DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL 060-147**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/13/22**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE AT THE VILLAGES OF MECKL	**13825 HUNTON LANE HUNTERSVILLE, NC 28078**

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)	COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey 10/11/22- 10/13/22.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 review, and interviews the facility failed to administer medications and follow physician's orders for 3 of 7 residents (Resident #5, #6 and #7). The findings are: 1. Review of Resident #5's current FL2 dated 05/25/22 revealed diagnoses included hypertension, coronary artery disease, history of a heart attack and history of a stroke. Review of Resident #5's Physician's orders dated 07/08/22 revealed: -An order for amlodipine besylate (used to treat	D358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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D 358	Continued From page 1 high blood pressure) 5mg tablet every morning. -The order also indicated to hold the amlodipine besylate if systolic blood pressure was less than 110 or pulse was less than 60. Observations of the medication pass on 10/12/22 at 8:39am revealed: -The medication aide (MA) entered Resident #5's room and took Resident #5's blood pressure and pulse. -Resident #5's blood pressure was 133/58. -Resident #5's pulse was 83. -The MA prepared Resident #5's morning medications for administration but did not include amlodipine besylate for Resident #5. Interview with the MA on 10/12/22 at 8:43am revealed: -He was not aware he had not administered the amlodipine besylate to Resident #5 until after the surveyor brought it to his attention. -He was aware that he only administered four oral medications and he should have administered five oral medications. Refer to interview with the Administrator on 10/12/22 at 11:59am. Based on observations, record review and interviews it was determined that Resident #5 was not interviewable. 2. Review of Resident #6's current FL2 dated 07/22/22 revealed diagnoses included diabetes, Parkinson's disease and seizure disorder.	D 358		

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D 358	Continued From page 2 Review of Resident #6's Physician's orders dated 07/22/22 revealed: -An order for Lotrisone cream (used to treat inflamed fungal skin infections) to be applied to affected areas two times a day. -The order also indicated the resident could self-administer the Lotrisone cream. a. Observation of the medication pass on 10/12/22 at 7:45am revealed: -The medication aide (MA) did not administer Lotrisone cream to Resident #6. -The MA did not ask Resident #6 if he had self-administered his Lotrisone cream. -The MA was unable to locate the Lotrisone cream in the medication cart. -The MA was unable to locate the Lotrisone cream in Resident #6's room. Interview with Resident #6 on 10/12/22 at 7:59am revealed: -He had been out of the Lotrisone cream for months. -He had told at least 3 staff members that he needed the Lotrisone cream, but he still did not have any. Observation of Resident #6's bathroom on 10/12/22 at 10:42am revealed: -An uncapped tube of Lotrisone cream way lying on top of a plastic storage container between the commode and the sink. -Observation of the Lotrisone cream revealed an expiration date of August 2022. Interview with the Resident Care Director (RCD) on 10/12/22 at 11:45am revealed:	D 358		

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D 358	Continued From page 3 -He was unsure if the MAs checked expiration dates of medications before administering them to residents. -The MAs should have asked Resident #6 if he had administered his Lotrisone cream himself or if Resident #6 needed assistance twice daily. Refer to the interview with the Administrator on 10/12/22 at 11:59am. b. Review of the facility's Medication Administration Safety policy dated 01/07/16 revealed: - "Always check the expiration date on all drugs." - "Do not use a medication that is out of date." Review of the electronic Medication Administration Record (eMAR) for September 2022 revealed: -An entry for Lotrisone cream, apply to affected areas two times a day. -The Lotrisone cream was documented as administered twice daily from 09/01/22 to 09/30/22. Review of the eMAR for October 2022 revealed: -An entry for Lotrisone cream, apply to affected areas two times a day. -The Lotrisone cream was documented as administered twice daily from 10/01/22 to 10/11/22. Observation of the medication pass on 10/12/22 at 7:45am revealed: -The medication aide (MA) did not administer Lotrisone cream to Resident #6. -The MA did not ask Resident #6 if he had self-administered his Lotrisone cream. -The MA was unable to locate the Lotrisone cream in the medication cart. -The MA was unable to locate the Lotrisone cream in	D 358		

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D 358	Continued From page 4 Resident #6's room. Interview with Resident #6 on 10/12/22 at 7:59am revealed: -He had been out of the Lotrisone cream for months. -He had told at least 3 staff members that he needed the Lotrisone cream, but he still did not have any. Observation of Resident #6's bathroom on 10/12/22 at 10:42am revealed: -An uncapped tube of Lotrisone cream way lying on top of a plastic storage container between the commode and the sink. -Observation of the Lotrisone cream revealed an expiration date of 08/2022. Interview with the facility's contracted pharmacy representative on 10/13/22 at 9:55am revealed: -There was an active order for Lotrisone cream to be applied twice daily to affected areas for Resident #6. -Lotrisone cream was dispensed to the facility in April of 2021. Interview with the Resident Care Director (RCD) on 10/12/22 at 11:45am revealed: -He was unsure if the MAs checked expiration dates of medications before administering them to residents. -The MAs should have asked Resident #6 if he had administered his Lotrisone cream himself or if Resident #6 needed assistance twice daily. Interview with the facility's Registered Nurse (RN) consultant on 10/13/22 at 11:00am revealed the MA should have verified a medication kept in a resident's room had not expired before administering it.	D 358		

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D 358	Continued From page 5 Interview with the Administrator on 10/12/22 at 11:59am revealed staff should not have administered any expired medications to residents. 3. Review of Resident #7's current FL2 dated 02/07/22 revealed diagnoses included Parkinson's disease, memory loss and generalized muscle weakness. Review of Resident #7's Physician's orders dated 05/12/22 revealed as order for Novolog 100 unit/ml flexpen, check fingerstick blood sugar (FSBS) before meals and follow sliding scale: for FSBS 100-149 give 5 units, FSBS 150-200 give 6 units, FSBS 201-250 give 8 units, FSBS 251-300 give 9 units, FSBS 301-350 give 10 units, FSBS 351-400 give 11 units, FSBS greater than 400 give 12 units. Observation of the medication pass on 10/11/22 at 12:20pm revealed: -The MA checked Resident #7's FSBS at 12:20pm. -Resident #7 had a FSBS of 102. -The MA administered 5 units of sliding scale Novolog via flexpen. Interview with Resident #7 on 10/12/22 at 10:27am revealed: -The MA usually checked his FSBS before meals but not always. -On 10/11/22 the MA checked his FSBS after he had lunch. -He received an insulin injection but did not remember how many units the MA administered. -He felt ok and did not have any adverse reaction after receiving his sliding scale insulin. Interview with a MA on 10/12/22 at 10:42am revealed:	D 358		

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D 358	Continued From page 6 -She had taken Resident #7's FSBS after lunch yesterday. -She administered his sliding scale insulin according to the Physician's order. -There was a pharmacy in-service several months ago when the MAs were told by the pharmacy representative that it was okay to take the FSBS up to 20 to 30 minutes after a resident ate a meal. Interview with the Physician's Assistant (PA) on 10/12/22 at 11:23am revealed: -There was no detriment to the MA taking Resident #7's FSBS after his lunch meal on 10/12/22. -She expected the MAs to follow Physician's orders. -She expected the MAs to contact the Physician's office if they needed clarification of an order. Refer to the interview with the Administrator on 10/12/22 at 11:59am. _____ Interview with the Administrator on 10/12/22 at 11:59am revealed: -MAs should be following the medication administration rights to ensure medication is given correctly. -MAs should be administering medications per the Physician's order. -MAs should not be administering expired medications. -MAs should not be signing off on the eMAR that medications were administered that were not administered.	D 358		

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D 367	Continued From page 7	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 electronic medication administration record (eMAR) was accurate for 2 of 5 sampled residents (#1 and #5) related to documenting the removal of thrombo-embolic-deterrent (TED) hose (Resident #1), administration of a blood pressure lowering medication (Resident #5), application of hearing aids in bilateral ears (Resident #5) and the timeframe an anxiety reducing medication was ordered to be administered (Resident #5). The findings are:	D 367		

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D 367	Continued From page 8 1. Review of Resident #1's current FL2 dated 12/03/21 revealed: -Diagnoses included peripheral vascular disease. -An order to apply and remove TED hose. Review of Resident #1's record revealed there was an order dated 12/29/21 to discontinue TED hose. Interview with Resident #1 on 10/11/22 at 3:30pm revealed he stopped wearing TED hose several months ago. Review of Resident #1's August 2022 eMAR revealed: -There was an entry to remove TED hose at night. -There was documentation the TED hose were removed from 08/01/22 to 08/04/22 and from 08/07/22 to 08/31/22. Review of Resident #1's September 2022 eMAR revealed: -There was an entry to remove TED hose at night. -There was documentation the TED hose were removed from 09/01/22 to 09/06/22, 09/08/22 to 09/17/22, 09/19/22 to 09/28/22 and 09/30/22. Review of Resident #1's October 2022 eMAR revealed: -There was an entry to remove TED hose at night. -There was documentation the TED hose were removed from 10/01/22 to 10/10/22. Interview with a medication aide (MA) on 10/13/22 at 9:15am revealed: -Resident #1 was not using TED hose anymore and it should not be on the eMAR. -She was trained to report discrepancies that she found on the eMAR to one of the 3 supervisors (MA	D 367		

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D 367	Continued From page 9 Supervisor, Resident Care Director (RCD) or the Registered Nurse (RN) consultant). -An exception note should have been written until the order was taken off the eMAR. Interview with the Resident Care Director (RCD) on 10/12/22 at 8:15am and 2:58pm revealed: -He did not know why the MA's were documenting the removal of TED hose since they were discontinued several months ago. -MA's were trained to report discrepancies on the eMAR to the supervisors and should not document administration if it was not done. -An order was received several months ago to stop applying the TED hose. -When he updated the eMAR he removed the order to put them on in the morning but he forgot to remove the order to take them off in the evening. Interview with the facility's RN consultant on 10/13/22 at 8:30am and 9:14am revealed: -She worked at the facility 3 days a week. -The MA Supervisor, RCD and herself were responsible for updating the eMAR. -She was not aware the TED hose were discontinued. -Several months ago she became responsible for conducting chart audits. -She did not know how the error was not found since they were checking the eMAR's monthly. Interview with the MA Supervisor on 10/13/22 at 8:40am revealed: -Physician orders were reviewed monthly and compared to the eMAR. -The RCD, RN consultant and herself were all reviewing the eMARS monthly until April 2022 when it became	D 367		

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D 367	Continued From page 10 the RN consultant's responsibility. -The MA's were trained to write a note, detailing the discrepancy they found on the eMAR, and leave it in the MA Supervisor's office. -She did not know why this discrepancy was not reported or why it was not caught with the monthly reviews. Interview with the Administrator on 10/13/22 at 9:44am revealed: -The RN consultant was responsible for training the MA's on how to properly document on the eMAR. -The RN consultant, the MA Supervisor and the RCD were all responsible for conducting cart and record audits but she did not know how often they conducted them. -The MA's should not have documented incorrectly on the eMAR and she would have expected the error to be found on one of the audits. 2. Review of Resident #5's current FL2 dated 05/25/22 revealed diagnoses included hypertension, coronary artery disease, history of a heart attack and stroke. Review of Resident #5's Physician's orders dated 07/08/22 revealed: -An order for amlodipine besylate (used to treat high blood pressure) 5mg tablet every morning. -The order also indicated to hold the amlodipine besylate if systolic blood pressure was less than 110 or pulse was less than 60. Observations of the medication pass on 10/12/22 at 8:39am revealed: -The medication aide (MA) entered Resident #5's room and took his blood pressure and pulse.	D 367		

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D 367	Continued From page 11 -Resident #5's blood pressure was 133/58. -Resident #5's pulse was 83. -The MA prepared Resident #5's morning medications for administration but did not include amlodipine besylate for Resident #5. -After the MA administered Resident #5's medications, the MA returned to the medication cart and documented on the electronic Medication Administration Record (eMAR) he had administered the amlodipine besylate. Interview with the MA on 10/12/22 at 8:43am revealed: -He was not aware he had not administered the amlodipine besylate to Resident #5 until after he had signed the eMAR. -He was aware that he only administered four oral medications and he should have administered five oral medications. -He would not have recognized his mistake if the surveyor had not observed the amlodipine not being administered. -He was "nervous" and "did not pay 100% attention." Interview with the facility's Registered Nurse (RN) on 10/13/22 at 11:39am revealed: -She had not been aware there were problems with eMAR accuracy prior to 10/13/22. -Any medications should be documented as soon as they are administered by the MAs. Interview with the Administrator on 10/12/22 at 11:59am revealed: -MAs should be following the medication administration rights to ensure medications were administered per the physician's order.	D 367		

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D 367	Continued From page 12 -The MA should not have signed off on the eMAR for medications that were not administered. b. Review of Resident #5's signed Physician orders dated 07/08/22 revealed: -There was an order to place hearing aids in both ears every morning. -There was an order to remove hearing aids at night. Review of Resident #5's August 2022 eMAR revealed: -An entry to place hearing aids in both ears every morning scheduled for 8:00am with a note that stated hearing aids to be kept on the medication cart. -Placing hearing aides in both ears every morning was documented as administered on 08/01/22, 08/03/22 to 08/05/22, 08/09/22 to 08/10/22, 08/12/22 to 08/15/22, 08/17/22 to 08/19/22, 08/22/22 to 08/24/22, 08/26/22 to 08/30/22. Review of Resident #5's September 2022 eMAR revealed: -An entry to place hearing aids in both ears every morning scheduled for 8:00am with a note that stated hearing aids to be kept on the medication cart. -Placing hearing aids in both ears every morning was documented as administered from 09/05/22 to 09/07/22, 09/09/22 to 09/12/22, 09/14/22 to 09/16/22, 09/19/22 to 09/21/22, 09/23/22, 09/26/22 and 09/28/22 to 09/30/22. Review of Resident #5's October 2022 eMAR revealed: -An entry to place hearing aids in both ears every morning scheduled for 8:00am with a note that stated	D 367		

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D 367	Continued From page 13 hearing aids to be kept on the medication cart. -Placing hearing aids in both ears every morning was documented as administered from 10/03/22 to 10/05/22 and 10/10/22. -Placing hearing aids in both ears every morning was documented as not administered on 10/12/22 with the comment hearing aids were not available. Telephone interview with Resident #5's family member on 10/13/22 at 10:03am revealed: -Resident #5 was living in the assisted living section of the facility before he was admitted to the Special Care Unit (SCU) at the end of May 2022. -Resident #5 damaged one hearing aid and lost the other hearing aid before he was admitted to the SCU. -Resident #5 had not worn his hearing aids in months due to them lost and damaged. -Family visited two to three times per week and noticed a couple of weeks ago he was wearing a hearing aid in one ear. -She only saw Resident #5 wear the hearing aid one time in the SCU. -She was not aware Resident #5 had any hearing aids in the SCU and was curious if it was his hearing aid since it did not seem to work well for him. Interview with the MA on 10/12/22 at 8:50am revealed: -Resident #5 did not wear his hearing aids. -Resident #5 pulled them out of his ears several months ago and "stomped" on his hearing aids. -They have not worked since he stomped on them. -His family was made aware and decided they were not going to replace the hearing aids.	D 367		

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D 367	Continued From page 14 Interview with a MA on the SCU on 10/13/22 at 9:27am and 11:00am revealed: -He put one hearing aid in Resident #5's ear that morning (10/13/22) for the first time since Resident #5 had been admitted to the SCU. -He did not know Resident #5 had one working hearing aide on the medication cart until that morning (10/13/22) since he had not checked the hearing aid case that was on the medication cart in several weeks. -He could not remember if he told anyone that Resident #5 was missing his hearing aids. -The documentation that he entered on the eMAR for August, September and three times in October 2022 related to putting in Resident #5's hearing aids was inaccurate. -He did not always have time to document on the eMAR after completing an order and sometimes checked multiple orders off at the end of his shift. Interview with the RCD on 10/12/22 at 8:15am and 2:58pm revealed: -MAs were trained to report discrepancies on the eMAR to him, the MA Supervisor or the RN consultant. -The administration of Resident #5's hearing aid should not have been documented if it was not done. Interview with the RN consultant on 10/13/22 at 8:30am revealed: -She had the ability to edit the eMAR. -She heard Resident #5 was not using his hearing aids since they were broken. -No one asked her to edit the eMAR.	D 367		

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D 367	Continued From page 15 Interview with the Administrator on 10/13/22 at 11:25am revealed: -MAs should only document on the eMAR if the hearing aid was put into Resident #5's ears. -If there was an order on the eMAR that was no longer applicable then the MA should have brought it to the attention of the MA Supervisor, RCD or RN consultant. c. Review of Resident #5's signed Physician order dated 03/30/22 revealed an order for lorazepam 0.5mg tablet (used to treat anxiety), give one half tablet daily as needed for two weeks. Review of Resident #5's August 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. Review of Resident #5's September 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. Review of Resident #5's October 2022 eMAR revealed -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. Interview with a MA on 10/13/22 at 11:00am revealed:	D 367		

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D 367	Continued From page 16 -Before he administered an as needed medication, he pulled up the medication on the eMAR and compared it to the pharmacy label on the medication. -If the eMAR and pharmacy label on the medication did not match then he would not administer the medication and alert the MA Supervisor, RCD or RN consultant. -He would not have administered the lorazepam to Resident #5 if he noticed the discrepancy between the instructions on the eMAR and the pharmacy label or that it was past the two-week time period. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 10/12/22 at 3:11pm revealed: -Resident #5's order for lorazepam 0.5mg tablet give one half tablet daily as needed times two weeks was received on 03/30/22. -On 03/30/22, the pharmacy dispensed ten tablets of lorazepam based on the Physician's order. -The pharmacy had not received any other orders for Resident #5's lorazepam since 03/30/22. -The facility managed their own eMARs and the pharmacy was not able to access them. Interview with the MA Supervisor on 10/13/22 at 8:40am revealed: -She, the RCD and the RN consultant were able to edit the facility's eMARs. -She entered stop dates for medication when medication orders were written for a specific amount of time. -She was not aware Resident #5's lorazepam continued	D 367		

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D 367	Continued From page 17 to be on the eMAR when it was only ordered for two weeks on 03/30/22. -She also was not aware that Resident #5's lorazepam order was for two weeks but was entered into the eMAR for one week. -The discrepancies should have been identified during a medication cart audit. -She, the RCD and the RN consultant completed medication cart audits whenever they had time. -A medication cart audit consisted of looking for expired medication and comparing the Physician's orders to the eMAR and the medications on the cart. Interview with the Administrator on 10/13/22 at 11:25am revealed: -The MA Supervisor, RCD or RN consultant could enter medications on to the eMAR. -One person should have entered the medication on the eMAR and a second person should have checked that the order was entered correctly. -She was not sure if this process was being completed. -The medication carts should have been audited quarterly and the incorrect entry on the eMAR for Resident #5's lorazepam should have been identified. -She also expected the MAs to alert the MA Supervisor, RCD or RN consultant if there was a medication on the eMAR but it was not available on the medication cart. d. Review of Resident #5's signed Physician order dated 03/30/22 revealed an order for lorazepam 0.5mg tablet, give one half tablet daily as needed for two weeks.	D 367		

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D 367	Continued From page 18 Review of Resident #5's March 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was not documented as administered from 03/30/22 to 03/31/22. Review of Resident #5's April 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was documented as administered on 04/30/22. Review of Resident #5's May 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was documented as administered on 05/07/22, 05/11/22, 05/28/22, 05/30/22 and 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was documented as administered on 06/04/22. Review of Resident #5's July 2022 eMAR revealed:	D 367		

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D 367	Continued From page 19 -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was not documented as administered from 07/01/22 to 07/31/22. Review of Resident #5's August 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was not documented as administered from 08/01/22 to 08/31/22. Review of Resident #5's September 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was not documented as administered from 09/01/22 to 09/30/22. Review of Resident #5's October 2022 eMAR revealed: -An entry for lorazepam 0.5mg tablet give one half tablet by mouth daily as needed for one week. -The documented start date was 03/30/22 and there was not a stop date documented. -Lorazepam was not documented as administered from 10/01/22 to 10/12/22. Review of Resident #5's medications on the medication	D 367		

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D 367	Continued From page 20 cart on 10/12/22 at 12:26pm revealed lorazepam 0.5mg was not available to administer. Review of Resident #5's controlled substance sheet revealed: -Five tablets (10 doses) of 0.5mg were dispensed to the facility on 03/30/22. -One dose was administered on 04/30/22, there were nine doses remaining. -One dose was administered on 05/08/22, there were eight doses remaining. -One dose was administered on 05/11/22, there were seven doses remaining. -One dose was administered on 05/28/22, there were six doses remaining. -One dose was administered on 05/30/22, there were five doses remaining. -One dose was administered on 05/31/22, there were four doses remaining. -One dose was administered on 06/03/22, there were three doses remaining. -One dose was administered on 06/04/22, there were two doses remaining. -One dose was administered on 06/05/22, there was one dose remaining. -One dose was administered on 06/20/22, there were not any doses remaining. Interview with a MA on 10/13/22 at 11:00am revealed: -He documented the administration of one dose of lorazepam on Resident #5's controlled substance sheet on 06/20/22. -He was not aware that the lorazepam administered to	D 367		

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D 367	Continued From page 21 Resident #5 on 06/20/22 was not documented on the eMAR. -He noticed that the controlled substance sheet was signed at 12:00pm on 06/20/22 for Resident #5's lorazepam and that tended to be a busy time in the SCU. -He gave himself an hour to an hour and half to document medications on the eMAR after administering them. Interview with the RN consultant on 10/13/22 at 11:39am revealed: -She had not been aware there were problems with eMAR accuracy prior to 10/13/22. -Any medications given should be documented as soon as they are administered. Interview with the Administrator on 10/13/22 at 11:25am revealed: -She was not aware that some MAs were waiting an hour or more to document administered medications on the eMAR. -She expected medication to be documented on the eMAR before the MA administered medication to another resident. -She was not aware that the dates for administration of Resident #5's lorazepam on the controlled drug record did not match the eMAR.	D 367		