Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

(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 and Mecklenburg County Department of Social Services conducted an annual survey on March 25, 2025 through March 27, 2025.	D 000	This plan of correction is not to be interpreted as an admission of or an agreement with the findings or conclusions of the statement of deficiencies dated 3/27/25	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure Primary Care Provider (PCP) notification for 1 of 8 sampled residents (#3) related to a medication to treat elevated blood sugars and finger stick blood sugars (FSBS) greater than 350. The findings are: Review of Resident #3's current FL-2 dated 06/13/24 revealed diagnoses included type 2 diabetes, hypertension and dementia. Review of Resident #3's signed physician orders dated 02/20/25 revealed an order to check a FSBS three times a day before meals and administer lispro (used to treat high blood sugars) 5 units for FSBS greater than 350 and notify the PCP. Review of Resident #3's February 2025 eMAR revealed: -There was an entry to check a FSBS three times a day at 7:30am, 11:30am and 4:30pm,	D 273	Health Services Director or designee will conduct an in-service on medication administration training for all Medication Technicians to include following orders as written, notifying physician when required by order, proper documentation, ensuring resident takes medications before med tech leaves the room, and ensuring you are following current orders on the MAR. Inserviice will be completed by 5/30/25 Health Services Director or designee will audit documented parameters to ensure compliance with physician orders to include notification of physician when required weekly x 4 weeks, every other week for a month, and monthly thereafter for best practice. Results will be included on our QAPI/CQI meetings monthly for 3 months	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Samantha Starr TITLE Administrator (X6) DATE 5-20-25

Reviewed and acknowledged by Melissa J. Jones, 5/22/25.

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D 273	Continued From page 1 administer 5 units of lispro insulin for FSBS greater than 350 and notify the PCP. -On 02/21/25 at 11:31am, a FSBS was documented as 384. -There was no documentation the PCP had been notified of the FSBS greater than 350. Review of Resident #3's progress notes for February 2025 revealed there was no documentation Resident #3's PCP was notified of the FSBS greater than 350. Review of Resident #3's March 2025 eMAR revealed: -There was an entry to check FSBS three times a day 03/01/25 to 03/26/25 at 7:30am, 11:30am and 4:30pm, administer 5 units of lispro insulin for FSBS greater than 350 and notify the PCP. -On 03/06/25 at 4:22pm, a FSBS was documented as 360. -On 03/08/25 at 3:50pm, a FSBS was documented as 476. -On 03/12/25 at 4:35pm, a FSBS was documented as 411. -On 03/18/25 at 4:51pm, a FSBS was documented as 394. -On 03/19/25 at 3:51pm, a FSBS was documented as 382. -On 03/22/25 at 11:24am, a FSBS was documented as 368. -There was no documentation the PCP was notified for a FSBS greater than 350. Review of Resident #3's progress notes for March 2025 revealed there was no documentation Resident #3's PCP was notified of FSBSs greater than 350. Interview with the Special Care Coordinator (SCC) on 030/26/25 at 10:43am revealed:	D 273		

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D 273	Continued From page 2 -The MAs were responsible for calling hospice for Resident #3's FSBS greater than 350. -She was responsible for reviewing a passed medication report and the medication administration exception report daily to look for missed medications, blanks on the eMAR, and refusals, but those reports would not show if the insulin was administered incorrectly. -The passed medication reports and the medication administration reports would not indicate if the physician was notified for a FSBS greater than 350 because the MAs were to document on the eMAR and in the progress note. -She did not know hospice was not being notified of FSBSs greater than 350. -It was her responsibility to meet with the Health and Wellness Director (HWD) every morning and report her findings from those reports. Interview with the HWD on 03/26/25 at 3:19pm revealed: -The MAs were responsible for notifying Resident #3's hospice provider if the resident had a FSBS greater than 350. -The SCC was responsible for reviewing passed medications reports and medication exemption reports daily and responsible for reporting the findings to her daily, but the reports would not reveal insulin with parameters. -Their new computer documentation system did allow the facility to complete an audit report for insulin parameters, but she was not sure if the SCC was trained on how to run the report.-She did not know Resident #3 had FSBS greater than 350 and the hospice provider was not notified. Telephone interview with Resident #3's hospice provider on 03/26/25 at 12:07pm revealed: -She was not made aware when Resident #3's FSBS was greater than 350.	D 273		

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D 273	Continued From page 3 -She expected the staff to notify her for a FSBS greater than 350. -If she had been notified about Resident #3's FSBS had been greater than 350 on a consistent basis, then she would have changed the insulin. -On 03/25/25, she discontinued Resident #3's FSBSs and insulin orders. Interview with the Administrator on 03/27/25 at 11:26am revealed: -The MAs were responsible for notifying the hospice provider by phone when Resident #3's insulin was administered when the FSBS was greater than 350. -The MAs were responsible for completing a progress note in Resident #3's chart after the hospice provider was notified. -The HWD was responsible for reviewing Resident #3's progress notes daily and following up on what was charted. -The HWD was responsible for letting her know about any issues with the residents daily during their daily meetings. -She did not know Resident #3's hospice provider was not notified of FSBSs greater than 350.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 4 Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 3 sampled residents related to a medication used to treat anxiety and agitation (#4). The findings are: Review of Resident #4's current FL2 dated 09/23/24 revealed a diagnosis of acute on chronic respiratory failure, moderate persistent asthma and myasthenia gravis. Review of Resident #4's Resident Register revealed an admission date of 09/22/23. Review of a physician order dated 02/14/25 revealed: -There was an order to discontinue lorazepam (used to treat anxiety and agitation) 2mg/ml by mouth every four hours as needed on 02/14/25. -There was an order to start lorazepam 2mg/ml by mouth every eight hours as needed on 02/14/25. Review of Resident #4's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 2mg/ml by mouth every four hours as needed with a start date of 02/06/25 and documentation of administration on 02/08/25 at 9:34am and at 12:18 pm. -There was no entry for lorazepam 2mg/ml by mouth every eight hours as needed. Review of Resident #4's March 2025 eMAR revealed: -There was an entry for lorazepam 2mg/ml by mouth every four hours as needed with a start	D 276	Order was clarified by Health Services Director immediately and changed. Health Services Director or designee to re-educate Memory Care Coordinator and Resident Care Coordinator with an in-service on order processing and implementation to include comparing order to MAR before uploading to resident electronic record. Training will be complete by 5/30/25 Health Services Director or designee to conduct a MAR to cart audit by 5/30/25 and make adjustments as needed. Audit results will be reviewed at monthly QAPI/CQI meeting for 3 months.	

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D 276	Continued From page 5 date of 02/06/25 and no documentation of administration. -There was no entry for lorazepam 2mg/ml by mouth every eight hours as needed. Observation of medications on hand for Resident #4 on 03/26/25 at 12:24pm revealed lorazepam 2mg/ml by mouth every eight hours as needed, 90 tablets in a plastic bag with a dispense date of 03/25/25 listed on the pharmacy label. Interview with the medication aide (MA) on 03/26/25 at 12:29pm revealed: -She did not know Resident #4 was ordered for lorazepam every eight hours as needed on 02/14/25. -The Health and Wellness Director (HWD) was responsible for sending medication orders to the pharmacy. Telephone interview with a pharmacist with the facility's contracted pharmacy on 03/26/25 at 12:48pm revealed: -The pharmacy had not received an order for lorazepam 2mg/ml by mouth every eight hours as needed dated 02/14/25. -The pharmacy did receive an order for Resident #4's lorazepam 2mg/ml by mouth every eight hours as needed on 03/25/25. Telephone interview with the nurse at the office of Resident #4's Primary Care Provider (PCP) on 03/26/25 at 1:42pm revealed: -Lorazepam 2mg/ml by mouth every eight hours as needed was ordered on 02/14/25 for Resident #4. -She did not know Resident #4 had not received the lorazepam that was ordered on 02/14/25. -A MA at facility requested an order to be sent to the pharmacy for lorazepam 2mg/ml by mouth	D 276		

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D 276	Continued From page 6 every eight hours as needed on 03/25/25. Interview with the HWD on 03/27/25 at 3:46pm revealed: -She did not know Resident #4 had an order for lorazepam every eight hours as needed dated 02/14/25. -She was responsible for ensuring all medication orders were implemented. -Medications orders could be sent to the pharmacy electronically by the PCP or given to her if the PCP was in the facility. -She was responsible for faxing medication orders to the pharmacy. -She did not know how Resident #4's lorazepam every eight hours was missed. -There was no system in place to audit medication orders. Interview with the Administrator on 03/27/25 at 3:26pm revealed: -She did not know Resident #4 had an order for lorazepam every eight hours as needed dated 02/14/25. -The HWD and RCC were responsible for ensuring medication orders were implemented. -If a medication order was given while the PCP was in the facility, the HWD or RCC were responsible for faxing the order to the pharmacy. -Once the pharmacy received a medication order, the medication was added to the eMAR and electronically sent to the facility for the HWD or RCC to approve or decline the order. -There was no system in place to audit medication orders.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 7 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: Based on observations, interviews and record reviews, the facility failed to serve therapeutic diets as ordered to 1 of 5 sampled residents related to nectar thickened liquids (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 06/13/24 revealed: -The diagnoses included type 2 diabetes, hypertension and dementia. -Resident #3 had a physician's order for mechanical soft diet and nectar thickened liquids. -He resided in the Special Care Unit (SCU). Observation of the lunch meal on 03/25/25 at 12:35pm: -Resident was served ice cream for dessert. -Resident #3 ate 50% of the before the Special Care Unit Coordinator (SCUC) removed the ice cream and replaced it with applesauce. -A list of residents on a therapeutic diet was posted in the SCU kitchen. -A menu of what to serve residents on a thickened liquid diet was not posted. Interview with the PCA on 03/25/25 at 12:55pm revealed: -She was aware Resident #3 received thickened liquids. -She served ice cream to Resident #3 and did not know he was supposed to receive applesauce	D 310	Memory Care Coordinator conducted instant in-service was completed immediately with the staff member who gave incorrect dessert on thickened fluids and what is an acceptable alternative for ice cream. Health Services Director or designee will conduct education for care staff and dining staff on therapeutic diets to include acceptable substitutions and specific foods to avoid when on thickened fluid. Training will be completed by 5/30/25 Meals sent to Memory care will be labeled with the appropriate therapeutic diet and resident's name. Executive Director or designee will conduct an in-service with dietary staff on the new process of labeling the therapeutic meals. Inservice will be complete by 5/30/25. Culinary Services Director or designee will ensure meals are labeled accurately. Executive Director or designee will audit the implementation of this process weekly x 4 weeks and monthly x 3 months. Audit results will be included in our QAPI/CQI meetings monthly for 3 months.	

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D 310	Continued From page 8 instead. -She thought thickened liquids were related to beverages, not ice cream. -She knew there was a list of residents who received therapeutic diets and that the list was posted in the SCU kitchen. Interview with the Special Care Unit Coordinator (SCC) on 03/25/25 at 12:50pm revealed: -Resident #3 had an order for mechanical soft diet and thickened liquids. -A list of residents receiving therapeutic diets was listed in the SCU kitchen. -Resident #3 received a regular ice cream for lunch and should have received applesauce. -Residents on thickened liquids should receive a Magic Cup" (fortified nutritional dessert for thickened liquid diet) instead of ice cream (not thickened). -The Personal Care Aide (PCA) who served the ice cream to Resident #3 started two days prior and was still in training. -New hires had received training on what to serve residents who were on thickened liquids. -She expected Resident #3 to be served thickened liquids such as a "Magic Cup" or applesauce. Interview with the Resident Care Coordinator on 03/27/25 at 2:41pm revealed: -New employees received education on therapeutic diets during their orientation. -A list of residents receiving therapeutic diets was listed in the SCU kitchen. -Resident #3 should have received applesauce, pudding or a "Magic Cup" due to a mechanical soft diet with thickened liquids. -The new PCA who served Resident #3 ice cream should have waited for direction on what to serve Resident #3.	D 310		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure clarification of medication orders for 2 of 8 sampled residents (#6 and #2) for orders for medications to treat fluid retention and low potassium (#6) and an order for oxygen (#2). 1. Review of Resident #6's FL2 dated 05/01/24 revealed diagnoses included Ankylosing Spondylitis (an autoimmune disease that includes pain and stiffness in the spine and other joints), history of deep vein thrombosis, diabetes mellitus type 2 and congenital developmental delay. Review of Resident #6's after-visit summary dated 01/09/25 revealed a medication summary list which included torsemide (a medication used to treat fluid retention) 40 mg by mouth daily. Review of Resident #6's signed physician orders	D 344	Health Services Director to re-educate Memory Care Coordinator and Resident Care Coordinator with an in-service on order processing, the need for order clarification, and implementation to include comparing order to MAR before uploading to resident electronic record. Training will be complete by 5/30/25 Health Services Director or designee to conduct a MAR to cart audit by 5/30/25 and make adjustments as needed. Audit results will be reviewed at monthly QAPI/CQI meeting for 3 months. HSD or designee will conduct medication administration training to include following orders as written, proper documentation, not leaving medications in rooms with resident, and ensuring current orders are followed on the MAR. Training will be complete by 5/30/25.	

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D 344	Continued From page 10 dated 01/20/25 revealed: -An order for torsemide 20mg, two tablets (40mg) daily at 8:00am. -The scheduled directions on the order were crossed out with an X, with a handwritten note under diagnosis; one tablet every day as needed for edema. -On the back page of the physician orders were handwritten instructions, "use torsemide 20mg daily as needed for swelling only." -There were no additional orders for torsemide. Review of Resident #6's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for torsemide 20mg take two tablets (40mg) once daily. -Torsemide 20 mg take two tablets (40mg) once daily was documented as administered on 01/01/25- 01/31/25. -There was an additional entry under as needed medications for torsemide 20mg take one tablet by mouth daily as needed for swelling in the lower extremities with a note, "added on 01/20/2025." -There was no documentation torsemide 20mg was administered as needed from 01/01/25-01/31/25. Review of Resident #6's February 2025 eMAR revealed: -There was an entry for torsemide 20mg take two tablets (40mg) by mouth daily. -Torsemide 20 mg take two tablets (40mg) daily was administered on 02/01/25- 02/28/25. -There was an additional entry under as needed medications for torsemide 20mg take one tablet by mouth daily as needed for swelling in the lower extremities with a start date of 01/20/25. -There was no documentation torsemide 20mg was administered as needed from 02/01/25-	D 344		

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D 344	Continued From page 11 02/28/25. Review of Resident #6's March 2025 eMAR revealed: -There was an entry for torsemide 20mg take two tablets (40mg) by mouth daily. -Torsemide 20 mg take two tablets (40mg) daily was administered on 03/01/25- 03/25/25. -There was an additional entry under as needed medications for torsemide 20mg take one tablet by mouth daily as needed for swelling in the lower extremities. -There was no documentation torsemide 20mg was administered as needed from 03/01/25-03/25/25. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/26/25 at 4:43pm revealed: -The pharmacy received an order from the Primary Care Provider (PCP) on 12/10/24 for torsemide 40mg one time a day. -The pharmacy received an order on 01/20/25 for torsemide 20mg take 1 tablet as needed. -The pharmacy did not receive a discontinue order for the torsemide 40mg one time a day and thought the torsemide 20mg was an additional order. -The pharmacy dispensed 60 tablets of 20mg tablets on 12/12/24, 01/08/25, 02/06/25 and 03/10/25. -The pharmacy did not dispense any of the torsemide 20mg take 1 tablet as needed and was unsure as to why. Interview with Resident #6's PCP on 03/27/25 at 9:05am revealed: -She began seeing Resident #6 in March 2025. -She reviewed his current eMAR, hospitalizations reports, after visit summaries from outpatient	D 344		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 12 providers, current medications and saw he had been receiving 40mg of torsemide daily. -He was taking torsemide for his congestive heart failure and lower edema. -She felt this order was appropriate and would be concerned with taking him off the scheduled dose to a torsemide 20mg as needed for swelling. -She did not think Resident #6 needed the torsemide 20 mg as needed for swelling and has not seen any changes to his swelling. Interview with the Administrator on 03/27/25 at 3:28pm revealed Resident #6 had several different doctors and would switch PCP's. Refer to interview with the Resident Care Coordinator (RCC) on 03/27/2025 at 11:26am. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. b. Review of an after-visit summary dated 12/09/25 revealed a medication summary list which included potassium chloride 20meq 1 tablet daily. Review of an after-visit summary dated 01/9/25 revealed a medication summary list which included potassium chloride 20meq 1 tablet daily. Review of Resident #6's physician orders dated 01/20/25 revealed: -An order or Potassium chloride micro (a mineral supplement used to treat or prevent low amounts of potassium in the blood) 20meq ER daily at 8:00am. -The scheduled directions on the order were crossed out with an X, with a handwritten note, "one tablet daily as needed for edema with torsemide."	D 344		

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D 344	Continued From page 13 -On the back page of the physician orders were handwritten instructions, "use potassium chloride 20meq daily as needed when using torsemide." -There were no additional instructions for potassium chloride 20meq. Review of Resident #6's January 2025 eMAR revealed: -There was an entry for Potassium chloride micro 20meq daily at 8:00am. -Potassium chloride micro 20meq was documented as administered on 01/01/25- 01/31/25. -There was an additional entry under as needed medications for potassium chloride 20meq take one tablet daily as needed with torsemide, use only when giving torsemide with a note, "added on 01/20/2025." -There was no documentation potassium chloride 20meq was administered as needed from 01/01/25- 01/31/25. Review of Resident #6's February 2025 eMAR revealed: -There was an entry potassium chloride 20meq take one tablet daily as needed with torsemide, use only when giving torsemide. -Potassium chloride 20meq was documented as administered from 02/01/25- 02/28/25. -There was an additional entry under as needed medications for potassium chloride 20meq take one tablet daily as needed with torsemide, use only when giving torsemide. -There was no documentation potassium chloride 20meq was administered as needed from 02/01/25- 02/28/25. Review of Resident #6's March 2025 eMAR revealed: -There was an entry potassium chloride 20meq take one tablet daily as needed with torsemide,	D 344		

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D 344	Continued From page 14	D 344		

use only when giving torsemide.
-Potassium chloride 20meq was documented as administered from 03/01/25- 03/25/25.
-There was an additional entry potassium chloride 20meq take one tablet by mouth daily as needed with torsemide, use only when giving torsemide.
-There was no documentation potassium chloride 20meq was administered as needed from 03/01/25- 03/25/25.
Telephone interview with a pharmacist at facility's contracted pharmacy on 03/26/25 at 4:43pm revealed:
-The pharmacy received an order from the primary care physician (PCP) on 12/12/24 for potassium chloride 20meq 1 tablet daily.
-The pharmacy dispensed 30 tablets on 12/12/24, 01/08/25,02/06/25, and 03/10/25.
-The pharmacy received an order for potassium 20meq one tablet as needed with torsemide on 01/20/25.
-The pharmacy did not dispense any of the potassium 20meq 1 tablet as needed with torsemide and was unsure as to why.
-They did not receive an order to discontinue the potassium 20meq daily therefore the potassium chloride 20meq daily with torsemide was in addition to the potassium chloride 20meq daily.

Interview with Resident #6's PCP on 03/27/25 at 9:05am revealed:
-She began seeing Resident #6 in March of 2025.
-She reviewed his current eMAR, any hospitalizations, after visit summaries for medications and saw he had been receiving 20meq of potassium chloride daily.
-Resident #6 needs to take potassium chloride when taking the torsemide as the torsemide depletes the body of potassium so they must be taken together.
-She felt the order for potassium chloride 20meq

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D 344	Continued From page 15 1 tablet daily was appropriate and did not feel he would need the as needed dose to go along with the torsemide. -She did not see any changes to his swelling. Interview with the Administrator on 03/27/25 at 3:28pm revealed: -Resident #6 had several different doctors and would switch PCPs. -He is now seeing the facilities contracted PCP. Refer to interview with the RCC on 03/27/2025 at 11:26am. Refer to the interview with the Administrator on 03/27/25 at 3:30pm --- 2. Review of Resident #2's current FL2 dated 03/25/25 revealed: -Diagnoses included chronic obstructive pulmonary disease with hypoxia, acid reflux, hypertension, chronic kidney disease, vertigo, atrial fibrillation and history of alcohol related dementia. -There was an order for oxygen 2-4 LPM (liters per minute) continuous. -Resident #2's level of care was Special Care Unit (SCU). Review of Resident 2's Resident Register revealed an admission date of 12/20/24. Observation of Resident #2 on 03/25/25 at 10:00am revealed she was sitting on the edge of her bed and was receiving oxygen via nasal canula at 2 liters.	D 344		

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D 344	Continued From page 16 Review of Resident #2's January 2025, February 2025 and March 2025 eMAR revealed no entry of an order for oxygen 2-4 liters continuous. Interview with the SCC on 03/25/25 at 1:50pm revealed: -She entered Resident #2's room and delivered her breakfast tray this morning. -She did observe Resident #2's oxygen level while she was in the room. -She regularly consulted with the RCC about SCU residents. -She did not know why Resident #2's oxygen was not listed on her eMAR prior to today, for MAs to check and sign off as being received. -She expected Resident #2's oxygen to be monitored during each shift when medications were administered. Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 2:41pm revealed: -Resident #2 resided on the assisted living unit from 12/20/24 to 03/21/25. -Resident #2 was expected to manage her own oxygen while in assisted living or until she had a change in condition. -Resident #2 had multiple hospitalizations, and she was transferred to SCU on 03/21/25, after recent hospitalization and home visit. -She initially added oxygen 2-4 liters continuous, to the eMAR after clarifying with the PCP, then re-clarified the order to read 2 liters continuously. -Resident #2's oxygen should have been monitored and clarified upon transfer to SCU. Interview with the Primary Care Provider (PCP) on 03/27/25 at 9:04am revealed: -She recently took over as PCP and assessed Resident #2 on 03/25/25 after recent hospitalization.	D 344		

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D 344	Continued From page 17 -Resident #2 was admitted to the facility on oxygen 2 liters in December 2024. -Resident #2 utilized 2-4 liters during her recent hospitalization. -Resident #2 appeared to be stable on 2 liters of oxygen when she was assessed on 03/25/25. -Her oxygen order level should have been clarified when she was discharged from the hospital. -She expected Resident #2's oxygen to be added to the eMAR and monitored. Interview with the Administrator on 03/27/25 at 3:30pm revealed: -Oxygen was not routinely added to the eMAR for assisted living residents. -Oxygen should have been added to the eMAR for SCU residents. -Resident #2 was recently transferred from the assisted living building to the SCU building and her oxygen should have been added to the eMAR. -She expected Resident #2's oxygen to be clarified and added to her eMAR. Refer to interview with the RCC on 03/27/2025 at 11:26am. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. Interview with the RCC on 03/27/25 at 11:26am revealed: -She was ultimately responsible for reviewing resident FL2s, clarifying orders and assuring orders were appropriately and/or timely added to resident eMARs. -She would review orders monthly or when a new order would come in and compare the orders to the eMAR and would clarify orders if needed.	D 344		

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D 344	Continued From page 18 -The RCC, SCC, HWD and MAs were responsible for communicating discrepancies with orders that needed to be clarified with the PCP in order to avoid medication errors. Interview with the Administrator on 03/27/25 at 3:30pm revealed: -The RCC, SCC, HWD and MAs were responsible for auditing and comparing the physician orders, eMARs and medication carts to assure proper administration of medications. -When orders are received and do not match the current standing order the HWD should clarify the orders. -She expected all medications orders to be clarified appropriately to avoid medication errors and to assure proper administration to all residents.	D 344		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 1 of 7 sampled residents (#7) had signed physician orders for medications used for self-administration. Review of Resident #7's current FL-2 dated 08/28/24 revealed diagnoses included displaced fracture of the base neck right femur,	D 345	All medications that were not on the physician's orders were immediately removed from resident room and a room sweep was conducted to ensure no other unauthorized medications were present. Family was immediately notified. Regional Health Services Director or designee will in-service Health Services Director and Executive Director on Sinceri policy regarding residents who self-administer. Training will be complete by 5/8/25	

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D 345	Continued From page 19 osteoporosis, and left artificial hip joint. Review of Resident #7's provider communication/orders form dated 09/03/24 revealed an order for Resident #7 to self-administer her medications. Observations of Resident #7's medications sitting on her dresser on 03/26/25 at 12:02pm revealed: -There was a bottle of acetaminophen extended-release 650mg (for arthritis pain). -There was a bottle of glucosamine/chondroitin (a dietary supplement). -There was a bottle of turmeric curcumin with ginger powder 500mg (a dietary supplement). -There was a bottle of vitamin C supplement 500mg with rose hips (a vitamin supplement). -There was a bottle of tea tree oil (dietary supplement). -There was a bottle of Olmesartan (for high blood pressure) 40mg, Take 1 by mouth daily. -There was a bottle of carvedilol 25mg, take 1 by mouth twice daily. Review of Resident #7's current FL-2 dated 08/28/24 medication orders revealed: -An order for acetaminophen 500mg, (for pain relief), take 2 by mouth twice daily. -An order for amlodipine besylate 5mg, (for high blood pressure), take 0.5 tab every evening. -An order for aspirin 81mg, (for pain relief) take 1 by mouth twice daily. -An order for calcium carbonate with vitamin D (a vitamin supplement) take 1 by mouth twice daily. -An order for carvedilol 25mg, (for high blood pressure) take 1 by mouth twice daily. -An order for hydrocodone-acetaminophen, (for chronic pain), take 1 by mouth every 6 hours as needed for pain. -An order for MiraLAX powder 17gm, (for	D 345	Health Services Director or designee to conduct room checks weekly for 4 weeks, and monthly thereafter. Anything found that is not permitted will immediately be removed. Executive Director or designee will audit the room check forms weekly for 4 weeks. Room check results will be brought to the QAPI/CQI meeting for review x 3 months	

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D 345	Continued From page 20 constipation), take 1 scoop by mouth daily. -An order for preparation H cream 5-14-4%, (to relieve rectal pain), use three times daily -An order for senna docusate sodium 8.6-50mg, (for constipation), take 2 by mouth every 24 hours as needed for constipation. -There were no physician orders for turmeric, glucosamine/chondroitin, vitamin C, or tea tree oil. Review of Resident #7's Physician's Order Report dated 02/24/25 revealed: -An order for acetaminophen 500mg, take 2 by mouth twice daily. -An order for amlodipine besylate 5mg, take 0.5 tab every evening. -An order for a Boost chocolate flavor (a nutritional supplement drink) one can by mouth twice daily. -There were no physician orders for turmeric, glucosamine/chondroitin, vitamin C, or tea tree oil. Interview with Resident #7 on 03/26/25 at 12:02pm and 3:52pm revealed: -She took acetaminophen 650mg, 2 tablets twice daily. -She did not use supplements and will get rid of them. -She used to take other medications that she no longer takes. -She kept her medications on her dresser to be able to reach them easily. A second interview with Resident #7 on 03/27/25 at 11:53am revealed: -Her Responsibly Party (RP) got her medications for her. -She took two acetaminophen tablets twice daily. -She took two Olmesartan each day for blood	D 345		

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pressure.
-She took one carvedilol two times a day for blood pressure.
-She did not take any other medications (turmeric, glucosamine/chondroitin, vitamin C, or tea tree oil).

Interview with Resident #7's RP on 03/27/25 at 1:20pm revealed:
-Resident #7 was very good with her medications and was able to self-administer them.
-She went over Resident #7's medication list on 03/03/25 with the Health Service Director (HSD).
-Resident #7 was taking carvedilol 25mg, twice daily; Olmesartan 40mg, once daily; acetaminophen extra strength, every morning and evening; and Preservision for macular degeneration.
-Resident #7's amlodipine was discontinued.
-She brought the Tylenol and Preservision to the facility.
-Resident #7's pharmacy sent the carvedilol and Olmesartan to Resident #7 by mail.
-Resident #7's eye doctor was concerned about her taking supplements because Preservision contains supplements.
-Resident #7's medications were current.
-Resident #7 kept her medications on her dresser so that they were within her reach.
-Preservision was on Resident #7's kitchen table, if she was taking it.

Interview with the Health Services Director (Diana has this interview)

Interview with the Administrator on 03/27/25 at 3:56pm revealed:
-Resident #7's RP brought her medications to the facility.
-The HSD completed a monthly

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D 345	Continued From page 22 self-administration evaluation with Resident #7 and ensured the facility had updated medication orders. -The facility was supposed to have the order for the medications that Resident #7 was taking. -The HSD sent multiple faxes to Resident #7's primary care physician to approve and sign. -The HSD checked the medications in Resident #7's room each month. -The HSD was supposed to check the medications in the resident's room and compare them with Resident #7's current medication order.	D 345		
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 interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents related to medications used to treat elevated blood sugars (#3). The findings are: Review of Resident #3's current FL-2 dated 06/13/24 revealed diagnoses included type 2 diabetes, hypertension and dementia.	D 358		

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D 358	Continued From page 23 a. Review of Resident #3's signed physician orders dated 02/20/25 revealed an order to check a finger stick blood sugar (FSBS) three times a day before meals and administer lispro (used to treat high blood sugars) 5 units for FSBS greater than 350 and notify the Primary Care Provider (PCP). Review of Resident #3's medications available for administration on 03/26/25 at 12:30pm revealed: -There was a lispro Kwikpen labeled to inject 5 units, three times a day as directed for blood sugar, with a dispense date of 06/30/24, with 300ml left to administer. -There was a second lispro Kwikpen labeled to inject 5 units, three times a day as directed for blood sugar, with a dispense date of 06/30/24, with 300ml left to administer. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/26/25 at 12:36pm revealed: -There was an order dated 11/05/24 for lispro (used to treat high blood sugars), administer 5 units three times a day for a FSBS greater than 350. -On 11/03/25, the pharmacy dispensed one lispro Kwikpen, 300ml (a 20-day supply) to the facility. -The lispro was not dispensed after that. Review of Resident #3's February 2025 eMAR revealed: There was an entry to check a FSBS three times a day at 7:30am, 11:30am and 4:30pm, administer 3 units of lispro insulin for FSBS greater than 350 and to notify the PCP. -On 02/20/25 at 8:09am, a FSBS was documented as 317 and lispro 5 units was administered instead of 0 units.	D 358	Once notified of the concern by the survey team, Health Services Director immediately conducted instant in-services with medication staff regarding proper documentation, blood sugar checks, parameters, and following orders accurately. Health Services Director or designee will conduct an in-service on medication administration training for all Medication Technicians to include following orders as written, notifying physician when required by order, proper documentation, ensuring resident takes medications before med tech leaves the room, and ensuring current orders are followed on the MAR. Inservice will be completed by 5/30/25 HSD or designee will audit documented parameters to ensure compliance with physician orders weekly x 4 weeks, and monthly thereafter.	

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D 358	Continued From page 24 -On 02/21/25 at 7:21am, a FSBS was documented as 187 and lispro 5 units was administered instead of 0 units. -On 02/23/25 at 6:46am, a FSBS was documented as 171 and lispro 5 units was administered instead of 0 units. -On 02/24/25 at 12:46pm, a FSBS was documented as 174 and lispro 5 units was administered instead of 0 units. -On 02/25/25 at 11:21am, a FSBS was documented as 212 and lispro 5 units was administered instead of 0 units. -On 02/28/25 at 7:28am, a FSBS was documented as 194 and lispro 5 units was administered instead of 0 units. Review of Resident #3's March 2025 eMAR revealed: -There was an entry to check a FSBS three times a day from 03/01/25 to 03/26/25 at 7:30am, 11:30am and 4:30pm, administer 5 units of lispro insulin for FSBS greater than 350 and notify the PCP. -On 03/01/25 at 6:36am, a FSBS was documented as 165 and lispro 5 units was administered instead of 0 units. -On 03/01/25 at 4:32pm, a FSBS was documented as 284 and lispro 5 units was administered instead of 0 units. -On 03/05/25 at 6:34am, a FSBS was documented as 131 and lispro 5 units was administered instead of 0 units. -On 03/09/25 at 8:38am, a FSBS was documented as 185 and lispro 5 units was administered instead of 0 units. -On 03/10/25 at 4:30pm, a FSBS was documented as 286 and lispro 5 units was administered instead of 0 units. -On 03/15/25 at 6:43pm, a FSBS was documented as 107 and lispro 5 units was	D 358		

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D 358	Continued From page 25 administered instead of 0 units. -On 03/17/25 at 3:43pm, a FSBS was documented as 333 and lispro 5 units was administered instead of 0 units. -On 03/19/25 at 7:35am, a FSBS was documented as 136 and lispro 5 units was administered instead of 0 units. -On 03/20/25 at 3:52pm, a FSBS was documented as 189 and lispro 5 units was administered instead of 0 units. -On 03/23/25 at 6:56am, a FSBS was documented as 261 and lispro 5 units was administered instead of 0 units. -On 03/25/25 at 7:49am, a FSBS was documented as 233 and lispro 5 units was administered instead of 0 units. -On 03/25/25 at 11:17am, a FSBS was documented as 159 and lispro 5 units was administered instead of 0 units. Refer to the interview with a MA on 03/27/27 at 10:40am. Refer to the interview with the Special Care Coordinator (SCC) on 030/26/25 at 10:43am. Refer to a telephone interview with Resident #3's hospice provider on 03/26/25 at 12:07pm. Refer to the interview with the HWD on 03/26/25 at 3:19pm. Refer to the interview with the Administrator on 03/27/25 at 11:26am. b. Review of Resident #3's February 2025 eMAR revealed: -There was an entry to check a FSBS three times a day at 7:30am, 11:30am and 4:30pm, administer 5 units of lispro insulin for FSBS	D 358		

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D 358	Continued From page 26 greater than 350 and notify the PCP. -On 02/21/25 at 11:31am, a FSBS was documented as 384. Review of Resident #3's March 2025 eMAR revealed: -There was an entry to check a FSBS three times a day 03/01/25 to 03/26/25 at 7:30am, 11:30am and 4:30pm, administer 5 units of lispro insulin for FSBS greater than 350 and notify the PCP. -On 03/06/25 at 4:22pm, a FSBS was documented as 360. -On 03/08/25 at 3:50pm, a FSBS was documented as 476. -On 03/12/25 at 4:35pm, a FSBS was documented as 411. -On 03/18/25 at 4:51pm, a FSBS was documented as 394. -On 03/19/25 at 3:51pm, a FSBS was documented as 382. -On 03/22/25 at 11:24am, a FSBS was documented as 368. Refer to the interview with a MA on 03/27/27 at 10:40am. Refer to the interview with the SCC on 030/26/25 at 10:43am. Refer to a telephone interview with Resident #3's hospice provider on 03/26/25 at 12:07pm. Refer to the interview with the HWD on 03/26/25 at 3:19pm. Refer to the interview with the Administrator on 03/27/25 at 11:26am. Interview with a MA on 03/27/27 at 10:40am revealed:	D 358		

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D 358	Continued From page 27 -On 03/17/25 at 3:43pm, she administered 5 units of insulin for a FSBS of 333 because she thought Resident #3 was "acting like" his FSBS was high and "not himself". -On 03/20/25 at 3:52pm, she administered 5 units of insulin for a FSBS of 189 because she got the less than and greater than symbols mixed up. -On 03/25/25 at 7:49am, she administered 5 units of insulin for a FSBS of 233 because she got the less than and greater than symbols mixed up. -On 03/25/25 at 11:17am, she administered 5 units of insulin for a FSBS of 159 because she got less than and greater than symbols mixed up. -She did not ask anyone or look the symbols up on the internet when she could not remember which symbol meant less than or greater than. Interview with the Special Care Coordinator (SCC) on 030/26/25 at 10:43am revealed: -She was responsible for reviewing a passed medication report and the medication administration exception report daily to look for missed medications, blanks on the eMAR, and refusals, but those reports would not show if insulin was administered incorrectly. -The passed medication reports and the medication administration reports would not indicate if the PCP was notified for a FSBS greater than 350 because the MAs were to document on the eMAR and in the progress note. -She did not know Resident #3 received insulin for a FSBS less than 350. -It was her responsibility to meet with the Health and Wellness Director (HWD) every morning and report her findings from those reports. Telephone interview with Resident #3's hospice provider on 03/26/25 at 12:07pm revealed: -She was not made aware when the insulin was administered for a FSBS less than 350 or when	D 358		

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D 358	Continued From page 28 Resident #3's FSBS was greater than 350. -She expected the staff to notify her for a FSBS greater than 350 and when the insulin was administered for a FSBS less than 350. -If she had been notified about Resident #3's FSBSs greater than 350 on a consistent basis, then she would have changed the insulin. -When Resident #3 was administered insulin for a FSBS less than 350 could have caused the blood sugar to drop and she did not have any notifications pertaining to low FSBS. -On 03/25/25, she discontinued Resident #3's FSBSs and insulin orders. Interview with the HWD on 03/26/25 at 3:19pm revealed: -The SCC was responsible for reviewing daily passed medications reports and the medication exemption reports and report the findings to her daily, but those reports would not reveal insulin with parameters. -Their new computer documentation system did allow the facility to complete an audit report for insulin parameters, but she was not sure if the SCC was trained on how to run the report. -She did not know Resident #3 was administered insulin for FSBS less than 350 instead of holding it and that Resident #3 had FSBS greater than 350 and the hospice provider was not notified. Interview with the Administrator on 03/27/25 at 11:26am revealed: -The MAs were responsible for following PCP orders and for notifying the hospice provider by phone when Resident #3's insulin was administered for a FSBSs less than 350 and when the FSBS was greater than 350. -The MAs were responsible for completing a progress note in Resident #3's chart after the hospice provider was notified.	D 358		

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D 358	Continued From page 29 -The HWD was responsible for reviewing Resident #3's progress notes daily and following up on what was charted. -The HWD was responsible for letting her know about any issues with the residents daily during their daily meetings. -She did not know Resident #3's hospice provider was not notified for FSBSs greater than 350 or insulin administered for FSBSs less than 350.	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 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 30 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 8 sampled residents (#2 and #6) related to the failure to accurately document the administration of a medication used for the relief of pain (#6), and administration of oxygen (#2). The findings are: 1. Review of Resident #6's FI-2 dated 05/01/2024 revealed: -A diagnosis of Ankylosing Spondylitis (an autoimmune disease that includes pain and stiffness in the spine and other joints), history of deep vein thrombosis, diabetes mellitus type 2 and congenital developmental delay. -There was an order for hydrocodone/acetaminophen 10/325mg (for chronic pain relief) take one tablet by mouth every six hours as needed for moderate pain. Review of Resident #6's physician orders dated 01/20/25 revealed: -There were two orders listed for hydrocodone /acetaminophen 10/325mg tablets take 1 tablet by mouth every six hours as needed for moderate pain. -One order had a start date of 12/10/24, and the second order had a start date of 12/17/24 Review of Resident #5's physician after-visit summary dated 12/09/24 revealed: -Instructions noted medication changes for hydrocodone/acetaminophen. -Hydrocodone-acetaminophen 10/325mg per tablet take 1 tablet by mouth every six hours as needed for moderate pain. -What changed: Another medication with the	D 367	Health Services Director or designee will conduct an in-service on medication administration training for all Medication Technicians to include following orders as written, notifying physician when required by order, proper documentation, ensuring resident takes medications before med tech leaves the room, and ensuring you are following current orders on the MAR. Inservice will be completed by 5/30/25 Pharmacy will conduct an audit review for duplicate orders and provide results to Health Services Director and Executive Director. Pharmacy audit will be complete by 5/14/25. Health Services Director or designee will review results and clarify as needed. Results of the pharmacy audit will be brought to QAPI/CQI meeting for review x 3 months	

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D 367	Continued From page 31 same name was changed, make sure to understand how and when to take each. - Hydrocodone/acetaminophen 10/325mg per tablet take 1 tablet by mouth every six hours as needed for moderate pain. -What changed: these instructions start on 12/17/24. -If unsure what to do until then ask your doctor or care provider. Review of Resident #6's physician after-visit summary dated 01/09/24 revealed: -A medication summary list which included two identical orders for hydrocodone/acetaminophen 10/325mg take 1 tablet by mouth every six hours as needed for moderate pain. -Both medications had an asterisk (*) by the medication. -At the end of the list was a bold box with an exclamation character (!!), which read; this list has two medications that are the same as other medications prescribed. -Read directions carefully and ask your doctor or care provider to review them. Review of Resident #6's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry under as needed medications (PRN) hydrocodone/acetaminophen 10/325mg tablets take one tablet every six hours for moderate pain. -There was a second entry under PRN medications hydrocodone/acetaminophen 10/325mg tablets take one tablet every six hours for moderate pain. Review of Resident #6's February 2025 eMAR revealed: -There was an entry under as needed	D 367		

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D 367	Continued From page 32 medications (PRN) hydrocodone/acetaminophen 10/325mg tablets take one tablet every six hours for moderate pain. -There was a second entry under PRN medications hydrocodone/acetaminophen 10/325mg tablets take one tablet every six hours for moderate pain. -Hydrocodone/acetaminophen 10/325mg was documented as administered on 02/22/25 at 12:58pm on the first entry. - Hydrocodone/acetaminophen 10/325mg was documented as administered on 02/22/25 at 12:58pm on the second entry. Review of Resident #6's controlled substance count sheet for February 2025 revealed: -Resident #6 received a hydrocodone/acetaminophen on 02/22/25 at 8:00am and 1:00pm. -The Medication Aides (MA) initials on the controlled substance count sheet were the same for 8:00am and 1:00pm and matched the eMAR for 02/22/25 at 12:58pm. Interview with a medication aide (MA) on 03/26/25 at 4:20pm revealed: -She identified her initials as documenting the hydrocodone/acetaminophen 10/325mg as given on both entries on the eMAR. -She must have checked it off wrong on the eMAR. -She wrote on the controlled substance count sheet on 02/22/25 at 8:00am and forgot to click on the eMAR. -She forgot to write a note when she documented it two times. -Resident #6 always would ask for his hydrocodone acetaminophen every morning at 8:00am so she knew that it was a mistake to document it twice at 12:58pm.	D 367		

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D 367	Continued From page 33 Telephone interview with the pharmacy manager at the facility's contracted pharmacy on 03/26/25 at 5:15pm revealed: -The pharmacy received an order for the hydrocodone/acetaminophen 10/325mg tablets take one tablet every six hours for moderate pain on 12/09/24 and dispensed on 01/14/25 as the PRN medication was not needed in December 2024, 01/14/25, 02/14/25, and 03/14/25. -She was not sure why it was showing up twice on the eMAR but would check into it. A second telephone interview with the pharmacy manager at the facility's contracted pharmacy on 03/27/25 at 11:50pm revealed: -She contacted the electronic records system which the facility used about the hydrocodone/acetaminophen 10/325mg order. -The electronic records system had sent the discontinue order to the facility, but it had not been accepted, and the electronic records system dismissed the order. -The facility did not accept the order and that is why the order was still showing in two places. -The facility did have the ability to discontinue the duplicate order. Interview with the Administrator on 03/27/25 at 10:45am revealed the hydrocodone/acetaminophen order was showing twice and there was no order to discontinue the order. Refer to interviews with the Health and Wellness Director (HWD) on 03/26/25 at 3:19pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. 3. Review of Resident #2's current FL2 dated	D 367		

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D 367	Continued From page 34 03/25/25 revealed: -Diagnoses included chronic obstructive pulmonary disease with hypoxia, acid reflux, hypertension, chronic kidney disease, vertigo, atrial fibrillation and history of alcohol related dementia. -There was an order for oxygen 2-4 LPM (liters per minute) continuous. -Resident #2's level of care was Special Care Unit (SCU). Review of Resident 2's resident register revealed an admission date of 12/20/24. Review of Resident #2's record revealed she was transferred from assisted living level of care to the special care unit on 03/21/25. Observation of Resident #2 on 03/25/25 at 10:00am revealed: -She was sitting on the edge of the bed and was receiving oxygen via nasal canula at 2 liters. -She stated she was on 2 liters of oxygen and denied shortness of breath. Review of Resident #2's January, February and March 2025 eMAR revealed no entry for oxygen 2-4 liters continuous. Interview with the Special Care Coordinator (SCC) on 03/25/25 at 1:50pm revealed: -She entered Resident #2's room and delivered her breakfast tray this morning. -She did observe Resident #2's oxygen level while she was in the room. -She did not know Resident #2's oxygen was not listed on the eMAR. -She regularly consulted with the Resident Care Coordinator (RCC) about SCU residents. -She expected Resident #2's oxygen to be	D 367	Health Services Director immediately added all oxygen orders to the MAR on 3/26/25 for medication technician sign off once notified by the survey team. Health Services Director or designee will add oxygen orders to the MAR going forward. Health Services Director or designee will audit oxygen orders every other week for 1 month, then monthly thereafter to ensure orders are on the MAR.	

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D 367	Continued From page 35 monitored during each shift when medications were administered. Interview with the RCC on 03/27/25 at 3:14pm revealed: -She was responsible for reviewing Resident #2's FL2, hospital discharge summary, clarifying orders and assuring the oxygen order was placed on the eMAR. -Resident #2 resided on the assisted living unit from 12/20/24 to 03/21/25. -Resident #2 was expected to manage her own oxygen while she resided in assisted living or until she had a change in condition. -Resident #2 had multiple hospitalizations and she was transferred to SCU on 03/21/25, after a recent hospitalization and home visit. -Her oxygen should have been clarified and added to the eMAR upon transfer to SCU. -She did not add Resident #2's order for oxygen 2-4 liters continuous to the eMAR until after she clarified it with the PCP today, then re-clarified the order to read 2 liters continuously. Interview with the Primary Care Provider (PCP) on 03/27/25 at 9:04am revealed: -She recently took over as PCP and assessed Resident #2 on 03/25/25 after recent hospitalization. -Resident #2 was admitted to the facility on oxygen 2 liters in December 2024. -Resident #2 utilized 2-4 liters during her recent hospitalization. -Resident #2 appeared to be stable on 2 liters of oxygen when she was assessed on 03/25/25. -Her oxygen order level should have been clarified when she was discharged from the hospital. -She expected Resident #2's oxygen to be added to the eMAR and monitored.	D 367		

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D 367	Continued From page 36 Interview with the Administrator on 03/27/25 at 3:30pm revealed: -Oxygen was not routinely added to the eMAR for assisted living residents. -Oxygen should have been added to the eMAR for SCU residents. -Resident #2 was recently transferred from the assisted living building to the SCU building and she expected Resident #2's oxygen to be added to the eMAR. Refer to the interview with the HWD on 03/26/25 at 3:19pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. Interview with the HWD on 03/26/25 at 3:19pm revealed: -The MAs were responsible to document accurately in the resident's eMAR. -The SCUC/RCC was responsible to review daily passed medications reports and the medication exemption reports, and report the findings to her on a daily basis. -She was responsible to inform the Administrator of any issues or concerns from the SCC/RCC reports at their daily meeting. Interview with the Administrator on 03/27/25 at 3:30pm revealed medication aides are to follow the rules and document correctly and that all medications are given correctly.	D 367		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and	D 377		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 377	Continued From page 37 stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure resident medications were stored in a safe and secure manner for 2 of 7 sampled residents who had medications used to treat high blood pressure and edema on a shelf (#10) and medications used to treat shortness of breath and allergies, on bedside table (#2). 1. Review of Resident #10's current FL-2 dated 06/13/24 revealed: -Diagnoses included type 2 diabetes, hypertension and dementia. -An order for lasix 20 mg (used to treat fluid retention) every day. Review of Resident #10 signed physician order dated 02/27/25 for metoprolol succinate 25mg every day. Observation of Resident #10's previous room #43 on 03/26/25 at 8:46am revealed: -A surveyor found a medication cup sitting on the shelf in room #43. -There was a small round white tablet with "EP" and 116 imprinted on it on one side and the other side was blank. -There was a larger larger round white tablet with "MT1" imprinted on one side and an "M" imprinted on the other side. a. Review of Resident #10's March 2025 electronic medication administration record (eMAR) revealed there was an entry for lasix	D 377	Medications were immediately removed from the empty room. HSD or designee will conduct medication administration training for all medication technicians to include following orders as written, proper documentation, blood sugar checks, parameters, not leaving medications in rooms, and ensuring you are following current orders on the MAR. Training will be complete by 5/30/25. Health Services Director or designee will monitor 1 medication pass weekly for 4 weeks, and monthly thereafter. Results will be brought to the monthly QAPI/CQI meeting x 3 months.	

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D 377	Continued From page 38 20mg every day documented as administered 03/15/25 to 03/18/25 at 9:00am and on 03/19/25 at 10:30am. b. Review of Resident #10's March 2025 eMAR revealed there was an entry for metoprolol succinate 25mg every day documented as administered 03/15/25 to 03/18/25 at 9:00am and on 03/19/25 at 10:30am. Interview with a medication aide (MA) on 03/26/25 at 3:07pm revealed: -She was to administer medications to residents and wait until they took them. -Most of the time she takes the medication cup out of the room with her so there could be the possibility medication could be left in the cup. Interview with Resident #10 on 03/26/25 at 3:20pm revealed: -She was in room #43 for about a week because the facility was completing work on her original room. -Lasix 20mg and metoprolol 25mg were medication she took daily around 10:30am. -The MAs did not always stay in the room and watched her take her medication because sometimes she needed to go to the bathroom first, or was not ready to take them yet, so the MA would leave the cup of medications. -She could not remember if she left the medication cup with the lasix and metoprolol sitting on the shelf. Interview with the Administrator on 03/27/25 at 11:26am revealed: -The MAs were responsible for watching the residents take their medications and remove any medication that were refused or not taken. -She did not know there were medications left in	D 377		

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D 377	Continued From page 39 room #43 in a medication cup. 2. Review of Resident #2's current FL2 dated 03/25/25 revealed: -Diagnoses included chronic obstructive pulmonary disease with hypoxia, acid reflux, hypertension, chronic kidney disease, vertigo, atrial fibrillation and history of alcohol related dementia. -Resident #2's level of care was Special Care Unit (SCU). Observation of Resident #2's room during the initial tour of the facility on 03/25/25 at 9:00am revealed: -There were medications on her bedside table that included nasal allergy relief spray, allergy relief pills, symbicort 160/4.5 inhaler, and two albuterol sulfate HFA inhalation aerosol 90 mcg inhalers. -Resident #2's name was not located on the nasal allergy relief spray, the allergy relief pills, and the albuterol sulfate inhalers. -Resident #2's name was located on a hospital pharmacy label attached to the Symbicort 160/4.5 inhaler. Interview with Resident #2 on 03/25/25 at 9:00am revealed: -She remembered that she recently cleaned out her purse and placed the items on her bedside table. -She could not remember when she last used the medications inhalers on her bedside table. Observation of Resident #2's medication on hand on 03/25/25 revealed Resident #2's albuterol AER	D 377	Medications found in resident's room were immediately removed by the Memory Care Coordinator. Memory Care Coordinator or designee to conduct room checks weekly for 4 weeks, and monthly thereafter. Anything found that is not permitted will immediately be removed. Executive Director or designee will audit the room check forms weekly for 4 weeks. Room check results will be brought to the QAPI/CQI meeting for review x 3 months	

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D 377	Continued From page 40 HFA 90mcg inhaler was stored on the medication cart. a. Review of Resident #2's physician order dated 02/12/25 for albuterol AER HFA 90mcg, inhale one puff by mouth four times a day as needed, wait one minute between each puff, expires 12 months after opening, check expiration, prime first before first use or if not used greater than 2 weeks, prime, and spray three times shaking well before each spray. Review of Resident #2's record revealed there was no active order for the two albuterol inhalers found on Resident #2's bedside table. Review of Resident #2's January 2025 electronic Medication Administration Record (eMAR) for revealed: -There was an entry for albuterol AER HFA 90mcg, inhale one puff by mouth four times a day as needed, wait one minute between each puff, expires 12 months after opening, check expiration, prime first before first use or if not used greater than 2 weeks 2 weeks, prime, and spray three times shaking well before each spray. -There was no documentation albuterol AER HFA inhaler was administered as needed. Review of Resident #2's February 2025 eMAR revealed: -There was an entry for albuterol AER HFA 90mcg, inhale one puff by mouth four times a day as needed, wait one minute between each puff, expires 12 months after opening, check expiration, prime first before first use or if not used greater than 2 weeks 2 weeks, prime, and spray three times shaking well before each spray. -There was no documentation albuterol AER HFA inhaler was administered as needed.	D 377		

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D 377	Continued From page 41 Review of Resident #2's March 2025 eMAR revealed: -There was an entry for albuterol AER HFA 90mcg, inhale one puff by mouth four times a day as needed, wait one minute between each puff, expires 12 months after opening, check expiration, prime first before first use or if not used greater than 2 weeks 2 weeks, prime, and spray three times shaking well before each spray. -There was no documentation albuterol AER HFA inhaler was administered as needed. Refer to the interview with a MA on 03/25/25 at 10:25am. Refer to the interview with the Special Care Coordinator (SCC) on 03/25/25 at 1:50pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. b. Review of Resident #2's record on 03/25/25 revealed there was no active order for the nasal allergy relief spray that was found on Resident #2's bedside table. Refer to the interview with a MA on 03/25/25 at 10:25am. Refer to the interview with the SCC on 03/25/25 at 1:50pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. c. Review of Resident #2's record on 03/25/25 revealed there was no active order for the allergy relief pills that was found on Resident #2's bedside table.	D 377		

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D 377	Continued From page 42 Refer to the interview with a MA on 03/25/25 at 10:25am. Refer to the interview with the SCC on 03/25/25 at 1:50pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. d. Review of Resident #2's record on 03/20/25 revealed there was no active order for Symbicort 160/4.5 that was found on Resident #2's bedside table. Refer to the interview with a MA on 03/25/25 at 10:25am. Refer to the interview with the SCC on 03/25/25 at 1:50pm. Refer to the interview with the Administrator on 03/27/25 at 3:30pm. _____ Interview with a MA on 03/20/25 at 10:25am revealed: -She did not see any medications on Resident #2's bedside table when she entered her room at the start of her shift. -She agreed to check Resident #2's room for the items observed on the bedside table. -She entered Resident #2's room, observed and removed the nasal allergy relief spray, allergy relief pills, Symbicort inhaler, and two albuterol sulfate HFA inhalers from Resident #2's bedside table, while the Surveyor stood in the hallway. -Resident #2 had an active order for albuterol AER HFA on the medication cart used to store resident medications. -Resident #2 did not have an active order for the	D 377		

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D 377	Continued From page 43 nasal allergy relief spray, allergy relief pills, and a Symbicort inhaler. -Resident #2 did not have an order to self-administer any medications and the medications should not have been on the bedside table. -Resident #2 was transferred to the SCU after she was discharged from the hospital and may have arrived with the medications in her personal belongings. -The medications found on Resident #2's bedside table should have been stored for safekeeping. Interview with the SCC on 03/25/25 at 1:50pm revealed: -She performed morning room checks on all residents in the SCU and did not see any medications on Resident #2's bedside table. -She asked Resident #2 about the medications found on the bedside table and was told the medications had been there for weeks and had been in her purse. -Resident #2 was discharged from the hospital on 03/18/25, then she spent a few days at her son's home, then admitted to the SCU on 03/21/25. -Resident #2 did not have an active order to self-administer any medications on the SCU. -She expected any medications found in Resident #2's personal belongings should have been removed and stored in a secure manner. Interview with Administrator on 03/27/25 at 3:30pm revealed: -There was no protocol in place to ensure there were no unsafe items entering the SCU. -Resident #2 did not have an order to self-administer any medications. -She expected all medications found in Resident #2's bedroom to be stored in a safe and secure manner, on the medication cart or returned to her	D 377		

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D 377	Continued From page 44 family or destroyed.	D 377		