STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 follow-up survey March 26-27, 2025.	D 000	Response to the citied deficiencies does not constitute and admission or agreement or conclusion set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state law.	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards as evidenced by personal care and cleaning products being unsecured in residents' rooms in the Special Care Unit (SCU). The findings are: Review of the facility's census on 03/26/25 revealed there were 32 residents on the Special Care Unit (SCU). Observation of the SCU on 03/26/25 from 8:20am to 9:05am revealed: -In room 501, there was a container of anti-fungal body powder on the nightstand with a warning label reading "Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away". -In the bathroom in room 501, on top of the toilet tank, there was a bottle of all-purpose cleaner,	D 079	Four Oaks is committed to providing a safe, clean, and unobstructed Special Care Unit (SCU) free from all hazards. The facility will ensure cleaning chemicals are monitored while in use and then locked and secured in a designated storage closest. Ingestible items will be kept in a locked cabinet in a secure location. The Maintenance Technician inspected all storage cabinets and closets throughout the SCU to confirm they close and lock properly. Rooms, cabinets, and closets will be inspected by the SCC, Executive Director (ED) or designee to ensure all areas are clean, safe, and free of hazards for the residents daily for 30 days and random daily checks thereafter.	5/11/25 3/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Deeley — TITLE: Executive Director — (X6) DATE: 05/09/2025

Reviewed and acknowledged on 05/09/25 by JL

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D 079	Continued From page 1 degreaser, and spot remover with a warning label reading "Keep out of reach of children. Warning: eye irritant. Keep away from eyes. For eye contact, flush with water for 15 minutes. If irritation persists, get prompt medical attention,. If swallowed, give 1 or 2 glasses of water and call a physician, poison control center, or emergency room immediately". -In the 500 hall shower room, there was a black metal storage cabinet, and the door did not completely close, which left an approximately 3 inch opening. -There was a bottle of body wash visible through the opening of the black metal storage cabinet. -In room 603, there was a deodorant stick on the nightstand with a warning label reading "For external use only. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away. -There was a female resident and two male residents wandering in the hallways. -A personal care aide (PCA) redirected one of the male residents out of another resident's room at 8:39am. Interview with a PCA on 03/26/25 at 9:01am revealed: -All personal care products should be stored in one of locked cabinets in the shower rooms or in the medication rooms. -No personal care products should be left in the residents' rooms. -Personal care items and cleaners were secured for the residents' safety. -The metal cabinets in the shower rooms were difficult to lock. -Most of the time, she stored the residents' personal care products in the medication room because the metal cabinets did not work properly. -A home health nurse may have left the	D 079	Clinical Nurse Consultant (CNC) conducted an in-service with the SCU staff concerning the importance of keeping hazardous and personal care items locked away in a SCU ED in-serviced all staff on the importance of ensuring that all hazardous and ingestible items are maintained in a secured storage area.	3/28/25 3/28/25

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D 079	Continued From page 2 anti-fungal powder and cleaner in room 501. -She was unsure why any other personal care products were in the residents' rooms. -She was not aware of any residents who attempted to ingest non-food items. -There were a few residents on the SCU who wandered and required redirection. Second observation of the SCU on 03/26/25 at 1:09pm revealed in the bathroom in room 501, on the floor under the sink, there was a bottle of all-purpose cleaner, degreaser, and spot remover with a warning label reading "Keep out of reach of children. Warning: eye irritant. Keep away from eyes. For eye contact, flush with water for 15 minutes. If irritation persists, get prompt medical attention,. If swallowed, give 1 or 2 glasses of water and call a physician, poison control center, or emergency room immediately". Third observation of the SCU on 03/26/25 at 4:28pm revealed in the bathroom in room 501, on the right side of the sink, there was a bottle of all-purpose cleaner, degreaser, and spot remover with a warning label reading "Keep out of reach of children. Warning: eye irritant. Keep away from eyes. For eye contact, flush with water for 15 minutes. If irritation persists, get prompt medical attention,. If swallowed, give 1 or 2 glasses of water and call a physician, poison control center, or emergency room immediately." Fourth observation of the SCU on 03/27/25 from 6:51am to 7:50am revealed: -In the bathroom in room 501, on the top of the toilet tank, there was a bottle of all-purpose cleaner, degreaser, and spot remover with a warning label reading "Keep out of reach of children. Warning: eye irritant. Keep away from eyes. For eye contact, flush with water for 15	D 079		

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D 079	Continued From page 3 minutes. If irritation persists, get prompt medical attention,. If swallowed, give 1 or 2 glasses of water and call a physician, poison control center, or emergency room immediately". -There was a male resident wandering in the hallway and in and out of other resident's rooms. Interview with a medication aide (MA) on 03/26/25 at 4:05pm revealed: -Personal care products should be stored in the locked cabinets in the shower rooms. -There should be no personal care products or cleaning products in the residents' rooms. -Residents could be harmed if they ingested personal care products. -Residents could pick up items and put them in their mouth or ingest something that should not be eaten. -There were a few residents in the SCU who wandered. -She was not aware of any residents who had ingested any personal care products or cleaning products. -The SCU staff should be checking the residents' rooms during each shift to ensure no products were left in the residents' rooms. Interview with the Special Care Coordinator (SCC) on 03/26/25 at 9:15am revealed: -She started working at the facility approximately 1 month ago. -All personal care products should be stored in the medication room on the SCU. -There should not be any personal care products in the residents' rooms. -Personal care products and cleaners should be secured so residents could not ingest them. -The facility staff may have used the products and forgotten to return the items to the locked space provided.	D 079		

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D 079	Continued From page 4 -She was not aware of any residents who attempted to ingest non-food items. Interview with the Clinical Nurse Consultant (CNC) on 03/27/25 at 11:50am revealed: -Personal care products should be stored in the medication room on the SCU. -There should be no personal care products or cleaning products in residents' rooms. -The SCU staff should check the residents' rooms each shift and any time they enter residents' rooms and remove any products. -Personal care products and cleaners could be dangerous or poisonous to residents if ingested. Interview with the Administrator on 03/27/25 at 8:58am revealed: -Personal care products should be stored in the locked cabinets in the SCU shower rooms. -Personal care products or cleaning supplies should not be left in the residents' rooms -She was aware of an issue with one of the cabinets in the shower rooms not locking properly. -If the cabinets were not locking properly, the SCU staff should store the personal care products or cleaning supplies in the medication room. -Personal care products and cleaning supplies could be harmful to residents if ingested or if the products got into the residents' eyes. Interview with the facility's contracted primary care provider (PCP) on 03/27/25 at 8:30am revealed the facility staff should keep personal care products and cleaning supplies secured in SCU for the residents' safety.	D 079		

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D 105	Continued From page 5	D 105		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a heating unit was maintained in an operating condition on a consistent basis for approximately five months. The findings are: Review of the Weather U.S. website weather report revealed: -The outside weather temperature in the Four Oaks, NC area in January 2025 ranged from 34.3 degrees Fahrenheit (F) to 49.3 degrees F. -The outside weather temperature in the Four Oaks, NC area in February 2025 ranged from 36.9 degrees F to 53.6 degrees F. -The outside weather temperature in the Four Oaks, NC area in March 2025 ranged from 43 degrees F to 60.4 degrees F. Observations of the 400 hall on 03/26/25 during the initial tour of the facility from 8:24am to 9:36am revealed: -In room 418 at 8:24am, there was an unplugged radiator style electric heater positioned close to the wall between the two beds. -In room 415 at 8:38am, there was a glowing red light on the front panel of a portable electric heater plugged into a wall outlet. -In room 413 at 8:42am, there was a glowing red	D 105	All new units were installed and repairable units were repaired 3/28/25. Temperature checks for random rooms will be done by the Maintenance tech, ED or designee daily for 30 days then random weekly checks. All rooms were checked, and all spaces heaters were removed from residents rooms.	3/28/25 3/28/25

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D 105	Continued From page 6 light on the front panel of a radiator style electric heater with warm air blowing. -In room 412 at 8:51am, there was an unplugged radiator style electric heater positioned next to the dresser. Interview with a resident in room 413 on 03/26/25 at 8:42am revealed: -The portable electric heater was placed in the room when the weather was cold. -The previous Administrator had given her the portable electric heater. -She used the heater to stay warm. -Sometimes she could feel air blowing in the room from the window. Interview with a resident in room 412 on 03/26/25 at 8:51am revealed: -He used the portable electric heater to heat the room. -He got cold at night. -He could not remember how long the portable electric heater had been in the room. -"The pump that works this room ain't working." -The heat was not working in some of the rooms, including the room he was in. Interview with the Administrator on 03/26/25 at 9:24am revealed: -The portable electric heaters were in the facility because of inconsistent room temperatures. -The facility heating and air conditioning (HVAC) unit was delivered to the facility earlier today (03/26/25) to be installed. -She was not sure when the installation would occur. Interview with the Regional Vice President of Operations (RVPO) on 03/26/25 at 4:00pm revealed:	D 105		

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D 105	Continued From page 7 -An HVAC unit was ordered from a local supply company. -He did not know when the HVAC unit had been ordered but installment would be completed on 03/26/25. -He thought the HVAC unit had not been working for "not quite two months". Interview with the Regional Maintenance Director (RMD) on 03/27/25 at 3:28pm revealed: -He had been working on the heating unit at the facility "back and forth" since October 2024. -There were two units not working at the facility. Observation of the thermostats located in the hallway of the main office on 03/27/25 at 3:30pm revealed: -There were 10 thermostats attached to the wall. -There was a sign posted above the thermostats that read "DO NOT ADJUST THERMOSTATS". -Unit 6 was set for 73 degrees and registered at 68 degrees. -Unit 8 was set for 73 degrees and registered at 70 degrees. Review of facility Order Confirmation documents from a supply company that were presented by the Administrator on 03/27/25 revealed: -There was a purchase order # of ORD-3/20/25 for a motor; fan. -There was a purchase order # for "FOUR OAKS" with a ship date for 3/25/25 for a heat pump. -There was a order confirmation delivery ticket for a heat pump dated 03/26/25.	D 105		
D 108	10A NCAC 13F .0311(b)(2) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to	D 108		

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D 108	Continued From page 8 maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. This rule apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure portable electric heaters were not used in residents' rooms on the 400 hall of the facility. The findings are: Observation of room 415 on 03/26/25 at 8:38am during the initial facility tour revealed: -There were no thermostat or temperature measuring devices in the room. -There was a black radiator style portable heater with a black cord extended from the heater to a wall outlet plug positioned in the center of the floor. -There was a glowing red light visible on the top front panel of the heater. -There was warm air coming from the heater. -There were two residents in the room. Interview with a resident in room 415 on 03/26/25 at 8:38am revealed: -She recently moved into the room. -The portable electric heater belonged to the roommate. -Her roommate used the heater. Observation of room 413 on 03/26/25 at 8:42am during the initial facility tour revealed:	D 108	All HVAC units were installed and repaired throughout the facility. All rooms were checked and all space heaters were removed from the residents room.	3/28/25

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D 108	Continued From page 9 -There were no thermostat or temperature measuring devices in the room. -There was a black radiator style portable heater with a black cord extended from the heater to a wall outlet plug positioned by a chair that was positioned by a bed. -There was a glowing red light visible on the top front panel of the heater. -There was warm air coming from the heater. -There were two residents in the room. Interview with a resident in room 413 on 03/26/25 at 8:42am revealed: -The portable electric heater was placed in the room when the weather was cold. -The previous Administrator had given her the portable electric heater. -She used the heater to stay warm. -Sometimes she could feel air blowing in the room from the window. Observation of room 412 on 03/26/25 at 8:51am revealed: -There were no thermostat or temperature measuring devices in the room. -There was a portable heater positioned close to the dresser in the room. -The heater was in the off position. Interview with a resident in the room on 03/26/25 at 8:51am revealed: -He used the portable electric heater to heat the room. -He got cold at night. -He could not remember how long the portable electric heater had been in the room. -The heat was not working in some of the rooms, including the room he was in. Interview with the Administrator on 03/26/25 at	D 108		

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D 108	Continued From page 10 9:24am revealed: -The portable electric heaters were in the facility because of inconsistent room temperatures. -The facility heating and air conditioning unit was delivered to the facility earlier today (03/26/25) to be installed. -She was not sure when the installation would occur. Interview with the Regional Vice President of Operations (RVPO) on 03/26/25 at 4:00pm revealed: -He did not know when the HVAC unit had been ordered but installment would be completed on 03/26/25. -He thought the HVAC unit had not been working for "not quite two months". -He knew there were not supposed to be portable electric heaters used in the facility. Observations of rooms on the 400 hall on 03/27/25 from 9:32am to 9:47am revealed there were portable electric heaters unplugged in rooms 415 and 418. Interview with the Regional Maintenance Director (RMD) on 03/27/25 at 3:28pm revealed: -He had been working on the heating unit at the facility "back and forth" since October 2024. -There were two units not working at the facility. -He was not able to tell which units serviced which resident rooms. -Portable heaters were placed in resident rooms during the last snowstorm. -The maintenance staff was responsible for removing the portable electric heaters from the resident rooms. -The facility did not currently have a maintenance staff person.	D 108		

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D 108	Continued From page 11 Observation of the thermostats located in the hallway of the main office on 03/27/25 at 3:30pm revealed: -There were 10 thermostats attached to the wall. -There was a sign posted above the thermostats that read "DO NOT ADJUST THERMOSTATS". -Unit 6 was set for 73 degrees and registered at 68 degrees. -Unit 8 was set for 73 degrees and registered at 70 degrees. Interview with the RMD on 03/27/26 at 3:30pm revealed he thought unit 6 might be one of the units that was not working properly. Interview with the Administrator on 03/27/25 at 3:35pm revealed: -The portable electric heaters were removed from rooms on the 400 hall on 03/26/25 and 03/27/25. -It was "an oversight" that the portable electric heaters were in use. -She was aware of the rule regarding the use of portable heater use prohibited.	D 108		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.	D 113	Maintenance Tech, ED, or designee will check water temps in 10 rooms plus common areas weekly and adjust hot water system as needed.	4/7/25 and ongoing.

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D 113	Continued From page 12 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 4 of 5 fixtures with water temperatures ranging from 117.8 to 121.6 degrees F. The findings are: Review of the facility's census on 03/18/25 revealed there were 32 residents on the Special Care Unit (SCU). Observation of the water temperatures on the SCU on 03/26/25 from 8:20am to 9:05am revealed: -The hot water temperature in the bathroom sink in room 501 was 121.3 degrees Fahrenheit (F). -The hot water temperature in the bathroom sink in room 508 was 121.6 degrees F. -The hot water temperature in the sink in the 500 hall shower room was 120.6 degrees F. -The hot water temperature in the bathtub/shower combination in the 500 hall shower room was 117.8 degrees F. Second observation of the water temperatures on the SCU on 03/27/25 from 6:51am to 7:08am revealed: -The hot water temperature in the bathroom sink in room 501 was 118.0 degrees F. -The hot water temperature in the bathroom sink in room 508 was 118.0 degrees F. -The hot water temperature in the sink in the 500 hall shower room was 118.6 degrees F. -The hot water temperature in the bathtub/shower combination in the 500 hall shower room was 117.7 degrees F.	D 113		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 113	Continued From page 13 Interview with a personal care aide (PCA) on 03/26/25 at 8:34am revealed: -Most of the residents on the SCU needed some type of assistance with bathing. -The water in the facility was either too cold or too hot. -The water temperature in the facility seemed to vary from day to day. -She adjusted the water temperature before she assisted residents into the shower. -She would notify the maintenance staff if she noticed the water seemed too hot or cold. Interview with the Special Care Coordinator (SCC) on 03/26/25 at 9:15am revealed: -She started working at the facility approximately 1 month ago. -The water temperatures in the facility seemed to be either too hot or too cold. -The facility did not currently have a Maintenance Director. -She was unsure who was responsible for checking the water temperatures in the facility. -She was concerned about the water temperature being too hot because residents could be burned by hot water. Review of the facility's January 2025 water temperature logs revealed: -On 01/03/25, there were 2 fixtures checked on the SCU and the hot water temperatures ranged from 100.4 degrees F to 102 degrees F. -On 01/14/25, there were 6 fixtures checked on the SCU and the hot water temperatures ranged from 91.5 degrees F to 98.7 degrees F. -There was documentation on 01/14/25 indicating a part was needed for the water heater and the part was ordered. -On 01/20/25, there was no documentation of any	D 113		

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D 113	Continued From page 14 fixtures being checked on the SCU. -On 01/24/25, there was 1 fixture checked on the SCU and the hot water temperature was 105.6 degrees F. Review of the facility's February 2025 water temperature logs revealed: -On 02/03/25, there were 27 fixtures checked on the SCU and the hot water temperatures ranged from 73.4 degrees F to 101.7 degrees F. -On 02/11/25, there was no documentation of any fixtures being checked on the SCU. -On 02/21/25, there were 8 fixtures checked on the SCU and the hot water temperatures ranged from 101.4 degrees F to 109.3 degrees F. -On 02/24/25, there were 22 fixtures checked on the SCU and the hot water temperatures ranged from 57.2 degrees F to 107 degrees F. Review of the facility's March 2025 water temperature logs revealed: -On 03/04/25, there were 3 fixtures checked on the SCU and the hot water temperatures ranged from 104 degrees F to 112 degrees F. -On 03/12/25, there were 4 fixtures checked on the SCU and the hot water temperatures ranged from 107.7 degrees F to 110.3 degrees F Interview with the Administrator on 03/26/25 at 10:40am revealed: -The maintenance staff was responsible for checking the water temperatures. -The facility did not currently have any maintenance staff. -The last Maintenance Director stopped working at the facility a couple of weeks ago. -The Regional Maintenance Manager (RMM) assisted the facility with any maintenance issues. -The RMM was currently responsible for checking the water temperatures in the facility.	D 113		

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D 113	Continued From page 15 Second interview with the Administrator on 03/27/25 at 8:58am: -She hired a new Maintenance Director on 03/25/25. -The RMM was assisting the facility with maintenance issues or concerns until the new Maintenance Director started. -The RMM came to the facility on a weekly basis or if contacted by phone. -She was aware that there were some issues with the water temperatures in the facility, but she was unsure if the water temperatures were too hot or too cold. -She was unsure if the previous Maintenance Director had contacted a plumber for the water heater. -She was unsure what the range should be for hot water temperatures. -She was concerned if the water was too hot, residents could be burned by the hot water. Telephone interview with the RMM on 03/27/25 at 11:26am revealed: -The last time he was at the facility was on 03/25/25 to repair a door. -He was not informed of any water temperature issues on 03/25/25. -He was not informed of the facility having any issues with water temperatures in recent months. -He was usually contacted if there were maintenance emergencies in a facility. -He provided emergency assistance to 30 facilities, so he did not have a schedule to visit the facility. -Most water heater issues in the facilities were handled by the Maintenance Director and Administrator in the facility. -He was not aware the facility's previous Maintenance Director was no longer working at	D 113		

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D 113	Continued From page 16 the facility until a few days after he left his position. -The hot water temperatures should be between 100 degrees F and 116 degrees F. -He did not usually check water temperatures when he visited facilities. -The facility should be checking water temperatures on each hall or unit weekly and checking different rooms each week. -He was unsure if the previous Maintenance Director was checking and recording water temperatures. -The facility's SCU had a water heater to heat the water for rooms on that unit. -He would come to the facility today, 03/27/25, to adjust the water heater. Interview with the RMM on 03/27/25 at 5:10pm revealed: -He adjusted the temperature on the SCU water heater. -The water temperatures were coming down, but some were still hotter than 116 degrees F. -He was going to adjust the water heater again and keep rechecking the temperatures until the water temperatures were in the 100-116 degrees F range.	D 113		
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:	D 310	Four Oaks shall assure that all residents shall be served therapeutic diets as ordered by the Primary Care Physician (PCP).	

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D 310	Continued From page 17 Based on observations, interviews, and record reviews the facility failed to ensure a therapeutic diet was served as ordered for 1 of 5 sampled residents (#4) with a mechanical soft with chopped meat diet order. The findings are: Review of Resident #4's current FL-2 dated 01/17/25 revealed diagnoses included several early onset Alzheimer's dementia with agitation and failure to thrive in adult. Review of Resident #4's record revealed there was a diet order dated 03/10/25 for a mechanical soft with chopped meats diet. Review of the undated diet chart kept on the counter in the kitchen revealed Resident #4 was not listed. Review of Resident #4's diet order that was kept on a shelf in the kitchen dated 02/04/25 revealed there was a diet order for a puree diet. Review of the facility's breakfast menu for Thursday, 03/27/25, revealed cold cereal, grits, eggs of choice, bacon, fresh fruit, whole grain toast 100 juice and milk were to be served. Review of the breakfast Therapeutic spreadsheet diet extension for Thursday, 03/27/25 revealed the mechanical soft chopped diet should have been served as moistened cereal, grits with excess liquid drained, soft and bite-sized/scrambled eggs, diced sausage/gravy, chopped soft fruit, soft and bite-sized/moistened whole grain bread/no toasting and juice and milk at ordered thickness.	D 310	The Executive Director in-serviced the Dietary manager and all staff on therapeutic diets and the importance of documentation and reporting any issues regarding food and nutrition. Facility managers will ensure that all therapeutic diets are served as ordered by PCP during weekly audits and walk through during meal times. Any concerns identified will be addressed immediately. Facility managers will discuss any new residents diet orders to include therapeutic diets and any current residents diet changes made by a PCP during daily stand up and ensure dietary staff and care staff are aware of any changes.	4/10/25 4/10/25 4/10/25

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D 310	Continued From page 18 Observation of the Special Care Unit (SCU) breakfast meal service on 03/27/25 from 7:08am to 7:50am revealed: -At 7:11am, Resident #4 was served milk and cranberry juice. -At 7:19am, Resident #4 was served his breakfast plate. -Resident #4's breakfast plate was a 3-compartment divided plate with pureed eggs in both smaller compartments, and pureed grits in the larger compartment. -At 7:30am, Resident #4 was served a dish of vanilla pudding. -Resident #4 finished eating his meal at 7:50am and consumed approximately 75% of his meal. Review of the facility's lunch menu for Thursday 03/27/25 revealed crispy fried chicken, macaroni and cheese, stir fried broccoli, green salad, dinner roll, apple slices and beverage of choice was to be served. Review of the lunch Therapeutic spreadsheet diet extension for Thursday 03/27/25 revealed the mechanical soft chopped diet should have been served as soft and bite sized chicken, moistened bite-sized macaroni and cheese, soft and bite-sized stir-fried broccoli, chopped cooked vegetables, bite-sized moistened dinner roll, applesauce and beverage of choice at ordered thickness. Observation of the SCU lunch meal service on 03/27/25 from 12:10pm to 12:55pm revealed: -At 12:40pm, Resident #4 was served water, iced tea, and milk. -At 12:45pm, Resident #4 was served his lunch plate. -Resident #4's lunch plate was a 3-compartment divided plate with pureed broccoli and pureed	D 310		

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D 310	Continued From page 19 macaroni and cheese in the smaller compartments, and pureed stewed chicken in the larger compartment. Observations of the kitchen on 03/27/25 at 12:12pm revealed: -Resident plate covers were labeled with the resident's name and diet order. -There was no plate cover with Resident #4's name or diet order. Interview with the Cook on 03/27/25 at 12:12pm revealed: -The Dietary Manager (DM) was out. -He had been a Cook at the facility for 7 months. -He had been working at the facility for long enough to remember the residents' diets. -He also used the labeled plate covers to determine what diet each resident was served. -The DM labeled the plate covers with each resident's name and diet order. -If there were diet changes, the new diet order would be given to the DM and she would inform him. -If there were diet changes while the DM was out of the building, a personal care aide (PCA) would provide him with the new diet order. -He was unsure what Resident #4's diet order was without the plate cover that would have had his name and diet order on it. -Resident #4's diet order dated 02/04/25 showed he was to be served a puree diet. -He was not aware of any diet order for Resident #4 other than the order located in the kitchen dated 02/05/25. Interview with a medication aide (MA) on 03/27/25 at 11:10am and 1:11pm revealed: -Resident #4 was on a puree diet. -She knew resident's diets because dietary staff	D 310		

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D 310	Continued From page 20 usually told staff what the diets were. -The Special Care Coordinator (SCC) informed staff when diet orders changed. -She was not aware of the diet order dated 03/10/25 for a mechanical soft with chopped meats diet. Interview with a MA, who also works as a PCA, on 03/27/25 at 1:16pm revealed: -PCAs and MAs would not know a resident's diet unless someone from the dietary staff or administration told them. -PCAs and MAs did not review diet orders in the computer system. -The 03/10/25 diet order for mechanical soft with chopped meats for Resident #4 was in the computer system under dietary. -She was not aware of the 03/10/25 diet order prior to today (03/27/25). Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 1:20pm revealed: -Resident #4 had a diet order in the computer system dated 03/10/25 for a mechanical soft with chopped meat diet. -She was not aware Resident #4 was being served a puree diet. -The facility received notification of diet changes from hospital discharge paperwork or the primary care provider (PCP). -The PCP had a meeting with the RCC and Special Care Coordinator (SCC) after each visit and informed them of order changes. -She made sure the dietary staff received a copy of the signed diet orders. -Orders were uploaded into the computer system but she was unsure if dietary staff used the computer system. -She had no concern about the texture of Resident #4's diet.	D 310		

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D 310	Continued From page 21 -She was concerned about the process of the order not being updated. Interview with the SCC on 03/27/25 at 1:47pm and 4:30pm revealed: -She had been the SCC for 1 month. -She was not aware of the 03/10/25 diet order for Resident #4 for a mechanical soft diet with chopped meats. -Diet order changes came from the PCP to the SCC and RCC email or from hospital discharge paperwork. -The RCC and SCC went through orders and scanned the orders into their computer system. -The RCC and SCC made sure the orders were signed and gave them to the DM. -Before she became the SCC, staff from sister facilities were handling the diet orders and Resident #4's order got lost during that time. -She was concerned with the orders not getting to where they needed to go. -She did not know why the order did not get to the dietary staff. -The dietary staff prepared Resident #4's food based on the order they had in the kitchen. -The diet order in the computer system would have had to be printed for dietary staff. Interview with the Administrator on 03/27/25 at 4:19pm revealed: -Order changes came from the PCP through email to the facility. -Diet orders were placed in the residents' charts by the RCC or SCC. -The RCC and SCC communicated diet order changes to DM. -The DM communicated the diet orders to the cook and the dietary aide (DA). -The DM was responsible for ensuring dietary staff had the correct orders.	D 310		

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D 310	Continued From page 22 -She was not aware of the specific diet order for Resident #4. -She just became the Administrator last month (February) and was still learning the residents. -She was not aware Resident #4 was being served a pureed diet. -Either there was a gap in communication between the RCC, SCC and dietary staff or there was communication that was not followed through on. -She expected the diet orders to be clearly communicated to the RCC and SCC. -When diet order changes came from the PCP, they understood this to mean that the old diet order was discontinued. -The dietary staff should have updated diet orders and should prepare the appropriate meal for each resident based on the diet order. -Residents have rights and the facility wanted to ensure the rights were being upheld. -Resident #4 not receiving the diet that was ordered posed a resident's rights issue. -She did not know where the miscommunication occurred regarding Resident #4's diet order. Interview with the PCP on 03/27/25 at 1:30pm revealed: -She signed the diet order dated 03/10/25 for mechanical soft with chopped meats for Resident #4. -Resident #4 had issues with swallowing in the past. -Speech therapy evaluated Resident #4 and determined that he needed to be on a puree diet because his cognitive impairment prevented him from completing the evaluation. -In her progress note dated 03/03/25, she documented the need for a puree diet for Resident #4. -She did not know why she signed the diet order	D 310		

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D 310	Continued From page 23 dated 3/10/25 for mechanical soft with chopped meats. -Sometimes there was a layover between her signing orders and that could explain why the 03/10/25 diet order was done. -Resident #4 should have been on a puree diet because there was no completed speech evaluation to say that he could tolerate any other 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 6 residents (#6) observed during a medication pass and sampled for record review, including an error with a medication used for seizures. The findings are: Review of Resident #6's current FL-2 dated 08/28/24 revealed: -Diagnoses included osteoarthritis, esophageal	D 358	An immediate cart audit was completed for the resident in question to ensure all other medications were in the community. Residents family and the residents PCP were notified. Care managers completed an audit on all the residents medication. Each residents MAR was printed and reconciled against all medications on the cart. The pharmacy were notified if any medications were missing to ensure all medications were in the care. CNC conducted an in-service on the medications administration, six rights of medication, reviewing orders, and ordering of medication.	3/28/25 3/28/25 3/28/25 3/28/25

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D 358	Continued From page 24 reflux, anxiety, and epilepsy. -There was an order for phenytoin sodium extended capsule (generic for Dilantin which is used to treat seizures) 100mg take two capsules twice daily. Observation of the 8:00am medication pass on 03/26/25 revealed: -The medication aide (MA) was not observed to scan the first pharmacy labeled medication multi-dose package (MDP) which contained five tablets. -The MA scanned the second pharmacy labeled medication MDP which contained one tablet. -The MA prepared a seventh pill (Ativan used to treat anxiety) from a pharmacy labeled blister pack container. -The MA prepared and administered 7 medications to Resident #6 from two pharmacy labeled multi-dose medication packages. -There were no phenytoin sodium capsules prepared or administered to Resident #6. Review of Resident #6's March 2025 electronic medication administration records (eMAR) revealed: -There was a printed entry for phenytoin sodium extended capsule 100mg take two capsules (200mg) by mouth twice daily scheduled for 8:00am and 8:00pm. -There was documentation for administration of the Phenytoin Sodium extended capsule 100 mg two capsules twice daily at 8:00am and 8:00pm for the entire month of March 2025, including the 8:00am scheduled dose for 03/26/2025. Interview with the MA on 03/26/25 at 11:29am revealed: -She did not see phenytoin sodium in the pharmacy packaged medications for Resident #6.	D 358	Resident Care Coordinator (RCC) /Special Care Coordinator (SCC) will conduct weekly cart audits. Each care will be audited and checked twice a month. Med-Techs will conduct medication audits of random residents each shift to ensure each residents medications are check monthly. RCC/SCC will conduct weekly med-pass observations to ensure medications are being ordered and passed properly. CNC will conduct random med-pass observation during site visits. Executive Director or designee will perform random audits on the med-tech audits twice a month.	5/11/25 5/11/25 5/11/25 5/11/25 5/11/25

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D 358	Continued From page 25 -She did not know why she documented administering the phenytoin sodium when it was not administered. -When a pharmacy labeled MDP of medications was scanned, there would be a message that populated on the eMAR if a medication was missing from the MDP of medications. -The MA was responsible for checking the medications to make sure all medications that were supposed to be administered were available. Second interview with the MA on 03/26/25 at 1:45pm revealed: -She contacted the contracted pharmacy provider. -A 13-day supply of Resident #6's phenytoin sodium was sent to the facility on 03/13/25. -The pharmacy needed a new prescription for the phenytoin sodium. -The contracted pharmacy provider would have notified the Primary Care Provider (PCP) or the resident care coordinator (RCC) of the need for a new prescription to refill the phenytoin sodium. -She was not sure of the last time Resident #6 had been administered the phenytoin sodium. Telephone interview with a pharmacist for the contracted provider pharmacy on 03/26/25 at 4:16pm revealed: -Phenytoin sodium 100mg two capsules twice daily was a current order for Resident #6. -On 03/03/25, phenytoin sodium 100mg capsules, quantity of 12 capsules for a three-day supply, was dispensed to the facility. -On 03/06/25, phenytoin sodium 100mg capsules, quantity of 28 capsules for a seven-day supply, was dispensed to the facility. -On 03/13/25, phenytoin sodium 100mg capsules, quantity of 28 capsules for a seven-day supply,	D 358		

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D 358	Continued From page 26 lasting until the end of 03/20/25, was dispensed to the facility. -It appeared Resident #6 had been without the phenytoin sodium for six days. -There were no refills remaining on the prescription for Resident #6's phenytoin sodium. -The facility was responsible for obtaining the refill prescription from the PCP and faxing the prescription to the pharmacy. -The pharmacy technician may have faxed the PCP to request a refill prescription, but he could not tell. -A refill prescription for the phenytoin sodium was received today (03/26/25) from the PCP. -The facility was supposed to send a signed physician order sheet quarterly to prevent the residents from running out of medications. -Phenytoin sodium was typically used to control seizures and whatever the underlying treatment use would be exacerbated if not administered. Interview with a second MA on 03/26/25 at 4:39pm revealed: -The phenytoin sodium was usually packaged in a bubble pack. -She "usually" scanned the MDP of medications and sometimes she did not use the medication packaging scanner. -She did not recall if she scanned Resident #6's MDP of medications on 03/20/25, 03/21/25, or 03/24/25 when she documented administration for the 8:00pm dosage of phenytoin sodium. -She did not know how she documented administration for the phenytoin when the medication was not available for administration. -She was not aware of Resident #6 having any seizure activity. Interview with Resident #6 on 03/26/25 at 4:45pm revealed:	D 358		

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D 358	Continued From page 27 -She was prescribed Dilantin (phenytoin sodium) for epilepsy. -She had a seizure about three weeks ago. -She was lying in bed and "went to shaking". -The paramedics came. -She did not know the names of other medications she was prescribed. -She would not know whether she had been administered the phenytoin sodium until she had a seizure. Interview with Resident #6's PCP on 03/27/25 at 8:51am revealed: -She was contacted on 03/26/25 by the facility regarding the need for a refill prescription for Resident #6's phenytoin sodium. -She sent the refill script to the pharmacy on 03/26/25 and requested the script to be sent to the backup pharmacy for delivery. -She had not received any communication regarding the phenytoin sodium prescription need, prior to 03/26/25 at noon. -She was not informed of any missed doses of phenytoin sodium for Resident #6 until 03/26/25. -She tried to make sure Dilantin, or any seizure medication was automatically refilled because the resident did not need to miss the medication. -If Dilantin was missed, the risk of having seizures would be increased which would increase the risk for falls and even death. Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 9:57am revealed: -MAs were supposed to check medications three times, including against the eMAR and prior to dispensing from medication package, prior to administration. -If a medication was not in the MDP of medications, the MA was supposed to call the pharmacy to inquire about the medication.	D 358		

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D 358	Continued From page 28 -The MAs were responsible for reordering medications, either through the eMAR system or calling the medication reorder to the pharmacy. -The PCP was notified by the facility or pharmacy when a refill prescription was needed. -If the facility received the refill prescription, the MA or RCC sent the prescription to the pharmacy. -When the pharmacy notified the facility that a refill prescription was needed, the request was forwarded to the PCP, and the PCP would send an electronic prescription to the pharmacy. -She thought the medication scanners were not working, and if the scanners were working, it would not scan a medication that was not in the medication MDP. Interview with the Administrator on 03/27/25 at 3:45pm revealed: -MAs were supposed to reconcile resident medications delivered to the facility. -She expected the MAs to perform medication cart audits every shift to ensure medications were available for administration. -She expected medications to be administered as ordered. Second telephone interview with the PCP on 03/27/25 at 5:20pm revealed: -She saw Resident #6 on 03/27/25. -She planned lab work to be drawn on 03/28/25 to check the Dilantin level. -It was important for the residents' Dilantin level to stay in a therapeutic range that was safe and would prevent seizure activity. -She was not aware of Resident #6 having any seizure activity. -Resident #6 was prescribed Phenobarbital and Ativan, which were used for seizures, which probably helped support the resident's stability.	D 358		

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D 358	Continued From page 29 The facility failed to administer a medication used to control seizure activity to Resident #6 as ordered for six days. The facility's failure placed the resident at risk for increased seizure activity which also placed the resident at increased risk for falls and death. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/27/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 11, 2025.	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	D 367	CNC conducted an in-service on medication administration, six rights of medication, reviewing orders and ordering of medication. RCC/SCC will print E-mar compliance report daily to review for accurate and compliant medication administration. Report will be reviewed in daily meeting with ED and noted concerns will have immediate follow- up. Reports that have needed follow-up will be signed off by both ED and Care managers.	3/28/25 3/28/25

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D 367	Continued From page 30 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 6 sampled residents (#5, #6) related to the documentation of fingerstick blood sugar (FSBS) levels (#5), and accurate documentation for administration of a seizure medication (#6). The findings are: 1. Review of Resident #5's current FL2 dated 03/06/25 revealed diagnoses included unspecified dementia without behavioral disturbance, hypertension, type 2 diabetes mellitus, renal failure, and schizoaffective disorder Review of Resident #5's primary care provider's (PCP) order dated 12/16/24 revealed: -There was an order to check fingerstick blood sugar (FSBS) twice daily. -There was an order for Lantus insulin pen inject 18 units subcutaneously twice daily, hold for FSBS 120 and below (Lantus insulin pen is an injectable medication used to control blood sugar levels). Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus insulin pen inject 18 units subcutaneously twice daily scheduled for	D 367	CNC will conduct random med-pass observation during site visits. This will check compliance with giving medication, parameters, and MAR accuracy. Med-techs will conduct medication audits of random residents each shift to ensure each residents medication are check monthly. RCC/SCC will conduct weekly med-pass observation and cart audits to ensure medications are being ordered and pass properly. ED/or designee will perform random audits on the med-tech audit twice a a month.	5/11/25 5/11/25 5/11/25 5/11/25

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D 367	Continued From page 31 7:30am and 5:30pm. -There was an entry for FSBS twice daily scheduled for 7:30am and 5:30pm. -There was an additional entry for FSBS twice daily scheduled for 8:00am and 8:00pm starting 02/12/25. -From 02/13/25 to 02/28/25, the FSBS readings for 7:30am and 8:00am were documented as the same reading for 14 of 16 days. -On 02/18/25 and 02/20/25, the FSBS for 8:00am was documented as "duplicate order". -From 02/13/25 to 02/28/25, the FSBS for 5:30pm and 8:00pm was documented as the same reading for 10 of 16 days. -On 02/20/25 at 8:00pm, the FSBS for 8:00pm was documented as "duplicate order". Review of Resident #5's March 2025 eMAR revealed: There was an entry for Lantus insulin pen inject 18 units subcutaneously twice daily scheduled for 7:30am and 5:30pm. -There was an entry for FSBS twice daily scheduled for 7:30am and 5:30pm. -There was an additional entry for FSBS twice daily scheduled for 8:00am and 8:00pm. -From 03/01/25 to 03/26/25, the FSBS readings for 7:30am and 8:00am were documented daily as the same reading. -From 03/01/25 to 03/26/25, the FSBS readings for 5:30pm and 8:00pm were documented as the same reading for 21 of 25 days. Interview with Resident #5 on 03/26/25 at 4:15pm revealed: -The facility staff checked her blood sugar a couple of times each day. -She received an insulin injection twice a day with her meals. -She was unsure if anyone checked her FSBS at	D 367		

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D 367	Continued From page 32 8:00pm. -She was unsure how often her FSBS should be checked. Interview with a medication aide (MA) on 03/26/25 at 4:05pm revealed: -She worked on all shifts at the facility. -When a resident had orders for FSBS, the eMAR prompted the MA to check the resident's FSBS. -Resident #5 had orders to check her FSBS twice a day when she received her Lantus injections. -She always checked Resident #5's FSBS at 7:30am and 5:30pm, right before she gave Resident #5's Lantus because there were orders to hold the medication if her FSBS was 120 or less. -She noticed Resident #5's eMAR gave a prompt to check her FSBS again after her FSBS was checked at 7:30am and 5:30pm. -She did not recheck Resident #5's FSBS again, she documented the same reading when the eMAR showed another prompt. -If she worked second shift (3:00pm-11:00pm), she checked Resident #5's FSBS at 5:30pm, but did not check the FSBS again when it showed on the eMAR at 8:00pm. -She documented Resident #5's 5:30pm FSBS result when the FSBS showed on the eMAR at 8:00pm. -She was unsure why the order to check Resident #5's FSBS was on the eMAR twice. -If MAs had any questions about the eMAR or medication orders, they were supposed to report the concerns to the Special Care Coordinator (SCC). -She did not notify the SCC when she saw the order to check Resident #5's FSBS was on the eMAR twice because the SCC had not been working at the facility long.	D 367		

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D 367	Continued From page 33 Interview with the SCC on 03/27/25 at 12:25pm revealed: -She started working at the facility as the SCC approximately 1 month ago. - When residents had orders for FSBS, the eMAR prompted the MA to check the residents' FSBS. -The MAs should check Resident #5's FSBS before her insulin was administered. -She was not aware there were 2 different entries on the eMAR to check Resident #5's FSBS. -The MA should not document the same reading twice at different times on the eMAR. -MAs should report any concerns or issues with the eMAR to her. -The facility did not currently have a system in place to check the eMARs for accuracy. Interview with the Administrator on 03/27/25 at 4:55pm revealed: -When residents had orders for FSBS, the eMAR prompted the MA to check the residents' FSBS. -If there were duplicate orders on the eMAR, the MAs should report the duplicate order to the SCC. -If there were any concerns or questions about medication orders, the MA should discuss the concern with the SCC. -The MAs should have reported Resident #5's FSBS duplicate order to the SCC and not documented the same FSBS reading at two different times on the eMAR. Interview with Resident #5's PCP on 03/27/25 at 8:30am revealed: -Resident #5 was on Lantus insulin and FSBS checks due to her diagnosis of diabetes. -The facility staff should be checking Resident #5's FSBS twice daily at 7:30am and 5:30pm before her Lantus was administered. -If the facility staff saw duplicate orders on the	D 367		

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D 367	Continued From page 34 eMAR or had questions about medications orders, the staff should contact her for questions or concerns. 2. Review of Resident #6's current FL-2 dated 08/28/24 revealed: -Diagnoses included osteoarthritis, esophageal reflux, anxiety, and epilepsy. -There was an order for phenytoin sodium extended capsule (generic for Dilantin which is used to treat seizures) 100mg take two capsules twice daily. Review of Resident #6's March 2025 electronic medication administration records (eMAR) revealed: -There was a printed entry for phenytoin sodium extended capsule 100mg take two capsules (200mg) by mouth twice daily scheduled for 8:00am and 8:00pm. -Phenytoin Sodium extended capsule 100 mg two capsules twice daily at 8:00am and 8:00pm was documented as administered on 03/01/25 through 03/26/25 at 8:00am. Interview with the medication aide (MA) on 03/26/25 at 11:29am revealed: -She did not know why she documented administering the phenytoin sodium when it was not administered. -When a pharmacy labeled multi-dose package (MDP) of medications was scanned, there would be a message that populated on the eMAR if a medication was missing from the MDP of medications. -The MA was responsible for checking the medications to make sure all medications that were supposed to be administered were available.	D 367		

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D 367	Continued From page 35 Second interview with the MA on 03/26/25 at 1:45pm revealed she was not sure of the last time Resident #6 had been administered the phenytoin sodium. Telephone interview with a pharmacist for the contracted provider pharmacy on 03/26/25 at 4:16pm revealed: -Phenytoin sodium 100mg two capsules twice daily was a current order for Resident #6. -On 03/03/25, phenytoin sodium 100mg capsules, quantity of 12 capsules for a three-day supply, was dispensed to the facility. -On 03/06/25, phenytoin sodium 100mg capsules, quantity of 28 capsules for a seven-day supply, was dispensed to the facility. -On 03/13/25, phenytoin sodium 100mg capsules, quantity of 28 capsules for a seven-day supply, lasting until the end of 03/20/25, was dispensed to the facility. -It appeared Resident #6 had been without the phenytoin sodium for six days. Interview with a second MA on 03/26/25 at 4:39pm revealed she did not know how she documented administration for the phenytoin when the medication was not available for administration. Interview with the memory care coordinator (MCC) on 03/27/25 at 12:25pm revealed: -She started working at the facility as the MCC approximately 1 month ago. -The facility did not currently have a system in place to check the eMARs for accuracy. Interview with the Administrator on 03/27/25 at 4:00pm revealed she expected the MAs to document accurately.	D 367		

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D 367	Continued From page 36 Refer to tag 358 10A NCAC 13F .1004(a) Medication Administration.	D 367		