm for 11 of 31 opportunities on 10/01/23, 10/07/23, 10/08/23, 10/10/23-10/12/23, 10/17/23, 10/23/23-10/25/23 and 10/30/23.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for risperidone 2.0 mg take one tablet 2 times a day with a 2mg dose scheduled for administration at 8:00am, with entries for 7:00pm and 8:00pm daily.
- Risperidone 2.0 mg was documented as "resident refused" at 7:00pm for 2 of 14 opportunities on 11/18/23 and 11/26/23.
-Risperidone 2.0 mg was documented as "resident refused" at 8:00pm for 6 of 16 opportunities on 11/01/23, 11/03/23, 11/06/23, 11/09/23, 11/12/23 and 11/14/23.

Review of Resident #1's progress notes revealed:
-There was no documentation Resident #1 had experienced incidents related to behaviors.
-There was no documentation the Mental Health Provider was notified for refused medications.

Refer to the interview with Resident #1 on 12/07/23 at 9:44am.

Refer to the interview with a medication aide (MA) on 12/06/23 at 11:40am.

Refer to the interview with a second MA on 12/07/23 at 7:50am.

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Refer to the telephone interview with Resident #1's Mental Health Provider on 12/06/23 at 3:19pm.

Refer to the interview with the Resident Care Coordinator on 12/07/23 at 11:40am.

Refer to the interview with the Administrator on 12/07/23 at 12:10pm.

____

Interview with Resident #1 on 12/07/23 at 9:44am revealed:
-She did not refuse medications when she was awake.
-She went to bed around 7:00pm most nights.
-She did not take her evening medications every night because she did not want to get up to take them after she went to bed.
-She did not have any episodes of depression or seeing things like she had before.
-She slept well and had a good appetite.

Interview with a medication aide (MA) on 12/06/23 at 11:40am revealed:
-He administered evening medications to residents.
-When Resident #1 went to bed early she did not want to be bothered to take her evening medications.
-If a resident refused medication often or 3 days in a row, he wrote the refusal on the 24-hour report sheet that was handed into the facility's office.
-He thought the Resident Care Coordinator (RCC) or Administrator informed the provider of residents' refused medications.
-He never notified the Mental Health Provider of Resident #1's multiple refusals in October and November 2023.

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Interview with a second MA on 12/07/23 at 7:50am revealed:
-He worked the evening shift and administered 8:00pm medications to the residents.
-Sometimes, Resident #1 was in bed before the 8:00pm medication pass and would not wake up to take her medications.
-He had verbally notified the RCC or Administrator that Resident #1 had refused evening medications occasionally, but he did not remember specific dates/times in which he did so.
-He had not notified Resident #1's Mental Health Provider because the RCC or Administrator usually notified providers.
-He did not know if the RCC or Administrator audited residents' eMARs for refused medications and notified the PCP.

Telephone interview with Resident #1's Mental Health Provider on 12/06/23 at 3:19pm revealed:
-He was not notified that Resident #1 had refused her risperidone and mirtazapine 11 times in October 2023 and 8 times in November 2023.
-The facility should be letting him know if residents were refusing medications frequently.
-Resident #1 was prescribed mirtazapine to improve her mood, sleep and appetite.
-If she did not receive a constant dose of mirtazapine, she could have difficulty sleeping and have disruptive behaviors.
-He prescribed risperidone due to her history of delusions.
-She could have a return of delusions if she was not administered a constant dose of risperidone.
-He would have considered reducing her doses of both medications or discontinuing the mirtazapine since she was sleeping through the evening or asked staff to administer the medications earlier so that she would not refuse.

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Interview with the RCC on 12/07/23 at 11:40am revealed:
-There was not a schedule to audit eMARs. He or the Administrator would audit for refusals when they had time.
-The MAs told him or the Administrator when residents refused medications and he would inform the provider of the refusals.
-He was aware of frequent refusals of evening medications by Resident #1.
-Resident #1 had not had any behaviors and slept well.
-She refused evening medications at times because she did not want to wake up to take them.
-He had informed her primary care provider (PCP) of other refused medications, but he missed informing her Mental Health Provider that she refused her mirtazapine and risperidone frequently.

Interview with the Administrator on 12/07/23 at 12:10pm revealed:
-She or the RCC were responsible to audit eMARs for refused medications.
-Staff notified the RCC or the Administrator after 2 or 3 missed doses of a medication.
-She had not audited residents' eMARs due to staffing issues.
-She had informed Resident #1's PCP, but had not specifically notified her Mental Health Provider of refusal of psychiatric medications.
-There was no documentation available for review for medication staff having notified the Mental Health Provider for Resident #1 refusing evening doses of mirtazapine and risperidone in October 2023 and November 2023.
-The facility and the PCP agreed to move evening administrations times from 8:00pm to 7:00pm.

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{D 273}	Continued From page 8 -The earlier administration time gave the MAs time from 6:00pm to administer residents' evening medications before they went to bed. -Moving the time was meant to prevent residents from refusing evening medications at bedtime. -She expected the MAs to administer medications earlier for known refusals of medications such as Resident #1.	{D 273}		
{D 392}	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was an accurate accounting for the receipt, administration, and disposition of controlled medications for 1 of 5 sampled residents (#2) related to an anti-anxiety medication. The findings are: Review of Resident #3's current FL2 dated 12/04/23 revealed: -Diagnoses included anxiety, bipolar disorder, and schizoaffective disorder. -Under the medication section, there was documentation to see physician's orders. a. Review of Resident #3's physician's orders dated 12/04/23 revealed an order for lorazepam	{D 392}		

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0.5mg 1 tablet twice daily (a Schedule IV controlled substance used to treat anxiety).

Review of Resident #3's FL2 dated 03/06/23 revealed under the medication section, there was documentation to see physician's orders.

Resident #3's physician's orders dated 03/06/23 revealed an order for lorazepam 0.5mg 1 tablet twice daily.

Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-Lorazepam was documented as administered for 22 of 32 opportunities between 10/01/23 and 10/31/23.
-Lorazepam was documented as not administered on 10/09/23 at 8:00pm, 10/10/23 at 8:00am and 8:00pm, 10/11/23 at 8:00am and 8:00pm, 10/12/23 at 8:00am, 10/23/23 at 8:00pm, 10/24/23 at 8:00am and 8:00pm, and 10/25/23 at 8:00am due to Resident #3 was out of the facility.

Review of Resident #3's medication release form dated 10/09/23 revealed:
-There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation that 7 tablets of lorazepam were released to Resident #3 when he left the facility on 10/09/23.
-There was no documentation of when Resident #3 returned to the facility or how many tablets of lorazepam were returned to the facility.

Review of Resident #3's medication release form

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dated 10/23/23 revealed:
-There was an entry for lorazepam 0.5mg, but there were no directions for administration.
-There was documentation that 7 tablets of lorazepam were released to Resident #3 when he left the facility on 10/23/23.
-There was documentation on an attached eMAR that 3 tablets of lorazepam were returned to the facility on 10/26/23.

Review of Resident #3's inventory history for lorazepam 0.5mg tablets for October 2023 revealed:
-On 10/01/23, the beginning balance was 24 tablets.
-On 10/12/23, there was a balance of 7 tablets and 7 tablets were documented as disposal bringing the balance to 0 tablets.
-On 10/12/23, there was a balance of 0 tablets and 1 tablet was added and documented as delivered bringing the balance to 1 tablet.
-On 10/12/23, there was documentation Resident #1's lorazepam was reconciled with a balance of 1 tablet.
-On 10/13/23, there was a balance of 0 tablets and 28 tablets were added and documented as delivered bringing the balance to 28 tablets.
-On 10/26/23, there was a balance of 5 tablets and 4 tablets were documented as disposal bringing the balance to 1 tablet.
-On 10/27/23, there was a balance of 0 tablets and 28 tablets were added and documented as delivered bringing the balance to 28 tablets.
-The remaining balance on the inventory history on 10/31/23 was 18 tablets.

Review of Resident #3's November 2023 eMAR revealed:
-There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at

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8:00am and 7:00pm or 8:00pm.
-Lorazepam was documented as administered for 47 of 60 opportunities between 11/01/23 and 11/30/23.
-Lorazepam was documented as not administered on 11/06/23 at 8:00pm, 11/07/23 at 8:00am and 8:00pm, 11/08/23 at 8:00am, 11/10/23 at 8:00am, 11/20/23 at 8:00pm, 11/21/23 through 11/23/23 at 8:00am and 8:00pm, and 11/24/23 at 8:00am due to Resident #3 was out of the facility and medication was not available on 11/10/23.

Review of Resident #3's medication release form dated 11/06/23 revealed:
-There was an entry for lorazepam 0.5mg scheduled for administration at 8:00am and 8:00pm.
-There was documentation that 7 tablets of lorazepam were released to Resident #3 when he left the facility on 11/06/23 and 3 tablets were returned to the facility on 11/09/23.

Review of Resident #3's medication release form dated 11/20/23 revealed:
-There was no documentation lorazepam 0.5mg was released to Resident #3 when he left the facility on 11/20/23.
-There was documentation to see the eMAR, but there was no eMAR attached to the medication release form.
-There was documentation Resident #3 returned on 11/24/23.

Review of Resident #3's inventory history for lorazepam 0.5mg tablets for November 2023 revealed:
-On 11/01/23, the beginning balance was 18 tablets.
-On 11/08/23, there was a balance of 7 tablets

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{D 392}	Continued From page 12 and 4 tablets were documented as disposal bringing the balance to 3 tablets. -On 11/10/23, there was a balance of 0 tablets and 28 tablets were added and documented as delivered bringing the balance to 28 tablets. -On 11/23/23, there was a balance of 8 tablets and 28 tablets were added and documented as delivered bringing the balance to 36 tablets. -The remaining balance on the inventory history on 11/30/23 was 23 tablets. Review of Resident #3's eMAR for 12/01/23 through 12/06/23 revealed: -There was an entry for lorazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 7:00pm. -Lorazepam was documented as administered for 11 of 11 opportunities between 12/01/23 and 12/06/23. -Lorazepam was documented as not administered on 11/06/23 at 8:00pm, 11/07/23 at 8:00am and 8:00pm, 11/08/23 at 8:00am, 11/10/23 at 8:00am, 11/20/23 at 8:00pm, 11/21/23 through 11/23/23 at 8:00am and 8:00pm, and 11/24/23 at 8:00am due to Resident #3 was out of the facility; there was documentation medication was not available on 11/10/23. Review of Resident #3's inventory history for lorazepam 0.5mg tablets for 12/01/23 through 12/06/23 revealed: -On 12/01/23, the beginning balance was 23 tablets. -The remaining balance on the inventory history on 12/06/23 was 12 tablets. Observation of Resident #3's medications available for administration on 12/06/23 at 2:07pm revealed: -There were 2 colored medication cassettes of	{D 392}		

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lorazepam 0.5mg with instructions to take 1 tablet twice daily.
-The pink medication cassette had 2 tablets remaining and the gray medication cassette had 3 tablets remaining for a total of 5 tablets.

Based on review of Resident #3's inventory tracking for lorazepam 0.5mg tablets, medication release forms, observation of lorazepam 0.5mg tablets on hand for administration, the facility did not have an accurate accounting for administration or disposition of 7 lorazepam 0.5mg tablets for Resident #3.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/07/23 at 10:01am revealed:
-Resident #3 had an order for lorazepam 0.5mg 1 tablet twice daily.
-Lorazepam was refilled by the pharmacy every 2 weeks with dispensed dates on 10/12/23, 10/25/23, 11/10/23, 11/21/23, and 12/05/23 with a quantity of 28 tablet on each dispensed date.
-The start dates for the medications may be off because medications were delivered on Thursdays and should have started on the next Friday.

Interview with the Resident Care Coordinator (RCC) on 12/07/23 at 11:10pm revealed:
-Resident #3 often left the facility on therapeutic leave and his medications, including lorazepam, were sent with him.
-When medications were sent with Resident #3, there was no deduction made from the inventory history until he returned to the facility.
-Once Resident #3 returned to the facility, he deducted the number of whole tablets Resident #3 used while he was gone.
-When there was documentation of disposal on

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the inventory history, that was the quantity of lorazepam tablets Resident #3 used while on therapeutic leave.
-He and the Administrator compared the inventory history to the eMAR,for Resident #3's lorazepam, but no one compared the inventory history to the lorazepam available in the medication cart.

Refer to interview with a medication aide (MA) on 12/07/23 at 9:36am.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/23 at 11:10am.

Refer to the interview with the Administrator on 12/07/23 at 12:01pm.

b. Review of Resident #3's physician's orders dated 12/04/23 revealed an order for lorazepam 1mg, ½ tablet 3 times daily as needed (a Schedule IV controlled substance used to treat anxiety).

Review of Resident #3's FL2 dated 03/06/23 revealed under the medication section, there was documentation to see physician's orders.

Resident #3's physician's orders dated 03/06/23 revealed order for lorazepam 1mg, ½ tablet 3 times daily as needed.

Review of Resident #3's October 2023 eMAR revealed:
-There was an entry for lorazepam 1mg ½ tablet three times daily as needed scheduled for administration as needed.
-Lorazepam was documented as administered 3 times on 10/08/23, 10/15/23, and 10/27/23.

Review of Resident #3's medication release form

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dated 10/09/23 revealed there was no documentation lorazepam 1mg 1/2 tablets were released to Resident #3 when he left the facility on 10/09/23.

Review of Resident #3's medication release form dated 10/23/23 revealed:
-There was an entry for lorazepam 1mg, but there were no directions for administration.
-There was documentation that 6 and 1/2 tablets of lorazepam were released to Resident #3 when he left the facility on 10/23/23.
-There was documentation on an attached eMAR that 6 and 1/2 tablets of lorazepam were returned to the facility on 10/26/23.

Review of Resident #3's inventory history for lorazepam 0.5mg tablets for October 2023 revealed:
-On 10/08/23, the beginning balance was 38 whole tablets.
-On 10/27/23, there was a balance of 37 tablets and 1 whole tablet was documented as administered bringing the balance to 36 tablets.
-The remaining balance on the inventory history on 10/27/23 was 36 tablets.

Review of Resident #3's November 2023 eMAR revealed:
-There was an entry for lorazepam 1mg ½ tablet three times daily as needed scheduled for administration as needed.
-Lorazepam was documented as administered 5 times on 11/03/23, 11/04/23, 11/05/23, 11/09/23, and 11/10/23.

Review of Resident #3's medication release form dated 11/06/23 revealed:
-There was an entry for lorazepam 1mg ½ tablet as needed.

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-There was documentation that 3 whole tablets of lorazepam were released to Resident #3 when he left the facility on 11/06/23 and 2 whole tablets were returned to the facility on 11/09/23.

Review of Resident #3's medication release form dated 11/20/23 revealed:
-There was no documentation lorazepam 1mg was released to Resident #3 when he left the facility on 11/20/23.
-There was documentation to see the eMAR, but there was no eMAR attached to the medication release form.
-There was documentation Resident #3 returned on 11/24/23.

Review of Resident #3's inventory history for lorazepam 1mg tablets for November 2023 revealed:
-On 11/03/23, the beginning balance was 36 tablets.
-On 11/08/23, there was a balance of 34 and 1/2 tablets and 1 whole tablet was documented as disposal bringing the balance to 33 and 1/2 tablets.
-The remaining balance on the inventory history on 11/29/23 was 32 tablets.

Review of Resident #3's eMAR for 12/01/23 through 12/06/23 revealed:
-There was an entry for lorazepam 1mg ½ tablet three times daily as needed scheduled for administration as needed.
-Lorazepam was documented as administered 1 time on 12/08/23.

Review of Resident #3's inventory history for lorazepam 1mg tablets for 12/01/23 through 12/06/23 revealed:
-On 12/05/23, the beginning balance was 32

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tablets.
-The remaining balance on the inventory history on 12/05/23 was 31 and 1/2 tablets.

Observation of Resident #3's medications available for administration on 12/06/23 at 2:07pm revealed:
-There were 5 medication cassettes of lorazepam 1mg with instructions to take ½ tablet three times daily as needed.
-The 5 medication cassettes of lorazepam 1mg were dispensed by the pharmacy on 12/23/23 with a quantity of 45 whole tablets (90 half tablets).
-There was a quantity of 15 half tablets remaining in the first cassette.
-There was a quantity of 11 half tablets remaining in the second cassette.
-There was a quantity of 11 half tablets remaining in the third cassette (3 of the tablets were crushed).
-There was a quantity of 12 half tablets remaining in the fourth cassette.
-There was a quantity of 13 half tablets remaining in the fifth cassette.
-The total number of half tablets remaining in the medication cart was 62 half tablets (31 whole tablets).

Based on review of Resident #3's inventory tracking for lorazepam 1mg tablets, medication release forms, observation of lorazepam 1mg tablets on hand for administration, the facility did not have an accurate accounting for administration or disposition of 1/2 lorazepam 1mg tablet for Resident #3.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/07/23 at 10:01am revealed:

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-Resident #3 had an order for lorazepam 1mg ½ tablet three times daily as needed.
-Lorazepam was dispensed by the pharmacy on 12/23/23 with a quantity of 90 half tablets and there had not been any other requests to refill the medication.

Interview with the RCC on 12/07/23 at 11:10pm revealed:
-When as needed lorazepam was dispensed by the pharmacy, the quantity was entered into the inventory history as whole tablets.
-When half tablets were administered as needed, a half tablets (0.5) was deducted from the inventory history.
-He did not know why 1 whole tablet would have been deducted.

Refer to interview with a medication aide (MA) on 12/07/23 at 9:36am.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/07/23 at 11:10am.

Refer to the interview with the Administrator on 12/07/23 at 12:01pm.

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Interview with a MA on 12/07/23 at 9:36am revealed:
-When he administered Resident #3's lorazepam, he entered a deduction of 1 tablet of the scheduled 0.5mg tablet and deduction of 0.5 tablet for the as needed 1mg tablet on the inventory history.
-He did not count the number of tablets remaining in the medication cart for Resident #3's scheduled or the as needed lorazepam.
-The only time he counted Resident #3's lorazepam was when it was delivered from the pharmacy and he added it to his controlled

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substance medication count.
-He did not know if anyone else counted Resident #3's scheduled or as needed lorazepam tablets to ensure the count matched the inventory history.
-He did not know the quantity Resident #3's lorazepam in the medication cart did not match the balance on the inventory history.

Interview with the RCC on 12/07/23 at 11:10pm revealed:
-He and the Administrator compared the inventory history for Resident #3's lorazepam to the eMAR about once a month, but no one compared the inventory history to the lorazepam available in the medication cart.
-He was not aware the number of scheduled and as needed lorazepam in the medication cart did not match the remaining balances on the inventory history.

Interview with the Administrator on 12/07/23 at 12:01pm revealed:
-The MA's were comparing the inventory history to the medication available in the medication cart daily after and prior to every shift, but there had been a pause in the daily auditing due to changes in the staff's shift hours.
-There was not a currently a daily auditing of controlled substances.
-When lorazepam was sent home with Resident #3 during a therapeutic leave, the number of tablets sent home was not deducted at the time of his departure.
-The RCC deducted the number of tablets used during the leave of absence when Resident #3 returned to the facility.
-She knew there were some discrepancies between the inventory history and the medication count because of there were times when quantities of lorazepam were deducted from the

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total count when Resident #3 returned from his therapeutic leave.
-The MAs were responsible for documenting the number of tablets sent home with Resident #3 and the number of tablets returned on the medication release form or on the eMAR attached to the form.
-The RCC was responsible for deducting the medication used during the therapeutic leave from the ending balance when Resident #3 returned to the facility.
-She was in the process of training day shift MAs to document the quantities of lorazepam sent home with Resident #3 and returned to the facility to ensure accurate accounting.