Stacey, Shonda M

From: reggie@xpress-groups.com
Sent: Thursday, February 20, 2020 1:17 PM
To: Stacey, Shonda M
Subject: [External] Re: The Villas at Benson #3 POC
Attachments: 20200220131120.pdf

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Hello Ms. Stacey,

Please find attached our Plan of Correction (POC) for Villas III.

Kind regards,

Reggie Ogbonna

On 2020-02-05 07:39, Stacey, Shonda M wrote:
> Greetings Mr. Ogbonna,
>
> The attached correspondence is related to the Plan of Correction for
> The Villas at Benson #3. If you have any questions please contact me
> at 984-365-2578.
>
> Sincerely,
>
> SHONDA STACEY, MSN, RN-BC
>
> Nurse Consultant
>
> Division of Health Service Regulation, Adult Care Licensure Section
>
> NC Department of Health and Human Services
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> SHONDA STACEY, MSN, RN-BC
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051066	A. BUILDING: _____ B. WING _____	12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BENSON 3	606 E MORRIS AVENUE BENSON, NC 27504

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on December 30, 2019.	C 000		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to store food so that it was protected from contamination in the freezer, refrigerator, storage closet and cabinets. The findings are: Review of the Johnston County Inspection of Residential Care Facility dated 06/04/19 revealed an "A" score with 2 demerits for storing raw eggs above ready to eat foods. Observation of the side by side refrigerator on 12/30/19 at revealed: -There was an opened and undated family sized bag of sausage links on the third shelf of the freezer side. -There was an opened and undated package of turkey wings in the rear portion of the third shelf of the freezer side. -There was a foiled item without a label or date on top of the package of turkey wings. -There was an opened and undated family sized package of French toast sticks on the fourth shelf of the freezer side.	C 257	10A NCAC 13G.0904(a)(2) All food and beverage being procured, stored,prepared or served by the facility are beingprotected food contamination. The facility hired a new cook and he has taking the food safe serve class. The other staff membershave under taken a safe food storage, preparation and serving methods. Henceforth, all food packaging that is opened will be properly marked with the exact date that it was opened. Any perishables that are not used in two days will be discarded. The assistant RCC will be responsible for the change.	1/5/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/5/20 resigned

Reviewed and accepted with revisions- SS 02/25/20

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C 257	Continued From page 1 -There was an opened and undated family sized package of sausage patties in the bottom drawer of the freezer. -There was an opened and undated package of ready to eat pancakes in the bottom drawer of the freezer. -There was an opened and undated package of ready to eat waffles in the bottom drawer of the freezer. -There was an opened package of cornmeal on the door shelf of the refrigerator. -There was a package of food wrapped in aluminum foil without a label or date in the refrigerator drawer. -There was a storage bag with croissants without a label or date in the refrigerator drawer. -There were two storage containers without a label or date on the top shelf of the refrigerator side. -There was a foiled item without a label or date on the top of one of the storage containers on the top shelf of the refrigerator side. Observation of the kitchen cabinets on 12/30/19 at 8:45 am revealed: -There was an opened and undated box with an opened bag of cereal on the top shelf. -There was an opened and undated box with several tea bags on the bottom shelf. -There was an opened disposable plastic container with a label for coleslaw that contained an unknown white powder on the top shelf of the cabinets. -There was an opened and undated box of iodine salt on the top shelf of the cabinets. -There was an opened and undated sleeve of saltine crackers on the bottom shelf of the cabinets. Observation of the closet in the dining room area	C 257	Henceforth, the facility will stop using improvised containers for storage. In addition, will continue to label and date any food item in a storage container to identify content and date it was placed in the container.	

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C 257	Continued From page 2 on 12/30/19 at revealed: -The closet had disposable briefs, linens, activity supplies and cardboard boxes stored inside. -There was an opened 20 ounces bottle of ranch dressing on top of a cardboard box which was sitting on the floor. -There was an opened 20 ounces bottle of ketchup sitting on a cardboard box which was sitting on the floor. -There was an opened container of non-dairy creamer on a cardboard box which was sitting on the floor. -There was an opened 24 ounces bottle of sugar free syrup on a cardboard box which was sitting on the floor. -There was an unopened jar of grape jelly on a cardboard box which was sitting on the floor. Interview with a Supervisor in Charge (SIC) on 12/30/19 at 2:55 pm revealed: -There was a cleaning schedule for the kitchen, and it was in the Administrator's office. -She did not work in the facility but worked next door at a sister facility. -Staff who worked at the facility called her to ask questions because she was a senior SIC. -She also trained staff at the facility and sister facilities. -She spent three days to one week with new hires and part of staff training was food storage. -She taught them to label and date opened food items and to keep prepared foods for two days, then throw it away. -She also taught them to store eggs and raw foods on lower levels of the refrigerator and to look at the expiration dates on all food packages. -She did not make rounds in the facility and she did not know staff stored food in open packages. -She did not know what food items were contained in the aluminum foil or storage	C 257	Continued 10A NCAC 13.G .904 (a)(2) As part of the training provided to the staff, all opened salad dressing, ketchup, jelly, and similiar products will not only be dated, but should be stored in the refrigerator.	

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C 257	Continued From page 3 containers because she did not normally work in the facility. -She did not know there were opened packages of food in the freezer until that day, 12/30/19, and she did not now how long the packages were there. -She did not know the closet in the dining room area had condiments stored there and she did not know why staff stored the condiments in the closet. -She removed the condiments from the closet once she saw them on 12/30/19. -The SIC who worked in the facility was on leave and would not return until the new year. -The RCC and Administrator made rounds through the kitchen, but she did not know the last time they made a round in the facility. -The RCC went to a different facility's kitchen each day. -The SIC on duty was responsible for food storage. -The RCC attempted to have a monthly meeting with staff to address any issues that came up in the various facilities. Attempted telephone interview with another SIC on 12/30/19 at 2:52 pm was unsuccessful. Interview with the Resident Care Coordinator on 12/30/19 at 3:07 pm revealed: -She made three rounds every day through each facility; one in the morning, one at 2:00 pm and one before she left in the evening. -The last round she made in the kitchen at the facility was 12/17/19 or 12/18/19. -She knew this because the turkey wings in the freezer belonged to her. -She placed the turkey wings in the freezer during the summer and forgot about them. -She told herself on 12/17/19 or 12/18/19 to	C 257		

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C 257	Continued From page 4 remove them but she forgot again. -She did not notice the other unlabeled, undated, and opened food package in the freezer. -She was focused on the turkey wings not the other items in the freezer. -She looked on the refrigerator side of the refrigerator approximately two weeks ago, 12/17/19 or 12/18/19. -She saw the sausage packages in the refrigerator, but she did not know if the packages were opened. -She expected and taught staff to store opened food items in storage bags or containers. -She provided a black marker for staff to date and label stored food. -She had not seen the black marker since placing it in the facility in July 2019. -She reminded staff to label and date opened food items but did not go back to check to see if staff actually dated or labeled food items. -She taught staff to discard prepared food after 3 to 7 days depending on if the food was prepared using eggs or milk. -She did not look in the closet in the dining room during her rounds and she did not know staff stored condiments on boxes which sat on the floor. -The SIC on duty today, 12/30/19, called and told her there were condiments in the closet of the facility. -She did not know why staff stored opened and unopened condiments in the closet and she had to start checking all areas of the facility. -The SIC on duty was responsible for storing food properly and she was responsible for ensuring staff followed through with this task. Interview with the Acting Administrator on 12/30/19 at 4:57 pm revealed: -He was covering the facility while the	C 257		

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C 257	Continued From page 5 Administrator was on leave. -The Administrator would return on 01/02/20. -He was responsible for the financial management of the facilities like payroll, marketing, advertisement, hiring, and maintenance. -He did rounds within the facility, but his focus was needed supplies, repairs, resident requests, and any items needed by staff to perform their duties. -He expected staff to label and date all opened foods and seal opened foods in a storage bag or container. -He expected staff to discard prepared foods after one to three days. -The Administrator knew all the procedures concerning what was taught to staff and he was just filling in while the Administrator was absent. -He would make the Administrator aware of the food items not stored properly in the freezer, refrigerator, cabinets and the dining room closet.	C 257		
C 330	10A NCAC 13G .1004(a) Medication Administration 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 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer	C 330	10A NCAC 13G.1004(a) Medication Administration Henceforth, the facility has a dedicated staff member is responsible for 100% of audit of MAR, for receiving new orders or discontinued orders, forwarding and verifying orders to the pharmacy and residents doctors office. Assistant RCC will = audit - 100% audit of MARS. Amended- SS- 02/25/20	

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C 330	Continued From page 6 medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1 and #3) as related to a medication for abnormal heart rhythms, two laxatives (#1) , an anti-psychotic medication and medication used to treat anxiety (#3). 1. Review of Resident #1's current FL-2 dated 08/23/19 revealed: -Diagnoses included schizophrenia, congestive heart failure, and cardiomyopathy. -There was an order for amiodarone 200mg daily (used to treat abnormal heart rhythms). Review of Resident #1's hospital discharge summary dated 12/09/19 revealed Resident #1 was hospitalized 12/06/19-12/09/19 for constipation, urinary retention, and dehydration. Review of Resident #1's discharge medication list dated 12/09/19 revealed: -There was an order for amiodarone 200mg every morning. -There was an order for Miralax 17 grams daily. -There was an order for Senokot 8.6mg daily (a laxative used to treat constipation). a. Review of Resident #1's medication administration record (MAR) for December 2019 revealed: -There was an entry for amiodarone 200mg daily. -There was documentation amiodarone 200mg had been administered 12/01/19-12/06/19 at 8:00am. -There was undated documentation that amiodarone had been discontinued. Observation of Resident #1's available medication revealed there was no amiodarone available for administration.	C 330	Amended-SS-2/25/20 Assistant RCC will be responsible for auditing orders for residents With the procedure in place, all MAR record will be audited weekly. The individual is also responsible for re-admission whenever a resident is discharged from the hospital and brought back to the facility. The staff member will meet weekly on Tuesdays with the RCC to go through all and any medication related situations and all proposed solutions or recommendations.	

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C 330	Continued From page 7 Telephone interview with a representative from Resident #1's pharmacy on 12/30/19 at 2:58pm revealed: -Resident #1 had an order for Amiodarone 200mg daily. -An outcome of not taking amiodarone as ordered was an abnormal heart rhythm. Refer to interview with the Supervisor-in-Charge (SIC) on 12/30/19 at 1:45pm. Refer to interviews with the Resident Care Coordinator (RCC) on 12/30/19 at 2:32pm and 3:30pm. Refer to interview with the acting Administrator on 12/30/19 at 4:58pm. Attempted telephone interview with Resident #1's primary care physician on 12/30/19 at 12:25pm and 3:10pm was unsuccessful. b. Review of Resident #1's MAR for December 2019 revealed there was no entry for Miralax 17 grams daily. Observation of Resident #1's available medication revealed there was no Miralax available for administration. Telephone interview with a representative from Resident #1's pharmacy on 12/30/19 at 2:58pm revealed the pharmacy did not have an order for Miralax for Resident #1. Refer to interview with the SIC on 12/30/19 at 1:45pm. Refer to interviews with the RCC on 12/30/19 at	C 330		

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C 330	Continued From page 8 2:32pm and 3:30pm. Refer to interview with the acting Administrator on 12/30/19 at 4:58pm. Attempted telephone interview with Resident #1's primary care physician on 12/30/19 at 12:25pm and 3:10pm was unsuccessful. c. Review of Resident #1's MAR for December 2019 revealed there was no entry for Senokot 8.6mg daily. Observation of Resident #1's available medication revealed there was no Senokot available for administration. Telephone interview with a representative from Resident #1's pharmacy on 12/30/19 at 2:58pm revealed the pharmacy did not have an order for Senokot for Resident #1. Refer to interview with the SIC on 12/30/19 at 1:45pm. Refer to interviews with the RCC on 12/30/19 at 2:32pm and 3:30pm. Refer to interview with the acting Administrator on 12/30/19 at 4:58pm. Attempted telephone interview with Resident #1's primary care physician on 12/30/19 at 12:25pm and 3:10pm was unsuccessful. Interview with the SIC on 12/30/19 at 1:45pm revealed: -The RCC reviewed the FL-2s and hospital discharge summaries when the residents came back from the hospital.	C 330		

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C 330	Continued From page 9 -The Administrator double-checked the orders. -The RCC checked the MARs for accuracy each month. -The RCC reviewed Resident #1's hospital discharge medication list. -The RCC sent the discharge medication orders to the pharmacy. -She reviewed records to make sure orders were correct. -No one noticed the discrepancies between the hospital discharge medication list and the orders on the MAR. Interview with the RCC on 12/30/19 at 2:32pm revealed: -She completed Resident #1's medication reconciliation when he was discharged from the hospital. -She faxed the discharge medication list to Resident #1's physician. -She would not document a medication had been discontinued on the MAR without documenting a new order in its place. -No one double-checked her work. -She had no explanation for the discrepancies between the discharge medication list and the orders on the MAR.	C 330		
	3:30pm revealed. -She faxed the orders to the pharmacy and documented the orders on the MAR. -She faxed Resident #1's discharge medication list to the pharmacy on 12/09/19 at 3:40pm. -Resident #1's physician did not write any new orders since Resident #1 had been discharged from the hospital. -She tried to call the physician's office at 2:00pm, but it was closed. -She wanted to verify the physician received the			

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C 330	Continued From page 10 discharge medication list she had previously faxed. -She and the SIC reviewed the MARS monthly. -She checked the new MAR with the previous MAR at the beginning of each month. -The SIC would check the MARs after the RCC checked them. -She was responsible for MAR accuracy. -She planned to have the medication aides (MA) review orders and double-check her work. Interview with the acting Administrator on 12/30/19 at 4:58pm revealed: -He expected accurate records to be kept related to medication orders, medication received from the pharmacy, and medication administration. -The RCC was responsible for reviewing hospital discharge paperwork. -The RCC and the SIC checked the orders and MARs for accuracy. -The MA was the first in line to ensure the MARs were correct. -The MA was expected to report concerns to the RCC or the SIC. -Random MAR audits were being done by the Administrator, the RCC, and the SIC. -The audits were done on a sample of the residents, not on the entire population. -The audits included verifying the orders with the entries on the MAR. -He did not know the frequency of the random audits. -He intended to meet with staff to make sure "this doesn't happen again." 2. Review of Resident #3's current FL-2 dated 07/17/19 revealed: -Diagnoses included major neurocognitive disorder, schizophrenia, hypertension, and uncontrolled type 2 diabetes mellitus.	C 330		

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C 330	Continued From page 11 -There was a medication order for clozapine 25 mg (used to treat schizophrenia) one tablet twice daily. Review of Resident #3's subsequent physician orders revealed there was an order dated 10/10/19 to discontinue current clozapine order and start clozapine 25 mg two tablets every morning and one tablet every evening. Review of Resident #3's Psychiatric provider visit notes revealed Resident #3 was seen on 08/16/19, 09/13/19, 10/10/19, 11/08/19, and 12/19/19. Review of Resident #3's October 2019 medication administration record (MAR) revealed: -There was a printed entry for clozapine 25 mg take one tablet twice daily, scheduled for 8:00 am and 8:00 pm. -There was documentation of administration from 10/01/19 to 10/31/19 at 8:00 am and 8:00 pm. -There was no entry for clozapine 25 mg take two tablets every morning and one tablet every evening. Review of Resident #3's November 2019 MAR revealed: -There was a printed entry for clozapine 25 mg take one tablet twice daily, scheduled for 8:00 am and 8:00 pm. -There was a diagonal line marked through the printed entry for clozapine 25 mg one tablet twice daily and there was documentation of "discontinued 10/11/19 see new order" beside the entry where staff initialed for administration. -There was documentation of administration of clozapine from 11/01/19 to 11/11/19 at 8:00 am and 8:00 pm and on 11/12/19 at 8:00 am. -There was a handwritten entry for clozapine 25	C 330	Amended- SS- 02/25/20 10A NCAC 13G .1004(a) Assistant RCC Henceforth, a newly appointed dedicated staff member will be in addition to conducting full and complete on MAR's, also be responsible for reviewing all discharge orders whenever a resident is re-admitted after hospitilization. She is responsible for any discontinued medications, any new orders, faxing those orders to the pharmacy and the residents physician. Verifying that the pharmacy and doctor's office did receive and process the orders. Making sure that any orders are properly and fully documented in the MAR and to make sure the Medication Techs are aware of any changes in the orders.	

Division of Health Service Regulation

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	FCL051066	A. BUILDING: ______ B. WING ______	12/30/2019

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C 330	Continued From page 12	C 330		

mg two tablets daily, scheduled for 8:00 am.
-There was documentation of administration of clozapine from 11/12/19 to 11/30/19 at 8:00 am.
-There was another handwritten entry for clozapine 25 mg one tablet at bedtime, scheduled for 8:00 pm.
-There was documentation of administration of clozapine from 11/11/19 to 11/30/19 at 8:00 pm.

Review of Resident #3's December 2019 MAR revealed:
-There was a printed entry for clozapine 25 mg take one tablet twice daily, scheduled for 8:00 am and 8:00 pm.
-The word "Discontinued" was written over the printed entry for clozapine 25 mg take one tablet twice daily, and "discontinued see new orders was written beside the entry in the space used for staff initials of administration.
-There was a handwritten entry for clozapine 25 mg two tablets daily, scheduled for 8:00 am.
-There was documentation of administration of clozapine from 12/01/19 to 12/30/19 at 8:00 am.
-There was another handwritten entry for clozapine 25 mg one tablet at bedtime, scheduled for 8:00 pm.
-There was documentation of administration of clozapine from 12/01/19 to 12/29/19 at 8:00 pm.

Observation of Resident #3's medication on hand on 12/30/19 at 11:05 am revealed:
-There was one package of clozapine 25 mg tablets, with two tablets per bubble pack dispensed on 12/06/19.
-There were 11 of 30 doses available for administration.
-There was another package of clozapine 25 mg tablets with one tablet per bubble pack dispensed [illegible]
-There were 15 of 30 doses available for

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C 330	Continued From page 13 administration. Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable. Telephone interview with a Pharmacist at the facility contracted pharmacy on 12/30/19 at 1:42 pm revealed: -There was an order dated 11/08/19 for Resident #3 8 clozapine and it was a phone order from the Psychiatric provider. -There was no order dated 10/10/19 in the computer system. -There was an order dated 08/27/19 for clozapine 25 mg twice daily. -Clozapine 25 mg was dispensed on 11/08/19 and 12/06/19 for 90 total tablets for Resident #3. -The label on the clozapine package was adjusted by the pharmacy, but one package of 60 tablets was dispensed for the morning dose and another package of 30 tablets was dispensed for the evening dose. -Resident #3's morning dose of clozapine had two tablets per bubble in the package and the evening dose package had one tablet per bubble. -The pharmacy placed orders on the MARs, but if an order was changed after the MARs were sent the facility would have to place the order on the MAR. -If Resident #3 did not receive the additional dose of clozapine he may have increased signs and symptoms of schizophrenia. Attempted telephone interview with the facility contracted Psychiatric provider on 12/30/19 at 9:57 am, 10:22 am, and 12:11 pm was unsuccessful. Interview with a Supervisor in Charge (SIC) on	C 330		

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C 330	Continued From page 14 12/30/19 at 11:28 am revealed: -She did not work at the facility normally and was assigned to a sister facility next door. -She was a senior SIC and trained new hires. -She taught new SICs to compare the MARs with the physician's order. -The Resident Care Coordinator and the Administrator reviewed medication orders two to three times per week. -The Administrator was on leave at that time and was supposed to return on 01/02/20. -The RCC reviewed the new MARs at the beginning of the month and the Administrator reviewed the MARs at the end of the month. -The RCC was responsible for placing new orders or changed orders on the MARs. -The facility contracted Psychiatric provider visited residents monthly. -The residents will be seen again on 01/22/20 by the Psychiatric provider. -When the Psychiatric provider visited the facility to see residents, she told the RCC of any changes. -The RCC received the Psychiatric provider's notes and printed them off. -The RCC would have faxed any medication order changes from the Psychiatric provider because the notes were sent to the RCC. -The Psychiatric provider also faxed over medication orders to the pharmacy. -Staff depended on the RCC to place new or changed orders on the MAR because the RCC received the orders. -The pharmacy provided blank MARs to the facility so that new or changed medication orders could be placed on a MAR for residents. -She did not know about Resident #3's clozapine order change in October 2019. -The SIC who usually worked in the facility was on leave and would return after the holidays.	C 330		

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C 330	Continued From page 15 Attempted telephone interview with another SIC on 12/30/19 at 2:52 pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 12/30/19 at 3:07 pm revealed: -She received the notes from the Psychiatric provider, and she spoke with her before she left after seeing the residents. -The Psychiatric provider's notes were in her office and she read over them before placing them in the resident's records. -She did not see Resident #3's clozapine order change on the 10/10/19 Psychiatric provider notes. -She expected the staff to tell her about the clozapine order change in October 2019 since she missed it. -The staff must have filed the clozapine order because she did not see it and the Psychiatric provider told her about the order change when she came to the facility on 11/08/19. -She thought she faxed over the order to the pharmacy 11/08/19 when the Psychiatric provider told her about Resident #3's clozapine order change. -She did not know the Psychiatric provider telephoned the pharmacy to provide the order for Resident #3's clozapine change. -Based on the November 2019 MAR, Resident #3 did not receive the increased dose of clozapine until 11/10/19. -She did not need to make the Psychiatric provider aware of the missed clozapine doses because she made her aware on 11/08/19. -She was responsible for ensuring the medication orders were placed on the MAR so that staff administered the correct dose. Interview with the Acting Administrator on	C 330		

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C 330	Continued From page 16 12/30/19 at 4:57 pm revealed: -He was filling in for the Administrator while she was on vacation. -The Administrator would return on 01/02/20. -The Administrator knew more about the medication processes because she was a nurse. -He expected SICs to give the medications like the physician ordered. -He did not know about Resident #3's clozapine but would share the information with the Administrator upon her return. -He thought the Administrator reviewed a sample of resident's records when she visited the facility but not all of them. -He thought the RCC was responsible for ensuring medication orders were changed on the MARs. 3. Review of Resident #3's current FL-2 dated 07/17/19 revealed diagnoses included major neurocognitive disorder, schizophrenia, hypertension, and uncontrolled type 2 diabetes mellitus. Review of Resident #3's subsequent physician orders revealed there was an order dated 09/13/19 for lorazepam 0.5 mg (used to treat anxiety) one-half tablet twice daily as needed for acute agitation. Review of Resident #3's October 2019 medication administration record (MAR) revealed there was no entry for lorazepam 0.5 mg as needed. Review of Resident #3's November 2019 MAR revealed: -There was a printed entry for lorazepam 0.5 mg take one-half tablet twice daily as needed -There was another handwritten entry for	C 330		

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C 330	Continued From page 17 lorazepam 0.5 mg take one-half twice daily as needed. Review of Resident #3's December 2019 MAR revealed there was a printed entry for lorazepam 0.5 mg take one-half tablet twice daily, as needed. Observation of Resident #3's medication on hand on 12/30/19 at 11:05 am revealed there were 54 of 60 lorazepam one-half tablets available for administration with a dispense date of 09/16/19. Based on observations, record reviews and interviews, it was determined Resident #3 was not interview able. Telephone interview with a Pharmacist at the facility contracted pharmacy on 12/30/19 at 1:42 pm revealed: -Resident #3's lorazepam was ordered on 09/16/19 and 30 tablets were dispensed on 09/16/19. -The pharmacy did cut the tablet in half and each bubble contained a one-half tablet. -MARs were provided for the facility but he did not know why the lorazepam was not placed on the October 2019 MAR. Attempted telephone interview with the facility contracted Psychiatric provider on 12/30/19 at 9:57 am, 10:22 am, and 12:11 pm was unsuccessful. Interview with a Supervisor in Charge (SIC) on 12/30/19 at 2:55 pm revealed: -She did not work at the facility normally and was assigned to a sister facility next door. -She was a senior SIC and trained new hires. -She taught new SICs to compare the MARs with	C 330		

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C 330	Continued From page 18 the physician's order. -The MARs were supplied by the pharmacy but the RCC was provided with blank MARS to write new or changed orders on to a MAR for residents. -The RCC reviewed MARS at the beginning of the month for accuracy. -She did not know why the lorazepam was not placed on the October MARs. -She saw that Resident #3 had one page of MAR for October 2019. -The RCC would have been responsible for ensuring the lorazepam was on the new October 2019 MAR. -Resident #3's lorazepam was placed on the September 2019, November 2019, and December 2019 MAR. Attempted telephone interview with another SIC on 12/30/19 at 2:52 pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 12/30/19 at 3:07 pm revealed: -She received emails or faxes from the Psychiatric provider with the resident's orders. -She was the person who always processed medication orders unless she was off from work. -She did not recall being off in October 2019. -She thought the SIC who worked in the facility in October 2019 should have told her about the missed lorazepam 0.5 mg entry. -The SIC no longer worked at the facility. -She checked the new MARs against the old MARs but missed placing Resident #3's lorazepam 0.5 mg on the October MAR. -This was an oversight on her part and she was responsible for ensuring the MARs were accurate. Interview with the Acting Administrator on	C 330		

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C 330	Continued From page 19 12/30/19 at 4:57 pm revealed: -He was "filling in" while the Administrator was on leave. -He was responsible for the payroll, advertising, marketing, repairs and hiring of certain positions. -He had limited knowledge concerning medications. -He thought the RCC was responsible for medication orders and the Administrator audited residents' MARs. -He did not have any knowledge concerning Resident #3's lorazepam but he would relay the information to the Administrator when she returned.	C 330	Elizabeth - Administrator 2/15/20	