STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	FCL093011		03/27/2015

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MOORE'S REST HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
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WARRENTON, NC 27589

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 27, 2015.	C 000		
C 207	10A NCAC 13G .0702(c)(4) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure clarification with the physician of FL-2 medication and diet orders for 3 of 3 sampled residents. (#1, #2, #3.) The findings are: 1. Review of the current FL-2 dated 10/17/14 for Resident # 2 revealed: - Diagnoses of diabetes mellitus, mental retardation, hyperlipidemia and schizophrenia. - Medication orders on the FL-2 not clarified were Risperdone 2mg at bedtime and 1mg twice daily. (Used to treat schizophrenia.); Fluoxetine 40mg each morning. (Used to treat depression, panic attacks and obsessive behaviors.); Seroquel XR 300mg at bedtime. (Extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia and depression in	C 207		

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C 207	Continued From page 1 some residents.) A. Review of the medication administration records (MAR) for February 2015 and March 2015 revealed Risperdone 2mg at bedtime and 1mg twice daily had not been documented as administered for either month. Review of medications for Resident # 2 revealed there was no Risperdone 2mg by mouth at bedtime and 1mg by mouth twice daily on hand for administration. Interview on 3/27/15 at 3:50 p.m. with the Administrator revealed: - Orders dated 10/16/15 were still being used for Seroquel and Fluoxetine. - He was responsible for having orders clarified along with the supervisor-in-charge (SIC). - Neither he nor the SIC had clarified the Risperdone medication listed on the FL-2 with the physician because it had been stopped prior to the current FL-2. - The FL-2 was never faxed to the pharmacy as a new order sheet. - The Administrator said he would clarify the Risperdone with the physician's office today. - The new FL-2's will be checked against the current medications and will verify correct orders with differences. Refer to interview on 3/27/15 at 3:50 p.m. B. Review of the medication administration records for March 2015 as related to Fluoxetine administration revealed the current FL-2 order for Fluoxetine 40mg each morning had been documented as Fluoxetine 20mg each morning. Review of medications for Resident # 2 revealed	C 207		

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C 207	Continued From page 2 there was Fluoxetine 20mg on hand for administration. Review of orders on 10/16/15, one day prior to the current FL-2 dated 10/17/15, revealed Fluoxetine 20mg each morning. C. Review of the medication administration records for March 2015 as related to Seroquel administration revealed the current FL-2 order for Seroquel 300mg by mouth at bedtime had been documented as Seroquel 200mg at bedtime. Review of medications for Resident # 2 revealed there was Seroquel 200 mg on hand for administration. Review of orders on 10/16/15, one day prior to the current FL-2 dated 10/17/15 revealed Seroquel 200mg by mouth at bedtime. Refer to interview on 3/27/15 at 3:05 p.m. with the Administrator. 2. Review of the current FL-2 dated 12/05/14 for Resident #1 revealed: - Diagnoses of Schizophrenia, Epilepsy, Diabetes Mellitus Type II, Hypertension, Rhabdomyolosis and high lipids. - Diet order included Regular ADA (American Diabetic Association). No clarification of the diet order was found on record review. Interview on 3/27/15 at 3:05 p.m. with the Administrator revealed: - All residents were on regular diets. - He had not clarified this diet order with the physician.	C 207		

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C 207	Continued From page 3 - He would ensure all diet orders incomplete or incorrect or missing would be clarified on the FL-2. Observation on 3/27/15 at 12:30 p.m. all resident including Resident # 1 received the same regular diet. 3. Review of the current FL-2 dated 8/15/14 for Resident # 3 revealed: - Diagnoses of Type II Diabetes Mellitus, Schizophrenia, Bipolar Disorder, and Hypertension. Review of the February 2015 medication administration record (MAR) revealed Novolin 70/30 insulin 50 units subcutaneously (SQ) was administered at 7:30 a.m. from 2/01/15 - 2/28/15 with no indication of refusals by the resident. (Insulin is used to control blood sugar levels.) Review of the March 2015 MAR revealed Novolin 70/30 insulin 50 units SQ was listed and administered 3/01/15 - 3/27/15 at 7:30 a.m. Review of medications on hand for Resident # 3 revealed Humulin 70/30 insulin/100u 50 units SQ Review of 7:30 a.m. FSBS checks for Resident # 3 revealed: - February 2015 FSBS at 7:30 a.m. ranged from 101-205. - March 2015 FSBS at 7:30 a.m. 101 - 200. Review of the record for Resident # 3 revealed there was not an order for insulin injections with neither Humulin 70/30 nor Novolin 70/3 in the record. Interview on 3/27/15 at 11:25 a.m. with the	C 207		

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C 207	Continued From page 4 Administrator revealed: - Resident # 3 received finger stick blood sugar (FSBS) checks daily and had been receiving insulin since admission (7/24/03). - The resident was administered insulin if the blood sugar was not normal. - If the FSBS check was normal, the resident usually refused the insulin. - The physician was aware of these refusals. - The Administrator thought there was an order in the resident's record for insulin. Neither he nor the Supervisor-In-Charge had clarified the insulin with the physician since it was left off of the FL-2. - He thought the FL-2 was not an order sheet. - He would locate the order. - The facility would complete MAR, medications and order checks monthly to ensure orders were in the records. - The facility will clarify the FL-2 if not complete or clear. _____ Interview on 3/27/15 at 3:50 p.m. with the Administrator revealed: - The Administrator was responsible for ensuring medication orders on the current FL-2 matched the current medications being administered. - The Administrator indicated there were prescriptions written on 10/16/14, the day before the current FL-2 dated 10/17/14. - He thought these prescriptions were the current orders not the ones written the next day on the FL-2. - Neither he nor the SIC had clarified the discrepancy in the orders written 10/16/14 and the FL-2 orders dated 10/17/14. - The medications were being administered by the 10/16/14 orders.	C 207		

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C 207	Continued From page 5 - The new FL-2's will be checked against the current medications and will verify correct orders with differences. - The SIC was not available for interview.	C 207		
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all medication orders were in the residents' records for 3 of 3 sampled residents. (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 12/05/14 revealed diagnoses of Schizophrenia, Epilepsy, Diabetes Mellitus Type II, Hypertension, Rhabdomyolosis and high lipids. Review of Resident #1's medications on hand revealed there was Fluoxetine (Used to treat depression, panic and obsessive disorders.), Simvastin (Used to lower fatty acids and cholesterol in the blood.) and Phenytoin 100 mg three times per day. (Used to treat epilepsy.). Review of the March 2015 medication administration record (MAR) revealed: - Fluoxetine 20 mg daily had been documented as administered from 3/01/15 - 3/27/15. - Simvastin 20 mg had been initialed as administered at 8 p.m. from 3/01/15 - 3/27/15 . - Phenytoin 100 mg three times per day was not	C 316		

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C 316	Continued From page 6 listed for administration. Review of Resident # 1's medications on hand revealed all three medications, Simvastin, Phenytoin and Fluoxetine were available for administration. Review of the record for Resident #1 revealed there were not orders for Simvastin 20 mg at bedtime, Fluoxetine 20 mg daily nor for Phenytoin 100 mg three times per day. Interview on 3/27/15 at 4:05 p.m. with the Administrator revealed: - Resident # 1 was definitely receiving the Phenytoin, Simvastin and Fluoxetine. - The orders for these medications should be in the resident's record. - He would check for the orders. - The Supervisor-In-Charge (SIC) and the Administrator ensure the orders were in each resident's record. - The SIC was not available for interview. Interview on 3/27/15 at 4:20 p.m. with Resident #1 revealed: - The resident received all of the medications ordered by the physician. - The resident was taking Simvastin, Phenytoin, and Fluoxetine like always. - The physician told the resident each medication and when to take it. - The resident would know if a medication was not administered or if it was incorrect from what the physician told her she would not take the medication. An order for Simvastin was provided dated the day of the survey, 3/27/15, for Simvastin 20 mg at bedtime.	C 316		

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C 316	Continued From page 7 No further documentation of orders missing was provided by the end of the survey. Refer to the interview on 3/27/15 at 3:50 p.m. with the Administrator. 2. Review of the FL-2 dated 10/17/14 for Resident # 2 revealed diagnoses of diabetes mellitus, mental retardation, hyperlipidemia and schizophrenia. Review of the medication administration record (MAR) for March 2015 revealed: - ASA 81mg. daily was initialed as administered from 1/26/15 on 2/16/15. (Aspirin used as a blood thinner to prevent clots.) - Invega 6 mg by mouth daily. (Used to treat schizophrenia.) was initialed as administered for 3/01/15 - 3/27/15. Review of the resident's medications on hand revealed: - ASA 81 mg was available for administration. - There was no Invega for administration. Review of Resident #2's record did not reveal orders for ASA or Invega. Interview on 3/27/15 at 3:50 p.m. with the Administrator revealed: - Resident # 1 was definitely receiving the ASA and Invega and he was supposed to receive these medications. - The Invega was injected at the clinic by the nurse. - The orders for these medications should be in the resident's record. - He would check for the orders and clarify with the physician.	C 316		

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C 316	Continued From page 8 - The Supervisor-In-Charge (SIC) and the Administrator ensure the orders were in each resident's record. - The facility is not reviewing medication against the new MARs and orders but would start doing this to ensure medication were listed correctly according to orders in the record. An Invega order was provided for review and was dated 10/16/14 (One day prior to the FL2 dated 10/17/14) and was for 324 mg/1.5 ml injection every 28 days. No current orders, on or after the FL-2 of 10/17/14 for ASA or Invega were provided by the end of the survey. Refer to the interview on 3/27/15 at 3:50 p.m. with the Administrator. 3. Review of the current FL-2 dated 8/15/14 for Resident # 3 revealed: - Diagnoses of Type II Diabetes Mellitus, Schizophrenia, Bipolar Disorder, and Hypertension. - Medication orders for Diazepam Liquid 7 mg (7 ml = 7 mg) by mouth at bedtime.; Enteric Coated Aspirin 81 mg daily by mouth; Benazepril 20 mg twice daily by mouth. (Used to treat high blood pressure); Therum Complete 50+ each morning. (A vitamin and mineral supplement); Benztropine 1 mg each morning. (Used to treat side effects form some medications.; Glipizide 10 mg daily by mouth (Used to control blood sugar.) A. Review of the February 2015 medication administration record (MAR) revealed Novolin 70/30 insulin 50 units subcutaneously (SQ) was administered at 7:30 a.m. from 2/01/15 - 2/28/15 with no indication of refusals by the resident.	C 316		

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C 316	Continued From page 9 (Insulin is used to control blood sugar levels.) Review of the March 2015 MAR revealed Novolin 70/30 insulin 50 units SQ was listed and administered 3/01/15 - 3/27/15 at 7:30 a.m. Review of medications on hand for Resident # 3 revealed Humulin 70/30 insulin/100u 50 units SQ. Review of 7:30 a.m. FSBS checks for Resident # 3 revealed: - February 2015 FSBS at 7:30 a.m. ranged from 101-205. - March 2015 FSBS at 7:30 a.m. 101 - 200. Review of the record for Resident # 3 revealed there was not an order for insulin injections with neither Humulin 70/30 nor Novolin 70/3 in the record. Interview on 3/27/15 at 11:25 a.m. with the Administrator revealed: - Resident # 3 received finger stick blood sugar (FSBS) checks daily and had been receiving insulin since admission. - The resident was administered insulin if the blood sugar was not normal. - If the FSBS check was normal, the resident usually refused the insulin. - The physician was aware of these refusals. - The Administrator thought there was an order in the resdient's record for insulin. - He would locate the order. - The facility would complete MAR, medications and order checks monthly to ensure orders were in the records. B. Review of the February 2015 and March 2015 MAR revealed:	C 316		

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C 316	Continued From page 10 - Invega 234 mg give 1.5 ml intramuscularly every 28 days. - Invega was documented as administered 2/04/15 and 3/10/15. - Depakote ER 500 mg at bedtime at 8 p.m. was documented as administered from 2/01/15 - 2/28/15 and 3/01/15 - 3/04/15. - No other dates were listed for administration on the March 2015 MAR. Interview on 3/27/15 at 11:25 a.m. with the Administrator revealed: He was sure resdient were receiving all medications as ordered - He would locate the orders. - The facility would complete MAR, medications and order checks monthly to ensure orders were in the records. Refer to the interview on 3/27/15 at 3:50 p.m. with the Administrator. _____ Interview on 3/27/15 at 3:50 p.m. with the Administrator revealed: - Resident were definitely receiving medications as ordered. - The orders for these medications should be in the residents' records. - He would check for the orders and clarify with the physician. - The Supervisor-In-Charge (SIC) and the Administrator ensure the orders were in each resident's record. - The facility is not reviewing medication against the new MARs and orders but would start doing this to ensure medication were listed correctly according to orders in the record.	C 316		

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C 342	Continued From page 11	C 342		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 3 of 3 sampled residents' medication administration records (MAR) were accurate and complete. (#1, #2, #3.) The findings are: 1. Review of Resident # 1's current FL-2 dated 12/05/14 revealed: - Diagnoses of Schizophrenia, Epilepsy, Diabetes Mellitus Type II, Hypertension, Rhabdomyolosis and high lipids. - Medication orders included Benztropine 1mg twice daily by mouth. (Used to treat side effects	C 342		

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C 342	Continued From page 12 from the use of this medication.); Depakote 100 mg at bedtime. (Used to treat seizures and mania.); Fluphenazine 10 mg daily by mouth.; and Lorazepam 1 mg three times per day by mouth. (Used to treat anxiety.) Record review for Resident #1 included a subsequent medication order on 1/05/15 for Trazadone 100 mg at bedtime by mouth. (Used to treat depression.) Review of the record for Resident #1 revealed there were not orders for Simvastin 20mg at bedtime nor for Fluoxetine 20mg daily. Review of the resident's medication on hand revealed there were Simvastin and Fluoxetine available for administration. Review of the resident's medications on hand revealed there were medications available for all of the medications ordered including those without orders in the record. (Simvastin and Fluoxetine.) Review of the February 2015 medication administration record (MAR) revealed: - Simvastin had not been documented although it was listed for administration for February 2015. - Trazadone was not listed on the MAR for administration.. - Lorazepam 1 mg three times per day was not listed for administration. Review of the February 2015 MAR for Resident #1 revealed Benztropine, Depakote, Lorazepam, Simvastin, Fluoxetine, Trazadone, and Fluphenazine were listed for administration but no documentation had been completed.	C 342		

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C 342	Continued From page 13 Review of the March 2015 Medication Administration Record (MAR) revealed medications listed without orders in the record included: - Simvastin 20 mg at bedtime had been documented a night ahead for 3/28/15 by the medication aide (MA). - Fluoxetine 20 mg each morning by mouth was documented ahead for 8 p.m. on 3/27/15 the day of the survey. - Lorazepam 1 mg three times per day was not listed for administration. - Trazadone 100 mg at bedtime was not listed for administration. - Fluphenazine 10mg daily was not listed for administration. Review of the resident's medications revealed Phenytoin was available for administration but was not on the MAR. Interview with the Administrator on 3/27/15 at 3:45 p.m. revealed Resident # 2 was definitely administered Phenytoin. Interview on 3/27/15 at 4:20 p.m. with the resident revealed she takes the Phenytoin daily as well as all of her medications. Interview with four facility residents during the tour on 3/27/15 revealed they all received their medications everyday with no exceptions since their admissions. Refer to interview with residents on facility tour on 3/27/15 at 9:45 a.m. Refer to interview on 3/27/15 at p.m. with the Administrator.	C 342		

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C 342	Continued From page 14 2. Review of the current FL-2 dated 8/15/14 for Resident # 3 revealed: - Diagnoses of Type II Diabetes Mellitus, Schizophrenia, Bipolar Disorder, and Hypertension. - Medication orders for Diazepam Liquid 7 mg (7 ml = 7 mg) by mouth at bedtime.; Benazepril 20 mg twice daily by mouth. (Used to treat high blood pressure); Glipizide 10 mg daily by mouth (Used to control blood sugar.) Review of the March 2015 MAR revealed: - Diazepam was listed for administration but only initialed from 3/01/15 - 3/04/15 at 8 p.m. with no explanation documented. - Benazepril was listed for administration but only initialed from 3/01/15 - 3/05/15 at 8 p.m. with no explanation documented. Review of the February 2015 and the March 2015 MAR revealed: - Depakote ER 500 mg at bedtime at 8 p.m. was documented as administered from 2/01/15 - 2/28/15 and 3/01/15 - 3/04/15. - There was no documentation for administration on the March 2015 MAR. Review of the resident's record revealed there was no order for Depakote ER 500 mg at bedtime as listed on the MAR. Interview on 3/27/15 at 1:30 p.m. with Resident # 3 revealed he was administered all of his medications, fingerstick blood sugar checks and insulin by the medication aide daily. Refer to interview with residents on facility tour on 3/27/15 at 9:45 a.m. Refer to interview on 3/27/15 at 3:30 p.m. with the	C 342		

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C 342	Continued From page 15 Administrator 3. Review of the current FL-2 for Resident # 2 revealed: - Diagnoses of Diabetes Mellitus Type II, Schizophrenia, Mental Retardation and Hyperlipidemia. - Medications ordered were Glipizide 5 mg daily. (Used to control blood sugar.); Simvastin 20 mg daily (Used to control cholesterol.); Risperdone 1 mg twice daily with 2 mg at bedtime. (Used to treat Schizophrenia.); Fluoxetine 40 mg every morning. (Used to treat depression, panic and obsessive compulsive disorders).; Benztropine 1 mg daily by mouth (Used to treat side effects of some mediations); Bupropion XL 300 mg each morning. (Used to treat depression.); Lisinopril 10mg daily. (Used to treat hypertension.); Seroquel XR 300 mg at bedtime. (Used to treat schizophrenia and episodes of mania.); Temazepam 30 mg at bedtime. (Used to treat short term insomnia.) Review of the February 2015 medication administration record (MAR) revealed: - None of the current FL-2 of 10/17/15 medications listed for administration on the MAR were documented as administered. Review of the medication administration record (MAR) for March 2015 revealed: - Invega 6 mg by mouth daily. (Used to treat schizophrenia.) was initialed as administered for 3/01/15 - 3/27/15. Review of the resident's medications on hand revealed there was no Invega 6 mg daily was available for administration. Interview on 3/27/15 at 3:50 p.m. with the	C 342		

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C 342	Continued From page 16 Administrator reveled: - The Supervisor-In-Charge (SIC) was just marking it as administered as she went along administering all of the medications. - The SIC did actually give this Invega by mouth as it was an injection for the resident given to him at the clinic. - The MAR was listed incorrectly. - He would get the correct order and have the SIC document the MAR as ordered. Refer to interview on 3/27/15 at 3:30 p.m. with the Administrator. Refer to interview with residents on facility tour on 3/27/15 at 9:45 a.m. _____ Interview on 3/27/15 at 3:30 p.m. with the Administrator revealed: - The SIC had not documented on the MAR since he had turned some of the MARs upside down in the notebook. - The SIC was the previous owner/Adminstrator and who had been administering medications for many years. - The Administrator said he was sure residents got their medications administered but they just were not documented. - The Administrator would check behind the SIC to ensure documentation was completed. - He would have the facility nurse or another SIC double check the MARs. - The Administrator said the SIC was not available at this time. Interview with four facility residents during the tour at 9:30 a.m. on 3/27/15 revealed they all received their medications everyday with no exceptions since their admissions.	C 342		

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C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a readily retrievable record of controlled substances was available for accurate reconciliation of medications to treat anxiety for 2 of 2 sampled residents. (#1 and #3). The findings are: 1. Review of Resident # 1's current FL-2 dated 12/05/14 revealed: - Diagnoses of Schizophrenia, Epilepsy, Diabetes Mellitus Type II, Hypertension, Rhabdomylosis and high lipids. - Controlled substance orders of Lorazepam 1 mg by mouth three times per day. (Used to treat anxiety.) A subsequent medication order on 1/05/15 for Lorazepam 1 mg three times per day by mouth was listed. Review of the facility medication administration records (MAR) revealed Lorazepam was not documented as administered on the February 2015 and the March 2015 MARs. Record review for Resident # 1 revealed: - There was no control substance log for February 2015 and March 2015.	C 367		

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C 367	Continued From page 18 - There was no documentation of receipt of the Lorazepam. Review of Resident # 1's medication on hand revealed: - The prescription bottle had Lorazepam 1 mg three times per day listed on the label. - The Lorazepam 1 mg was last dispensed on 3/08/15 and had 60 pills when received. - Sixteen pills were left in the bottle. Interview with the Administrator on 3/27/15 at 4:05 p.m. revealed: - He was in the facility most of the time. - He was very confident that the medication aide Supervisor-In-Charge (SIC) administered all of the residents' medications as ordered. - The SIC administered the Lorazepam three times per day as ordered for Resident # 1. - He was not aware the MAR and a controlled substance logs were not documented for the administration of the Lorazepam. - A controlled substance log did not come with the Lorazepam medication as it comes from a pharmacy that does not provide them. - He was not aware he could create one or check with the pharmacy for a controlled substance log to ensure a readily retrievable record of administration of the Lorazepam. - He had not been told by the pharmacist nor was this indicated in the pharmacy reviews to complete the controlled substance logs. - He would ensure the SIC documented on the controlled substance log as required. - He would ensure controlled medications would have documentation of when received and the amount received. Interview on 3/27/15 at 4:20 p.m. with Resident #1 revealed:	C 367		

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C 367	Continued From page 19 - The resident received all of the medications ordered by the physician. - The physician told the resident each medication and when to take it. - The resident would know if a medication was not administered or if it was incorrect from what the physician told her she would not take the medication. - She was receiving the Lorazepam as the physician told her. The medication aide was unavailable for interview. Based on the review of the Lorazepam medication on hand, no controlled substance log nor complete MAR documentation, it was not able to determine correct reconciliation of Resident # 2's Lorazepam. 2. Review of the current FL-2 dated 8/05/14 for Resident # 3 revealed: - Diagnoses of Type II Diabetes Mellitus, Schizophrenia, Bipolar Disorder, and Hypertension. - A controlled substance order for Diazepam Liquid 7 mg (7 ml = 7 mg) by mouth at bedtime. Review of the facility medication administration records (MAR) revealed: - Diazepam was listed for administration on the February 2015 and was initialed as administered at 8 p.m. 2/01/15 - 2/28/15. - Diazepam was listed for administration on the March 2015 and was initialed as administered at 8 p.m. from 3/01/15 - 3/04/15 and there was no documentation for 3/05/15 - 3/26/15. Record review for Resident # 3 revealed: - There was no controlled substance log	C 367		

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C 367	Continued From page 20 completed for February 2015 for the Diazepam. - The March 2015 Diazepam controlled substance log dated 3/11/15 was present in the facility but was folded up and had not been completed. - There was no documentation of receipt of the Diazepam for February 2015. Review of medication for Resident # 3 revealed: - Bottle # 1 - Diazepam 7 mg daily 210 supply with syringe for administering was available. This bottle was dispensed on 1/20/15. - Bottle #1 had a small undeterminable amount in the bottle. - Bottle # 2 of Diazepam 210 ml was dispensed on 3/11/15. - By markings on Bottle # 2 there was between 125 ml - 150 ml left in the bottle. Interview on 3/27/15 at 11:45 a.m. with Resident # 3 revealed: - The Supervisor-In-Charge (SIC) administered his medications as ordered as far as he knew. - The MA gave him the liquid Diazepam each night at bedtime with a syringe filled with orange liquid. Interview on 3/27/15 at 12 p.m. with the Adminsitrator revealed: - The Administrator knew the SIC was not filling out the controlled substance logs. - He did not realize the importance of the controlled substance log documentation. - He had not been told by the pharmacist nor was this indicated in the pharmacy reviews to complete the controlled substance logs. - He did not know where the February 2015 controlled substance log was and did not know why there was a small amount left if Bottle # 1. - The SIC should have documented and	C 367		

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C 367	Continued From page 21 disposed of the remaining amount if expired or not ordered any longer. Based on the amount left in Bottle # 2 and Bottle # 1, no controlled substance log nor accurate MAR completion, it was able to determine accurate reconciliation of Resident # 3's Diazepam. _____ Interview with the Administrator on 3/27/15 at 4:05 p.m. revealed: - The administrator is in the facility most of the time. - The medication aide administered the Lorazepam three times per day. as ordered. - He was not aware the MAR and a control log was not documented for the administration the controlled substance. - A control log does not come with the is medication as it comes from another pharmacy. - He was not aware he could create one or check with the pharmacy for a control log to ensure a readily retrievable record of administration of the Lorazepam. - He would ensure the medication aide documented on a control log as required. - He would ensure controlled medications would have documentation of when received and the amount received.	C 367		