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(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 a follow-up survey from 04/08/25 to 04/10/25.	D 000		
D 050	10A NCAC 13F .0305(e) Physical Environment 10A NCAC 13F .0305 Physical Environment (e) The requirements for bathrooms, toilet rooms, bathtubs, showers, a manufactured walk-in tub, or a similar manufactured bathtub, and central bathing rooms are: (1) minimum bathroom and toilet rooms shall include a toilet and a hand lavatory for each 5 residents, and a bathtub, shower, a manufactured walk-in tub, or a similar manufactured bathtub for each 10 residents or portion thereof. The hand lavatory shall be trimmed with valves that can be operated without hands. If the hand lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the hand lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; (2) entrance to bathrooms and toilet rooms shall not be through a kitchen, another person's bedroom, or another bathroom; (3) toilet rooms and bathrooms for staff and visitors shall be in accordance with the North Carolina State Building Code: Plumbing Code; (4) bathrooms and toilet rooms accessible to the physically handicapped shall be provided as required by the North Carolina State Building Codes;	D 050		

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D 050	Continued From page 1 (5) bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more toilets shall have privacy partitions or curtains for each toilet. Each bathtub, shower, a manufactured walk-in tub, or a similar manufactured bathtub shall have privacy partitions or curtains. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities; (6) hand grips shall be installed at all toilets, bathtubs, showers, a manufactured walk-in tub, and similar manufactured bathtubs; (7) there shall be one central bathing room opening off the corridor in a facility. In multi-level facilities, each resident floor shall contain a minimum of one central bathing room opening off the corridor. Central bathing room(s) shall have the following: (A) a door of three feet minimum width; (B) a roll-in shower designed to allow the staff to help a resident in taking a shower without the staff getting wet. The roll-in shower shall be designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each resident bedroom in the facility, the central bathing area is not required to have a roll-in shower; (C) a bathtub, a manufactured walk-in tub, or a similar manufactured bathtub designed for easy transfer of residents into the tub. Bathtubs shall be accessible on three sides. Manufactured walk-in tubs or a similar manufactured bathtub shall be accessible on at least two sides. Staff shall not be required to reach over or through the tub faucets and other fixture fittings to assist the resident in the tub;	D 050		

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D 050	Continued From page 2 (D) a toilet and a lavatory trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet shall have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and (E) individual cubicle curtain enclosing each toilet, bathtub, shower, manufactured walk-in tub, or a similar manufactured bathtub and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures. (8) where the tub and shower are in separate rooms, each room shall have a lavatory and a toilet. The lavatory shall be trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; (9) in facilities where resident bedrooms do not have direct access to a bathroom or toilet room, bathrooms and toilet rooms shall be evenly distributed throughout the facility for residents' use; (10)resident toilet rooms and bathrooms shall not be used for storage or other purposes;	D 050		

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D 050	Continued From page 3 (11)toilet rooms and bathrooms shall be well lighted; (12)toilet rooms and bathrooms shall have an exhaust system per the North Carolina State Building Codes. Exhaust vents shall be vented directly to the outdoors; (13)nonskid surfacing or strips shall be installed in showers, bath areas, and bathtubs; and (14)the floors of the bathrooms and toilet rooms shall be water-resistant and slip-resistant. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the bathroom was well lit and mechanically ventilated for a resident's room (138-A) evidenced by a bedroom lamp being used for lighting in the bathroom and the ventilation fan not operating. Observations of resident room 138-A on 04/08/25 at 8:40am revealed: -There was a bedroom lamp plugged into a wall socket. -The lamp was sitting on a shower chair in front of the bathroom sink. -The lamp was being used to light the bathroom. -The bathroom light constantly flickered when the light switch was flipped on. -The ventilation fan did not start when the switch was flipped on. Interview with a resident in room 138-A on 04/08/25 at 8:42am revealed: -The light and ventilation fan had not worked for weeks. -She had notified staff weeks ago about the light and ventilation fan not working. -She had to move the lamp and shower chair whenever she needed to use the sink.	D 050		

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D 050	Continued From page 4 Interview with the Resident Care Coordinator (RCC) on 04/09/25 at 8:30am revealed: -She was aware the light and ventilation fan were not working in room 138-A. -The Maintenance Technician notified her that a part had been ordered to repair the light and ventilation switch. -She thought she was notified a week ago but was not sure of the exact date. -She was aware the resident was using a lamp to light the bathroom. -She had not come up with an alternative plan for lighting the bathroom. Interview with the Maintenance Technician on 04/09/25 at 8:40am revealed: -He was aware the light and ventilation fan were not working in room 138-A. -The RCC notified him approximately one week ago. -He was responsible for making the repairs in the facility. -Staff could directly tell him of needed repairs or complete a written request. -He ordered a part on 04/03/25 but it had not been delivered. Interview with the Administrator on 04/09/25 at 8:55am revealed: -She was not aware of the light and ventilation fan not working in room 138-A. -She was not aware the resident had been using a bedroom lamp to light her bathroom. -She was concerned the lamp sitting on a shower chair could be a hazard. -The RCC nor Maintenance Technician had notified her a part was on back order. -The Maintenance Technician was responsible for making repairs in the facility.	D 050		

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D 050	Continued From page 5 -She expected to be notified by the Maintenance Technician or the RCC if a part needed to make a repair was not delivered within a week of being ordered.	D 050		
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: The facility failed to administer medication as ordered for 2 of 4 residents observed during the morning medication pass who had orders for an anticonvulsant and a vitamin supplement (Resident #7) and a potassium supplement (Resident #8). The findings are: The medication error rate was 8% as evidenced by 3 errors of 34 opportunities during the 8:00am medication pass on 04/09/25. 1. Review of Resident #7's current FL2 dated 02/27/25 revealed diagnoses included vascular dementia, depression and bipolar disorder. a. Review of Resident #7's current FL2 dated 02/27/25 revealed there was an order for carbamazepine (a medication used to treat	D 358		

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D 358	Continued From page 6 bipolar disorder) 200mg take 1 tablet twice daily. Observation of the morning medication pass on 04/09/25 at 8:30am revealed: -The medication aide (MA) removed 13 different types of oral medications from the medication cart and compared each medication label to the medications due on the electronic medication administration record (eMAR). -The MA administered a quantity of 16 oral medications with water to Resident #7. -There were no carbamazepine tablets administered to Resident #7. Review of Resident #7's April 2025 eMAR revealed: -There was an entry for carbamazepine 200mg twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation carbamazepine was administered on 04/09/25. Observation of the medications on hand for Resident #7 on 04/09/25 at 1:25pm revealed there were no carbamazepine 200mg tablets on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 04/10/25 at 9:27am revealed: -There was a current order on file for carbamazepine 200mg twice daily for Resident #7. -Carbamazepine was dispensed on 02/18/25 and 03/20/25 for quantities of 60 tablets each for Resident #7. -A quantity of 60 carbamazepine tablets was a 30-day supply for Resident #7. Interview with Resident #7 on 04/09/25 at 3:40pm	D 358		

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revealed:
-She took the medications that were administered to her by staff.
-She did not know if she was administered carbamazepine on 04/09/25.

Interview with a MA on 04/09/25 at 1:18pm revealed:
-She had not administered carbamazepine to Resident #7 on 04/09/25 at 8:30am because there was no carbamazepine on the medication cart.
-If a resident was out of a medication, the MAs were supposed to reorder medications for residents by calling or faxing the pharmacy.
-She documented Resident #7's carbamazepine as administered on the eMAR on 04/09/25.
-She did not know she documented medication administration of carbamazepine to Resident #7 on 04/09/25 when Resident #7 was not administered carbamazepine.

Interview with Resident #7's psychiatric provider on 04/10/25 at 11:15am revealed:
-She did not know Resident #7 was not administered carbamazepine as ordered during the morning of 04/09/25.
-Carbamazepine was prescribed for bipolar disorder.
-There was no potential outcome or side effects from Resident #7 missing one dose of carbamazepine.

Interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:10am revealed:
-She was not aware that Resident #7 was not administered carbamazepine as ordered on the morning of 04/09/25.
-She did not know why Resident #7 was not administered carbamazepine but the medication

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was an order on the eMAR and should have been administered on 04/09/25.

Interview with the Administrator on 04/10/25 at 10:35am revealed:
-She was not aware that Resident #7 was not administered carbamazepine on 04/09/25 during the medication pass at 8:00am.
-Resident #7's carbamazepine was available for administration but she did not know why it was not administered on 04/09/25.

Refer to interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:11am.

Refer to interview with the Administrator on 04/10/25 at 10:36am.

b. Review of Resident #7's current FL2 dated 02/27/25 revealed there was an order for omega 3-dha-epa-fish oil (a medication used as a vitamin supplement) 300mg (120mg-180mg)-1000mg take 2 capsules daily.

Observation of the morning medication pass on 04/09/25 at 8:30am revealed:
-The medication aide (MA) removed 13 different types of oral medications from the medication cart and compared each medication label to the medications due on the electronic medication administration record (eMAR).
-The MA administered a quantity of 16 oral medications with water to Resident #7.
-There were no omega 3-dha-epa-fish oil capsules administered to Resident #7.

Review of Resident #7's April 2025 eMAR revealed:
-There was an entry for omega 3-dha-epa-fish oil 300mg (120mg-180mg)- 1000mg take two

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capsules (2000mg) daily at 8:00am.
-There was documentation omega 3-dha-epa-fish oil was administered on 04/09/25.

Observation of the medications on hand for Resident #7 on 04/09/25 at 1:25pm revealed there were no omega 3-dha-epa-fish oil 300mg (120mg-180mg)- 1000mg capsules on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 04/10/25 at 9:27am revealed there was not an order on file for omega 3-dha-epa-fish oil 300mg (120mg-180mg)- 1000mg capsules for Resident #7 and the medication had never been dispensed.

Interview with Resident #7 on 04/09/25 at 3:40pm revealed:
-She took the medications that were administered to her by staff.
-She did not know if she was administered omega 3-dha-epa-fish oil on 04/09/25.

Interview with a MA on 04/09/25 at 1:18pm revealed:
-She had not administered omega 3-dha-epa-fish oil to Resident #7 on 04/09/25 at 8:30am because there was no omega 3-dha-epa-fish oil on the medication cart.
-If a resident was out of a medication, the MAs were supposed to reorder medications for residents by calling or faxing the pharmacy.
-She documented Resident #7's omega 3-dha-epa-fish oil as administered on the eMAR on 04/09/25.
-She did not know she documented medication administration of omega 3-dha-epa-fish oil to Resident #7 on 04/09/25 when Resident #7 was

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D 358	Continued From page 10 not administered omega 3-dha-epa-fish oil. Interview with Resident #7's primary care provider (PCP) on 04/10/25 at 9:40am revealed: -She did not know Resident #7 was not administered omega 3-dha-epa-fish oil during the morning of 04/09/25. -She expected medications to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:10am revealed: -She was not aware that Resident #7's omega 3-dha-epa-fish oil was not administered as ordered on the morning of 04/09/25. -She did not know Resident #7 had orders for two different fish oil medications. Interview with the Administrator on 04/10/25 at 10:35am revealed: -She did not know that Resident #7 was not administered omega 3-dha-epa-fish oil on 04/09/25 during the medication pass at 8:00am. -Resident #7's omega 3-dha-epa-fish oil was available for administration but she did not know why it was not administered on 04/09/25. -Resident #7's omega 3-dha-epa-fish oil was an over-the-counter medication which was why it was never dispensed from the pharmacy. Refer to interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:11am. Refer to interview with the Administrator on 04/10/25 at 10:36am. 2. Review of Resident #8's current FL2 dated 12/05/24 revealed: -Diagnoses included hypertension, anemia and coronary artery disease.	D 358		

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-There was an order for potassium chloride (a medication used to treat low potassium levels) 20mEq take two tablets daily.

Observation of the morning medication pass on 04/09/25 at 8:30am revealed:
-The medication aide (MA) removed 12 different types of oral medications from the medication cart and compared each medication label to the medications due on the electronic medication administration record (eMAR).
-The MA administered a quantity of 14 oral medications with water to Resident #8.
-There were no potassium chloride tablets administered to Resident #8.

Review of Resident #8's April 2025 eMAR revealed:
-There was an entry for potassium chloride 20mEq take two tablets daily scheduled for administration at 8:00am.
-There was documentation potassium chloride was administered on 04/09/25.

Observation of the medications on hand for Resident #8 on 04/09/25 at 1:25pm revealed there were no potassium chloride tablets on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 04/10/25 at 9:27am revealed:
-There was no current order on file for potassium chloride for Resident #8.
-Potassium chloride was discontinued in his system.
-Potassium chloride was last dispensed on 01/13/25 for a quantity of 60 tablets for Resident #8.
-A quantity of 60 potassium chloride tablets was a

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D 358	Continued From page 12 30-day supply for Resident #8. Interview with Resident #8 on 04/09/25 at 3:54pm revealed: -She was not administered potassium chloride on 04/09/25. -She sometimes refused her potassium chloride. Interview with a MA on 04/09/25 at 1:18pm revealed: -She had not administered potassium chloride to Resident #8 on 04/09/25 at 8:30am because there was no potassium chloride on the medication cart. -If a resident was out of a medication, the MAs were supposed to reorder medications for residents by calling or faxing the pharmacy. -She documented Resident #8's potassium chloride as administered on the eMAR on 04/09/25. -She did not know she documented medication administration of potassium chloride to Resident #8 on 04/09/25 when Resident #8 was not administered potassium chloride. Interview with Resident #8's PCP on 04/10/25 at 9:40am revealed: -Potassium chloride was prescribed for potassium replacement. -She expected medications to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:10am revealed: -She was not aware that Resident #8 was not administered potassium chloride as ordered on the morning of 04/09/25. -She did not know why Resident #8 was not administered potassium chloride.	D 358		

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(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 358	Continued From page 13 Interview with the Administrator on 04/10/25 at 10:35am revealed she was not aware that Resident #8 was not administered potassium chloride on 04/09/25 during the medication pass at 8:00am. Refer to interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:11am. Refer to interview with the Administrator on 04/10/25 at 10:36am. _____ Interview with the Resident Care Coordinator (RCC) on 04/10/25 at 10:11am revealed: -She expected the MAs to call the pharmacy if a medication was not available for administration. -She contacted the PCP if there was any doubt if a medication should be administered to a resident. Interview with the Administrator on 04/10/25 at 10:36am revealed: -She expected MAs to reorder medications when there were eight doses remaining in the medication card if the medication was not on cycle fill. -MAs were expected to call, fax or reorder medications electronically from the pharmacy. -She did not know if anyone was completing medication cart or eMAR audits. -She did not know when the last time a medication cart or eMAR audit was completed. -MAs were responsible to administer medications as ordered.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366		

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D 366	Continued From page 14 (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 a medication aide (MA) observed a resident (#2) take their medication. The findings are: Review of Resident #2's current FL2 dated 09/18/24 revealed diagnoses included spinal stenosis, chronic pulmonary embolism, emphysema, peripheral vascular disease and chronic pain syndrome. Observation of Resident #2's room on 04/08/25 at 9:30am revealed: -There was a cup of medications on Resident #2's dresser. -There were 13 tablets in the cup including: 3 white oblong tablets, 4 small white round tablets, 1 medium white round tablet, 1 blue medium round tablet, 2 small pink round tablets, 2 yellow oblong tablets and one small beige tablet. -There was a small cup of white creme with a white plastic spoon inserted in the creme. Interview with Resident #2 on 04/08/25 at 9:35am revealed: -She knew the pills and creme were on the dresser.	D 366		

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D 366	Continued From page 15 -The MA came in to administer the medications earlier, but she did not want to get up because she was still sleepy. -The MA told her she would leave the medications on the dresser for her when she woke up. -She said this was the first time the MA left her medication. Review of Resident #2's physician orders dated 1/27/25 revealed: -There was an order for gabapentin (used to treat pain) 800mg 1 tablet four times daily. -There was an order for sertraline (used to treat depression) 100mg two tablets once daily. -There was an order for vitamin D2 (used to treat vitamin D deficiency) 1,250mcg 1 tablet once a week on Thursday. -There was an order for cetirizine (used to treat allergies)10mg 1 tablet daily. -There was an order for oxycodone with Tylenol (used to treat pain) 10-325mg 1 tablet four times daily. -There was an order for pravastatin (used to treat high cholesterol) 80mg 1 tablet at bedtime. -There was an order for bupropion (used to treat depression) 300mg one daily. -There was an order for bupropion (used to treat depression) 150mg one daily. -There was an order for lisinopril (used to treat hypertension) 20mg one tablet daily. -There was an order for trazadone (used to treat anxiety) two tablets at bedtime. -There was an order for tizanidine (used to treat muscle spasms) 4mg one tablet three times daily. -There was an order for famotidine (used to treat hypertension) 20mg one tablet daily. -There was an order for desitin creme (used to treat skin irritation) 13% applied two times daily. -There was an order for diazepam (used to treat	D 366		

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anxiety) 2mg one tablet three times daily.
-There was an order for zolpidem (used to treat insomnia) 10mg one tablet at bedtime.
-There was an entry for lactobacillus salivarius (used to treat bacteria) 175mg one tablet daily.
-There was an order for oxybutynin chloride (used to treat overactive bladder) 15mg 1 tablet twice daily.
-There was an order for apixaban (used to treat blood clots) 5mg 1 tablet twice daily.
-There was an order for omeprazole (used to reduce stomach acid) 20mg 1 tablet twice daily.
-There was an order for sucralfate (used to prevent ulcers) 1 tablet twice daily.
-There was an order for guaifenesin (used for mucus relief) 600mg 1 tablet twice daily.
-There was an order for mirabegron (used to treat overactive bladder) 5mg 1 capsule twice daily.

Review of Resident #2's electronic medication administration record (eMAR) for April 2025 revealed:
-There was documented administration for gabapentin 800mg 1 tablet daily scheduled at 8:00am.
-There was documented administration for sertraline 100mg two tablets once daily scheduled at 8:00am.
-There was documented administration for cetirizine 10mg 1 tablet daily scheduled at 8:00am.
-There was documented administration for bupropion 300mg one daily scheduled at 8:00am.
-There was documented administration for bupropion 150mg one daily scheduled at 8:00am.
-There was documented administration for lisinopril 20mg one tablet daily scheduled at 8:00am.
-There was documented administration for tizanidine 4mg one tablet three times daily

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scheduled at 8:00am.
-There was documented administration for famotidine 20mg one tablet daily scheduled at 8:00am.
-There was documented administration for desitin creme 13% applied two times daily scheduled at 8:00am.
-There was documented administration for diazepam 2mg one tablet three times daily scheduled at 8:00am.
-There was documented administration for lactobacillus salivarius 175mg one tablet daily scheduled for administration at 8:00am.
-There was documented administration for oxybutynin chloride 15mg 1 tablet twice daily scheduled at 8:00am.
-There was documented administration for apixaban 5mg 1 tablet twice daily scheduled at 8:00am.
-There was documented administration for omeprazole 20mg 1 tablet twice daily scheduled at 8:00am.
-There was documented administration for sucralfate 1 gm apply twice daily scheduled at 8:00am.
-There was documented administration for guaifenesin 600mg 1 tablet twice daily scheduled at 8:00am.
-There was documented administration for mirabegron 5mg 1 capsule twice daily scheduled at 8:00am.
-There was documented administration for Vitamin C 500mg 1 capsule three times daily scheduled at 8:00am.

Interview with a MA on 04/09/25 at 10:30am revealed:
-She administered medications to Resident #2 on 04/08/25 at 8:00am.
-She pulled the medications and matched them to

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the medications listed on the eMAR.
-She brought the medications to the resident's room and documented the medications as administered on the eMAR.
-She did not watch the resident take the medications.
-She was aware she was supposed to watch all residents take their medications before leaving the room.
-The resident knew about all her medications, so she was not concerned about leaving the medications.
-This was the first time she left medications in a resident's room.

Telephone interview with a second MA on 04/09/25 at 10:44am revealed:
-When she administered medication in a resident's room, she handed the resident the cup of medication and water, and she watched the resident take the medication.
-She made sure the resident swallowed the medication and checked the medication off as administered on the eMAR.
-She had not left any medication in Resident #2's room.

Interview with the Resident Care Coordinator (RCC) on 04/09/25 at 10:55am revealed:
-MAs should pull the medications to be given to the residents and make sure the medication and dosage matched the order on the eMAR.
-If a resident was asleep, the MA should have woken the resident up and attempted to administer the medication.
-If the medication was not administered, the MA should not have documented it as administered.
-She expected staff to watch all residents take their medications before leaving the room and not leave medications unattended.

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D 366	Continued From page 19 Interview with the Administrator on 04/09/25 at 11:10am revealed: -She was not aware medications were left unattended in Resident #2's room. -If Resident #2 did not take the medication at the time of administration, the MA should have taken the medication back to the medication room and tried again later. -Medications were not to be left in a resident's room unless they had a self-administration order. -She expected the MA to administer the medication and watch residents take the medication before documenting it was administered on the eMAR.	D 366		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all medications stored by the facility were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration for 1 of 1 sampled residents (#6) including two pain relievers and a nasal spray. The findings are:	D 378		

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D 378	Continued From page 20 Review of the facility's policy titled "Medication Storage" revealed "all medications, including over the counter, are always kept in locked storage." Review of Resident #6's current FL2 dated 09/16/24 revealed diagnoses included memory loss, major depression, chronic diastolic congestive heart failure, and diabetes mellitus type 2. a. Observation on 04/09/25 at 4:10pm revealed: -Resident #6 was asleep in her recliner. -There was a full bottle of acetaminophen 500mg capsules on the table beside the recliner. -The medication bottle was visible from the doorway. A second observation on 04/10/25 at 7:49am revealed the bottle of acetaminophen 500mg remained on the table beside Resident #6's recliner. Review of Resident #6's signed physician's orders dated 04/01/25 revealed there was no order for acetaminophen 500mg for Resident #6. Interview with Resident #6 on 04/09/25 at 1:05pm revealed: -She just picked up the bottle of acetaminophen 500mg at the drugstore yesterday. -She liked to keep the acetaminophen 500mg in her room because sometimes she needed it. -She did not know if she had an order for the acetaminophen 500mg. Review of electronic correspondence with a representative from Resident #6 's primary care provider's (PCPs) office on 04/09/25 at 2:53pm revealed:	D 378		

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-Resident #6 could receive acetaminophen on as needed basis.
-The acetaminophen 500mg could not be self-administered.
-The acetaminophen 500mg could not be administered without an order.

Refer to interview with the personal care aide (PCA) on 04/09/25 at 1:10pm.

Refer to interview with the medication aide (MA) on 04/10/25 at 8:15am.

Refer to interview with Resident Care Coordinator (RCC) on 04/10/25 at 10:25am.

Refer to interview with the Administrator on 04/10/25 at 10:40am.

b. Observation on 04/09/25 at 4:10pm revealed:
-Resident #6 was asleep in her recliner.
-There was a full bottle of ibuprofen 200mg on the table beside the recliner.
-The bottle of ibuprofen 200mg was visible from the doorway.

A second observation on 04/02/25 at 7:49am revealed the bottle of ibuprofen 200mg remained on the table beside Resident #6's recliner.

Review of Resident #6's signed physician's orders dated 04/01/25 revealed there was no order for ibuprofen 200mg for Resident #6.

Interview with Resident #6 on 04/09/25 at 1:05pm revealed:
-She just picked up the bottle of ibuprofen 200mg at the drugstore yesterday.
-She liked to keep the ibuprofen 200mg in her room because sometimes she needed it for

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headaches and other pain.
-She did not know if she had an order for the ibuprofen 200mg.

Review of electronic correspondence with a representative from Resident #6's primary care provider's (PCP's) office on 04/09/25 at 2:53pm revealed the PCP did not want Resident #6 to receive ibuprofen due to her kidney function.

Refer to interview with the personal care aide (PCA) on 04/09/25 at 1:10pm.

Refer to interview with the medication aide (MA) on 04/10/25 at 8:15am.

Refer to interview with Resident Care Coordinator (RCC) on 04/10/25 at 10:25am.

Refer to interview with the Administrator on 04/10/25 at 10:40am.

c. Observation on 04/09/25 at 4:10pm revealed:
-Resident #6 was asleep in her recliner.
-There was an almost full bottle of nasal spray on the table beside Resident #6's recliner.

A second observation on 04/02/25 at 7:49am revealed the bottle of nasal spray remained on the table beside Resident #6's recliner.

Review of Resident #6's signed physician's orders dated 04/01/25 revealed there was no order for nasal spray for Resident #6 .

Interview with Resident #6 on 04/09/25 at 1:05pm revealed:
-She had the bottle of nasal spray to use because she had the flu recently and it helped with congestion.

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D 378	Continued From page 23 -She usually kept the medication in her drawer. -She did not know if she had an order for the nasal spray. Review of electronic correspondence with a representative from Resident #6's primary care provider's (PCPs) office on 04/09/25 at 2:53pm revealed the PCP did not recommend Resident #6 using the nasal spray. Refer to interview with the personal care aide (PCA) on 04/09/25 at 1:10pm. Refer to interview with the medication aide (MA) on 04/10/25 at 8:15am. Refer to interview with Resident Care Coordinator (RCC) on 04/10/25 at 10:25am. Refer to interview with the Administrator on 04/10/25 at 10:40am. _____ Interview with the PCA on 04/09/25 at 1:10pm revealed: -She was expected to check resident rooms to make sure there were not any medications in their rooms. -She was in Resident #6's room today to check on her and did not see the medication in her room. -If she did find medication in a resident's room, she would remove it from the room and take it to the medication aide (MA). Interview with the medication aide (MA) on 04/10/25 at 8:15am revealed: -Resident #6 did not self-administer her medications. -She did not see the nasal spray, acetaminophen, or ibuprofen in Resident #6's room.	D 378		

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D 378	Continued From page 24 -Resident #6 should not have medications in her room. -She looked for medications in resident rooms when she did her medication administration. -If she did find medications in a resident's room, she should remove it. Interview with the RCC on 04/10/25 at 10:25am revealed: -PCAs and MAs should be checking resident rooms for medications when they provide care. -Medications should not be at the bedside. -If a resident had an order to self-administer medications, they should be kept in locked storage. -She was concerned that Resident #6 had medications in her room and no one noticed. -She was concerned Resident #6 had medications in her room that did not have a physician's order. Interview with the Administrator on 04/10/25 at 10:40am revealed: -She expected the PCAs and MAs to be alert to medications in the resident rooms. -Residents should not have medications left out in their rooms. -She was concerned the resident could take too much of the medication or the resident might take something they should not take. -She was concerned another resident or visitor could take the medication if it was not kept in locked storage.	D 378		