Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045067	A. BUILDING _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA VILLAGE	600 CAROLINA VILLAGE HENDERSONVILLE, NC 28792

(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 survey from 02/25/25 to 02/26/25.	D 000	1. Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.). 1A. An in-service for all staff who administers medications was completed in regards to watching all residents take medications, not leaving any medications at bedside without an order, and not documenting administration of medications until medications being taken was witnessed. Pharmacy also with scheduled medication pass observations to be completed week of 3/17/2025. 2. Indicate what measures will be put in place to prevent the problem from occurring again, indicate who will monitor the situation to ensure it will not occur again, indicate how often the monitoring will take place, and completion dates by which the plan of correction will be completed. 2A. The Administrator, Resident Care Coordinator, and/or his/her designee, will complete a random sample of residents during medication passes to watch medication administration and documentation, two times a week, for four weeks, with completion of process on 4/16/2025.	
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 1 resident (Resident #1) take all prepared medications resulting in medications being left unattended on the resident's nightstand in her room. The findings are: Review of Resident #1's current FL2 dated 09/04/24 revealed: -Diagnoses included mild cognitive impairment, unspecified pain, and gastric reflux. -There was no information documented regarding Resident #1's orientation. -There was an order for a probiotic (used to treat digestive issues) one capsule daily. -There was an order for Metamucil (used to treat constipation) two capsules twice daily.	D 366		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Holly Styles, RN | RN | Care Center Administrator | 3/17/25

STATE FORM 6899 — UONT11 — If continuation sheet 1 of 13

Reviewed & Acknowledged DMJ 3/17/25

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Observation during the initial facility tour on 02/25/25 at 10:08am revealed:
-There was a medication cup with 2 off-white capsules and 1 white capsule inside the medication cup on the nightstand in Resident #1's room.
-Two capsules were off-white and were the same size and shape.
-One capsule was white and smaller than the other capsules.

Interview with Resident #1 on 02/25/25 at 10:08am revealed:
-All the MAs left her morning medications on her nightstand because she did not like to wake up early to take her medications.
-She liked to take her time swallowing each medication individually.
-She had taken all her medications this morning except for the three capsules in her medication cup.
-She was not sure what the three medications in her medication cup were, but she thought they might be for her stomach issues.

Interview with the MA on 02/25/25 at 10:28am revealed:
-She took Resident #1's medication to her room this morning between 7:30am and 7:45am.
-Resident #1 was oriented so she always left Resident #1's medications on her nightstand when she was sleeping.
-She was able to identify the three medications in Resident #1's medication cup as one probiotic capsule and two Metamucil capsules.
-Resident #1 did not have an order to self-administer any of her medications.
-She did not witness Resident #1 taking her morning medications on 02/25/25.
-She knew she was supposed to observe

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Resident #1 take all her medications and not leave medications in Resident #1's room.

Interview with the Resident Care Coordinator on 02/25/25 at 2:37pm revealed:
-The MAs were trained not to leave medications with the resident.
-The MAs were trained to observe the residents take their medications, then document the medications had been administered.
-She was unsure why the MA would have left oral medications with Resident #1 without observing her take them.

Telephone interview with the Nurse Practitioner (NP) on 02/25/25 at 3:40pm revealed:
-Resident #1 did not need to keep oral medications or any medication she could possibly overdose with in her room.
-She was unsure if Resident #1 would be able to identify all the oral medications she was prescribed.
-Resident #1 should be observed by the MA taking her medications.

Interview with the Administrator on 02/26/25 at 8:45am revealed:
-Resident #1 used to administer her own medications, but began having some difficulties in November 2024 and Resident #1 "reluctantly agreed" to have the facility MAs administer her medications.
-Resident #1 had an order beginning 02/25/25 that she could self-administer her nasal spray only.
-Resident #1 had no orders to self-administer any of her oral medications.
-The MAs were aware they were not supposed to leave medications in a resident's room.
-The MA should not have left Resident #1's oral

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D 366	Continued From page 3 medications in her room without observing her take them.	D 366		
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 1 of 5 sampled residents (Resident #1).	D 367	1. Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.). 1A. An in-service for all staff who administers medications was completed in regards to watching all residents take medications, not leaving any medications at bedside without an order, and not documenting administration of medications until medications being taken was witnessed. Pharmacy also with scheduled medication pass observations to be completed week of 3/17/2025. 2. Indicate what measures will be put in place to prevent the problem from occurring again, indicate who will monitor the situation to ensure it will not occur again, indicate how often the monitoring will take place, and completion dates by which the plan of correction will be completed. 2A. The Administrator, Resident Care Coordinator, and/or his/her designee, will complete a random sample of residents during medication passes to observe medication administration and documentation, two times a week, for four weeks, with completion of process on 4/16/2025.	

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The findings are:

Review of Resident #1's current FL2 dated 09/04/24 revealed:
-Diagnoses included mild cognitive impairment, gastric reflux, unspecified pain, hypertension, anxiety, depression, and neuropathy.
-There was an order for Ibuprofen (used to treat pain) two 200mg tablets twice daily.
-There was an order for Lexapro (used to treat anxiety) 20mg tablet daily.
-There was an order for Metamucil (used to treat gastric issues) 2 capsules twice daily.
-There was an order for Methenamine Hippurate (used for urinary tract infection prevention) 1 gram tablet twice daily.
-There was an order for Pepcid (used to treat gastric reflux and gastric pain) 20mg tablet twice daily.
-There was an order for Probiotic (used for chronic candidiasis) 1 capsule daily.
-There was an order for Tylenol (used to treat pain) extended release 650mg 2 tablets twice daily.
-There was an order for Vitamin B 12 (used as a supplement) 1000mcg tablet daily.
-There was an order for Vitamin C (used for urinary tract infection prevention) 1000mg tablet daily.
-There was an order for Vitamin D 3 (used to treat a vitamin deficiency) 12mcg daily.

Observation during the initial facility tour on 02/25/25 at 10:08am revealed there was a medication cup with 2 off-white capsules and 1 white capsule inside the medication cup on the nightstand in Resident #1's room.

Interview with Resident #1 on 02/25/26 at 10:08am revealed:

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-All the MAs left her morning medications on her nightstand because she did not like to wake up early to take her medications.
-She liked to take her time swallowing each medication individually.
-She had taken all her medications this morning except for the three capsules in her medication cup.
-She was unsure what time she had taken each of the medications because she did not know what time she got up the morning of 02/25/26.
-She was not sure what the three medications in her medication cup were, but she thought they might be for her stomach issues.

Observation of the facility eMAR administration history report for 02/25/25 revealed:
-There was documentation Ibuprofen two 200mg tablets were administered at 7:40am.
-There was documentation Lexapro 20mg tablet was administered at 7:40am.
-There was documentation Metamucil two capsules were administered at 7:40am.
-There was documentation Methenamine Hippurate 1 gm tablet was administered at 7:40am.
-There was documentation Peocid (used to treat gastric reflux and gastric pain) 20mg tablet was administered at 7:40am.
-There was documentation Probiotic 1 capsule was administered at 7:40am.
-There was documentation Tylenol extended release 650mg 2 tablets were administered at 7:40am.
-There was documentation Vitamin B-12 1000mcg tablet was administered at 7:40am.
-There was documentation Vitamin C 1000mg tablet was administered at 7:40am.
-There was documentation Vitamin D3 125mcg tablet was administered at 7:40am.

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Interview with the MA on 02/25/25 at 10:28am revealed:
-She took Resident #1's medication to her room this morning between 7:30am and 7:45am.
-Resident #1 was oriented so she always left Resident #1's medications on her nightstand while she was sleeping.
-She was able to identify the three medications left in Resident #1's medication cup as one probiotic capsule and two Metamucil capsules.
-There were several other oral medications she had taken to Resident #1's room on 02/25/25.
-She did not witness Resident #1 taking any of her morning medications on 02/25/25.
-She documented on the eMAR that she had administered Resident #1's medications when she went back to the medication cart.

Interview with the Resident Care Coordinator on 02/25/25 at 2:37pm revealed:
-The MAs were trained to observe the residents swallow oral medications, then document the medications had been administered.
-The MA should not document on the eMAR that she administered any medication unless she witnessed the resident take the medication.

Interview with the Administrator on 02/26/25 at 8:45am revealed:
-The MAs should not be documenting a time a medication was administered if they did not observe the resident take the medication at the time documented.

[illegible] 10A NCAC 13F .1005 Self-Administration of Medications

10A NCAC 13F .1005 Self -Administration Of

1. Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.).

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D 375	Continued From page 7 Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #1) had a physician's order to self-administer medications related to two oral medications used to treat gastric reflux and a topical medication used to treat pain. The findings are: Review of Resident #1's current FL2 dated 09/04/24 revealed: -Diagnoses included mild cognitive impairment, gastric reflux, and unspecified pain. -There was no information documented regarding Resident #1's orientation. Review of the licensed health professional support notes dated 12/09/24 revealed Resident #1 had "recently relinquished control of [illegible] medications over to staff." 1. Observation during the initial facility tour on 02/25/25 at 10:08am revealed a plastic bottle of	D 375	1A. An in-service for all staff who administers medications was completed in regards to watching all residents take medications, not leaving any medications at bedside without an order, and not documenting administration of medications until medications being taken was witnessed. Pharmacy also with scheduled medication pass observations to be completed week of 3/17/2025. During survey, on Tuesday morning, 2/26/2025, all rooms were checked for medications at bedside and medications removed, or orders obtain for keeping at bedside and/or self-administration. All self-administration of medication orders checked in facility, as well as assessments for self-administration of medications. A memo is to be given out at resident council and to all residents on 4/3/2025 in regards to the policy of self-administration and that if they order medications, they need to alert nursing staff. 2. Indicate what measures will be put in place to prevent the problem from occurring again, indicate who will monitor the situation to ensure it will not occur again, indicate how often the monitoring will take place, and completion dates by which the plan of correction will be completed. 2A. The Administrator, Resident Care Coordinator, and/or his/her designee, will complete a random [illegible] resident's rooms to audit for medications, two times a week, for four weeks, with completion of process on 4/16/2025.	

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calcium carbonate (used to treat gastric reflux) 500mg tablets that appeared 75% full on the seat of Resident #1's rollator.

Interview with Resident #1 on 02/25/25 at 10:08am revealed:
-The medication aide (MA) kept her medications on the medication cart, but she was able to self-administer her medications as well.
-She most recently took a calcium carbonate tablet 2 or 3 days ago.

Review of Resident #1's physician's orders dated 11/21/24 revealed:
-A medication order for calcium carbonate 500mg tablet every 8 hours as needed for heartburn.
-There was no medication self-administration order for Resident #1.

Review of the medication administration record (eMAR) for February 2025 revealed:
-An order for calcium carbonate 500mg tablet every 8 hours as needed for heartburn.
-There was no documentation on the eMAR the calcium carbonate 500mg tablet had been administered during February 2025.

Refer to interview with a MA on 02/25/25 at 10:28am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/25/25 at 2:37pm.

Refer to telephone interview with the primary care provider (PCP) on 02/25/25 at 3:40pm.

Refer to interview with the Administrator on 02/26/25 at 8:45am.

2. Observation during the initial facility tour on

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02/25/25 at 10:08am revealed a 12-ounce plastic bottle of liquid Mylanta (used to treat gastric reflux) that had been opened on the seat of Resident #1's rollator.

Interview with Resident #1 on 02/25/25 at 10:08am revealed:
-The MA kept her medications on the medication cart, but she was able to self-administer her medications as well.
-She most recently took a dose of Mylanta last week.

Review of Resident #1's physician's orders dated 12/27/24 revealed:
-A medication order for Mylanta maximum strength 20ml every 6 hours as needed for indigestion.
-There was no medication self-administration order for Resident #1.

Review of the medication administration record (eMAR) for February 2025 revealed:
-An order for Mylanta 20ml every 6 hours as needed for indigestion.
-There was no documentation on the eMAR the Mylanta had been administered during February 2025.

Refer to interview with a MA on 02/25/25 at 10:28am.

Refer to interview with the RCC on 02/25/25 at 2:37pm.

Refer to telephone interview with the PCP on 02/25/25 at 3:40pm.

Refer to interview with the Administrator on 02/26/25 at 8:45am.

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3. Observation during the initial facility tour on 02/25/25 at 10:08am revealed there was a tube of diclofenac sodium (used topically to treat pain) gel 1% that appeared 75% full on the seat of Resident #1's rollator.

Interview with Resident #1 on 02/25/25 at 10:08am revealed:
-The MA kept her medications on the medication cart, but she was able to self-administer her medications as well.
-She had a lot of pain in both knees and rubbed diclofenac sodium on her knees almost daily, with the most recent use on 02/24/25.

Review of Resident #1's physician's orders dated 01/15/25 revealed:
an order for Voltaren (diclofenac sodium) gel 1% 2 grams topically three times daily to both knees.

Review of Resident #1's physician's orders dated 02/12/25 revealed an order to discontinue the use of Voltaren gel 1% 2 grams topically three times daily to both knees.

Review of the medication administration record (eMAR) for February 2025 revealed:
-An order for Voltaren gel 1% 2 grams three times daily to both knees.
-There was no documentation on the eMAR the Voltaren gel had been administered during February 2025.

Refer to interview with a MA on 02/25/25 at 10:28am.

Refer to interview with the RCC on 02/25/25 at 2:37pm.

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Refer to telephone interview with the PCP on 02/25/25 at 3:40pm.

Refer to interview with the Administrator on 02/26/25 at 8:45am.

Interview with a MA on 02/25/25 at 10:28am revealed:
-She took Resident #1's medication to her room on 02/25/25 morning between 7:30am and 7:45am.
-She did not observe any medications on the seat of Resident #1's rollator.
-Resident #1 did not have an order to self-administer any of her oral or topical medications.
-She was not aware Resident #1 was self-administering her diclofenac sodium, calcium carbonate, or Mylanta.

Interview with the RCC on 02/25/25 at 2:37pm revealed:
-Resident #1 did not have any orders to self-administer any oral or topical medications.
-Resident #1 had self-administered her medications through November of 2024, but then the facility took over.
-She went through all the medication in Resident #1's room in Resident #1's presence, and threw away all expired medications, removed medications that were currently active orders to the medication cart, and threw away the other medications that Resident #1 stated she no longer used.
-She was not aware Resident #1 had medications in her room since they were removed in November 2024.

Telephone interview with the PCP on 02/25/25 at 3:40pm revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA VILLAGE	600 CAROLINA VILLAGE HENDERSONVILLE, NC 28792

(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 375	Continued From page 12 -Resident #1 did not need to keep any oral medications or the topical pain medication in her room. -Resident only had one medication order for self-administration of a nasal spray that she wrote on 02/25/25. Interview with the Administrator on 02/26/25 at 8:45am revealed: -Resident #1 had no orders to self-administer oral or topical medications, but she did have an order to self-administer a nasal spray. -Resident #1 used to self-administer her medications, but the decision was made for the facility to take over after she was struggling with her medication self-administration due to a health condition that occurred in November 2024. -She spoke with Resident #1 on 02/25/25 about the medications in her room. -Resident #1 told her she was ordering medications she wanted through an internet company. -They did not open resident mail, so they were unaware she was receiving medications by mail.	D 375		