

Division of Health Service Regulation

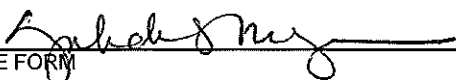
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL039018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TRE' MORE MANOR ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 6016 PINE TOWN ROAD OXFORD, NC 27565			
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/18/25 and 03/19/25.	D 000			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) for a medication used to improve appetite and mood. The findings are: Review of Resident #1's current FL-2 dated 01/30/25 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, insomnia, and congestive heart failure. -There was an order for Mirtazapine (used to improve appetite, insomnia, and mood) 15mg once daily at bedtime. Review of Resident #1's signed physician's orders dated 02/21/25 revealed an order for Mirtazapine 15mg once daily at bedtime.	D 358	D.358 The facility administrator conducted a cart audit on 3/20/25 to ensure all medications were available on the cart as ordered by the PCP. All meds not prescribed were removed. The Resident Care Coordinator will conduct a cart audit monthly to ensure all meds are available as prescribed. All findings will be corrected immediately. The QA team will discuss findings during the quarterly meetings. The QA team will consist of the administrator, Resident Care Coordinator, and shift med tech supervisors. Completed 3/20/25		

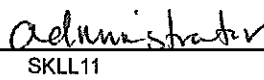
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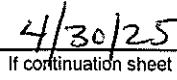
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE




Administrator


4/30/25

STATE FORM 6899 SKLL11 If continuation sheet 1 of 16

Reviewed and acknowledged 05/13/25


Janet Thornburg

Division of Health Service Regulation

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D 358	Continued From page 1 Review of Resident #1's Resident Register revealed an admission date of 02/04/25. Review of Resident #1's February 2025 electronic medication administration record (eMAR) from 02/05/25-02/28/25 revealed: -There was an entry for Mirtazapine 15mg once daily at bedtime with a scheduled administration time of 9:00pm. -There was documentation that Resident #1's Mirtazapine 15mg was administered at 9:00pm from 02/05/25-02/28/25. Review of Resident #1's March 2025 eMAR from 03/01/25-03/18/25 revealed: -There was an entry for Mirtazapine 15mg once daily at bedtime with a scheduled administration time of 9:00pm. -There was documentation that Resident #1's Mirtazapine 15mg was administered at 9:00pm from 03/01/25-03/18/25. Review of Resident #1's medications on hand on 03/18/25 at 10:04am revealed: -The bottle was labeled as Mirtazapine 30mg with the directions to take one tablet at bedtime. -The bottle was dispensed on 10/22/24 for 30 tablets. -There was one tablet remaining in the bottle. -There was a punch card of Mirtazapine 15mg dispensed on 02/11/25 with 30 of 30 tablets remaining on the card. Review of Resident #1's medications on hand on 03/19/25 at 7:59am revealed: -The bottle was labeled as Mirtazapine 30mg with the directions to take one tablet at bedtime. -The bottle was dispensed on 10/22/24 for 30 tablets. -There were no tablets remaining in the bottle.	D 358			

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D 358	Continued From page 2 Interview with Resident #1 on 03/19/25 at 10:22am revealed he had a poor memory and did not know what medications he took. Telephone interview with a representative from the facility's contracted pharmacy on 03/18/25 at 12:18pm revealed: -Thirty tablets of Mirtazapine 15mg were dispensed on 02/05/25 for Resident #2 and were delivered to the facility on 02/19/25 with the cycle-filled medications. -There was no other dispensing of Mirtazapine 15mg. Interview with a medication aide (MA) on 03/18/25 at 11:10am revealed: -She was trying to "use up" Resident #2's medication bottles he brought to the facility when he moved in. -She did not have to cut any pills in half for Resident #2. Interview with the same MA on 03/19/25 at 10:57am revealed her process to administer medication was to read the bottle/package, and make sure the information matched the eMAR before administering the medication. Telephone interview with a second MA on 03/19/25 at 8:03am revealed: -She referred to the eMAR to administer medications. -She did not recall having to cut any medications in half for Resident #2. -Most of the time medications came from the pharmacy pre-cut. -She did not cut any of Resident #2's medications last night, 03/18/25. -She recalled there was a bottle of medication	D 358			

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D 358	Continued From page 3 that had one tablet remaining in the bottle and she administered the last tablet. Telephone interview with Resident #2's primary care provider (PCP) on 03/19/25 at 12:29pm revealed: -Resident #2 Mirtazapine was ordered for his appetite because he was not eating very well. -She was going to evaluate and if he was stable, she planned to discontinue the medication. -Mirtazapine was also used to improve mood. -She expected the order to be carried out as written and if it did not match then it should have been clarified. Interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:27am revealed: -He checked medications in when the medications were delivered to the facility. -The MA should have compared Resident #2's Mirtazapine bottle to the eMAR and if it did not match, she should have talked to the Administrator. Interview with the Administrator on 03/19/25 at 8:08am revealed: -Most medications were delivered from the pharmacy pre-cut. -She had not cut any of Resident #2's medications. -She looked at Resident #2's Mirtazapine bottle to make sure it was the right medication and time but did not see the dosage was not the same as the eMAR. -She should have checked the dosage.	D 358			
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366			

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D 366 Continued From page 4 10A NCAC 13F .1004 Medication Administration (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 staff documented on the electronic medication administration record (eMAR) immediately following the administration of medications for 2 of 6 residents (#6 and #7) during the 8:00am/9:00am medication pass and for 1 of 3 sampled residents (#3). The findings are: Review of the facility's undated medication administration policy revealed the staff would provide documentation of the eMAR after observing the residents taking the medications and before administration of medications to another resident. 1. Review of Resident #3's current FL-2 dated 01/30/25 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance, visual hallucinations, and adjustment disorder with depressed mood. -There was an order for quetiapine 12.5mg (used to regulate mood, behaviors, and thoughts) twice daily as needed (PRN) for agitation.	D 366 <i>D.366</i> The facility administrator scheduled a med administration refresher immediately on 3/20/25 to ensure knowledge noted on appropriate documentation of meds were reviewed. All med techs were in-serviced and understood the importance of appropriate documentation. The administrator will ensure that upon need and dispensing, documentation is noted immediately. Review of appropriated reporting to oncoming shifts were reviewed. The admin will ensure documentation support med administration. Med administration and appropriate documentation will be reviewed during the quarterly QA meeting. The QA team will consist of the administrator, The RCC and supervising medication technicians. Completed 3/20/25	(X5) COMPLETE DATE	

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D 366	Continued From page 5 Review of Resident #3's February 2025 electronic eMAR from 02/26/25 to 02/28/25 revealed: -There was an entry for quetiapine 50mg, ¼ tablet (12.5mg) twice daily PRN for agitation. -There was no documentation quetiapine was administered from 02/26/25 to 02/28/25. Review of Resident #3's March 2025 eMAR from 03/01/25 to 03/17/25 revealed: -There was an entry for quetiapine 50mg, ¼ tablet (12.5mg) twice daily PRN for agitation. -There was documentation quetiapine was administered on 03/03/25 and 03/06/25; there was no other documentation of administration. Observation of Resident #3's medication on hand on 03/18/25 revealed: -There was a punch card with 30 of 30 ¼ tablets dispensed on 02/26/25 available for administration. -There was a second punch card with 9 of 30 ¼ tablets dispensed on 02/26/25 available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 03/18/25 at 11:55am revealed: -The pharmacy had an order for quetiapine 12.5mg twice daily PRN for agitation. -The pharmacy used quetiapine 50mg tablets and cut them in fourths. -The pharmacy dispensed 2 punch cards 02/26/25 each containing 30 ¼ tablets of quetiapine. Based on observation, interviews, and record reviews it was determined that 60 ¼ tablets were dispensed, with 2 ¼ tablets documented as administered and 39 ¼ tablets remaining, leaving 19 tablets unaccounted for.	D 366			

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D 366	Continued From page 6 Interview with the medication aide (MA) on 03/19/25 at 10:57am revealed: -She administered Resident #3 her PRN quetiapine when Resident #3 became agitated. -She had administered the PRN quetiapine this month (March 2025) once or twice. -She documented on the eMAR when she administered a PRN medication, and she would go back in about an hour to document if the medication was effective. -She did not realize she had not documented on the March 2025 eMAR when she administered Resident #3 quetiapine PRN. -She should have documented the PRN medication on Resident #3's eMAR. Interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:28am revealed: -All PRN medications should be documented on the eMAR. -The MA should return to the eMAR in an hour to document the effectiveness of the PRN medication. Interview with the Administrator on 03/19/25 at 11:50am revealed: -The documentation of a PRN medication should be documented on the eMAR, however, the staff would notify her each time Resident #3 became agitation and the PRN medication was administered. -She was aware each time a PRN quetiapine was administered to Resident #3 but she understood the importance of documenting the administration of and effectiveness of the medication. Refer to the interview with the RCC on 03/19/25 at 11:28am.	D 366		

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D 366	Continued From page 7 Refer to the interview with the Administrator on 03/19/25 at 11:50am. 2. Review of Resident #6's current FL-2 dated 10/29/24 revealed diagnoses included cerebral palsy, hyperlipidemia, and hypertension. Review of a signed physician's order dated 02/19/25 revealed: -Diagnoses of major depressive disorder and generalized anxiety disorder. -There was an order for Sertraline 150mg (used to treat depression) daily in the morning. Observation of the 8:00am/9:00am medication pass on 03/19/25 at 8:08am revealed: -The medication aide (MA) prepared 7 medications for administration. -One of the medications prepared for administration was Sertraline 100mg, 1.5 tablets (150mg). -The MA administered Resident #6 his medications including Sertraline 100mg, 1.5 tablets. -The MA returned to the medication cart and electronically signed the eMAR for the 8:00am medications. Review of Resident #6's March 2025 eMAR on 03/19/25 revealed: -There was an entry for Sertraline 100mg take 1.5 tablets daily in the morning with a scheduled administration time of 9:00am. -There was no documentation sertraline 150mg was administered on 03/19/25 at 9:00am. Interview with the MA on 03/19/25 at 10:57am revealed: -She administered Resident #6's 8:00am and 9:00am medications during the medication pass.	D 366			

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D 366	Continued From page 8 -The 8:00am medications and the 9:00am medications were on different computer screens. -She documented that she administered the 8:00am medications but forgot to go to the 9:00am computer screen to document the administration of the 9:00am medications. Refer to the interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:28am. Refer to the interview with the Administrator on 03/19/25 at 11:50am. 3. Review of Resident #7's current FL-2 dated 02/21/25 revealed: -Diagnoses included dementia, schizoaffective disorder bipolar type, anemia, and hypertension. -There was an order for aspirin 81mg (used as a blood thinner) daily. -There was an order for ferrous sulfate 325mg (used as a supplement) daily. -There was an order for risperidone 3mg (used to treat symptoms of schizophrenia such as unusual thinking, loss of interest in life inappropriate emotions) every morning and at bedtime. Observation of the 8:00am/9:00am medication pass on 03/19/25 at 8:22am revealed: -The medication aide (MA) prepared 4 medications for administration. -The MA prepared aspirin 81mg, ferrous sulfate 325mg, and risperidone 3mg for administration. -The MA administered four medications to Resident #7, including aspirin, ferrous sulfate and risperidone. -The MA returned to the medication cart and electronically signed the eMAR for the 8:00am medication. Interview with the MA on 03/19/25 at 10:57am	D 366		

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D 366	Continued From page 9 revealed: -She administered Resident #6's 8:00am and 9:00am medications during the medication pass. -The 8:00am medications and the 9:00am medications were on different computer screens. -She documented that she administered the 8:00am medications but forgot to go to the 9:00am computer screen to document the administration of the 9:00am medications. Refer to the interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:28am. Refer to the interview with the Administrator on 03/19/25 at 11:50am. <u>Interview with the RCC on 03/19/25 at 11:28am</u> revealed: -The MAs should document on the eMAR after the administration of each medication. -The documentation on the eMAR should occur immediately after the administration of the medication and before preparing medications to administer to another resident. <u>Interview with the Administrator on 03/19/25 at 11:50am</u> revealed: -The documentation of the administration of a medication should occur after the medication was administered. -The documentation ensured the medication was administered. -She expected the MAs to document all medications that were administered.	D 366			
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 371			

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D 371	Continued From page 10 (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who administered eye drops and sublingual drops and failed to sanitize her hands or change gloves between the administration of the medications. The findings are: Observation of the 9:00am medication pass on 03/19/25 at 10:13am revealed: -The MA gathered two eye drops and a sublingual drop from the medication cart. -The MA sanitized her hands and donned gloves, picked up the two boxes of eye drops and the box of sublingual drops and walked to Resident #7's room. -The MA administered an eye drop into each eye of Resident #7. -The MA administered a second eye drop into each eye of Resident #7. -The MA administered two drops of the sublingual medication to Resident #7. -The MA did not change gloves or wash/sanitize her hands between eye drops or before sublingual drops. Review of the MAs medication Administration Clinical Skills Checklist dated 01/15/07 revealed the MA was checked off for the satisfactory	D 371	D. 371 The facility administrator scheduled a medication technician refresher on 3/20/25 to ensure review of appropriate techniques when administering eye gts. All med techs were inserviced and understood all techniques for appropriate dispensing of meds and ensuring appropriate infection control techniques. The administrator followed med techs during eye gtt dispensing to ensure appropriate techniques were followed. The facility administrator will review understanding of techniques during the quarterly QA meeting. The QA team will consist of the administrator, RCC and lead med techs. Any issues with techniques will be corrected immediately and inservices scheduled as needed. completed 3/20/25	

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D 371	Continued From page 11 completion of the administration of eye drops using appropriate technique. Interview with MA on 03/19/25 at 10:57am revealed: -She washed her hands and put on gloves before she administered the eye drops and sublingual drops to Resident #7. -She did not wash her hands or change gloves between the two eye drops of before the sublingual drops. -She had never been told she needed to wash her hands and change gloves after a different eye drop and before sublingual drops. Interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:28am revealed: -The MA should wash/sanitize her hands and change gloves between the 1st and 2nd eye drops and before administering the sublingual drops. -He expected the MAs to wash/sanitize their hands and change gloves to decrease the chance of infection. Interview with the Administrator on 03/19/25 at 11:50am revealed: -She expected the MA to wash/sanitize her hands and change gloves after the eye drops and before the administration of the sublingual drops. -She did not realize the MA should wash/sanitize her hands between the two eye drops that were being administered.	D 371			
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	D 378			

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D 378	Continued From page 12 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 and interviews, the facility failed to ensure medications were stored securely as evidenced by a medication cart, a medication storage room, and an office with medications sitting on a table, which were left unlocked and unattended. The findings are: Review of the facility's undated policy on the storage of medications revealed all medications, prescription, and non-prescription, administered by facility staff including those requiring refrigeration, will be kept locked except for when staff responsible for medication administration were in close proximity and could see the medications. Observation of the facility on 03/18/25 and 03/19/25 at various times between 8:00am-4:00pm revealed residents were ambulating in the hallways by the medication room, medication cart, and offices when there was no staff in the immediate area. Review of residents records on 03/18/25 revealed residents who were identified as intermittently and/or constantly disoriented. 1. Observation of the medication cart on 03/18/25 at 8:10am revealed: -The medication cart was unlocked and	D 378	D. 378 All medications stored in any unlocked was addressed immediately. All medications stored inappropriately have been removed and placed in a secure safe area. Review with the medication aides of safety, medication storage, locking of carts and any areas that require supervision was conducted on 3/20/25. All staff was insured on Resident safety, appropriate storage and reporting any issues noticed immediately. Any and all areas of concern that require locking has been addressed with all staff. The QA team will discuss any issues of safety, storage and reporting during the quarterly QA team meeting. The QA team will consist of the administrator, RCC and lead supervising med techs. Completed 3/20/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL039018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TRE' MORE MANOR ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 6016 PINE TOWN ROAD OXFORD, NC 27565	
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D 378	Continued From page 13 unsupervised. -There was a souffle cup on top of the medication cart, it contained a white tablet. -The tablet was identified as Lorazepam 0,.5mg (used to treat anxiety). Observation of the medication cart on 03/18/25 at 9:17am revealed the medication cart was unlocked and unsupervised. Observation of the facility on 03/18/25 at 9:58am revealed: -The medication cart was unlocked and unsupervised. -There were 6 punch cards of medication lying on top of the medication cart. -There was a souffle cup with medication tablets in the cup. -The medication aide (MA) was in an office and was not in sight of the medication cart. -The MA returned to the medication cart and added additional tablets to the souffle cup from the punch cards before returning the cards to the drawer and locking the cart. Observation of the medication cart on 03/18/25 at 1:10am revealed the medication cart was unlocked and unsupervised. Observation of the medication cart on 03/19/25 at 8:49am revealed the medication cart was unlocked and unsupervised. Interview with the MA on 03/19/25 at 10:57am revealed: -Before she went to a resident's room to administer medication, she locked the medication cart. -She did not leave medications on top of the medication cart.	D 378	

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D 378	Continued From page 14 -If the medication cart was left unlocked, and the medications were on top of the cart, she probably just forgot. -She did not know there was a tablet in a souffle cup on top of the medication cart. Interview with the Resident Care Coordinator (RCC) on 03/19/25 at 11:27am revealed the MA should make sure all medications were "put away" and the medication cart locked before leaving the area. Interview with the Administrator on 03/19/25 at 11:48am revealed the medication cart should be locked and no medications on top when the MA is not within sight of the medication cart. 2. Observation of a room labeled as the medication room on 03/18/25 at 8:30am and 12:45pm revealed: -The medication room was unlocked; the door was opened with no direct supervision from staff. -There was a box of mucous relief tablets sitting on the shelf in the medication room. -There was a small bottle of a water infusion drop with vitamin C and electrolytes. Observation of the medication room on 03/19/25 at 8:49am revealed: -The medication room was unlocked; the door was opened with no direct supervision from staff. -There was a 16-ounce bottle of mineral oil lubricant laxative. -There was a small bottle of a water infusion drop with vitamin C and electrolytes. -There was a box of mucous relief tablets. Interview with the MA on 03/19/25 at 10:57am revealed: -Medications were not kept in "that" room.	D 378		

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D 378	Continued From page 15 -Medications were kept in the medication cart or a locked office. -She had not paid any attention to medication in the unlocked room. Interview with the RCC on 03/19/25 at 11:27am revealed: -The room was usually kept open because there were no medications in the room. -He should Have kept an eye on the room to ensure no medications had been left in the room. Interview with the Administrator on 03/19/25 at 11:48am revealed: -The room labeled as a medication room was not a medication room. -She did not know there was medication in the room. -If there were medications in the room, the room should have been locked. 3. Observation of an office behind the receptionist's desk on 03/18/25 at 1:26pm revealed: -The door was open; the door was opened with no direct supervision from staff. -A bottle of a supplement was sitting on the desk and was visible from the hallway. -A container was sitting on the table in the office; it contained multiple bottles of prescription medication and over-the-counter supplements. Interview with the Administrator on 03/19/25 at 11:48am revealed if there was medication in the office, the office should have been locked.	D 378	