STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059027	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL RETIREMENT COMMUNITY	120 FLEMING AVENUE MARION, NC 28752

(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 and the McDowell County Department of Social Services conducted an annual survey from March 19, 2025 to March 20, 2025.	D 000		
D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to have menus identified as the current menu day for guidance of food service staff. The findings are: Observation of the kitchen on 03/19/25 at 10:00am revealed: -There were weekly menus created by the facility and were not signed by a Registered Dietician (RD). -The "facility-created" lunch menu dated 03/19/25 revealed sloppy joe, tater tots, coleslaw, lemon pie and a beverage would be served.	D 291		

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D 291	Continued From page 1 -There were weekly menus created by the food service provider that were signed by a RD. -The current (week #2) lunch menu created by the food service provider dated 03/19/25 revealed beef tips over noodles, green beans, frosted cake, dinner roll, 2% milk, alternate fish filet sandwich with coleslaw. -The "facility-created" menu did not have similar substitutions that matched the menus provided by the food service provider. -A list of therapeutic diets for named residents was posted in the kitchen. -An extension diet menu (menu guide used to prepare therapeutic diets ordered by a physician) was not located in the kitchen. Observation of the lunch meal on 03/19/25 at 12:00pm revealed: -Residents were served according to the "facility-created" lunch menu. -Residents on a regular diet were served sloppy joe on a sub roll, "Cheetos", water, sweetened or unsweetened tea and an oatmeal cream pastry for dessert. -Residents on a therapeutic diet were served either pureed or chopped sloppy joe, mashed potatoes, applesauce, oatmeal cream. -Residents were not served lunch from the current menu (week #2 beef tips over noodles, green beans, frosted cake, dinner roll, 2% milk, alternate fish filet sandwich with coleslaw) provided by the facility's food service provider. Interview with the Dietary Manager on 03/20/25 at 3:49pm revealed: -The Administrator and Co-Administrator were responsible for providing the menus to the kitchen. -The "facility-created" menus were based off substitution preferences of some residents.	D 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 291	Continued From page 2 -The food service provider menus were used as a guide at times when the "facility-created" menus were made. -She was responsible for preparing therapeutic diets as evidenced by pureed, chopped, mechanical soft and thickened liquids, if needed. -The cooks assisted her with preparing meals from the menu as she instructed them to do. -She did not know what extension diet menus were. -She did not know "facility-created" menus used as substitutions, needed to be verified by a RD. Interview with the Co-Administrator on 03/20/25 at 3:40pm revealed: -The facility was in the process of changing food service providers. -She did not realize the food choices on the "facility-created" menu items were not similar to the food service provider issued menus. -She expected extension diet menus to be available in the kitchen for guidance. -She expected approved substitution menus to be followed.	D 291		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSE HILL RETIREMENT COMMUNITY	120 FLEMING AVENUE MARION, NC 28752

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D 296	Continued From page 3 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to have matching therapeutic diet menus for residents who had physician ordered therapeutic diets. The findings are: Observation of the kitchen on 03/19/25 at 10:00am revealed: -There were no therapeutic diet menus being referenced for meal preparation. -A list of residents with therapeutic diets was posted for staff reference. -Directions on how to thicken liquids was posted in the kitchen. -The list of therapeutic diets posted in the kitchen included mechanical soft, fine chopped, pureed, and nutritional shakes. Interview with the Dietary Manager on 03/19/25 at 10:00am revealed: -She utilized the meal tray cards as a reminder of what resident received a therapeutic diet. -She was responsible for preparing therapeutic diets such as pureed diets, thickened liquids, mechanical soft diet, and chopped meats diet. -She was not familiar with extension diet menus and did not know they were supposed to be in the kitchen for dietary staff to use as a guide when preparing therapeutic diets meals. -The Administrators were responsible for providing the menus to the kitchen. Interview with the Co-Administrator on 03/20/25 at 3:40pm revealed: -She was not aware extension diet menus were not available in the kitchen for staff to use as a	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 296	Continued From page 4 guide when preparing therapeutic diets. -The facility currently provided therapeutic diets for residents who were on chopped meats, mechanical soft, pureed diets and nutritional supplements. -There were no current residents in the facility who received thickened liquids. -She expected extension diet menus to be available in the kitchen for guidance.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an accurate therapeutic diet list for guidance of food service staff for 1 of 5 sampled residents (#5) with an order for a mechanical soft diet. (#1) The findings are: Review of Resident #5's current FL2 dated 06/26/24 revealed diagnoses included Dementia. Review of a 6-month signed physician order	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSE HILL RETIREMENT COMMUNITY	120 FLEMING AVENUE MARION, NC 28752

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D 309	Continued From page 5 dated 06/30/24 revealed an order for a mechanical soft diet. Observation in the kitchen on 03/19/25 at 10:00am revealed there was a therapeutic diet list posted on the wall and Resident #5 was to be served a mechanical soft diet. Observation of the lunch meal on 03/19/25 at 12:00pm revealed Resident #5 was served a pureed diet of a sloppy joe and mashed potatoes and the staff assisted Resident #5 with eating. Interview with the Dietary Manager on 03/20/25 at 3:44pm revealed: -Resident #5 was on the therapeutic diet list posted in the kitchen as a pureed diet. -She referenced the therapeutic diet list when preparing meals for the residents. -The management staff were responsible for making changes to the therapeutic diet menu post in the kitchen when a new order was completed by the physician. -On 09/30/24, someone from the office brought her the yellow copy of an order dated 09/30/24 for a pureed diet for Resident #5. -She made the order change on Resident #5's dietary card which she placed on Resident #5's dietary tray and sent to the floor to identify which meal was for Resident #5. -She then placed the yellow copy of the order in her dietary folder in the kitchen. -She did not receive the copy of the order dated 12/30/24 for a mechanical soft diet. Telephone interview with the facility's contracted hospice nurse on 03/20/25 at 11:28am revealed Resident #5 was ordered a mechanical soft diet on 12/30/24.	D 309		

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D 309	Continued From page 6 Interview with Administrator on 03/20/25 at 11:40am revealed: -On 12/30/24, there was an order for a mechanical soft diet for Resident #5. -In December 2024, Resident #5 had been loosing weight, and her family was bringing in cakes and cupcakes to get Resident #5 to eat better. -Resident #5 was eating the cakes and cupcakes without difficulty but she was not eating a mechanical soft diet as well because of teeth issue, so she used her nursing judgement to puree Resident #5's meals and Resident #5 was able to tolerate the pureed diet much better. -She did not want to change the mechanical soft diet because the family was bringing her sweets and Resident #5 was now gaining weight because of the sweets and the pureed diet. -She did not know she could ask hospice to complete an order to include both a mechanical soft and pureed diet.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered to 1 of 5 sampled residents (#5) related to a mechanial soft diet. The findings are:	D 310		

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D 310	Continued From page 7 Review of Resident #5's current FL2 dated 06/26/24 revealed diagnoses included Dementia. Review of a 6-month signed physician order dated 06/30/24 revealed an order for a mechanical soft diet. Observation of the lunch meal on 03/19/25 at 12:00pm revealed Resident #5 was served a pureed diet of a sloppy joe and mashed potatoes and the staff assisted Resident #5 with eating. Interview with the Dietary Manager on 03/20/25 at 3:44pm revealed: -Resident #5 was on the therapeutic diet list posted in the kitchen as a pureed diet. -She referenced the therapeutic diet list when preparing meals for the residents. -The management staff were responsible for making changes to the therapeutic diet menu post in the kitchen when a new order was completed by the physician. -On 09/30/24, someone from the office brought her the yellow copy of an order dated 09/30/24 for a pureed diet for Resident #5. -She made the order change on Resident #5's dietary card which she placed on Resident #5's dietary tray and sent to the floor to identify which meal was for Resident #5. -She then placed the yellow copy of the order in her dietary folder in the kitchen. -She did not receive the copy of the order dated 12/30/24 for a mechanical soft diet. Telephone interview with the facility's contracted hospice nurse on 03/20/25 at 11:28am revealed Resident #5 was ordered a mechanical soft diet on 12/30/24.	D 310		

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D 310	Continued From page 8 Interview with the Administrator on 03/20/25 at 11:40am revealed: -On 12/30/24, there was an order for a mechanical soft diet for Resident #5. -In December 2024, Resident #5 had been loosing weight, and her family was bringing in cakes and cupcakes to get Resident #5 to eat better. -Resident #5 was eating the cakes and cupcakes without difficulty but she was not eating a mechanical soft diet as well because of teeth issue, so she used her nursing judgement to puree Resident #5's meals and Resident #5 was able to tolerate the pureed diet much better. -She did not want to change the mechanical soft diet because the family was bringing her sweets and Resident #5 was now gaining weight because of the sweets and the pureed diet. -She did not know she could ask hospice to complete an order to include both a mechanical soft and pureed diet.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to administer	D 358		

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D 358	Continued From page 9	D 358		

medications as ordered for 1 of 5 sampled residents (Resident #1) related to a medication used to treat constipation.

The findings are:

Review of Resident #1's current FL2 dated 04/17/24 revealed diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, and cognitive communication deficit.

Review of Resident #1's Resident Register revealed an admission date of 04/18/24.

Review of Resident #1's record revealed she was receiving hospice services when she was admitted to the facility.

Review of Resident #1's record revealed an order for senna 8.6 mg, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation.

Review of Resident #1's Medication Administration Record (MAR) for January 2025 revealed:
-There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at bedtime (8:00pm) for constipation.
-Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 01/01/2025 - 01/31/2025.

Review of Resident #1's MAR for February 2025 revealed:
-There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at bedtime (8:00pm) for constipation.
-Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 02/01/25 - 02/28/25.

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D 358	Continued From page 10 Review of Resident #1's MAR for March 2025 revealed: -There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at bedtime (8:00pm) for constipation. -Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 03/01/25 - 03/19/25. Observation of Resident #1's medications available for administration on 03/20/25 at 5:55pm revealed: -There was a bubble pack of senna 8.6mg, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation. -The bubble pack of senna 8.6mg had a dispensed quantity of 120 tablets. -There were 86 tablets of senna 8.6mg remaining on hand and bubble packed in groups of 4 tablets. -There was one bubble that was opened, and 2 tablets remained from previous medication administration. Interview with the facility's contracted pharmacy on 03/20/25 at 5:20pm revealed: -Resident #1 had an order for senna 17.2mg tablets, take 2 tablets at bedtime that was filled on 05/09/24. -On 05/09/24, they clarified the order with the hospice provider for an order of senna 8.6mg tablets, take 4 tablets at bedtime since senna was not produced in 17.2mg tablets. -There was an active order for senna 8.6mg tablets, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation. -They dispensed senna 8.6mg, 120 tablets on 05/09/24, 06/16/24, 09/19/24, and 02/15/25 to the facility.	D 358		

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D 358	Continued From page 11 Interview with the Hospice Nurse on 03/20/25 at 12:20pm revealed: -Resident #1 was receiving hospice services and senna 8.6mg, take 2 tabs at bedtime. -He was not sure why there was a physician's order for senna 8.6mg take 4 tablets. -He expected the physician's order for senna to be clarified. Interview with the Medication Aide (MA) on 03/20/25 at 5:45pm revealed: -She did not know why Resident #1's senna 8.6mg tablets medication was sent from the pharmacy in groups of 4 tablets. -She did not know why "4" tablets of senna was crossed out on the MAR and "2" tablets of senna was written in. -When she worked second shift, she administered 2 senna tablets to Resident #1 at bedtime as documented on the MAR. Interview with the Administrator on 03/20/25 at 6:52pm revealed: -She and the Co-Administrator were responsible for auditing the MARs against the medications on hand for administration. -She was responsible for crossing out "4 tablets" of senna and writing in "2 tablets" on Resident #1's January 2025, February 2025, and March 2025 MAR. -Resident #1 was stable and did not experience constipation when administered 2 tablets of senna 8.6mg. -The hospice provider was responsible for managing and clarifying Resident #1's medications. -She did not know why Resident #1's MARs continued to be generated by the contracted pharmacy with an order for senna 8.6mg tablets take 4 tablets at bedtime.	D 358		

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D 358	Continued From page 12 Telephone interview with the Hospice Nurse on 03/21/25 at 9:31am revealed: -Resident #1 had an active order for senna 8.6 tablets take 4 tablets at bedtime. -He clarified the order today and was able to change the order to 2 tablets since Resident #1's constipation was managed on 2 tablets instead of 4 tablets.	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: (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).	D 367		

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D 367	Continued From page 13	D 367		

This Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to ensure the medication administration records (MAR) were accurate for 1 of 5 sampled residents (Resident #1) related to inaccurate documentation of a medication used to treat constipation.

The findings are:

Review of Resident #1's current FL2 dated 04/17/24 revealed diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, and cognitive communication deficit.

Review of Resident #1's Resident Register revealed an admission date of 04/18/24.

Review of Resident #1's record revealed she was receiving hospice services when she was admitted to the facility.

Review of Resident #1's record revealed an order for senna 8.6 mg, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation.

Review of Resident #1's Medication Administration Record (MAR) for January 2025 revealed:
-There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at bedtime (8:00pm) for constipation.
-Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 01/01/25 - 01/31/2025.

Review of Resident #1's MAR for February 2025 revealed:
-There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at

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	HAL059027	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL RETIREMENT COMMUNITY	120 FLEMING AVENUE MARION, NC 28752

(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
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bedtime (8:00pm) for constipation.
-Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 02/01/2025 - 02/28/25.

Review of Resident #1's MAR for March 2025 revealed:
-There was an entry for senna 8.6mg tablet, take 2 tablets (amount handwritten) by mouth day at bedtime (8:00pm) for constipation.
-Senna 8.6mg, 2 tablets by mouth at bedtime was documented as administered at 8:00pm from 03/01/25 - 03/19/25.

Observation of Resident #1's medications available for administration on 03/20/25 at 5:55pm revealed:
-There was a bubble pack of senna 8.6mg, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation.
-The bubble pack of senna 8.6mg had a dispensed quantity of 120 tablets and dispensed date of 02/15/25.
-There were 86 tablets of senna 8.6mg remaining on hand and bubble packed in groups of 4 tablets.
-There was one bubble that was opened, and 2 tablets remained from previous medication administration.

Interview with the facility's contracted pharmacy on 03/20/25 at 5:20pm revealed:
-Resident #1 had an order for senna 17.2mg tablets, take 2 tablets at bedtime that was filled on 05/09/24.
-On 05/09/24, they clarified the order with the hospice provider for an order of senna 8.6mg tablets, take 4 tablets at bedtime since senna was not produced in 17.2mg tablets.
-There was an active order for senna 8.6mg

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tablets, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation.
-They dispensed senna 8.6mg, 120 tablets on 05/09/24, 06/16/24, 09/19/24, and 02/15/25 to the facility.
-They managed, clarified and sent MARs to the facility after they received active orders from the provider.

Interview with Resident #1's Hospice Nurse on 03/20/25 at 12:20pm revealed:
-Resident #1 was receiving hospice services and senna 8.6mg, take 2 tabs at bedtime.
-He was not sure why there was a physician's order for senna 8.6mg take 4 tablets.
-He expected the physician's order for senna to be clarified.

Interview with the facility's contracted pharmacy on 03/20/25 at 5:20pm revealed:
-Resident #1 had an order for senna 17.2mg tablets, take 2 tablets at bedtime that was filled on 05/09/24.
-On 05/09/24, they clarified the order with the hospice provider for an order of senna 8.6mg tablets, take 4 tablets at bedtime since senna was not produced in 17.2mg tablets.
-There was an active order for senna 8.6mg tablets, take 4 tablets (34.4mg) by mouth every day at bedtime for constipation.
-They dispensed senna 8.6mg, 120 tablets on 05/09/24, 06/16/24, 09/19/24, and 02/15/25 to the facility.

Interview with the Medication Aide (MA) on 03/20/25 at 5:45pm revealed:
-She did not know why Resident #1's senna 8.6mg tablets medication was sent from the pharmacy in groups of 4 tablets.
-She did not know why "4" tablets of senna was

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D 367	Continued From page 16 crossed out on the MAR and "2" tablets of senna was written in. -When she worked second shift, she administered 2 senna tablets to Resident #1 at bedtime as documented on the MAR. Interview with the Administrator on 03/20/25 at 6:52pm revealed: -She and the Co-Administrator were responsible for auditing the MARs against the medications on hand for administration. -She was responsible for crossing out "4 tablets" of senna and writing in "2 tablets" Resident #1's January 2025, February 2025, and March 2025 MAR. -She did not know why Resident #1's MARs continued to be generated by the contracted pharmacy with an order for senna 8.6mg tablets take 4 tablets at bedtime. -She expected all MARs to reflect correct physician orders that included dose and route for proper medication administration. Telephone interview with the Hospice Nurse on 03/21/25 at 9:31am revealed: -Resident #1 had an active order for senna 8.6 tablets take 4 tablets at bedtime. -He clarified the order and was able to change the order to 2 tablets since Resident #1's constipation was managed on 2 tablets instead of 4 tablets.	D 367		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and	D 377		

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procedures.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure resident medications were stored in a safe and secure manner for 1 of 8 sampled residents (Resident #1) who had medications (used to treat skin irritations and skin infections) at bedside.

The findings are:

Review of Resident #1's current FL2 dated 04/17/24 revealed diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, and cognitive communication deficit.

Review of Resident #1's Resident Register revealed an admission date of 04/18/24.

Review of Resident #1's record revealed she was receiving hospice services when she was admitted to the facility.

a. Review of Resident #1's record revealed a physician's order dated 12/30/24 for calmoseptine ointment (used to treat skin irritations), apply to areas that are exposed to moisture as needed.

Review of Resident #1's Medication Administration Record (MAR) for January 2025 revealed:
-There was an entry for calmoseptine ointment, apply to red areas that are exposed to moisture as needed.
-Calmoseptine ointment was not administered as needed from 01/01/25 to 01/31/25.

Review of Resident #1's MAR for February 2025 revealed:

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-There was an entry for calmoseptine ointment (used to treat skin irritations), apply to red areas that are exposed to moisture as needed.
-Calmoseptine ointment was not administered as needed from 02/01/25 to 02/28/25.

Review of Resident #1's MAR for March 2025 revealed:
-There was an entry for calmoseptine ointment, apply to red areas that are exposed to moisture as needed.
-Calmoseptine ointment was not administered as needed from 03/01/25 to 03/19/25.

Observation of medications on hand revealed:
-Resident #1's calmoseptine ointment was not located on the medication cart used to store medications.
-Calmoseptine ointment was located in Resident #1's room at bedside.
Refer to interview with the medication aide (MA) on 03/20/25 at 5:45pm.

Refer to interview with the Administrator on 03/20/25 at 6:52pm.

b. Review of Resident #1's record revealed a physician's order dated 02/21/25 for nystatin powder 100,000 units (used to treat skin infections), apply under breasts and abdomen folds twice daily.

Review of Resident #1's MAR for February 2025 revealed:
-There was an entry for nystatin powder, apply under breasts and abdomen folds twice daily.
-Nystatin powder was documented as administered from 02/21/25 to 02/28/25.

Review of Resident #1's MAR for March 2025

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revealed:
- There was an entry for nystatin powder, apply under breasts and abdomen folds twice daily.
-Nystatin powder was documented as administered from 03/01/25 to 03/20/25.

Observation of Resident #1's medications on hand revealed:
-Resident #1's nystatin powder 100,000 units was not located on the medication cart used to store medications.
-Nystatin powder 100,000 units was located in Resident #1's room at bedside.

Refer to interview with the medication aide (MA) on 03/20/25 at 5:45pm.

Refer to interview with the Administrator on 03/20/25 at 6:52pm.

Interview with the medication aide (MA) on 03/20/25 at 5:45pm revealed:
-Resident #1 had an active order for nystatin powder and calmoseptine ointment.
-She could not locate Resident #1's nystatin powder and calmoseptine ointment on the medication cart used to store resident medications.
-She observed and removed nystatin powder and calmoseptine ointment from Resident #1's bedside as the surveyor stood outside the door.
-Resident #1 did not have an order to self-administer medications and was not able to apply the nystatin powder or calmoseptine ointment on her own.
-The nystatin powder and calmoseptine ointment may have been left in Resident #1's room on the previous shift.

Interview with the Administrator on 03/20/25 at

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D 377	Continued From page 20 6:52pm revealed: -Resident #1 did not have an order to self-administer any medications. -She expected medications found in Resident #1's bedroom to be stored in a safe and secure manner, on the medication cart used to store medications. -The previous shift may have left the nystatin powder and calmoseptine ointment during care.	D 377		