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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 04/22/25 to /4/23/25.	D 000		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 33 of 52 assisted living (AL) residents in addition to other beverages. The findings are: Review of the facility's daily menu for 04/22/25 and 04/23/25 revealed water was listed to be served for breakfast, lunch, and dinner meal service. Observation of the lunch meal service on 04/22/25 for the AL dining room between 11:45am and 12:45pm revealed: -There were 43 residents present for the lunch meal service. -Beverages available included milk, tea, coffee, and water. -The beverages were ordered by the residents	D 306		

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from the daily lunch menu and served by the personal care aides (PCA) and medication aides (MA) from a beverage cart.
-Ten residents were served water and all the other residents were served other beverages.
-No other residents were served water.

Observation of the breakfast meal service on 04/23/25 for the AL dining room between 7:45am and 8:30am revealed:
-There were 30 residents present for the breakfast meal service.
-Beverages available included juice, milk, tea, coffee, and water.
-The beverages were ordered by the residents from the daily lunch menu and served by the PCAs and MAs from a beverage cart.
-Twelve residents were served water and all the other residents were served other beverages.
-No other residents were served water.

Interview with a resident on 04/22/25 at 12:30pm revealed:
-If she wanted water with her meals, she had to ask for it.
-She would drink water with every meal if it was served to her with each meal.

Interview with a second resident on 04/23/25 at 8:10am revealed:
-Residents ordered beverages from PCAs and MAs for each meal from beverage choices on the daily menu.
-If she wanted water with his meals, she had to ask for it.

Interview with a PCA on 04/22/25 at 12:45pm revealed:
-She assisted in the AL dining room during meals and she relied on residents to choose beverages

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from the daily menu.
-Water was on the daily menu and was always available as a beverage on the beverage cart for the AL residents.
-A few residents ordered and were served water, but the other residents were served a mixture of other beverages.
-She was aware water was not served with the lunch meal service on 04/22/25 for 33 residents.
-She did not know water should have been served to all residents with each meal and thought water was optional.

Interview with an MA on 04/23/25 at 8:30am revealed:
-She assisted in the AL dining room during meals and served the residents beverages from the beverage cart based on residents' choice from the daily menu.
-A few residents ordered water, but the other residents mostly ordered other beverages.
-She was aware water was not served with the lunch meal service on 04/22/25 for 33 residents or with the breakfast meal service on 04/23/25 for 18 residents.
-She did not know water should have been served to all residents with each meal and thought water was optional.

Interview with a second MA on 04/23/25 at 8:45am revealed:
-He assisted in the AL dining room during meals and served the residents beverages from the beverage cart based on residents' choice from the daily menu.
-A few residents ordered water, but the other residents mostly ordered other beverages.
-He was not aware water was not served with the lunch meal service on 04/22/25 for 33 residents because he was not in the dining room for the

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lunch meal service.
-He was aware water was not served with the breakfast meal service on 04/23/25 for 18 residents.
-He did know water should have been served to all residents with each meal but had told by management that water should be optional and not pre-poured.

Interview with the Dietary Manager (DM) on 04/23/25 at 9:00am revealed:
-Beverages were prepared and served from a beverage cart by the PCAs and MAs at every meal based upon the residents' beverage order from the daily menu.
-Water was always available as a beverage for the AL residents.
-She was not aware water was not served with the lunch meal service on 04/22/25 for 33 residents or with the breakfast meal service on 04/23/25 for 18 residents.
-She was not aware water should have been served daily to all AL residents with each meal and thought it was optional.

Interview with the Health and Wellness Director (HWD) on 04/23/25 at 8:50am revealed:
-Beverages were prepared and served by the PCAs and MAs with each meal.
-Water was always available as a beverage for all residents.
-She was aware water was not served with the lunch meal service on 04/22/25 for 33 residents or with the breakfast meal service on 04/23/25 for 18 residents.
-She did not know water should have been served to all residents with each meal and thought water was optional.

Interview with the District Director of Clinical

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D 306	Continued From page 4 Services (DDCS) on 04/23/25 at 3:25pm revealed: -She was not aware AL residents had not been served water with each meal. -She thought water was optional for the residents and only had to be offered to the residents by the staff.	D 306		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 residents related to a medication used to treat elevated blood sugars (#2 and (#4), a nasal spray (#3), and not holding medication used to treat high blood pressure outside of the parameters (#1). The findings are: 1. Review of Resident #2's current FL2 dated 03/18/25 revealed: - Diagnoses included cellulitis, non-pressure chronic ulcer on left heel, type II diabetes and hypertension.	D 358		

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D 358	Continued From page 5 -There was an order for Janumet extended release (XR) (medication used to treat elevated blood sugars) 50-500mg tablets 2 daily. -There was no order for fingerstick blood sugar levels. Review of the facility's Medication Administration Policy, effective 08/2010, revealed medication assistance and administration should be in accordance with the prescriber's orders. Review of Resident #2's Emergency Department discharge summery dated 04/23/25 revealed: -Resident # 2's diagnoses were hyperglycemia and hypertension. -Resident should continue taking Janumet XR 50-500mg twice a day. -There were no laboratory reports included in the discharge summary. Review of Resident #2's April 2025 electronic medication administration record (eMAR) 04/01/25-04/23/25 revealed: -There was an entry for Janumet XR 50-500mg 500mg tablets 2 tablets daily with a scheduled time of admission at 8:00am. -The Janumet was not available for admission 16 times from 04/01/25 to 04/22/25. Observation of Resident #2's medication on hand on 04/23/25 at 10:00am revealed there was no Janumet XR 50-500mg 2 tablets daily available for administration. Interview with the medication aide (MA) on 04/23/25 at 10:20am revealed: -He had administered medication to Resident. -He had not administered Janumet XR 50-500mg to her in the month of April because it had not been on the cart.	D 358		

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-He had not told anyone about the medication not being on the cart.
-The Health and Wellness Director (HWD) was responsible for reordering medications.

Attempted interview with Resident # 2 on 04/23/25 at 10:30pm was unsuccessful because she was out of the facility.

Interview with Resident #2's primary care provider (PCP) on 04/23/25 at 11:55am revealed:
-Resident #2 had an order for Janumet XR 50-500mg two tablets daily.
-She was not aware Resident #2 was not getting the Janumet XR until today, 04/23/25.
-She was aware that Resident #2 was taken to the hospital on 04/22/25 for elevated blood pressure and elevated blood sugar.
-The residents' hospitalization could have resulted from her not getting the Janumet.
-She would expect the facility to administer the medication as ordered.

Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 12:07pm revealed:
-There was an order for Janumet XR 50-500mg 2 tablets daily dated 03/18/25.
-The last dispense date was 03/21/25 for a 30-day supply.
-The facility returned the medication to the pharmacy on 04/03/25 with no explanation noted.
-There was a new order received today, 04/23/25, for Janumet XR 50-500mg 2 tablets daily for a 30-day supply.
-The order for Janumet XR 50-500mg 2 tablets daily for a 30-day supply will be dispensed today. 04/23/25.

Interview with the HWD on 04/23/25 at 2:15pm

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D 358	Continued From page 7 revealed: -She was not aware Resident # 2 was not administered Janumet XR until the PCP informed her today. -She was not aware the medication was returned to the pharmacy on 04/03/25. -She was aware the resident was sent out to the hospital on 04/22/25 for elevated blood sugar. -She and the Resident Care Coordinator (RCC) were responsible for doing cart audits monthly and contacting the pharmacy for clarity of orders that did not match the eMAR. -Her expectation was for medications to be administered as ordered. -She expected the MAs to let her know if the medication on the eMAR was not on the cart. Interview with the District Director of Clinical Services (DDCS) on 04/23/25 at 3:25pm revealed: -She was not aware Resident # 2 was not getting Janumet XR. -She was aware the resident was sent out to the hospital on 04/22/25 for elevated blood sugar. -The HWD was responsible for auditing the eMAR weekly to ensure medication orders matched what was on the cart. -The MAs were responsible for notifying the HWD or pharmacy if a medication was not in. -She expected the HWD to complete cart audit weekly. -She expected all medications to be administered as ordered. 2. Review of Resident #4's current FL2 dated 02/03/25 revealed: -Diagnoses included diabetes mellitus. -There was an order for semaglutide (a medication used to help regulate blood sugar) 3mg daily.	D 358		

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D 358	Continued From page 8 Review of Resident #4's February 2025 electronic medication administartion record (eMAR) from 02/03/25 to 02/28/25 revealed there was no entry for semaglutide 3mg daily. Review of Resident #4's March 2025 eMAR revealed there was no entry for semaglutide 3mg daily. Review of Resident #4's April 2025 eMAR 04/01/25-04/23/25 revealed there was no entry for semaglutide 3mg daily. Review of Resident #4's medications on hand on 04/23/25 at 10:00am revealed there was no semaglutide 3mg available for administration for Resident #4. Interview with Resident #4 on 04/23/25 at 10:10am revealed she was unsure of what medications she was taking. Interview with Resident #4's family member on 04/23/25 at 11:30am revealed: -She was not aware Resident #4 was not receiving semaglutide. -To her knowledge, the semaglutide was not discontinued. -She just received her pharmacy bill but had not reviewed it yet. Interview with Resident #4's primary care provider (PCP) on 04/23/25 at 2:43pm revealed: -She did not have semaglutide 3mg on her list of medications Resident #4 was taking. -When she completed Resident #4's history and physical, she entered the medications from Resident #4's eMAR and not the FL2. -Resident #4 received another oral medication	D 358		

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which should have helped control her blood sugars.
-She ordered labs for Resident #4 in February but she did not have a current A1C (a blood test that measures average blood sugar levels over the past 2-3 months) available for review.
-There was not an order to check Resident #4's finger stick blood sugars (FSBS).

Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 12:05pm revealed:
-There was an active order dated 02/05/25 for semaglutide 3mg daily for Resident #4.
-Thirty tablets of semaglutide 3mg were dispensed on 02/05/25.
-No other dispense dates were available for the semaglutide .
-The semaglutide would not be part of the facility's cycle fill; the facility would have to reorder the medication.
-The semaglutide was not reordered by the facility.
-There was no record the semaglutide that was dispensed on 02/05/25 was returned to the pharmacy.
-Resident #4 could experience a slow rise in blood sugars if not taking the semaglutide as ordered.

Interview with a medication aide (MA) on 04/23/25 at 2:52pm revealed:
-Semaglutide was not on Resident #4's eMAR.
-There was no semaglutide available to administer to Resident #4.
-He did audits on the medication carts on the weekends he worked but did not do anything with FL2s when residents were admitted.

Interview with the Health and Wellness Director

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(HWD) on 04/23/25 at 11:15am revealed:
-She and the Resident Care Coordinator (RCC) were responsible for faxing FL2s to the pharmacy when a resident was admitted and making sure the medications arrived from the pharmacy.
-She thought the semaglutide was not on the eMAR because the family did not want to pay for it.
-She was not sure why the pharmacy would send a months' supply and not send anymore and did not understand why the medication was not on the cycle fill.

Interview with the District Director of Clinical Services (DDCS) on 04/23/25 at 3:25pm revealed:
-She was not aware there was an issue with Resident #4's medication; she would have to look into why the semaglutide did not get put on the eMAR.
-The HWD and Administrator were responsible for reviewing FL2s when a resident was admitted and making sure the eMAR was complete.

3. Review of Resident #3's current FL2 dated 10/21/24 revealed:
-Diagnoses included atherosclerotic heart disease and diabetes mellitus type 2.
-There was an order for fluticasone nasal spray (a medication used to treat allergy symptoms) 2 sprays both nostrils daily.

Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone nasal spray 2 sprays both nostrils daily with a scheduled administration time of 6:00am.
-There was documentation fluticasone nasal spray 2 sprays both nostrils was administered

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daily at 6:00am from 02/01/25 to 02/15/25, 02/17/25 to 02/19/25, 02/22/25, and 02/24/25 to 02/27/25.

Review of Resident #3's March 2025 eMAR revealed:
-There was an entry for fluticasone nasal spray 2 sprays both nostrils daily with a scheduled administration time of 6:00am.
-There was documentation fluticasone nasal spray 2 sprays was administered on 03/01/25, 03/03/25 to 03/04/25, 03/09/25 to 03/12/25, 03/15/25, and 03/17/25 to 03/31/25.

Review of Resident #3's April 2025 eMAR from 04/01/25 to 04/23/25 revealed:
-There was an entry for fluticasone nasal spray 2 sprays both nostrils daily with a scheduled administration time of 6:00am.
-There was documentation fluticasone nasal spray 2 sprays both nostrils was administered from 04/01/25 to 04/23/25.

Observation of Resident #3's medications on hand on 04/22/25 at 2:45pm revealed there was no fluticasone nasal spray available for administration.

Interview with Resident #3 on 04/22/25 at 3:30pm revealed:
-He had not received nasal spray in a long time.
-He did not have any allergy symptoms.

Interview with Resident #3's primary care provider (PCP) on 04/23/25 at 11:47am revealed:
-She was not aware Resident #3 was not receiving his nasal spray.
-Resident #3 did not have any complaints about allergy symptoms recently.

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Telephone interview with a representative from the facility's contracted pharmacy on 04/22/25 at 3:03pm revealed:
-Resident #3 had an active order for fluticasone nasal spray 2 sprays both nostrils daily.
-One bottle of fluticasone nasal spray was dispensed on
06/01/23, 07/20/23, and 02/09/24.
-Fluticasone was not part of the facility's cycle fill; the facility staff would have to reorder the medication.
-There was no record the facility reordered the fluticasone for Resident #3.

Interview with a Medication Aide (MA) on 04/23/25 at 8:25am revealed:
-She found nasal spray in Resident #3's room on 04/22/25 and administered it.
-She took the bottle of nasal spray and put it on the medication cart.
-She could not recall if she administered the nasal spray to Resident #3 on 04/23/25.

Interview with the Health and Wellness Director (HWD) on 04/23/25 at 3:10pm revealed:
-She was not aware there was no fluticasone nasal spray available to administer to Resident #3.
-The MAs were able to reorder medications they did not have and should have reordered the fluticasone for Resident #3.
-She and the Resident Care Coordinator (RCC) were responsible for making sure medications were available to administer.

Interview with the District Director of Clinical Services (DDCS) on 04/23/25 at 3:25pm revealed:
-The HWD was responsible for reviewing eMARs and making sure the medications are available in

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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
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the facility.
-She expected the MAs to administer medications as ordered and if a medication was not available, call the pharmacy and follow up to ensure the medication was delivered.

Based on observations and interviews it was determined the Administrator was not interviewable due to being out of the facility.
4. Review of Resident #1's current FL2 dated 04/10/24 revealed:
-Diagnoses included major depressive disorder, unspecified hyperlipidemia, unspecified hypothyroidism, and unspecified anxiety disorder.
-There was an order for diltiazem (used to treat high blood pressure) 60mg 1 capsule daily, hold if systolic blood pressure (SBP) was less than 120.

Review of Resident #1's physician's orders dated 03/28/25 revealed an order for diltiazem 60mg 1 capsule daily, hold if SBP was less than 120.

Review of Resident #1's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for diltiazem 60mg 1 tablet once daily, hold if SBP was less than 120, scheduled to be administered at 12:00pm.
-There were 5 of 28 opportunities where diltiazem was not documented as held as ordered for SBP less than 120 as follows:
-On 02/14/25, SBP was documented as 115.
-On 02/19/25, SBP was documented as 118.
-On 02/22/25, SBP was documented as 113.
-On 02/24/25, SBP was documented as 115.
-On 02/28/25, SBP was documented as 99.
-There were no additional notes for diltiazem being administered for 02/14/25, 02/19/25, 02/22/25, 02/24/25, and 02/28/25.

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	HAL080014	A. BUILDING: _____ B. WING _____	04/23/2025

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Review of Resident #1's March 2025 eMAR revealed:
-There was an entry for diltiazem 60mg 1 tablet once daily, hold if SBP was less than 120, scheduled to be administered at 12:00pm.
-There were 4 of 31 opportunities where diltiazem was not documented as held as ordered for SBP less than 120 as follows:
-On 03/01/25, SBP was documented as 109.
-On 03/09/25, SBP was documented as 119.
-On 03/21/25, SBP was documented as 119.
-On 03/27/25, SBP was documented as 117.
-There were no additional notes for diltiazem being administered for 03/01/25, 03/09/25, 03/21/25, and 03/27/25.

Observation of medications available for administration for Resident #1 on 04/23/25 at 11:10am revealed 30 tablets of diltiazem were available for administration and were dispensed on 03/21/25.

Interview with Resident #1 on 04/22/25 at 10:00am revealed:
-She was not sure if she received diltiazem according to her primary care provider's (PCP) orders, but the MA did obtain her blood pressure (BP) levels every day.
-She denied any current symptoms related to fatigue or dizziness.

Interview with Resident #1's PCP on 04/23/25 at 11:45am revealed:
-She had ordered Resident #1's diltiazem to treat her high blood pressure levels related to her anxiety disorder.
-She was not aware Resident #1 had been administered diltiazem when her SBP levels were less than 120.
-She expected the facility staff to administer or

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hold Resident #1's diltiazem according to parameters directed in the PCP's orders.
-She expected a possible outcome for Resident #1 to have low blood pressure with possible confusion, dizziness, and fatigue if the diltiazem was not held as ordered.

Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 12:05pm revealed:
-Resident #1 had an active order for diltiazem 60mg 1 tablet once daily, hold if SBP was less than 120.
-The facility last dispensed 28 tablets of diltiazem on 04/18/25 and 30 tablets on 03/21/25.

Interview with a medication aide (MA) on 04/23/25 at 11:30am revealed:
-She was aware of the PCP's order and SBP parameters for Resident #1's diltiazem.
-The MAs were responsible for administering or holding residents' medications according to PCP orders.
-The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for reviewing the eMAR to ensure medications were administered correctly.
-She was not aware diltiazem had been administered to Resident #1 when it should have been held.

Interview with a second MA on 04/23/25 at 2:55pm revealed:
-He was aware of the PCP's order and SBP parameters for Resident #1's diltiazem.
-The MAs were responsible for administering or holding residents' medications according to PCP orders.
-He was not aware diltiazem had been administered to Resident #1 when it should have

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D 358	Continued From page 16 been held. Interview with the HWD on 04/23/25 at 3:10pm revealed: -She was aware of the PCP's order and SBP parameters for Resident #1's diltiazem. -She and the RCC were responsible for auditing the eMAR to ensure medications were administered as ordered by the physician even though the RCC was in the process of leaving the facility. -She was not aware Resident #1 had been administered diltiazem when her SBP levels were less than 120 as it must have been overlooked. Interview with the District Director of Clinical Services on 04/23/25 at 3:25pm revealed: -She expected the HWD to audit the eMARs on a weekly basis to ensure medications were administered according to physicians' orders. -She expected MAs to administer or hold medications as ordered by the physician. Based on observations and interviews it was determined the Administrator was not interviewable due to being out of the facility. _____ The facility failed to ensure medications were administered as ordered for 4 of 5 residents (#1, #2, #3, and #4) who did not receive a medication to control blood sugars (#2 and #4) which could result in a rise of blood sugar levels, a nasal spray used to treat allergy symptoms (#3), which could result in increased allergic reactions, and a resident who received a blood pressure medication when their BPs were out of parameters to hold (#1) which could result in a decrease of blood pressure with fatigue and dizziness. This failure was detrimental to the health and safety of the residents and constitutes	D 358		

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D 358	Continued From page 17 a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/25 for this violation.	D 358		