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
	FCL092045	A. BUILDING: _____ B. WING _____	12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIMS FAMILY CARE HOME	6337 MIMS ROAD HOLLY SPRINGS, NC 27540

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C 000	Initial Comments	C 000		
C 306	The Adult Care Licensure Section conducted an annual survey on December 30, 2019. 10A NCAC 13G .0907 (e) Respite Care 10A NCAC 13G .0907 Respite Care (e) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0702 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete. This Rule is not met as evidenced by: Based on interviews and observations the facility failed to maintain documentation of a current FL-2, tuberculosis test, and physician's orders while providing respite care for 1 of 1 resident sampled (#3). The findings are: Observation of the facility on 12/30/19 at 8:25am revealed Resident #3 was watching television in a bedroom at the end of the hallway; there were personal belongings on the bed and clothes stored in two black plastic trash bags on the floor	C 306	Facility will ensure that any nonresident that stay overnight, will have been tested for tuberculosis disease according to Rule .0702. Facility will keep TB documentation at the facility for all non-residents staying overnight. Facility will keep a binder with the TB information. SIC/Administrator will inform staff on the intent of any non-resident staying overnight. SIC/Administrator monitor and review this rule area at least bi-monthly. The SIC has a sign inbook with the dates of the stay, the FL-2, the Resident Register a Care Plan a TB test all with in the book during the residents respite stay. Lisa Mims 02/03/2020	3/6/2020

I have reviewed and accepted this POC with amendments via telephone with the SIC on 02/07/20.

Pamela Dailey 02/07/20

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Lisa Mims 02/03/2020

C 306	Continued From page 1	C 306	
	of the closet. Interview with the Supervisor-in-Charge (SIC) on 12/30/19 at 8:12am revealed a total of five people resided in the facility; two residents and three facility staff which included the SIC, a maintenance staff and the Administrator. Interview with Resident #3 on 12/30/19 at 8:25am revealed: -He thought he had lived at the facility for about a month or two, but he was getting ready to go with family back to his home that day. -He did not take medication but ate meals at the facility and slept in the bed; he stayed in "his own room" while he visited the facility. Interview with a resident on 12/30/19 at 8:30am revealed: -There six people lived in the facility; three were staff and three were residents. -Resident #3 had lived in the facility "off and on" for about six months, but he could not remember how many days a month or week Resident #3 stayed at the facility. -He thought Resident #3 was a family member of the SIC. Interview with the SIC on 12/30/19 at 8:33am revealed: -Resident #3 was not a resident and was a family member of the Administrator. -Resident #3 lived in another city and had only spent the previous night at the facility; he did not live at the facility. Interview with the Administrator on 12/30/19 at 9:00am revealed: -Resident #3 was a family member and lived in another city.		

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Lisa Mims 02/03/2020

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C 306	Continued From page 2 -Resident #3 would stay "off and on" for a week at a time; he stayed at the facility when the family he lived with went out of town. -Resident #3 did not have a record for review and did not pay because he was "family and did not live" at the facility. -She did not know if Resident #3 had a two-step tuberculosis test. -Resident #3 was not administered any medications. Interview with the SIC on 12/30/19 at 4:03pm revealed: -Resident #3 stayed overnight at the facility "off and on" for a few days at a time; she thought he stayed over night once every couple of months. -Resident #3 stayed at the facility when his guardian traveled out of town; the Administrator had the guardian's contact information. -Resident #3 did not have a record or any documentation; she thought he did not need documentation because he was not a resident. -She did not know if Resident #3 had a test for tuberculosis. -The facility staff did not provide any direct care for Resident #3 or administer medications to him while he stayed at the facility. Attempts to interview the maintenance staff on 12/30/19 were unsuccessful. Attempt of a second interview with the Administrator on 12/30/19 was unsuccessful.	C 306	
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the	C 330	Facility will ensure that all extra medications will be sent back to the pharmacy. To eliminate an ample supply on hand. Lisa Mims 12/03/2020

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C 330	Continued From page 3 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 record reviews, observations, and interviews, the facility failed to administer three medications as ordered by a licensed practitioner for 1 of 2 sampled residents (#1) including a medication used to treat eye pressure, a medication used to treat high cholesterol, and a medication used to treat mood disorders. The findings are: Review of Resident #1's current FL-2 dated 05/29/19 revealed diagnoses included diabetes mellitus type two, hypertension, blindness, chronic kidney disease stage three, history of psychosis, anemia, osteoarthritis, and benign prostatic hyperplasia with urinary incontinence. a. Review of Resident #1's current FL-2 dated 05/29/19 revealed there was a medication order for dorzolamide 2% ophthalmic drops (used to treat eye pressure caused by glaucoma) one drop to each eye three times daily. Review of Resident #1's physician's orders dated 08/29/19 revealed there was a medication order for dorzolamide 25 ophthalmic one drop into affected eyes three times daily. Review of Resident #1's October 2019	C 330	SIC/Administrator/Staff will not use any existing eye drop upon receiving the new, unless otherwise, noted that it is acceptable to administer by the pharmacist. SIC/Administrator will consult with pharmacy regarding disposing unused eye drops. The SIC has started a log book to keep track of returned medication to the pharmacy. The SIC is also documenting on the pill pack the date of the administration of the medication as it is administered to the residents. Type text here Lisa Mims 02/03/2020	Immediately 2/28/2020

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C 330 Continued From page 4

medication administration record (MAR) revealed: -There was and entry for dorzolamide 2% one drop into affected eyes three times daily, scheduled at 8:00am, 2:00pm and 8:00pm. - There was documentation the dorzolamide 2% was administered three times a day, every day from 10/01/19 to 10/31/19.

Review of Resident #1's November 2019 MAR revealed:
-There was and entry for dorzolamide 2% one drop into affected eyes three times daily, scheduled at 8:00am, 2:00pm and 8:00pm. - There was documentation the dorzolamide 2% was administered three times a day, every day from 11/01/19 to 11/30/19.

Review of Resident #1's December 2019 MAR revealed:
-There was and entry for dorzolamide 2% one drop into affected eyes three times daily, scheduled at 8:00am, 2:00pm and 8:00pm. - There was documentation the dorzolamide 2% was administered three times a day, every day from 12/01/19 to 12/30/19.

Observation of Resident #1's medication on hand on 12/30/19 at 11:38am revealed:
-There were two bottles of dorzolamide 2%. - The first bottle of dorzolamide 2% had a dispense date of 06/21/19 and the bottle was approximately two-thirds full.
-The second bottle of dorzolamide 2% had a dispense date of 12/18/19, the bottle was full, and the manufacture's seal was still intact.

Interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm revealed:
-There was an active order for dorzolamide 2%

C 330

Lisa Mims 01/08/2020

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C 330 | Continued From page 5

one drop in each eye three times a day. -The last three dispense dates for the dorzolamide 2% were 05/09/19, 06/21019 and 12/18/19; there were no dispense dates for the dorzolamide between June 2019 and December 2019.
-Each bottle of dorzolamide held 30 days of medication.
-The facility was responsible for contacting the pharmacy to order a refill of the dorzolamide. -An outcome for not administering the dorzolamide could have been increased pressure in the eye and eye discomfort.

Interview with a representative from Resident #1's primary care physician's (PCP) office on 12/30/19 at 2:56pm revealed:
-Resident #1 was ordered the dorzolamide 2% for pressure in the eye; the orders were dorzolamide 2% one drop in eyes three times daily.
-A possible outcome from the dorzolamide 2% not being administered as ordered would be pressure in the eye and eye pain.
-The facility should have called the PCP if Resident #1 was not administered the dorzolamide 2% as ordered; there was no documentation the PCP was notified concerning the dorzolamide 2%.

Interview with Resident #1 on 12/30/19 at 5:47pm revealed:
-His eye drops were applied only one time a day in the mornings by the Supervisor-in-Charge (SIC); he never refused his eye drops.
-If the SIC forgot to apply the eye drops, he would remind her, but she never forgot to apply them. -He did not have head aches or eye pain, and he did not feel pressure behind his eyes.
-He was blind and could only see a little light.

C 330

Lisa Mims 01/08/2020

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330	Continued From page 6 Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/30/19 at 12:20pm revealed: -She was the only the only MA at the facility and she administered Resident #1 all his medications. -She administered Resident #1 his dorzolamide 2% eye drops in each eye three times a day, every day. -One bottle of dorzolamide 2% usually lasted about six months; the pharmacy automatically sent a new bottle twice a year. -Resident #1 was usually good about taking his eye drops and never refused. -She did not know why Resident #1 was ordered the dorzolamide 2% or what the outcome could be when doses were missed. Attempted interview with the Administrator on 12/30/19 was unsuccessful. b. Review of Resident #1's current FL-2 dated 05/29/19 revealed there was a medication order for simvastatin 20 mg (used to treat high cholesterol levels) take daily at bedtime. Review of Resident #1's physician's orders dated 8/29/19 revealed an order for simvastatin 20mg take daily at bedtime for cholesterol. Review of Resident #1's October 2019 medication administration record (MAR) revealed: -There was and entry for simvastatin 20mg take daily at bedtime, scheduled at 8:00pm. -There was documentation simvastatin was administered daily from 10/01/19 to 10/31/19. Review of Resident #1's November 2019 MAR revealed: -There was and entry for simvastatin 20mg take	C 330	Lisa Mims 02/05/2020	

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C 330	Continued From page 7	C 330	
	daily at bedtime, scheduled at 8:00pm. -There was documentation simvastatin 20mg was administered daily from 11/01/19 to 11/30/19. Review of Resident #1's December 2019 MAR revealed: -There was and entry for simvastatin 20mg take daily at bedtime, scheduled at 8:00pm. -There was documentation simvastatin 20mg was administered daily from 12/01/19 to 12/29/19. Observation of Resident #1's medication on hand on 12/30/19 at 11:38am revealed: -There were three medication cards for Resident #1's simvastatin 20mg. -The first medication card had a dispense date of 09/28/19 and 30 tablets were dispensed for administering; 24 tablets remained in the card. -The second medication card had a dispense date of 11/27/19 and 30 tablets were dispensed for administering; 30 tablets remained in the card. -The third medication card had a dispense date of 12/27/19 and 30 tablets were dispensed for administering; 30 tablets remained in the card. Interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm revealed: -There was an active order for simvastatin 20mg take daily at bedtime due to high cholesterol levels. -The last four dispense dates for simvastatin 20mg was 09/18/19, 10/18/19, 11/19/19, and 12/19/19; 30 tablets were dispensed each time. -The date on the package was the date the facility should have started administering the medication. -The outcome for not taking the medication as ordered for 30 days would have been possible increases in lipid levels.		Lisa Mims 02/03/2020

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C 330	Continued From page 8	C 330	
	Interview with a representative from Resident #1's primary care physician's (PCP) office on 12/30/19 at 2:56pm revealed: -Resident #1's current order was for simvastatin 20mg take one tablet daily at bedtime. -The facility had not contacted the PCP's office about any concerns with the simvastatin for Resident #1. -If Resident #1 was not administered the simvastatin as ordered a possible out come could have been increased cholesterol levels; she did not know if Resident #1 had an increase in his cholesterol levels. Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 12/30/19 at 12:09pm revealed: -Resident #1 always took his medication; he never refused to take his medication. -She was the only medication aide and gave Resident #1 all his medication; she gave him his "pills" twice a day once in the morning and once in the evening. -The pharmacy had sent extra cards of simvastatin when the medication was delivered. -She could not remember which months the extra medication cards of simvastatin were sent or how many months extra medication cards of simvastatin were sent by the pharmacy. -She never notified the pharmacy of the extra medication cards of simvastatin; she should have discarded the extra medication. -She was trying to "finish off" the September 2019 simvastatin so the medication was not wasted. -She thought she administered the August 2019 medication in September 2019, and the October 2019 medication in the month of October 2019. -She had administered all the October 2019 simvastatin medication card; she did not know how she "got off track" or how the cards got out of		

Lisa Mims 01/03/2020

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C 330		C 330	
	Continued From page 9 order. -The extra simvastatin was due to the extra medication the pharmacy sent. Refer to Interview to Interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm. Refer to interview with Resident #1 on 12/30/19 at 5:47pm. Refer to the interview with the SIC/MA on 12/30/19 at 3:35pm. Attempted interview with the Administrator on 12/30/19 was unsuccessful. c. Review of Resident #1's current FL-2 dated 05/29/19 revealed there was a medication order for quetiapine 200mg (used to treat schizophrenia, bipolar disorder and depression) take once daily at bedtime. Review of Resident #1's physician's orders dated 08/29/19 revealed an order for quetiapine 200mg take once daily at bedtime. Review of Resident #1's October 2019 medication administration record (MAR) revealed: -There was and entry for quetiapine 200mg take daily at bedtime, scheduled at 8:00pm. -There was documentation quetiapine 200mg was administered daily from 10/01/19 to 10/31/19. Review of Resident #1's November 2019 MAR revealed: -There was and entry for quetiapine 200mg take daily at bedtime, scheduled at 8:00pm.		Lisa Mims 12/03/2020

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C 330	Continued From page 10 -There was documentation quetiapine 200mg was administered daily from 11/01/19 to 11/30/19. Review of Resident #1's December 2019 MAR revealed: -There was and entry for quetiapine 200mg take daily at bedtime, scheduled at 8:00pm. -There was documentation quetiapine 200mg was administered daily from 12/01/19 to 12/29/19. Observation of Resident #1's medication on hand on 12/30/19 at 11:38am revealed: -There were three medication cards for Resident #1's quetiapine. -The first medication card had a dispense date of 10/28/19 and 30 tablets were dispensed for administering; 30 tablets remained in the card. -The second medication card of quetiapine had a dispense date of 11/27/19 and 30 tablets were dispensed for administering; 30 tablets remained in the card. -The third medication card had a dispense date of 12/27/19 and 30 tablets were dispensed for administering; 30 tablets remained in the card. Interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm revealed: -The last four dispense dates for Resident #1's quetiapine was 09/18/19, 10/18/19, 11/19/19, and 12/18/19; 30 tablets were dispensed each time. -The date on the package was the date the facility should have started administering the medication. -They only sent Resident #1 one card of quetiapine at a time and only sent enough tablets for 30 days. -An outcome of not taking quetiapine as ordered could be increased agitation, outburst and increased levels of psychosis.	C 330	SIC/Administrator/Staff will ensure that any extra pill packs, will be sent back to the pharmacy. SIC/Administrator/Staff will have written documentation from the pharmacy if medications are not to be returned. SIC/Administrator will monitor the medication administration record weekly for accuracy. Lisa Mims 01/03/2020	2/28/2020

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C 330	Continued From page 11	C 330		

Interview with a representative from Resident #1's primary care physician's (PCP) office on 12/30/19 at 2:56pm revealed:
-Resident #1 had a current order for quetiapine 200mg take one tablet once daily at bedtime. -Quetiapine was a psychiatric medication ordered for Resident #1; she was not sure of Resident#1's past behaviors so she did not know exactly why Resident #1 was ordered the quetiapine. -She did know possible outcomes from three or four days of missed doses could have included delusions, behavior issues and possible sleep issues.
-The facility should notify the PCP whenever Resident #1 missed any doses of quetiapine.

Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 12/30/19 at 12:20pm revealed:
-The pharmacy sent "extra [medication] cards" the last two months; she thought it was for Resident #1's quetiapine.
-She did not send the extra medication back to the pharmacy; she administered the mediation because she did not want to waste it. -She was sure she gave Resident #1 his quetiapine as ordered; she was the only MA for the facility.
-She had administered the last quetiapine tablet out of a medication card last night, 12/29/19, but she did not know the date on the card. -She had no other explanation for the three unused cards of quetiapine; she would start administering out of the December 2019 on 12/30/19.

Refer to interview to interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm.

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C 330	Continued From page 12	C 330	
	Refer to interview with Resident #1 on 12/30/19 at 5:47pm. Refer to the interview with the SIC/MA on 12/30/19 at 3:35pm. Attempted interview with the Administrator on 12/30/19 was unsuccessful. Interview with a representative from the facility's contracted pharmacy on 12/30/19 at 2:03pm revealed: -They did not intentionally send extra cards of medication or send extra cards of medication by "accident". -All orders were checked by the pharmacy before they were delivered to prevent errors or mistakes. -If there were ever extra cards sent to the facility or leftover medication for any reason the facility should have called them to return the extra medication. -The facility had never contacted the pharmacy for a pick up for an extra medication card or for any extra medication. Interview with Resident #1 on 1230/19 at 5:47pm revealed: -He took four "pills" every day at 4:30pm; the Supervisor-in-Charge (SIC) gave medication to him to take. -He always took his medication and never refused; the SIC never forgot to give him his medication and if she did forget he would reminder her. -He had been sleeping well and he had been "feeling good". Interview with the Supervisor-in-Charge/medication aide (SIC/MA)		Lisa Mims 02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092045	A. BUILDING: _____ B. WING _____	12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIMS FAMILY CARE HOME	6337 MIMS ROAD HOLLY SPRINGS, NC 27540

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C 330	Continued From page 13 on 12/30/19 at 3:35pm revealed: - She checked the medication the pharmacy delivered to the facility against the medication administration record (MAR); she checked the medication for the name and the dosage. -The pharmacy often sent duplicate medication cards. -When duplicate medication cards had come from the pharmacy, she notified the pharmacy of the duplicate cards via telephone and the pharmacy picked up the duplicate cards. -She thought she sent two duplicate cards back to the pharmacy in November 2019 and two duplicate cards in October 2019, but she did not remember the type of medication she sent back; she could not remember other months she had sent duplicate medication cards back to the pharmacy. -She did not check the medication for December 2019 for duplicate cards and could not give a reason why.	C 330		
C 352	10A NCAC 13G .1006 (a) Medication Storage 10a NCAC 13G .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the facility's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure self-administered medications kept in resident rooms for 1 of 2 sampled residents (Resident #2) were stored in a safe and secure manner at all times.	C 352	SIC/Administrator will ensure that residents with self-administered medications be stored in a safe and secure manner in the resident's room. The facility will ensure that all medication be stored in a secure clear container. SIC/Administrator/Staff will monitor all residents who have an order to self-administer medications daily. The SIC has provided a locked box for the resident to keep his medication secure. The SIC keeps a key to the box as well. The resident will be periodically assesed by his physician to assure he has the ability to continue self administering of his medication. Lisa Mims 02/03/2020	2/28/2020 Immediately 2/28/2020

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C 352

Continued From page 14

C 352

The findings are:

Review of Resident #1's current FL-2 dated 04/07/19 revealed:
-Diagnoses included diabetes mellitus type two, hypertension, hypersensitivity lung disease, chronic kidney disease, gastroesophageal reflux disease (GERD), neuropathy in feet, and hearing loss.
-A physician's order for the resident to self-administer all his medications.
-A physician's order for fingerstick blood sugars (FSBSs) once daily.
-Medication orders included: aspirin (a preventative heart medication) 81 mg daily, acetaminophen 325mg (used to treat minor aches and pains) take every eight hours as needed, ammonium lactate 12% (used to treat dry and scaly skin) apply to feet twice daily, colchicine 0.6mg (used to treat and prevent gout attacks) take twice daily as needed, glipizide 5mg (used to treat type two diabetes) take once daily, metoprolol 25mg (used to treat high blood pressure) take half a tablet (12.5mg) once daily, omeprazole 20mg (used to treat heartburn and GERD) take once daily, polyethylene glycol powder 17g (used to treat constipation) once daily as needed, potassium chloride 20mcq (used to treat low blood potassium) take once daily, simvastatin 40mg (used to treat high cholesterol) take daily at bedtime, tamsulosin 0.4mg (used to treat enlarged prostrate) take once daily, and Tradjenta 5mg (used to treat type two diabetes) take once daily.

Observation of Resident #2's room on 12/30/19 at 8:30am revealed:
-Resident #2's door was closed.
-There was a bedside table with a glucometer,

Lisa Mims 02/03/2020

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C 352	Continued From page 15	C 352	

test strips and a lancet pen with extra lancets setting on it.
-There was a small insulated bag with a zipper setting on top of a clear plastic container; the insulated bag was unzipped and contained ten mediation cards.
-There was a bottle of ammonium lactate 12% setting on the floor next to the clear plastic container.
-On the spare bed was a plastic shopping bag that contained eleven new, unused medication cards.
-The door to Resident #2's room had a lock on it, but the door was unlocked.
-Resident #2 did not have a roommate.

Interview with the Supervisor-in-Charge on 12/30/19 at 12:39 pm revealed:
-Resident #2 administered his own medication; he stayed "on top" of his medication and knew what the medication he took was for and when to take it.
-Resident #2 kept the medication in the zippered bag during the day but she locked the bag up with the other resident's medication in the evenings; she brought Resident #2 his medication every morning.
-Resident #2 did not leave his room, even for meals so she did not feel the medication needed to be locked up during the day time.
-The only other resident in the facility was blind and did not go into Resident #2's room so she was not worried about anyone else taking Resident #2's medication.
-She thought the medication was okay to leave in Resident #2's room during the day because he was always in his room.
-Resident #2 would know if someone took any of his medication because he kept it in a particular order by the time of day he was scheduled to take

Lisa Mims 07/03/2020

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C 352	Continued From page 16	C 352	

it.
-There was no medication storage policy.

Interview with Resident #2 on 12/30/19 at 2:58pm revealed:
-He kept all his medication in his room all the time, even in the evening; he did not want anyone to "mess up" the order of his medication.
-He self-administered all his medications, he kept a notebook to document his glucose checks and his medications.
-He had not been told medications kept in his room needed to be locked up or secured; he felt his medications were secure enough because he was in the room "all the time".
-He used to keep all his medication in the clear plastic container the insulated bag was setting on but it was too difficult to reach the clear plastic container from his bed; the plastic container did not have a lock on it either.
-He did not have a way to lock his medication up in his room; he did not leave his room and only staff and family, when they visited, came into his room.

Interview with the SIC on 12/30/19 at 3:53pm revealed:
-She was not aware Resident #2 had a shopping bag with eleven new medication cards in his room.
-She thought the unused cards were locked up with the other resident's medication.

Attempted interview with the Administrator on 12/30/19 was unsuccessful.

Attempted interview with Resident #2's primary care physician (PCP) on 12/30/19 at 2:24pm was unsuccessful.

Lisa Mims 02/03/2020

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C 352	Continued From page 17 Observation of the facility on 12/30/19 at various times revealed Resident #2's remained in his room and did not leave it; the door was closed but always unlocked	C 352	

Lisa Mims 2/03/2020