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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on 03/05/25 - 03/06/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 1 of 3 sampled residents (Resident #2) related to 3 missed appointments with a primary care provider (PCP) with fasting labs, one missed appointment with a pulmonary provider, and a computed tomography (CT) scan of the lungs. The findings are: Review of Resident #2's current FL2 dated 12/30/24 revealed diagnoses included peripheral artery disease, generalized anxiety disorder, depression, hypertension, tobacco use, chronic obstructive pulmonary disease (COPD), and emphysema. a. Review of Resident #2's record revealed there was an appointment card with Resident #2's primary care provider (PCP) dated 12/18/24 at 9:40am with handwritten documentation "fasting labs" written on the card. A request was made to the Administrator on	D 273		

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03/05/25 at 10:32am for Resident #2's lab results and PCP progress notes and the labs/progress notes were not provided.

Interview with Resident #2 on 03/05/25 at 12:13pm revealed:
-The Resident Care Coordinator (RCC) kept up with all his appointments.
-He did not know he had missed an appointment until his PCP office called him about 2 weeks ago and told him he had missed one.
-He did not know if he had any other appointments that were missed.

Interview with the RCC on 03/06/25 at 10:38am revealed:
-She was responsible for writing down all appointments for residents on a calender.
-She was responsible for taking all the residents to their appointments with providers.
-She was responsible for making follow-up appointments with providers.
-Resident #2 missed his appointment with his PCP on 12/18/24 because she forgot about the appointment when she transferred all the appointments for residents onto a calendar for 2025.
-Resident #2's appointment with his PCP was rescheduled to 02/14/25 and that appointment was missed because there was bad weather with snow and ice on the roads.
-Resident #2's appointment was rescheduled a third time on 02/18/25 and the appointment was missed because the PCP office did not tell her it was rescheduled on 02/18/25.
-She missed taking Resident #2 to several appointments because most providers did not give her a copy of office visits when she took Resident #2 to his appointments so she had no way of knowing when a follow-up appointment or

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referral was made.

Telephone interview with the Clinical Supervisor at Resident #2's PCP office on 03/05/25 at 11:10am and 03/06/25 at 11:20am revealed:
-Resident #2 was due for an annual visit and supposed to have fasting labs completed on 12/18/24 and was a "no show".
-Resident #2 had not had any labs completed in "over a year".
-The office called the facility and rescheduled Resident #2's appointment on 02/14/25 and Resident #2 was a "no show".
-Resident #2's appointment was rescheduled again on 02/18/25 with a facility staff member (she did not have the name of the person who the appointment was rescheduled with documented in the computer) and Resident #2 was a "no show".
-There was a note in the computer system that the facility was notified each time Resident #2 missed an appointment and the appointment was rescheduled with facility staff.
-Resident #2 still had not had fasting labs completed since the first appointment was scheduled on 12/18/24.
-Resident #2's PCP expected the facility to bring Resident #2 to his appointments as scheduled.

Interview with the Administrator on 03/05/25 at 12:39pm revealed:
-She did not know Resident #2 missed 3 appointments with his PCP and his fasting labs were not completed.
-The RCC was responsible to write all appointments for residents on a calender and take the residents to their appointments.
-She knew one appointment with Resident #2's PCP was rescheduled due to inclement weather.
-She expected the RCC to take the residents to

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their scheduled appointments.

b. Review of Resident #2's primary care provider (PCP) notes dated 08/08/24 revealed there was an order for a referral for a computed tomography (CT) scan of the lungs.

Interview with Resident #2 on 03/05/25 at 12:13pm revealed:
-The RCC kept up with all his appointments.
-He had a CT scan of his lungs "a long time ago" and did not know if another one had been ordered.
-He had experienced a harder time breathing due to shortness of breath that was worse in the mornings so he just had to take it slow while walking.
-He did not know if he had any other appointments that were missed.

Interview with the RCC on 03/06/25 at 10:38am revealed:
-She could not find any documentation that Resident #2's CT scan of the lungs was completed after it was ordered on 08/08/24.
-She was responsible for reviewing all progress notes from providers and scheduling referrals ordered for residents.
-She missed the referral for a CT scan of the lungs in Resident #2's PCP progress note dated 08/08/24.

Telephone interview with the Clinical Supervisor at Resident #2's PCP office on 03/06/25 at 11:20am revealed:
-Resident #2 was seen by his PCP on 08/08/24 and was ordered a referral for a CT scan of the lungs for lung cancer screening.
-She did not have any documentation that a CT scan of the lungs was completed for Resident #2.

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D 273	Continued From page 4 -It was important for Resident #2 to have a CT scan of his lungs completed because Resident #2 was a tobacco user and was at high risk of developing lung cancer. -Resident #2 not having a CT scan completed could cause lung cancer to be missed and could lead to a progression of cancer. Interview with the Administrator on 03/06/25 at 11:55am revealed: -She was not aware Resident #2 had a referral for a CT scan of the lungs and it was not completed. -The RCC was responsible for scheduling all appointments and taking the residents to their appointments. -She expected the RCC to schedule the CT scan of the lungs for Resident #2 when the referral was made and to have the CT scan completed. c. Review of Resident #2's physician's order dated 12/30/24 revealed there was an order for Anoro Ellipta (used to treat chronic obstructive pulmonary disease (COPD) 62.5mcg/25mcg inhale 1 puff daily. Interview with Resident #2 on 03/05/25 at 12:13pm revealed: -He saw a pulmonology provider last year (2024) because he had COPD and emphysema. -The pulmonologist ordered him another inhaler to help him breathe better but he was out of his inhaler medication. -He had experienced a harder time breathing due to shortness of breath that was worse in the mornings so he just had to take it slow while walking. -He did not know if he was supposed to follow-up with the pulmonary provider because the Resident Care Coordinator (RCC) kept up with	D 273		

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D 273	Continued From page 5 and took him to all of his appointments. Review of Resident #2's pulmonary provider notes revealed: -There was a progress note dated 03/27/24 with an order for a follow-up in 3 months. -There was no other progress notes available for review with Resident #2's pulmonary provider. Telephone interview with the Practice Manager at Resident #2's PCP office on 03/05/25 at 11:10am revealed Resident #2 may have missed an appointment with a pulmonary provider because she did not see a note in her system where Resident #2 was seen for a follow-up with the pulmonologist. Telephone interview with a medical assistant from Resident #2's pulmonary provider office on 03/05/25 at 11:54am revealed: -Resident #2 was referred to the pulmonary provider and was seen on 03/27/24. -Resident #2 was ordered a new inhaler medication for worsening COPD and emphysema. -Resident #2 had a follow-up scheduled on 07/01/24 and was a "no show" for the appointment. -The facility did not call to reschedule Resident #2's appointment. Interview with the RCC on 03/06/25 at 10:38am revealed: -She was responsible for scheduling all referrals made for residents and taking the residents to their appointments. -She did not take Resident #2 for a follow-up appointment with his pulmonary provider on 07/01/24 because she did not know Resident #2 had an appointment.	D 273		

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D 273	Continued From page 6 -She missed taking Resident #2 to several appointments because most providers did not give her a copy of office visits with referrals or when follow-up appointments were made so she had no way of knowing about the appointments. Interview with the Administrator on 03/05/25 at 12:39pm revealed: -She was not aware Resident #2 missed a follow-up appointment with his pulmonary provider. -The RCC was responsible for scheduling all appointments and taking the residents to their appointments. -The RCC wrote all appointments for residents on a calendar. -She did not see an appointment handwritten on the calender on 07/01/24 for Resident #2. -She expected the RCC to take Resident #2 to his appointments or reschedule the appointments if missed.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 3 sampled residents (#1 and #2) who had orders for a depakote level (#1), and	D 276		

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fasting labs (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 10/21/24 revealed:
-Diagnoses included schizoaffective disorder.
-Depakote (treats mood disorders) 500mg two times daily.

Review of a physician order for Resident #1 dated 11/26/24 revealed:
-There was an order to recheck Depakote blood level the week of 12/01/24.
-There was an illegible physician assistant's signature beside the order.

Review of Resident #1's laboratory results revealed there was not a Depakote level.

Interview with the medication aide (MA) on 03/05/25 at 11:50am revealed:
-The Resident Care Coordinator (RCC) was responsible to ensure the physician's order were complete.
-She did not know why the Depakote level was not done and did not see the order.

Interview with the RCC on 03/06/25 at 10:37am revealed:
-She did not remember the order for the Depakote level and did not know who ordered it.
-She was responsible for transporting the residents to the local hospital or physician's office for laboratory blood draws.
-She did not remember if she transported Resident #1 for get the Depakote blood draw.
-She and the MA were responsible for ensuring physician orders were complete.
-The facility's contracted Registered Nurse (RN)

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was responsible for a second check of orders to ensure they were completed.
-She did not know why this order was missed.

Telephone interview with the facility's contracted RN on 03/05/25 at 12:19pm revealed:
-She worked in the facility once every two weeks and her tasks included completing care plans, FL2s, and Licensed Healthcare Professional Support (LHPS) tasks.
-The MA and RCC were responsible for ensuring physician orders were completed
-She did not audit physician orders because she was responsible for other tasks.

Interview with the Administrator on 03/06/25 at 9:40am revealed:
-The MA, RCC, and RN were all responsible for ensuring that all physician's orders were complete.
-The RCC transported residents to have their blood drawn.
-She did not know why this was missed.

2. Review of Resident #2's current FL2 dated 12/30/24 revealed diagnoses included peripheral artery disease, generalized anxiety disorder, depression, hypertension, tobacco use, chronic obstructive pulmonary disease (COPD), and emphysema.

a. Review of Resident #2's record revealed there was an appointment card with Resident #2's primary care provider (PCP) dated 12/18/24 at 9:40am with handwritten documentation "fasting labs" written on the card.

A request was made to the Administrator on 03/05/25 at 10:32am for Resident #2's lab results and PCP progress notes dated 12/18/24 and the

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labs/progress notes were not provided.

Interview with Resident #2 on 03/05/25 at 12:13pm revealed:
-The RCC kept up with all his appointments.
-He did not know he had missed an appointment until his PCP office called him about 2 weeks ago and told him he had missed one.
-He did not know if he had any other appointments that were missed.

Interview with the RCC on 03/06/25 at 10:38am revealed:
-She was responsible for writing down all appointments for residents on a calender.
-She was responsible for taking all the residents to their appointments with providers.
-Resident #2 missed his appointment with his PCP on 12/18/24 because she forgot about the appointment when she transferred all the appointments for residents onto a calendar for 2025.
-Resident #2's appointment with his PCP was rescheduled to 02/14/25 and that appointment was missed because there was bad weather with snow and ice on the roads.
-Resident #2's appointment was rescheduled a third time on 02/18/25 and the appointment was missed because the PCP office did not tell her it was rescheduled on 02/18/25.

Telephone interview with the Clinical Supervisor at Resident #2's PCP office on 03/05/25 at 11:10am and 03/06/25 at 11:20am revealed:
-Resident #2 was due for an annual visit and supposed to have fasting labs completed on 12/18/24 and was a "no show".
-Resident #2 had not had any labs completed in "over a year".
-Resident #2's appointment was rescheduled on

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02/14/25 and was a "no show".
-Resident #2's was rescheduled again on 02/18/25 and was a "no show".
-There was a note in the computer system that the facility was notified each time Resident #2 missed an appointment and the appointment was rescheduled.
-Resident #2 still had not had fasting labs completed since the first appointment was scheduled on 12/18/24.
-Resident #2's PCP expected the facility to bring Resident #2 to his appointments as scheduled.

Interview with the Administrator on 03/05/25 at 12:39pm revealed:
-She did not know Resident #2 missed 3 appointments with his PCP and his fasting labs were not completed.
-The RCC was responsible to write all appointments for residents on a calender and take the residents to their appointments.
-She knew one appointment with Resident #2's PCP was rescheduled due to inclement weather.
-She expected the RCC to take the residents to their scheduled appointments.

b. Review of Resident #2's primary care provider (PCP) notes dated 08/08/24 revealed there was an order for a referral for a computed tomography (CT) scan of the lungs.

A request was made to the Resident Care Coordinator (RCC) on 03/06/25 at 10:38am for Resident #2's CT scan of the lungs and the CT scan was not provided.

Interview with Resident #2 on 03/05/25 at 12:13pm revealed:
-The RCC kept up with all his appointments.
-He had a CT scan of his lungs "a long time ago"

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and did not know if another one had been ordered.
-He had experienced a harder time breathing due to shortness of breath that was worse in the mornings so he just had to take it slow while walking.
-He did not know if he had any other appointments that were missed.

Interview with the RCC on 03/06/25 at 10:38am revealed:
-She did not see the referral for a CT scan of the lungs in Resident #2's PCP progress note on 08/08/24.
-She took Resident #2 for a CT scan on his legs on 08/16/24 to check for a blood clot.
-She was responsible for scheduling all referrals made for residents.
-She missed scheduling an appointment for a CT scan of the lungs for Resident #2.

Telephone interview with the Clinical Supervisor at Resident #2's PCP office on 03/06/25 at 11:20am revealed:
-Resident #2 was seen by his PCP on 08/08/24 and was ordered a referral for a CT scan of the lungs for lung cancer screening.
-She did not have any documentation that a CT scan of the lungs was completed for Resident #2.
-It was important for Resident #2 to have a CT scan of his lungs completed because Resident #2 was a tobacco user and was at high risk of developing lung cancer.
-Resident #2 not having a CT scan completed could cause lung cancer to be missed and could lead to a progression of cancer.

Interview with the Administrator on 03/06/25 at 11:55am revealed:
-She was not aware Resident #2 had a referral

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D 276	Continued From page 12 for a CT scan of the lungs and it was not completed. -The RCC was responsible for scheduling all appointments and taking the residents to their appointments. -She expected the RCC to schedule the CT scan of the lungs for Resident #2 when the referral was made and to have the CT scan completed.	D 276		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a record of menu substitutions indicating what food was served to residents. The findings are:	D 292		

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Review of the lunch menu for 03/05/25 revealed the menu consisted of cornflake ranch chicken, garlic mashed potatoes, green beans, choice of bread, angel food cake with berries, and a beverage of choice.

Observation of the lunch meal service 03/05/24 from 12:15pm through 12:45pm revealed the residents were served fish sticks, French fries, coleslaw, tartar sauce, and 2 sugar free cookies.

Interview with the cook on 03/05/25 at 11:40am revealed:
-She did not serve what was on the menu because she did not have the food items to make what was listed.
-She went grocery shopping this morning (03/05/25) but did not buy what was on the menu because she bought what was on the grocery list the medication aide (MA) made for her.
-The MA was in charge of making out the weekly grocery list.
-She bought the frozen fish sticks last week but served something else, so she went ahead and served the fish sticks and French fries for lunch.
-She usually prepared the meals for residents by what was listed on the menu.
-The MA prepared the dinner meal for residents on 03/04/25 and had to substitute another meal because she had not gone grocery shopping yet.
-A 2025 calender was used to document menu substitutions.

Review of the substitutions menu for March 2025 revealed:
-On 03/05/25, there was handwritten documentation "switched menu for lunch".
-There were no substitutions documented on the calendar.
-There was no documentation that menu

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D 292	Continued From page 14 substitutions were made on 03/04/25 for the dinner meal. Review of the dinner menu for 03/04/25 revealed the menu consisted of a chili dog on a bun, baked beans, coleslaw, and fruit salad. Interview with a resident in the dining room on 03/05/25 at 11:40am revealed: -The facility did not offer chili dogs on a bun, baked beans, coleslaw, or fruit salad last night for dinner. -He was served vegetable soup for dinner on 03/04/25. Interview with a MA on 03/05/25 at 4:55pm revealed: -She worked the evening of 03/04/25 and prepared the dinner meal service for the residents. -She did not serve what was on the dinner menu on 03/04/25 because she did not have the grocery items to prepare the meal so she served vegetable soup to the residents. -She forgot to document the substitutions on the calendar where the menu substitutions were supposed to be documented. Interview with the Administrator on 03/06/25 at 11:55pm revealed: -The cook and the MA were trained to document all menu substitutions in detail on a calendar in the kitchen. -She was responsible for making sure the menu substitutions log was completed when substitutions were made. -She thought staff were documenting the substitutions correctly.	D 292		

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D 316	Continued From page 15	D 316		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post a current monthly activity calendar on the first day of the month for the 8 residents	D 316		

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D 316	Continued From page 16 residing in the facility. The findings are: Observation oin the hallway during the initial tour on 03/05/25 at 9:00am revealed: -There was an activity calendar posted on the wall for January 2025. -There were no other activity calendars posted. Interview with the medication aide (MA) on 03/06/25 at 10:30am revealed the Activity Director (AD) did not post an activity calendar for February and March 2025. Telephone interview with the AD on 03/06/25 at 11:07am revealed: -She did not post an activity calendar for March 2025 because the residents usually did not want to participate in an activity unless it was an outing. -There was only 1 or 2 residents that would participate in an activity in the facility. -She knew she should have posted an activity calendar. Interview with the Administrator on 03/06/25 at 9:40am revealed: -The AD was responsible for posting a monthly calendar for the residents to see. -She did not know why the March 2025 calendar was not posted.	D 316		
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,	D 358		

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (Resident #1, # 2, #3) related to medications to treat a mental disorder, ear wax buildup (#1), an inhaler (#2), and a medication used to treat elevated blood sugars (#3).

The findings are:

Review of the facility's undated Medication Administration Policy and Procedure revealed:
-The medication aide (MA) that administered the medications was responsible for reordering the medications.
-The medication administration records (MARs) were checked against the current physician's orders and any corrections were made on the new MARs.
-If a resident refused a medication, sign out the dose and then circle the initials and provide a short explanation on the back of the MAR.

1. Review of Resident #2's current FL2 dated 12/30/24 revealed diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, and tobacco use.

Review of Resident #2's physician's orders dated

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D 358	Continued From page 18 12/30/24 revealed an order for Spiriva (used to control the symptoms of COPD by relaxing the airways and keeping them open) 18mcg inhale 1 capsule daily, may keep at bedside. Interview with Resident #2 on initial tour of the facility on 03/05/25 at 8:50am revealed: -He was out of his inhalers and the pharmacy had not sent them to him yet. -He told the medication aide (MA) he needed his inhaler over a week ago and she told him it was on back order. -He experienced shortness of breath with exertion, and he just had to "take it slow". Review of Resident #2's January 2025 medication administration record (eMAR) revealed: -There was an entry for Spiriva 18mcg inhale 1 capsule daily. -There was documentation Spiriva 18mcg was administered daily from 01/01/25-01/31/25 at 9:00am. Review of Resident #2's February 2025 MAR revealed: -There was an entry for Spiriva 18mcg inhale 1 capsule daily. -There was documentation Spiriva 18mcg was administered daily from 02/01/25-02/28/25 at 9:00am. Review of Resident #2's 03/01/25-03/05/25 MAR revealed: -There was an entry for Spiriva 18mcg inhale 1 capsule daily. -There was no documentation Spiriva was administered with handwritten documentation "keep in room".	D 358		

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Observation of Resident #2's medications on hand on 03/05/25 at 10:33am revealed there was no Spiriva available for administration.

Interview with a medication aide (MA) on 03/05/25 at 10:40am and 3:04pm revealed:
-Resident #2 kept his inhalers in his room and self-administered them himself.
-Resident #2 told her he used his inhalers every day and she did not ask him specifically if he used the Spiriva.
-She signed Resident #2's Spiriva on the MAR as administered daily because she assumed Resident #2 administered it himself.
-Resident #2 told her when he needed a refill on his inhalers, and she would request a refill from the facility's contracted pharmacy.
-She did not know when she last requested a refill for Resident #2's Spiriva from the pharmacy.
-All of Resident #2's medications were dispensed by the facility's contracted pharmacy.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/05/25 at 10:49am revealed:
-Resident #2's Spiriva was last dispensed on 06/13/24 for a 30-day supply.
-Resident #2's Spiriva was not on cycle fill and a refill must be requested by the facility.

Telephone interview with the Clinical Supervisor at Resident #2's primary care provider's (PCP) office on 03/06/25 at 11:30am revealed:
-Resident #2 was ordered Spiriva for COPD and emphysema.
-The facility did not notify the PCP that Resident #2 had not received his inhaler since mid-July when the Spiriva would have run out.
-It was important for Resident #2 to be administered Spiriva because missed doses

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could lead to COPD exacerbation including increased shortness of breath and coughing, decreased lung function, and hospitalization.

Interview with the Administrator on 03/06/25 at 11:55am revealed:
-The MAs were responsible for requesting medication refills from the pharmacy.
-She was not aware Resident #2 ran out of his Spiriva and no refills were requested by the facility since 06/13/24.
-She expected the MAs to ask Resident #2 if he self-administered Spiriva before signing it as administered on the MAR since Resident #2 had an order to self-administer several inhalers.
-She expected the MAs to request refills for medications and make sure the medications were available to be administered.

Refer to the telephone interview with the facility's contracted registered nurse (RN) on 03/05/25 at 12:19pm.

Refer to the interview with the Administrator on 03/06/25 at 9:40am.

2. Review of Resident #3's current FL2 dated 02/27/24 revealed:
-Diagnoses included diabetes mellitus type 2, traumatic brain injury, schizoaffective disorder, and grand mal seizures.
-There was an order for metformin (used to control elevated blood glucose levels) 500mg take 1 tablet by mouth daily.

Review of Resident #3's physician's orders dated 02/28/25 revealed an order for metformin 500mg take 1 tablet by mouth daily.

Review of Resident #3's January 2025

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medication administration record (eMAR) revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.
-There was documentation metformin 500mg was administered daily at 9:00am from 01/01/25-01/31/25.

Review of Resident #3's February 2025 MAR revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.
-There was documentation metformin 500mg was administered daily at 9:00am from 02/01/25-02/28/25.

Review of Resident #3's 03/01/25-03/05/25 MAR revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.
-There was documentation metformin 500mg was administered daily at 9:00am from 03/01/25-03/05/25.

Observation of Resident #3's medications on hand on 03/05/25 at 4:40pm revealed there was no metformin 500mg available for administration.

Interview with a medication aide (MA) on 03/05/25 at 4:40pm revealed Resident #3 did not have metformin available for administration because she administered the last dose this morning (03/05/25) and had to request a refill from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/25 at 8:50am revealed:
-Resident #3's metformin was last dispensed on 12/30/24 in the quantity of 30 tablets and would

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last until the end of January 2024.
-The facility faxed over Resident #3's MARs on 03/05/25 and she saw where the MAs documented the administration of Resident #3's metformin daily when there would not have been enough supply.
-She was concerned that Resident #3 was not administered the metformin as ordered so she reached out to the pharmacy's clinical team on 03/05/25 to see if a nurse from the pharmacy could help the facility with medications but was told the facility used a different contracted nurse.
-Resident #3's metformin could be sent monthly on cycle fill if the facility had Resident 3's primary care provider (PCP) would sign 6-month physician's orders and fax them to the pharmacy instead of a signed monthly MAR.
-The facility usually faxed a MAR signed by the PCP so the pharmacy could only send refills for medications for one month.
-There was a note in the computer system that the pharmacy told a staff member at the facility that the MARs signed by the PCP were only good for a one-month refill.
-The pharmacy had not received a refill request or signed physician's orders for Resident #3's metformin since it was last dispensed on 12/30/24.

Interview with a MA on 03/06/25 at 9:23am revealed:
-She administered metformin to Resident #3 on 03/05/25.
-Resident #3 had a "bunch of old medicine" that was not expired so she administered the metformin from it.
-She ripped up the old bubble pack card for Resident #3's metformin and threw it away.
-All of Resident #3's medications were dispensed by the facility's contracted pharmacy and no other

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pharmacy was used.
-She could not explain where the extra metformin for Resident #3 came from and why she had enough to administer until 03/05/25 when the metformin would have run out on 01/30/25.

Telephone interview with a registered nurse (RN) at Resident #3's primary care provider's (PCP) office on 03/06/25 at 12:32pm revealed:
-Resident #3 was prescribed metformin to control elevated blood sugar levels for diabetes mellitus type 2.
-Resident #3's PCP wanted Resident #3 to continue taking metformin because he used to also have to take insulin to help control his blood sugars.
-Resident #3 not being administered the metformin would cause elevated blood sugar levels and could cause damage to his eyes, kidney problems, and heart disease.
-She expected the facility to administer Resident #3's metformin as ordered.

Interview with the Administrator on 03/06/25 at 11:55am revealed:
-She was not aware Resident #3 did not have enough supply of metformin to be administered in February 2025 or 03/01/25-03/05/25.
-The MAs were supposed to request medication refills from the pharmacy when the bubble pack was low in supply.
-She expected the MAs to administer medications as ordered and document accurately on the MAR if the medication was administered or not administered.

Refer to the telephone interview with the facility's contracted registered nurse (RN) on 03/05/25 at 12:19pm.

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D 358	Continued From page 24 Refer to the interview with the Administrator on 03/06/25 at 9:40am. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. 3. Review of Resident #1's current FL2 dated 10/21/24 revealed diagnoses included schizoaffective disorder, low sodium levels, and hypertension. a. Review of physician's orders for Resident #1 revealed there was an order for olanzapine (antipsychotic medication) 2.5mg every night at bedtime dated 02/24/25. Review of Resident #1's February 2025 MAR revealed: -There was a handwritten entry for olanzapine 2.5mg at bedtime with an administration time of 9:00pm. -There was documentation the olanzapine was administered at 9:00pm on 02/24/25 - 02/28/25. Review of Resident #1's MAR for 03/01/25 - 03/05/25 revealed there was not an entry for olanzapine 2.5mg on the MAR or any documentation it was administered. Observation of Resident #1's medications available for administration on 03/05/25 at 3:53pm revealed: -There was one bubble pack labeled olanzapine 2.5mg 1 tablet at bedtime. -There were thirty tablets dispensed on 02/24/25 and 26 tablets remained. Interview with the medication aide (MA) on 03/06/25 at 10:30am revealed:	D 358		

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-The pharmacy sent the resident's MARs to the facility for the next month during the last week of the current month.
-The Resident Care Coordinator (RCC) or the facility's contracted Registered Nurse (RN) were responsible for comparing the new monthly MARs with the previous monthly MARs to ensure accuracy.
-She missed transcribing the olanzapine to Resident #1's March 2025 MAR.

Interview with the RCC on 03/06/25 at 10:37am revealed:
-The RN was responsible for auditing the residents' records to ensure all orders were complete.
-The RCC and the MA were responsible for comparing the MARs month to month to ensure accuracy.
-The RN should have checked behind them tho ensure nothing was missed.

Telephone interview with Resident #1's Mental Health Provider (MHP) on 03/06/25 at 8:54am revealed:
-Resident #1 was prescribed olanzapine to decrease her tics (uncontrolled sudden, repetitive movement or sound that can be hard to control).
-The tics would increase if the olanzapine was not administered as ordered.

Interview with Resident #1 on 03/06/25 at 10:00am revealed she did not know she was not administered the olanzapine in March 2025.

Refer to the telephone interview with the facility's contracted RN on 03/05/25 at 12:19pm.

Refer to the interview with the Administrator on 03/06/25 at 9:40am.

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D 358	Continued From page 26 b. Review of Resdient #1's physician's orders revealed there was an order for Debrox drops for excessive ear wax 3 times per week dated 11/09/23. Review of Resident #1's monthly physician's orders revealed: -There was a computer-generated MAR for February 2025 signed by Resident #1's primary care provider without a date. -There was an entry on the MAR for Debrox drops place 4 drops into each ear 3 times per week. Review of Resident #1's January 2025 MAR revealed: -There was an entry for Debrox ear drops place 4 drops into each ear 3 times per week. -There was no documentation the ear drops were administered in January 2025. -Handwritten on the MAR next to Debrox ear drops was "DC'D" (discontinued). Review of Resident #1's February 2025 MAR revealed: -There was an entry for Debrox ear drops place 4 drops into each ear 3 times per week. -Handwritten on the MAR were circled initials (not administered) without a reason why. Review of Resident #1's MAR for 03/01/25 - 03/05/25 revealed: -There was an entry for Debrox ear drops place 4 drops into each ear 3 times per week. -Handwritten on the MAR were circled initials (not administered) without a reason why. Observation of Resident #1's medications available for administration on 03/05/25 at	D 358		

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D 358	Continued From page 27 3:54pm revealed: -There was one opened bottle labeled Earwax Removal Drops place 4 drops into each ear 3 times weekly. -The bottle was dispensed 11/09/23 and expired 11/08/24. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/05/25 at 4:05pm revealed: -The pharmacy received an electronic order for Resident #1 for Debrox ear drops on 11/09/23 with 12 refills. -The pharmacy dispensed one bottle on 11/09/23 and had not dispensed any other ear drops. -The pharmacy did not automatically dispense the medications because the facility was required to submit a request for a refill. -The pharmacy did not have any documentation that the facility requested a refill. -The pharmacy did not have an order to discontinue the ear drops and it had always been an active order. Interview with the MA on 03/06/25 at 10:30am revealed: -She did not administer Resident #1's ear drops because she thought they were discontinued. -She did not see an order to discontinue the ear drops and did not know why she thought they were discontinued. -She administered Resident #1's ear drops when they were first ordered but then Resident #1 refused them. -She forgot to write on the MAR that the resident refused them. -She was not involved in any order entry. -The RCC and the RN were responsible for medication orders and medication cart audits.	D 358		

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D 358	Continued From page 28 Interview with the RCC on 03/06/25 at 10:37am revealed: -She administered medications to Resident #1 one weekend per month and did not administer the ear drops to Resident #1. -She had a conversation with Resident #1's primary care provider (PCP) and thought the PCP discontinued the ear drops. -The facility's contracted RN was responsible for auditing medications and orders and did not know why she missed it. Interview with Resident #1 on 03/05/25 at 3:00pm revealed: -She did not know she had an order for ear drop medication. -She was not administered the ear drops -She would not have refused the ear drops had it been offered to her. Refer to the telephone interview with the facility's contracted RN on 03/05/25 at 12:19pm. Refer to the interview with the Administrator on 03/06/25 at 9:40am. _____ Telephone interview with the facility's contracted RN on 03/05/25 at 12:19pm revealed: -The MA and Resident Care Coordinator (RCC) were responsible for comparing the MARs month to month to ensure accuracy. -The MA and RCC were responsible for medication cart audits and physician orders. -She did not do any audits of the medication carts, physician orders, and MARs because she was responsible for other tasks. Interview with the Administrator on 03/06/25 at 9:40am revealed: -The MA, RCC, and the RN were all responsible	D 358		

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D 358	Continued From page 29 for medication cart audits, physician orders, and comparing the monthly MARs to the previous month to ensure accuracy. -Medications should have been administered. -The pharmacy should be notified when a medication is not available. _____ The facility failed to administer an inhaler to Resident #2 for over 7 months who had a diagnoses of COPD and emphysema and complained of shortness of breath which could cause COPD exacerbation including difficulty breathing, increased coughing, and potentially requiring hospitalization. Resident #3 missed daily doses of a medication to control elevated blood sugar levels from 02/01/25-03/05/25 placing Resident #3 at risk of elevated blood sugar levels with long term complications of potential eye damage, kidney damage, and heart disease. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/06/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2025.	D 358		
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:	D 367		

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D 367	Continued From page 30 (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 medication administration records (MARs) were accurate for 3 of 3 sampled residents (#1, #2, #3) related to the failure to document the administration of a mood disorder medication (#1), inaccurate documentation of an inhaler (#2) and a medication used to treat elevated blood sugars (#3). The findings are: 1. Review of Resident #1's current FL2 dated 10/21/24 revealed: -Diagnoses included schizoaffective disorder. -Depakote 500mg two times daily.	D 367		

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D 367	Continued From page 31 Review of Resident #1's Medication Administration Record (MAR) for February 2025 revealed: -There was an entry for Depakote (used to treat mental disorders) 500mg two times daily with an administration time of 9:00am and 9:00pm. -There was documentation the Depakote 500mg was administered at 9:00am from 02/01/25 - 02/28/25 and no documentation it was administered at 9:00pm from 02/01/25 - 02/28/25 and no reason why. Observation of Resident #1's medications available for administration on 03/06/25 at 11:54am revealed: -There were two bubble packs labeled Depakote 500mg 1 tablet twice daily and 62 tablets were dispensed on 02/26/25. -There were 31 tablets in one bubble pack and 29 tablets in the other. Interview with the medication aide (MA) on 03/05/25 at 3:00pm revealed: -She knew she administered the 9:00pm dose of Depakote to Resident #1 during the month of February 2025. -Resident #1 would have asked about her medication if she did not receive it because she knew what medications she should get. -She did not know why she did not document on the MAR she administered the 9:00pm dose to Resident #1. Interview with Resident #1 on 03/05/25 at 3:15pm revealed: -She knew what medications she was administered. -The MA always administered all her medications at bedtime.	D 367		

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D 367	Continued From page 32 Interview with the Administrator on 03/06/25 at 11:55am revealed she expected the MAs to administer medications as ordered and document accurately on the MAR if the medication was administered or not administered. 2. Review of Resident #2's current FL2 dated 12/30/24 revealed diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, and tobacco use. Interview with Resident #2 on initial tour of the facility on 03/05/25 at 8:50am revealed: -He was out of his inhalers and the pharmacy had not sent them to him yet. -He told the medication aide (MA) he needed his inhaler over a week ago and she told him it was on back order. -He experienced shortness of breath with exertion, and he just had to "take it slow". Review of Resident #2's physician's orders dated 12/30/24 revealed an order for Spiriva (used to control the symptoms of COPD by relaxing the airways and keeping them open) 18mcg inhale 1 capsule daily, may keep at bedside. Review of Resident #2's January 2025 medication administration record (eMAR) revealed: -There was an entry for Spiriva 18mcg inhale 1 capsule daily. -There was documentation Spiriva 18mcg was administered daily from 01/01/25-01/31/25 at 9:00am. Review of Resident #2's February 2025 MAR revealed: -There was an entry for Spiriva 18mcg inhale 1 capsule daily.	D 367		

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-There was documentation Spiriva 18mcg was administered daily from 02/01/25-02/28/25 at 9:00am.

Review of Resident #2's 03/01/25-03/05/25 MAR revealed:
-There was an entry for Spiriva 18mcg inhale 1 capsule daily.
-There was no documentation Spiriva was administered with handwritten documentation "keep in room".

Observation of Resident #2's medications on hand on 03/05/25 at 10:33am revealed there was no Spiriva available for administration.

Interview with a medication aide (MA) on 03/05/25 at 10:40am and 3:04pm revealed:
-Resident #2 kept his inhalers in his room and self-administered them himself.
-Resident #2 told her he used his inhalers every day and she did not ask him specifically if he used the Spiriva.
-She signed Resident #2's Spiriva on the MAR as administered daily because she assumed Resident #2 administered it himself.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/05/25 at 10:49am revealed:
-Resident #2's Spiriva was last dispensed on 06/13/24 for a 30-day supply and would last until 07/13/24 if administered as ordered.
-Resident #2's Spiriva was not on cycle fill and a refill must be requested by the facility.

Interview with the Administrator on 03/06/25 at 11:55am revealed:
-She did not know why the MAs documented Resident #2's Spiriva as administered daily on the

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MAR since 07/13/24 when the medication was unavailable.
-She expected the MAs to ask Resident #2 if he self-administered Spiriva before signing it as administered on the MAR since Resident #2 had an order to self-administer several inhalers.
-She expected the MAs to accurately document medications as administered or not administered on the MAR.
-The facility's contracted registered nurse (RN) completed MAR audits and compared the MARs to the medications available for administration on the cart.

3. Review of Resident #3's current FL2 dated 02/27/24 revealed:
-Diagnoses included diabetes mellitus type 2, traumatic brain injury, schizoaffective disorder, and grand mal seizures.
-There was an order for metformin (used to control elevated blood sugar levels) 500mg take 1 tablet by mouth daily.

Review of Resident #3's physician's orders dated 02/28/25 revealed an order for metformin 500mg take 1 tablet by mouth daily.

Review of Resident #3's January 2025 medication administration record (eMAR) revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.
-There was documentation metformin 500mg was administered daily at 9:00am from 01/01/25-01/31/25.

Review of Resident #3's February 2025 MAR revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.

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-There was documentation metformin 500mg was administered daily at 9:00am from 02/01/25-02/28/25.

Review of Resident #3's 03/01/25-03/05/25 MAR revealed:
-There was an entry for metformin 500mg take 1 tablet daily at 9:00am.
-There was documentation metformin 500mg was administered daily at 9:00am from 03/01/25-03/05/25.

Observation of Resident #3's medications on hand on 03/05/25 at 4:40pm revealed there was no metformin 500mg available for administration.

Interview with a medication aide (MA) on 03/05/25 at 4:40pm revealed Resident #3 did not have metformin available for administration because she administered the last dose this morning (03/05/25) and had to request a refill from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/25 at 8:50am revealed:
-Resident #3's metformin was last dispensed on 12/30/24 in the quantity of 30 tablets and would last until the end of January 2024.
-The facility faxed over Resident #3's MARs on 03/05/25 and she saw where the facility documented the administration of Resident #3's metformin daily when there would not have been enough supply.

Interview with the Administrator on 03/06/25 at 11:55am revealed:
-She did not know why the MAs documented Resident #3's metformin as administered on the MAR in February 2025 or 03/01/25-03/05/25

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D 367	Continued From page 36 when the supply of Resident #3's metformin would have lasted until 01/30/25. -She expected the MAs to document accurately on the MAR if the medication was administered or not administered. -The facility's contracted nurse completed MAR audits and compared the MARs to the medications available for administration on the cart. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable.	D 367		