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LAKEWOOD CARE CENTER	7981 OPTIMIST CLUB ROAD DENVER, NC 28037

(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 the Lincoln County Department of Social Services conducted an annual survey on May 13, 2025-May 14, 2025.	D 000		
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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 3 of 5 sampled residents (#2, #3, and #4) related to notifying the physician if systolic blood pressure was greater than 150 or less than 100 and diastolic blood pressure is greater than 100 or less than 50. The findings are: 1. Review of Resident #2's current FL2 dated 12/13/24 revealed: -Diagnoses included hypertension. -Resident #2 's blood pressure was to be taken twice weekly. Review of Resident #2's Primary Care Provider's (PCP) orders dated 03/27/25 revealed there was an order to check Resident #2's blood pressure twice weekly and notify the PCP if the systolic blood pressure (SBP) was greater than 150 or less than 100 and the diastolic blood pressure (DBP) was greater than 100 or less than 50. Review of Resident #2's March 2025 electronic	D 273		

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Medication Administration Record (eMAR) revealed:
-There was an entry to check Resident #2's blood pressure two times per week and to notify the PCP if the SBP was greater than 150 or less than 100 and DBP was greater than 100 or less than 50.
-There was documentation Resident #2's blood pressure on 03/10/25 at 10:00am was 96/53.
-There was documentation Resident #2's blood pressure on 03/13/25 at 10:00am was 107/48.
-There was documentation Resident #2's blood pressure on 03/17/25 at 10:00am was 97/59.
-There was documentation Resident #2's blood pressure on 03/27/25 at 10:00am was 119/46.
-There was documentation Resident #2's blood pressure on 03/31/25 at 10:00am was 98/53.

Review of Resident #2's April 2025 eMAR revealed:
-There was an entry to check Resident #2's blood pressure two times per week and to notify the PCP if the SBP was greater than 150 or less than 100 and DBP was greater than 100 or less than 50.
-There was documentation Resident #2's blood pressure on 04/07/25 at 10:00am was 97/61.
-There was documentation Resident #2's blood pressure on 04/10/25 at 10:00am was 85/67.
-There was documentation Resident #2's blood pressure on 04/07/25 at 10:00am was 96/87.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry to check Resident #2's blood pressure two times per week and to notify the PCP if the SBP was greater than 150 or less than 100 and DBP was greater than 100 or less than 50.
-There was documentation Resident #2's blood

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pressure on 05/01/25 at 10:00am was 109/47.

Review of Resident #2's record revealed there was no documentation the PCP was notified of blood pressures outside of parameters.

Attempted telephone interview with Resident #2's PCP on 05/14/25 at 11:32am was unsuccessful.

Refer to the interview with a medication aide on 05/14/25 at 1:13pm.

Refer to the interview with the Administrator on 05/14/25 at 12:47pm.

2. Review of Resident #3's current FL2 dated 11/27/24 revealed:
-Diagnoses included hypertension.
-Resident #3's blood pressure was to be taken once weekly.

Review of Resident #3's PCP orders dated 03/27/25 revealed there was an order to check Resident #3's blood pressure once weekly and notify the PCP if the systolic blood pressure was greater than 150 or 1ess than 100 and the diastolic blood pressure was greater than 100 or less than 50.

Review of Resident #3's April 2025 eMAR revealed:
-There was an entry to check Resident #3's blood pressure once weekly and notify the PCP if the systolic blood pressure was greater than 150 or less than 100 and the diastolic blood pressure was greater than 100 or less than 50.
-There was documentation that Resident #3's blood pressure on 04/28/25 at 10am was 95/56.

Review of Resident #3's May 2025 eMAR

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revealed:
-There was an entry to check Resident #3's blood pressure once weekly and notify the PCP if the systolic blood pressure was greater than 150 or less than 100 and the diastolic blood pressure was greater than 100 or less than 50.
-There was documentation that Resident #3's blood pressure on 05/05/25 at 10:00am was 152/84.

-Review of Resident #3's record revealed there was no documentation the PCP was notified of blood pressures outside of parameters.

Attempted telephone interview with Resident #3's PCP on 05/14/25 at 11:32am was unsuccessful.

Refer to the interview with a medication aide on 05/14/25 at 1:13pm.

Refer to the interview with the Administrator on 05/14/25 at 12:47pm.

3. Review of Resident #4's current FL2 dated 01/28/25 revealed:
-Diagnoses included hypertension.
-Resident #4's blood pressure was to be taken twice weekly.

Review of Resident #4's PCP orders dated 03/27/25 revealed there was an order to check Resident #2's blood pressure twice weekly and notify the PCP if the systolic blood pressure is greater than 150 or less than 100 and the diastolic blood pressure is greater than 100 or less than 50.

Review of Resident #4's March 2025 eMAR revealed:
-There was an entry to check Resident #4's blood

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pressure two times weekly and notify the PCP if the systolic blood pressure was greater than 150 or less than 100 and the diastolic blood pressure was greater than 100 or less than 50.
-There was documentation Resident #4's blood pressure on 03/07/25 at 8am was 93/58.
-There was documentation Resident #4's blood pressure on 03/10/25 at 8am was 99/65.

Review of Resident #4's April 2025 eMAR revealed:
-There was an entry to check Resident #4's blood pressure two times weekly and notify the PCP if the systolic blood pressure was greater than 150 or less than 100 and the diastolic blood pressure was greater than 100 or less than 50.
-Resident #4's blood pressure on 04/28/25 at 8:00am was 90/62.

Review of Resident #4's record revealed there was no documentation the PCP was notified of blood pressures outside of parameters.

Attempted telephone interview with Resident #4's PCP on 05/14/25 at 11:32am was unsuccessful.

Refer to the interview with a medication aide on 05/14/25 at 1:13pm.

Refer to the interview with the Administrator on 05/14/25 at 12:47pm.

_____

Interview with a medication aide (MA) on 05/14/25 at 1:13pm revealed:
-She was aware there was an order for blood pressures weekly but did not know she was to call the PCP if the blood pressure was over or under the parameters.
-She was never asked to audit any of the charts.

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D 273	Continued From page 5 Interview with the Administrator on 05/14/25 at 12:47pm revealed: -She was not aware staff was not notifying the PCP when blood pressures were outside of parameters. -She expected staff to be following orders. -Chart audits were completed two times a year with last review in March 2025. -She knew she was behind on chart audits.	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: Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents who had orders for a medication to treat mental health disorders (Resident #5). The findings are: Review of Resident #5's current FL2 dated 03/13/25 revealed: -Diagnoses included paranoid schizophrenia. -There was an order for olanzapine (a medication to treat mental health disorders) 20mg, one tablet at bedtime. Review of Resident #5's Primary Care Provider's	D 276		

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(PCP) orders dated 03/27/25 revealed there was an order for olanzapine 20mg, one tablet at bedtime.

Review of Resident #5's hospital discharge summary dated 04/16/25 revealed:
-Resident #5 was hospitalized for hyperglycemia (high blood sugar levels) from 04/14/25 through 04/16/25.
-There was an order Resident #5's olanzapine was changed to olanzapine 15mg, one tablet at bedtime.

Review of Resident #5's April 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for olanzapine 20mg, one tablet every night at bedtime.
-Olanzapine 20mg was documented as administered daily at 7:00pm except on 04/14/25 and 04/15/25 because the resident was out of the facility.

Review of Resident #5's May 2025 eMAR revealed:
-There was an entry for olanzapine 20mg, one tablet every night at bedtime.
-Olanzapine 20mg was documented as administered daily at 7:00pm from 05/01/25 through 05/12/25.

Telephone interview with a representative with the facility's contracted pharmacy on 05/14/25 at 11:50am revealed:
-The pharmacy was responsible for entering residents' medication orders into the eMAR system.
-The pharmacy received Resident #5's hospital discharge summary on 04/16/25.
-Pharmacy staff missed Resident #5's order

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change for olanzapine 15mg, one tablet at bedtime.

Telephone interview with a second representative with the facility's contracted pharmacy on 05/14/25 at 12:28pm revealed:
-Resident #5 was hospitalized for increased blood sugar levels.
-Olanzapine could cause increased blood sugar levels and she thought that may have been the reason the hospital decreased Resident #5's olanzapine dosage.

Interview with a medication aide (MA) on 05/14/25 at 1:16pm revealed:
-The MAs were not responsible for resident hospital discharge summaries or orders.
-The Administrator was responsible for sending hospital discharge summaries to the pharmacy for orders to be entered into the eMAR system.

Interview with the Administrator on 05/14/25 at 10:55am and 12:40pm revealed:
-She was responsible for sending orders to the pharmacy.
-Pharmacy staff were responsible for entering orders into the eMAR system.
-She sent Resident #5's discharge summary dated 04/16/25 to the pharmacy, the PCP, and the home health nurse.
-She tried to check the medication cart the day after a medication order was received to ensure the medication was delivered from the pharmacy but missed the olanzapine order change for Resident #5.
-The pharmacy received electronic prescriptions (e-script) from the hospital for Resident #5 new medications but did not receive an e-script for the olanzapine dosage change and that may be the reason the pharmacy missed the order.

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D 276	Continued From page 8 Attempted telephone interview with Resident #5's PCP on 05/14/25 at 11:32am was unsuccessful.	D 276		
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 a medication was administered as prescribed for 1 of 5 residents (Resident #3) related to a medication used to control blood sugar. The findings are: Review of Resident #3's current FL2 dated 11/27/24 revealed diagnoses included type 2 diabetes mellitus. Review of Resident #3's Primary Care Provider's (PCP) orders dated 03/27/25 revealed there was an order for Insulin Aspart Flexpen 100 unit/ml pen, inject 30 units under the skin three times daily before meals and hold if blood sugar is less than 100. Review of Resident #3's March 2025 electronic Medication Administration Record (eMAR)	D 358		

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revealed:
- Aspart Flexpen 100 unit/ml pen, inject 30 units under the skin three times daily before meals and hold if blood sugar is less than 100.
-There was documentation Resident #3's blood sugar on 03/08/25 at 11:30am was 96 and was given 30 units of Aspart Flexpen 100 units.
-There was documentation Resident #3's blood sugar on 03/16/25 at 11:30am was 104 and Aspart Flexpen 100 units was held.
-Documentation showed that Resident #3 did not have his finger stick blood sugar (FSBS) done on 03/30/25 at 11:30am.

Review of Resident #3's April 2025 eMAR revealed:
- Aspart Flexpen 100 unit/ml pen, inject 30 units under the skin three times daily before meals and hold if blood sugar is less than 100.
-There was documentation Resident #3's blood sugar on 04/05/25 at 11:30am was 81 and was given 30 units of Aspart Flexpen 100 units.
-There was documentation Resident #3's blood sugar on 01/19/25 at 11:30am was 116 and Aspart Flexpen 100 units was held.
-There was documentation Resident #3's blood sugar on 04/27/25 at 11:30am was 122 and Aspart Flexpen 100 units was held.

Review of Resident #3's record revealed there was no documentation the PCP was notified of the blood sugar discrepancies.

Interview with a medication aide (MA) on 05/14/25 at 11:13am revealed:
-She was aware of the blood sugar parameters on Resident #3.
-She was not aware Resident #3 did not have his FSBS done on 03/30/25.
-She was not aware of any issues on Resident

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D 358	Continued From page 10 #3's eMAR for March and April 2025. -She was not aware if audits were completed on Resident #3's eMAR. Interview with the Administrator on 05/14/25 at 12:47pm revealed: -She was not aware the staff did not follow orders. -She did not think the medication aides (MA) were aware because they would have made her aware. -She expected the MAs to follow orders. -Chart audits were to be completed twice a year, and the last audit was March 2025. Attempted telephone interview with Resident #3's PCP on 05/14/25 at 11:32am was unsuccessful.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 6 residents sampled who received anti-anxiety medication (Resident #6). The findings are:	D 392		

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D 392	Continued From page 11 Review of Resident #6's current FL2 dated 08/16/24 revealed: -Diagnoses included anxiety disorder. -There was an order fore lorazepam 0.5 mg, (a medication to treat anxiety) one tablet twice daily. Review of Resident #6 Primary Care Provider's (PCP) orders dated 03/27/25 revealed an order for lorazepam 0.5mg, one tablet twice daily. Review of Resident #6's Control Substance Count (CSCS) for lorazepam revealed: -Lorazepam 0.5mg, 28 tablets were dispensed to the facility on 05/01/25. -The directions indicated Resident #6 was to receive lorazepam 0.5mg, one tablet twice daily. Observation of a medication pass on 05/14/28 at 7:55am revealed: -The medication aide (MA) removed one tablet of lorazepam 0.5mg from the bubble pack for Resident #6. -There were four tablets remaining in the bubble pack. -The MA signed the CSCS after she administered lorazepam 0.5mg, one tablet to Resident #6. -The CSCS for Resident #6's lorazepam 0.5mg revealed there were 3 tablets remaining. Interview with the MA on 05/14/25 at 8:10am and 1:16pm revealed: -The MAs were responsible to document controlled substance administration in the residents' electronic Medication Administration Record (eMAR) and on the CSCS that were kept in a logbook on the medication cart. -The MAs were responsible to ensure the controlled substance count matched the CSCS. -The MAs were responsible to complete a	D 392		

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secondary controlled substance count form at the end of each shift that indicated the resident's name, the medication and frequency, the quantity remaining, the signature of the MA completing their shift and the signature of the MA arriving on shift.
-The secondary controlled sheet was placed in the Administrator's office after it was completed.
-She did not count off on controlled substances that morning with the MA that was completing her shift because that MA was dealing with a resident issue that was taking an extended amount of time.
-She took the medication cart keys from the MA completing her shift so she could begin her medication pass.
-Typically, at shift change the MA completing her shift and the MA coming on duty compared the CSCS book with the secondary form, not physically looking at the medications on hand.
-When she filled out the secondary form at the end of her shift, she usually looked at the medications on hand but did not do that during her previously worked shift yesterday (05/13/25).
-She was unsure how she and the other MAs missed the count was off.

Interview with the Administrator on 05/14/25 at 8:58am revealed:
-The MAs were responsible to ensure controlled substance medication counts matched what was documented on the CSCSs.
-She implemented the secondary form because staff were finding discrepancies.
-She expected the MA to count the medications on hand and put the quantity on the secondary form, while comparing it to the CSCS.
-The previous facility nurse was responsible for reviewing the secondary controlled substance count sheets, but she left her position on

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D 392	Continued From page 13 01/09/25.	D 392		