STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073022	A. BUILDING: _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ADULT CARE HOME	3067 CHUB LAKE ROAD ROXBORO, NC 27574

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/05/25.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 2 of 3 sampled residents (#1 and #2) including a supplement and a medication for gastric reflux (#1) a medication for gastric reflux (#2).	C 342		

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C 342	Continued From page 1 The findings are: 1. Review of Resident #1's current FL-2 dated 10/16/24 revealed diagnoses included hypertension, hypokalemia, and chronic obstructive pulmonary disease (COPD). a. Review of Resident #1's current FL-2 dated 10/6/24 revealed there was an order for omeprazole 40mg (used to treat gastric reflux) twice daily. Review of Resident #1's April 2025 eMAR revealed: -There was an entry for omeprazole 40mg twice daily with a scheduled administration time of 6:00am and 4:30pm. -There was documentation omeprazole was administered 17 of 30 opportunities at 6:00am from 04/01/25 to 04/30/25. -There were 13 blanks on the eMAR for omeprazole 40mg at 6:00am from 04/1/25 to 04/30/25. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for omeprazole 40mg twice daily with a scheduled administration time of 6:00am and 4:30pm. -There was documentation omeprazole was administered 17 of 31 opportunities at 6:00am from 05/01/25 to 05/31/25. -There were 14 blanks on the eMAR for omeprazole 40mg at 6:00am from 05/1/25 to 05/31/25. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/05/25 revealed: -There was an entry for omeprazole 40mg twice daily with a scheduled administration time of	C 342		

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6:00am and 4:30pm.
-There was documentation omeprazole was administered 17 of 31 opportunities at 6:00am from 06/01/25 to 06/05/25.
-There was 1 blank on the eMAR for omeprazole 40mg at 6:00am from 06/01/25 to 06/05/25.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/25 at 12:33pm revealed:
-Resident #1 had an order for omeprazole 40mg twice daily.
-The pharmacy dispensed 56 omeprazole 40mg, a 28-day supply, on 03/20/25, 04/14/25, and 05/13/25.

Observation of Resident #1's medication on hand on 06/05/25 at 11:45am revealed there were omeprazole 40mg available for administration that was dispensed on 05/13/25.

Telephone interview with a medication aide (MA) on 06/05/25 at 1:34pm revealed:
-She administered omeprazole 40mg to Resident #1 each morning.
-She clicked off on the eMAR after administration of the medication.
-She did not know the eMAR was blank after she had signed she had administered the medications.

Interview with the Administrator on 06/05/25 at 1:08pm revealed:
-She had not noticed the omeprazole had blanks at 6:00am administration time.
-The omeprazole had been administered as ordered at 6:00am each morning.
-She did not know why initials were not documented on the eMARs when the MA signed off on the EMAR.

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C 342	Continued From page 3 b. Review of Resident #1's current FL-2 dated 10/6/24 revealed there was an order for potassium chloride extended release (ER) 10mEq (used as a replacement supplement) daily. Review of Resident #1's April 2025 eMAR revealed: -There was an entry for potassium chloride 10mEq daily with a scheduled medication administration time of 8:00am. -There was documentation potassium chloride was administered 15 of 30 opportunities from 04/01/25 to 04/30/25. -There were 15 entries of an X placed on the eMAR every other day. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for potassium chloride 10mEq daily with a scheduled medication administration time of 8:00am. -There was documentation potassium chloride was administered 16 of 31 opportunities from 05/01/25 to 05/31/25. -There were 15 entries of an X placed on the eMAR every other day. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/05/25 revealed: -There was an entry for potassium chloride 10mEq daily with a scheduled medication administration time of 8:00am. -There was documentation potassium chloride was administered 3 of 5 opportunities from 06/01/25 to 06/05/25. -There were 2 entries of an X placed on the eMAR every other day.	C 342		

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Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/25 at 12:33pm revealed:
-Resident #1 had an order for potassium chloride 10mEq daily.
-The pharmacy dispensed 28 potassium chloride 10mEq, a 28-day supply, on 03/20/25, 04/14/25, and 05/13/25.

Observation of Resident #1's medication on hand on 06/05/25 at 11:45am revealed potassium chloride was available for administration that was dispensed on 05/13/25.

Telephone interview with a MA on 06/05/25 at 1:34pm revealed:
-She administered potassium chloride 10mEq to Resident #1 each morning.
-She clicked off on the eMAR after administration of the medication.
-She did not know the eMAR was blank after she had signed she had administered the medications.

Interview with the Administrator on 06/05/25 at 1:08pm revealed:
-She had not noticed the potassium chloride was set up to administer every other day in the eMAR.
-The potassium chloride showed on the eMAR to administer every day, and the medication had been administered daily as ordered.
-She did not know how the eMAR appeared as if the potassium chloride was to be given every other day when it was ordered for daily.

2. Review of Resident #2's current FL-2 dated 02/17/25 revealed:
-Diagnoses included rhabdomyolysis, muscle weakness, and insomnia.
-There was an order for omeprazole 20mg (used

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C 342	Continued From page 5 to treat gastric reflux) every morning. Review of Resident #2's April 2025 eMAR revealed: -There was an entry for omeprazole 20mg every morning with a scheduled administration time of 7:00am. -There was documentation omeprazole was administered 16 of 30 opportunities from 04/01/25 to 04/30/25. -There were 14 blanks on the eMAR for omeprazole 40mg from 04/1/25 to 04/30/25. Review of Resident #2's May 2025 eMAR revealed: -There was an entry for omeprazole 20mg every morning with a scheduled administration time of 7:00am. -There was documentation omeprazole was administered 16 of 30 opportunities from 04/01/25 to 04/30/25. -There were 14 blanks on the eMAR for omeprazole 40mg from 04/1/25 to 04/30/25. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/25 at 12:33pm revealed: -Resident #2 had an order for omeprazole 20mg daily. -The pharmacy dispensed 28 omeprazole 20mg, a 28-day supply, on 03/20/25, 04/14/25, and 05/13/25. Observation of Resident #1's medication on hand on 06/05/25 at 11:45am revealed there were omeprazole 20mg available for administration that was dispensed on 05/13/25. Telephone interview with a medication aide (MA) on 06/05/25 at 1:34pm revealed:	C 342		

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C 342	Continued From page 6 -She administered omeprazole 20mg to Resident #1 each morning. -She clicked off on the eMAR after administration of the medication. -She did not know the eMAR was blank after she had signed she had administered the medications. Interview with the Administrator on 06/05/25 at 1:08pm revealed: -She had not noticed the omeprazole had blanks at the 7:00am administration time. -The omeprazole had been administered as ordered at 7:00am each morning. the eMAR. -She did not know why initials were not documented on the eMARs when the MA signed off on the EMAR. _____ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/25 at 12:33pm revealed: -The pharmacy started using a third party for eMARs in January 2025. -The pharmacy entered the order into the computer system. -The third party created the eMAR and the facility would have access to the eMAR through the computer. Interview with the Administrator on 06/05/25 at 1:08pm revealed: -She printed the eMAR at the end of each month, reviewed them and took them to the Primary Care Provider (PCP) to sign. -She looked over the eMARs for accuracy each month before she took them to the PCP for signature. -The pharmacy was working with a third party to set up the eMARS on the computer.	C 342		

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C 342	Continued From page 7 -If the MA did not sign off on the eMAR when a medication was administered, she would get an alert on her computer. -If she received an alert, she would follow up as to why the medication was not administered . -She had not received any alerts in the past 3 months of a medication not being administered as ordered.	C 342		