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	HAL030010	A. BUILDING: _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/18/25 and 03/19/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #3's current FL2 dated 04/12/24 revealed: -Diagnoses included dementia and epilepsy. -Resident #3 was admitted to the facility on 02/25/2022. Review of Resident #3's immunization records revealed: -There was no documentation of a negative TB	D 234	Starting 3/20/2025 all admissions that have a chest x-ray will be required to have a negative skin or blood test prior to admission. This will be completed by the Director. Resident #3 had a TB skin test done on 4/1/2025 and read negative on 43/2025 to bring facility into compliance. 2nd step was also completed on 4/17/2025.	3/20/2025 4/17/2025

Reviewed and Acknowledged K.M. 04/21/25

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D 234	Continued From page 1 skin test. -There was no documentation of a positive TB skin test. -There was documentation of a negative chest x-ray to rule out TB dated 02/24/22. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Interview with the Resident Care Coordinator (RCC) on 03/19/25 at 10:45am revealed: -She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test. -She did not know a negative TB skin test or blood test must be completed instead of a chest x-ray upon a resident's admission to the facility. -She and the Manager were responsible to ensure TB testing was completed upon a resident's admission to the facility. Interview with the Manager on 03/19/25 at 10:55am revealed: -Resident #3 did not have a completed TB skin test on file. -Resident #3 only had a negative chest x-ray completed to rule out TB. -She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test. -She did not know a negative TB skin test or blood test must be completed instead of a chest x-ray upon a resident's admission to the facility. -She was responsible to ensure a first step TB skin test was completed upon a resident's admission to the facility. -The RCC was responsible to ensure a second step TB skin test was completed.	D 234		

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D 234	Continued From page 2 Telephone interview with the Administrator on 03/19/25 at 12:47pm revealed: -The Manager told her on 03/18/25 or 03/19/25 that Resident #3 did not have a completed TB skin test upon admission. -The Manager and RCC were responsible to ensure residents had TB testing completed upon admission to the facility.	D 234		
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 observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#3 and #5) including errors administering a resident's discontinued antidepressant and laxative medications (#5) and an order for a mood stabilizer (#3). 1. Review of Resident #5's FL-2 dated 12/12/24 revealed: -Diagnoses included type mixed vascular and neurodegenerative dementia with behaviors, traumatic brain injury, schizophrenia, and emphysema. -There was an order for mirtazapine (a	D 358	RCC is responsible to keep all orders updated as prescribed by the provider. Starting 3/20/2025 Director and MA's will also review all orders to ensure all staff is aware of changes. RCC will remove any discontinued medication from the cart at the time of discontinue. RCC will complete a cart audit weekly to ensure all medication is on the cart and any discontinued medication is removed. Cart Audit will be reviewed by the Director. Director and RCC will both review the MAR for each resident every workday to ensure all orders are being followed properly.	4/17/2025

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D 358	Continued From page 3	D 358		

medication used to treat depression) 30mg take 1 tablet every night at bedtime.
-There was an order for docusate sodium (a medication used to treat constipation) 100mg take 1 capsule every night at bedtime.

a. Review of Resident #5's signed physician order dated 12/26/24 revealed an order to discontinue mirtazapine 30mg 1 tablet every night at bedtime.

Review of Resident #5's January 2025 electronic medication administration record (eMAR) from 01/01/25 to 01/31/25 revealed:
-There was an entry for mirtazapine 30mg 1 tablet every night at bedtime scheduled for administration from 01/01/25 to 01/31/25.
-Mirtazapine was documented as administered for 5 of 31 opportunities on 01/20/25, 01/23/25, 01/26/25, 01/28/25, and 01/31/25.
-Mirtazapine should not have been administered and there were no additional notes for the mirtazapine administered to Resident #5.

Review of Resident #5's February 2025 eMAR from 02/01/25 to 02/28/25 revealed:
-There was an entry for mirtazapine 30mg 1 tablet every night at bedtime scheduled for administration from 02/01/25 to 02/28/25.
-Mirtazapine was documented as administered for 13 of 28 opportunities on 02/01/25, 02/02/25, 02/03/25, 02/07/25, 02/08/25, 02/09/25, 02/10/25, 02/12/25, 02/13/25, 02/18/25, 02/19/25, 02/23/25, and 02/26/25.
-Mirtazapine should not have been administered and there were no additional notes for the mirtazapine administered to Resident #5.

Review of Resident #5's March 2025 eMAR from 03/01/25 to 03/18/25 revealed:
-There was an entry for mirtazapine 30mg 1

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D 358	Continued From page 4 tablet every night at bedtime scheduled for administration from 03/01/25 to 03/18/25. -Mirtazapine was documented as administered for 9 of 17 opportunities on 03/04/25, 03/08/25, 03/09/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, and 03/17/25. -Mirtazapine should not have been administered and there were no additional notes for the mirtazapine administered to Resident #5. Observation of Resident #5's medications on hand on 03/19/25 at 9:40am revealed mirtazapine was not available for administration. Attempted telephone interview with the facility's contracted pharmacy on 03/19/25 at 10:10am was unsuccessful. Attempted telephone interview with Resident #5's primary care provider (PCP) on 03/19/25 at 9:28am was unsuccessful. Based on observations, interviews, and record review, it was determined Resident #5 was not interviewable. Interview with a medication aide (MA) on 03/19/25 at 9:50am revealed: -She administered Resident #5's medications during the morning shift. -Second shift MAs were responsible to administer Resident #5's mirtazapine since it was ordered as a bedtime medication. -She was not aware of Resident #5's signed physicians' order dated 12/26/24 to discontinue mirtazapine. -Resident #5's mirtazapine was available for administration prior to 03/18/25. -The Resident Care Coordinator (RCC) reviewed physician orders and ensured discontinued	D 358		

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D 358	Continued From page 5 medications were removed from the eMAR. Interview with a second MA on 03/19/25 at 10:30am revealed: -She administered Resident #5's medications during the morning and the evening shift. -Second shift MAs were responsible to administer Resident #5's mirtazapine since it was ordered as a bedtime medication. -She had administered Resident #5's mirtazapine at bedtime but was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue mirtazapine. -Resident #5's mirtazapine was available for administration prior to 03/18/25. -The RCC reviewed physician orders and ensured discontinued medications were removed from the eMAR. Interview with the RCC on 3/19/25 at 10:45am revealed: -She was aware MAs administered Resident #5's mirtazapine but was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue mirtazapine until 03/18/25. -She was responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR. -She had not reviewed Resident #5's physician's order dated 12/26/24. Interview with the Manager on 03/19/25 at 10:55am revealed: -She was aware MAs administered Resident #5's mirtazapine but was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue mirtazapine until 03/18/25. -She and the RCC were responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR.	D 358		

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D 358	Continued From page 6 -She had not reviewed Resident #5's signed physician's order from 12/26/24. -The MAs, RCC, and the Manager were responsible for administering medications as ordered by the provider. Telephone interview with the Administrator on 03/19/25 at 12:45pm revealed: -The RCC and the Manager were responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR. -She was not aware of Resident #5's physician's order dated 12/26/24 to discontinue mirtazapine until the Manager notified her on 03/18/25. -She expected MAs to administer or hold all medications as ordered by the provider. b. Review of Resident #5's signed physician's order dated 12/26/24 revealed an order to discontinue docusate sodium 100mg 1 capsule every night at bedtime. Review of Resident #5's January 2025 electronic medication administration record (eMAR) from 01/01/25 to 01/31/25 revealed: -There was an entry for docusate sodium 100mg take 1 tablet every night at bedtime scheduled for administration from 01/01/25 to 01/31/25. -Docusate sodium was documented as administered for 5 of 31 opportunities on 01/20/25, 01/23/25, 01/26/25, 01/28/25, and 01/31/25. -Docusate sodium should not have been administered and there were no additional notes for the docusate sodium administered to Resident #5. Review of Resident #5's February eMAR from 02/01/25 to 02/28/25 revealed:	D 358		

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D 358	Continued From page 7 -There was an entry for docusate sodium 100mg 1 tablet every night at bedtime scheduled for administration from 02/01/25 to 02/28/25. -Docusate sodium was documented as administered for 13 of 28 opportunities on 02/01/25, 02/02/25, 02/03/25, 02/07/25, 02/08/25, 02/09/25, 02/10/25, 02/12/25, 02/13/25, 02/18/25, 02/19/25, 02/23/25, and 02/26/25. -Docusate sodium should not have been administered and there were no additional notes for the docusate sodium administered to Resident #5. Review of Resident #5's March eMAR from 03/01/25 to 03/18/25 revealed: -There was an entry for docusate sodium 100mg 1 tablet every night at bedtime scheduled for administration from 03/01/25 to 03/18/25. -Docusate sodium was documented as administered for 9 of 17 opportunities on 03/04/25, 03/08/25, 03/09/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, and 03/17/25. -Docusate sodium should not have been administered and there were no additional notes for the docusate sodium administered to Resident #5. Observation of Resident #5's medications on hand on 03/19/25 at 9:40am revealed docusate sodium was not available for administration. Attempted telephone interview with the facility's contracted pharmacy on 03/19/25 at 10:10am was unsuccessful. Attempted telephone interview with Resident #5's primary care provider (PCP) on 03/19/25 at 9:28am was unsuccessful. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 8 review, it was determined Resident #5 was not interviewable. Interview with a medication aide (MA) on 03/19/25 at 9:50am revealed: -She administered Resident #5's medication during the morning shift. -Second shift MAs were responsible to administer Resident #5's docusate sodium because it was entered as a bedtime medication on the eMAR. -She was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue docusate sodium. -Resident #5's docusate sodium was available for administration prior to 03/18/25. -The Resident Care Coordinator (RCC) reviewed physician orders and ensured discontinued medications were removed from the eMAR. Interview with a second MA on 03/19/25 at 10:30am revealed: -She had administered Resident #5's medications during the morning and the evening shift. -Second shift MAs were responsible to administer Resident #5's docusate sodium since it was ordered as a bedtime medication. -She had administered Resident #5's docusate sodium but was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue docusate sodium. -Resident #5's docusate sodium was available for administration prior to 03/18/25. -The RCC reviewed physician orders and ensured discontinued medications were removed from the eMAR. Interview with the RCC on 3/19/25 at 10:45am revealed: -She was aware MAs administered Resident #5's docusate sodium but was not aware of Resident	D 358		

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D 358	Continued From page 9 #5's signed physician's order dated 12/26/24 to discontinue docusate sodium until 03/18/25. -She was responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR -She had not reviewed Resident #5's signed physician's order dated 12/26/24. Interview with the Manager on 03/19/25 at 10:55am revealed: -She was aware MAs administered Resident #5's docusate sodium but was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue docusate sodium until 03/18/25. -She and the RCC were responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR. -She had not reviewed Resident #5's signed physician's order dated 12/26/24. -The MAs, RCC, and the Manager were responsible for administering medications as ordered by the provider. Telephone interview with the Administrator on 03/19/25 at 12:45pm revealed: -The RCC and the Manager were responsible for reviewing physician orders and ensuring discontinued medications were removed from the eMAR. -She was not aware of Resident #5's signed physician's order dated 12/26/24 to discontinue docusate sodium until the Manager notified her on 03/18/25. -She expected MAs to administer or hold all medications as ordered by the provider. 2. Review of Resident #3's current FL-2 dated 04/12/24 revealed diagnoses included dementia, bipolar disorder, and epilepsy.	D 358		

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D 358	Continued From page 10 Review of Resident #3's signed physician's order dated 11/14/24 revealed there was an order for lithium carbonate (used to treat bipolar disorder) 450mg take 1 tablet at bedtime. Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lithium carbonate 450mg take 1 tablet at bedtime. -There was documentation lithium carbonate was not administered on 02/28/25. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for lithium carbonate 450mg take 1 tablet at bedtime. -There was documentation lithium carbonate was not administered from 03/01/25 to 03/05/25. -There was documentation lithium carbonate was not administered on 03/01/25 and 03/02/25 because the medication was not available to administer. Observation of Resident #3's medications on hand on 03/19/25 at 10:03am revealed there were 30 of 31 lithium carbonate tablets dated 03/20/25 available for administration. Attempted telephone interview with the facility's contracted pharmacy on 03/19/25 at 10:10am unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/19/25 at 9:28am unsuccessful. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.	D 358		

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D 358	Continued From page 11 Interview with a medication aide (MA) on 03/19/25 at 10:30am revealed: -She was unable to administer Resident #3's lithium carbonate on 03/01/25 and 03/02/25 because the medication was not available to administer. -She notified the Resident Care Coordinator (RCC) about Resident #3's lithium being unavailable to administer. -She thought Resident #3 missed doses of lithium carbonate because staff was waiting on the medication to be dispensed from the pharmacy. -She always notified the RCC or the Manager if a resident was out of a medication. -She and the other MAs were expected to notify the RCC or the Manager early before medication ran out. Interview with the RCC on 03/19/25 at 10:45am revealed: -She found out Resident #3 missed several doses of lithium carbonate in March 2025 a few days after Resident #3 ran out of the medication. -She thought Resident #3 may have run out of lithium carbonate and medication refills. -Sometimes it took a little longer for a medication to arrive from the pharmacy if the medication required a prescription refill. -She expected the MAs to let her know when there were five doses of medication remaining so she could contact the pharmacy to re-order the medication. -She and the MAs were responsible for administering medications as ordered. Interview with the Manager on 03/19/25 at 10:55am revealed: -She did not know Resident #3 was not administered lithium carbonate from 02/28/25 to	D 358		

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D 358	Continued From page 12 03/05/25 prior to 03/18/25. -MAs were expected to let her or the RCC know when there were approximately 8 doses of medication remaining. -She expected MAs to let her or the RCC know if a resident was out of a medication. -The MAs, RCC, and the Manager were responsible for administering medications as ordered by the provider. Telephone interview with the Administrator on 03/19/25 at 12:47pm revealed: -She did not know Resident #3 missed six consecutive doses of lithium carbonate in February and March 2025 prior to 03/18/25. -MAs were responsible to administer medications as ordered.	D 358		