STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041027	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTDALE MANOR	303 WESTDALE PLACE GREENSBORO, NC 27403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/02/25.	C 000		
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 observations, record reviews, and interviews, the facility failed to ensure the Medication Administration Records (MAR) were accurate for 3 of 3 sampled residents (#1, #2, and #3) regarding documenting the name or initials of the person administering the residents medications. The findings are:	C 342		

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C 342	Continued From page 1 1. Review of Resident #1's current FL-2 dated 11/14/24 revealed diagnoses included chronic schizophrenia, diabetes mellitus Type II, hypertension, hypercholesterolemia, and tobacco abuse. a. Review of Resident #1's physician's order dated 01/26/25 revealed there was an order for metformin 1000mg (a medication used to treat high blood sugar levels) twice a day. Review of Resident #1's February 2025 medication administration record (MAR) from 02/01/25 to 02/28/25 revealed: -There was an entry for metformin 1000mg twice a day scheduled for administration at 8:00am and 8:00pm. -Metformin was not documented as administered on 02/28/25 by the medication aide (MA) at 8:00pm. Observation of medications available for administration for Resident #1 on 04/02/25 at 12:30pm revealed metformin was available for administration and was dispensed on 03/13/25. b. Review of Resident #1's physician's order dated 01/26/25 revealed there was an order for glimepiride 4mg (a medication used to treat high blood sugar levels) twice a day. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for glimepiride 4mg twice a day scheduled for administration at 8:00am and 8:00pm. -Glimepiride was not documented as administered on 02/28/25 by the MA at 8:00pm.	C 342		

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C 342	Continued From page 2 Observation of medications available for administration for Resident #1 on 04/02/25 at 12:30pm revealed glimepiride was available for administration and was dispensed on 03/04/25. c. Review of Resident #1's physician's order dated 01/26/25 revealed there was an order for haloperidol 10mg (a medication used to treat schizophrenia) at bedtime. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for haloperidol 10mg at bedtime scheduled for administration at 8:00pm. -Haloperidol was not documented as administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #1 on 04/02/25 at 12:30pm revealed haloperidol was available for administration and was dispensed on 03/13/25. d. Review of Resident #1's physician's order dated 01/26/25 revealed there was an order for pravastatin (a medication used to lower high cholesterol levels) every evening. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for pravastatin 40mg every evening scheduled for administration at 8:00pm. -Pravastatin was not documented as administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #1 on 04/02/25 at 12:30pm revealed pravastatin was available for administration and was dispensed on 03/13/25. Interview with Resident #1 on 04/02/25 at 1:15pm	C 342		

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revealed:
-He was aware of most of the medications ordered by his physician.
-He relied on the MA and the Manager to administer his medications daily and he had not missed any morning or evening doses previously.

Attempted telephone interview with Resident #1's primary care provider on 04/02/25 at 1:00pm and 2:00pm was unsuccessful.

Interview with the Manager on 04/02/25 at 11:10am revealed:
-She, the MA, and the Administrator were responsible for reviewing the residents' MARs for accuracy at least twice a month and addressed any missing entries.
-She had administered all of Resident #1's medications on the morning and evening medication pass for 02/28/25 and thought she documented her initials on the MAR for the evening medication entries.
-She was not aware her initials were missing from the MAR from the evening medication pass on 02/28/25 and she had overlooked the missing entry due to multi-tasking.

Refer to the interview with the MA on 04/02/25 at 11:20am.

Refer to the telephone interview with the Administrator on 04/02/25 at 1:40pm.

2. Review of Resident #2's current FL-2 dated 12/19/24 revealed diagnoses included schizoaffective disorder, mild mitral regurgitation, and diabetes mellitus Type II.

a. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for

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metformin 500mg (a medication used to treat high blood sugar levels) twice a day.

Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for metformin 500mg twice a day scheduled for administration at 8:00am and 8:00pm.
-Metformin was not documented as administered on 02/28/25 by the MA at 8:00pm.

Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed metformin was available for administration and was dispensed on 03/05/25.

b. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for risperidone 4mg (a medication used to treat schizophrenia) twice a day.

Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for risperidone 4mg twice a day scheduled for administration at 8:00am and 8:00pm.
-Risperidone was not documented as administered on 02/28/25 by the MA at 8:00pm.

Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed risperidone was available for administration and was dispensed on 02/07/25.

c. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for quetiapine 50mg (a medication used to treat schizophrenia) three times a day.

Review of Resident #2's February 2025 MAR

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from 02/01/25 to 02/28/25 revealed:
-There was an entry for quetiapine 50mg three times a day scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Quetiapine was not documented as administered on 02/28/25 by the MA at 2:00pm and 8:00pm.

Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed quetiapine was available for administration and was dispensed on 03/05/25.

d. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for rosuvastatin 40mg (used to lower high cholesterol levels) daily.

Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for rosuvastatin 40mg daily scheduled for administration at 8:00pm.
-Rosuvastatin was not documented as administered on 02/28/25 by the MA at 8:00pm.

Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed rosuvastatin was available for administration and was dispensed on 03/05/25.

e. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for fluphenazine 10mg (a medication used to treat schizophrenia) at bedtime.

Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for fluphenazine 10mg daily at bedtime scheduled for administration at 8:00pm.
-Fluphenazine was not documented as

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C 342	Continued From page 6 administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed fluphenazine was available for administration and was dispensed on 03/05/25. f. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for divalproex sodium 250mg (a medication used to treat seizures) at bedtime. Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for divalproex sodium 250mg at bedtime scheduled for administration at 8:00pm. -Divalproex sodium was not documented as administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed divalproex sodium was available for administration and was dispensed on 03/05/25. g. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for trihexyphenidyl 2mg (a medication used to treat muscle stiffness) at bedtime. Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for trihexyphenidyl 2mg at bedtime scheduled for administration at 8:00pm. -Trihexyphenidyl was not documented as administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #2 on 04/02/25 at	C 342		

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12:40pm revealed trihexyphenidyl was available for administration and was dispensed on 03/05/25.

h. Review of Resident #2's physician's orders dated 02/11/25 revealed there was an order for chlorpromazine hydrochloride 25mg (a medication used to treat schizophrenia) at bedtime.

Review of Resident #2's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for chlorpromazine hydrochloride 25mg at bedtime scheduled for administration at 8:00pm.
-Chlorpromazine hydrochloride was not documented as administered on 02/28/25 by the MA at 8:00pm.

Observation of medications available for administration for Resident #2 on 04/02/25 at 12:40pm revealed chlorpromazine hydrochloride was available for administration and was dispensed on 03/05/25.

Interview with Resident #2 on 04/02/25 at 1:30pm revealed:
-He was not aware of the medications ordered by his physician.
-He relied on the MA and the Manager to administer his medications daily and he had not missed any morning or evening does previously.

Attempted telephone interview with Resident #2's primary care provider on 04/02/25 at 1:00pm and 2:00pm was unsuccessful.

Interview with the Manager on 04/02/25 at 11:10am revealed:
-She, the MA, and the Administrator were

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responsible for reviewing the residents' MARs for accuracy at least twice a month and addressed any missing entries.
-She had administered all of Resident #2's medications on the morning and evening medication pass for 02/28/25 and thought she documented her initials on the MAR for the evening medication entries.
-She was not aware her initials were missing from the MAR from the evening medication pass on 02/28/25 and she had overlooked the missing entry due to multi-tasking.

Refer to the interview with the MA on 04/02/25 at 11:20am.

Refer to the telephone interview with the Administrator on 04/02/25 at 1:40pm.

3. Review of Resident #3's current FL-2 dated 05/02/24 revealed diagnoses included schizophrenia, hyperlipidemia, and thrombocytopenia.

a. Review of Resident #3's physician's orders dated 01/28/25 revealed there was an order for clozapine 100mg (used to treat schizophrenia) twice a day.

Review of Resident #3's February 2025 MAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for clozapine 100mg twice a day scheduled for administration at 8:00am and 8:00pm.
-Clozapine was not documented as administered on 02/28/25 by the MA at 8:00pm.

Observation of medications available for administration for Resident #3 on 04/02/25 at 12:55pm revealed clozapine was available for

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C 342	Continued From page 9 administration and was dispensed on 03/14/25 b. Review of Resident #3's physician's orders dated 01/28/25 revealed there was an order for pravastatin sodium 40mg (a medication used to lower high cholesterol levels) daily. Review of Resident #3's February 2025 MAR from 02/01/25 to 02/28/25 revealed: -There was an entry for pravastatin sodium 40mg daily scheduled for administration at 8:00pm. -Pravastatin sodium was not documented as administered on 02/28/25 by the MA at 8:00pm. Observation of medications available for administration for Resident #3 on 04/02/25 at 12:55pm revealed pravastatin sodium was available for administration and was dispensed on 03/14/25. Interview with Resident #3 on 04/02/25 at 1:20pm revealed: -He was aware of the medications he was ordered from his physician. -He relied on the MA and the Manager to administer his medications daily and he had not missed any morning or evening doses previously. Attempted telephone interview with Resident #3's primary care provider on 04/02/25 at 1:00pm and 2:00pm was unsuccessful. Interview with the Manager on 04/02/25 at 11:10am revealed: -She, the MA, and the Administrator were responsible for reviewing the residents' MARs for accuracy at least twice a month and addressed any missing entries. -She had administered all of Resident #3's medications on the morning and evening	C 342		

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C 342	Continued From page 10 medication pass for 02/28/25 and thought she documented her initials on the MAR for the evening medication entries. -She was not aware her initials were missing from the MAR from the evening medication pass on 02/28/25 and she had overlooked the missing entry due to multi-tasking. Refer to the interview with the MA on 04/02/25 at 11:20am. Refer to the telephone interview with the Administrator on 04/02/25 at 1:40pm. _____ Interview with the MA on 04/02/25 at 1:30pm revealed: -She, the Manager, and the Administrator were responsible for reviewing the residents' MARs for accuracy at least twice a month and addressed any missing entries. -She had not worked on 02/28/25 and she was not aware of missing entries from the evening shift medication pass on 02/28/25 for any resident at the facility. Telephone interview with the Administrator on 04/02/25 at 1:40pm revealed: -She, the Manager, and the MA were responsible for reviewing the residents' MARs for accuracy at least twice a month and addressed any missing entries. -She was not aware of missing entries from the evening shift medication pass on 02/28/25 for any resident at the facility. -She expected the staff administering the medication to document the administration of a medication on the MAR accurately and at the time the medication was administered to the resident.	C 342		