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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 05/28/25 and 05/29/25.	D 000		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff performing a care task were competent for 1 of 5 sampled residents (#3) related to application of a debriding agent by medication aides (MAs) to a wound.	D 161		

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D 161	Continued From page 1 The findings are: Review of Resident #3's current FL-2 dated 05/06/25 revealed: -Diagnosis included encephalopathy, unspecified. -There was an order for Santyl 200 unit/gram apply topically to left 4th toe daily at 8:00 AM (Santyl is a topical enzyme medication used to remove damaged skin from wounds to promote healing of wounds). Review of Resident #3's previous FL-2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an order for Santyl 200 unit/gram apply topically to left 4th toe daily at 8:00 AM. -The facility medication aides (MAs) initialed that they performed application of Santyl 13 out of 17 daily opportunities between 05/13/25 and 05/29/25. -The Santyl was discontinued on 05/29/25. Observation of Resident #3's medications on hand on 05/29/25 at 2:45pm revealed there were 2 tubes of Santyl ointment in the medication cart; one with a dispense date of 05/12/25 that was unopened and one with no dispensing information that was partially used. Interview with Resident #3's hospice nurse on 05/29/25 at 8:55am revealed: -She was not aware that Santyl was ordered for the resident. -She had never applied Santyl to the resident.	D 161		

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-MAs should only be utilizing the facility standing orders for skin tears or wounds.
-She did not think MAs were allowed to apply Santyl to a wound.

Interview with a MA on 05/29/25 at 2:30pm revealed:
-She had been applying Santyl to Resident #3's wound whenever she worked on his hall.
-She applied Santyl by cleaning the wound with saline, putting Santyl on gauze, and then by dabbing the Santyl to the left 4th toe.
-Any date she or other MAs had documented their initials on the eMAR for the Santyl meant they applied the Santyl to the wound.
-She did not have the qualifications to apply Santyl or medications like it to wounds.

Interview with the Administrator on 05/29/25 at 2:55pm revealed:
-She previously thought Resident #3's Santyl was discontinued, but she had since reviewed the chart and eMAR and saw that the Santyl was ordered and being applied by MAs.
-MAs were not allowed to apply Santyl because it was a debridement medication.

Telephone interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed:
-She did not know the resident was receiving Santyl prior to being notified by the facility on 05/29/25 when she was asked for an order to discontinue the Santyl.
-Her last conversation regarding Santyl was asking the Administrator to discuss the Santyl with hospice when the resident returned to the facility from the skilled nursing facility.
-Santyl was a debriding agent that would harm healthy tissue if not applied correctly, specifically

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D 161	Continued From page 3 if applied to healthy skin. -She gave an order to discontinue the Santyl on 05/29/25.	D 161		
D 238	10A NCAC 13F .0703 (f) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to contact the primary care provider (PCP) for clarification of the FL-2 for 1 of 5 sampled residents (#3) related to a medication used for wound care. The findings are: Review of Resident #3's current FL2 dated 05/06/25 revealed: -Diagnosis included encephalopathy, unspecified. -There was an order for Lidocaine pain relief 4% patch apply to left shoulder in the morning (Lidocaine pain relief 4% patch is a topical medication that works by blocking nerve signals	D 238		

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at the nerve endings in the skin to reduce pain).
-There was an order for Santyl ointment 200 unit/gram apply topically to the left 4th toe one time a day (Santyl ointment is a topical enzyme medication used to remove damaged skin which promotes the growth of healthy skin).

Review of Resident #3's previous FL2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy.

Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 4% patch apply 1 patch topically to right hip at bedtime and remove in the morning after 12 hours for pain.
-Lidocaine 4% patch was documented as administered to the right hip at 8:00pm from 05/12/25 through 05/27/25.
-Lidocaine 4% patch was documented as removed daily at 8:00am from 05/13/25 through 05/28/25.
-There was no entry for Lidocaine 4% patch apply to left shoulder in the morning.
-There was an entry for Santyl ointment apply to left 4th toe topically daily for irritation scheduled to be administered at 8:00am.
-Santyl was documented as administered on 13 out of 17 opportunities.

Observation of Resident #3's medications on hand on 05/29/25 at 2:30pm revealed:
-There were 2 tubes of Santyl ointment in the medication cart; one with a dispense date of 05/12/25 that was unopened and one with no dispensing information that was partially used.
-There were 13 Lidocaine patches in a box.

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D 238	Continued From page 5 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/29/25 at 9:05am revealed: -When a resident was on a leave of absence from the facility, all medication orders remained active unless there was a discontinue order. -When Resident #3 returned, the facility faxed his new FL2 dated 05/06/25 on 05/12/25. -The order for Lidocaine patches was previously written on 12/02/24 with instructions to apply to left hip each night and remove in the morning. -The order remained active in their system and a refill could be requested at any time. Interview with the medication aide (MA) on 05/29/25 at 2:30pm revealed: -MAs were initialing that they applied Resident #3's Santyl. -She had applied Santyl medication to the patient's left 4th toe wound as directed by the eMAR. Telephone interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed: -She did not know the resident was receiving Santyl prior to being notified by the facility on 05/29/25 when she was asked for an order to discontinue the Santyl. -Her last conversation regarding Santyl was asking the Administrator to discuss the Santyl with hospice when the resident returned to the facility from the skilled nursing facility. -She gave an order to discontinue the Santyl the date of the interview, 5/29/25. -She did not know that the location for the Lidocaine patch was written on the FL-2 as left shoulder and had not heard any complaints of left shoulder pain from Resident #3.	D 238		

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D 238	Continued From page 6 Interview with Resident #3's hospice nurse on 05/29/25 at 8:55am revealed: -She was not aware that Santyl was ordered for the resident. -She had never applied Santyl to the resident. -MAs should only be utilizing the facility standing orders for skin tears or wounds. -She did not think MAs were allowed to apply Santyl to a wound. Interview with the Administrator on 05/29/25 at 2:55pm revealed: -Medication aides were not supposed to apply Santyl to any resident. -She should have contacted PCP to clarify both the Lidocaine patch order and the Santyl from the FL-2.	D 238		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;	D 255		

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D 255	Continued From page 7 (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) was assessed after a signification change in condition. The findings are: Review of Resident #3's current FL-2 dated 05/06/25 revealed diagnosis included encephalopathy, unspecified.	D 255		

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D 255	Continued From page 8 Review of Resident #3's previous FL2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy. Review of Resident #3's last completed Personal Care Physician Authorization and Care Plan dated 11/06/24 revealed: -Resident #3 was ambulatory with a rolling walker. -He was not on oxygen (O2). -There were no wound or skin details other than his skin was fragile, thin, and he liked to pick at scabs. -He was occasionally incontinent less than daily. -The listed and required personal care tasks included staff assistance with activities of daily living and administration of medications. -Resident #3 was independent for eating, toileting, ambulation/locomotion, grooming/personal hygiene, and transferring. -He required supervision for dressing. -He required extensive assistance for bathing. Review of Resident #3's Primary Care Routine Visit Notes dated 05/12/25 and 05/19/25 revealed: -The resident returned to the facility on 05/12/25 after an extended 7 week stay in a skilled nursing facility (SNF) following a two-week long hospitalization after a fall. -He was noted to have osteomyelitis of the left great toe which was treated with intravenous antibiotics at the SNF. -He required continuous O2 at 2 liters overnight. -The family requested a hospice referral. Observation of Resident #3 on 05/28/25 at	D 255		

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10:03am revealed:
-The resident presented with an empty breakfast tray on his bedside table.
-The resident had an oxygen concentrator in his room but he was not wearing oxygen.
-The resident was reclining in bed in an incontinent brief and T-shirt only.
-There was a fifty-cent coin-sized, yellow, wet, and uncovered wound to the inner side of his left foot.
-There was an intact dressing on the inner side of his right foot.

Second observation of Resident #3 on 05/29/25 at 9:15am revealed:
-The hospice nurse and the medication aide (MA) were in the resident's room.
-The resident had a quarter-sized, red skin tear with a small amount of red drainage on his left hand that was redressed by the MA.
-There were two quarter-sized, red, skin tears with scant drainage on his right arm assessed by the hospice nurse and dressed by the MA.
-The resident was in bed wearing an undershirt and incontinent brief only.

Interview with Resident #3 on 05/29/25 at 9:15am revealed:
-He no longer got out of bed alone and two facility staff had to help him transfer to his wheelchair.
-He had not been out of bed in three days.

Interview with a personal care aide (PCA) on 05/29/25 at 2:30pm revealed:
-She was not working at the facility before Resident #3 was hospitalized.
-Staff knew what care to provide because the tasks the resident needed assistance with were posted near the time clock.
-Staff had to assist Resident #3 with all personal

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care needs except feeding.
-Staff had to bring and set up a meal tray for the resident.
-The resident then fed himself with setup.
-Resident #3 was safest with a bed bath and she did not think the resident could be safely showered because of his decline.
-The resident was last out of bed on 05/25/25.
-The resident often asked staff to go back to bed to rest once he was up in his wheelchair.

Interview with a MA on 05/29/25 at 2:30pm revealed:
-Resident #3 was walking, dressing himself, and continent prior to his hospitalization in February of 2025.
-The resident was no longer safe in the shower like he was before hospitalization and should be bathed in bed for safety.
-The only wounds Resident #3 had before his hospitalization were occasional skin tears.
-The resident could now only get up to a wheelchair with two staff members assisting him with transfers.
-The resident was last out of bed on 05/25/25.
-The resident often asked staff to go back to bed to rest once he was up in his wheelchair.

Interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed:
-Hospice was consulted for the resident's decline in health that was noticed when he returned to the facility on 05/12/25.
-Resident #3's wounds and status were expected to worsen, and that was the reason hospice was ordered.
-Resident #3 was "definitely a different person" and had declined since his hospitalization in February 2025.
-The resident was confused previously but was

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D 255	Continued From page 11 walking and performing most activities of daily living without assistance before he was hospitalized. Interview with the Administrator on 05/29/25 at 2:55pm revealed: -Resident #3's condition had deteriorated, and the resident was "like a different person" and "not the same man that left us." -Resident #3's decline was noticed as soon as he returned to the facility. -The resident was walking and performing most of his own activities of daily living prior to his hospitalization. -She did not realize that the significant change assessment was overdue. -There was a tickler in the electronic medical record (eMAR) that prompted needed assessments of residents. -She was recently promoted to Administrator from her role of Resident Care Director (RCD), and it was her responsibility to create and update care plans.	D 255		
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 observations, interviews, and record reviews, the facility failed to meet the acute health care needs for 1 of 5 residents (#3) sampled related to failure to notify hospice that dressings for the left foot wound had come off.	D 273		

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D 273	Continued From page 12 The findings are: Review of Resident #3's current FL-2 dated 05/06/25 revealed diagnosis included encephalopathy, unspecified. Review of Resident #3's previous FL2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy. Review of Resident #3's Physician's Order Form dated 05/12/25 revealed there was an order for hospice to evaluate and admit if appropriate. Review of Resident #3's Patient Care Order (Verbal Order) Forms revealed: -There was an order dated 05/16/25 from hospice for wound care to decubitus/pressure ulcer unstageable to left foot: cleanse wound with skintegrity wound cleanser, allow area to dry, apply plurogel (promotes moist wound environment) to wound bed and cover with foam, change dressing twice weekly and as needed for draining/lifting; the hospice nurse performs wound care during visits. -There was an order dated 05/28/25 from hospice for decubitus/pressure ulcer right lower outer foot great toe: cleanse wound with skintegrity wound cleanser, allow area to dry, apply plurogel to wound bed and cover with a foam dressing, change the dressing twice weekly and as needed for drainage/lifting; the hospice nurse performs wound care during visits. Observation of Resident #3 on 05/28/25 at 10:03am revealed: - There was a card-sized, intact bandage applied to the inner side of the resident's right foot.	D 273		

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D 273	Continued From page 13 -There was a fifty-cent coin-sized, yellow, wet wound on the inner side of the resident's left foot with no dressing covering it. -There was a black, dime-sized, dry wound to the knuckle of his left 4th toe. Interview with a medication aide (MA) on 05/28/25 at 3:17pm revealed: -The hospice staff were responsible for providing wound care to both feet, not the facility staff. -The hospice nurse visited the resident anywhere from daily to three times a week to provide wound care for both feet. -The hospice nurse was in the facility today, 05/28/25, to dress the wounds to the resident's feet, but she had not looked at his feet to confirm that the dressings were in place. Telephone interview with the hospice nurse on 05/28/25 at 3:54pm revealed: -Resident #3 was admitted to hospice on 05/14/25. -Hospice was responsible for providing wound care for the wounds on both feet. -The right foot wound was new, she found this wound at a previous visit, and she did not receive notification that the wound was present from facility staff. -She had not started the ordered treatment on the resident's right foot wound because the supplies she ordered were not delivered yet. -She did not visit the resident today, 05/28/25, as thought by the MA. -She would come tomorrow and perform the visit including performing wound care to both feet. -She was not notified that the left foot dressing was missing. -Facility staff should notify her if the dressings on Resident #3's feet were missing.	D 273		

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	HAL074045	A. BUILDING: _____ B. WING _____	05/29/2025

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Observation of Resident #3 on 05/29/25 at 8:10am revealed:
-There was no dressing on the wound on the inner side of his left foot.
-He repeatedly rubbed both feet together and rubbed both feet on the footboard of the bed.
-The Administrator entered the resident's room at 8:15am, and she was on the phone with hospice reporting that the dressing was not on his left foot.

Interview with the Administrator on 05/29/25 at 8:15am revealed:
-Resident #3 handed her some used bandages this morning when she checked on him.
-She then saw the dressing was not on his left foot wound.
-She came back to the room to wrap the wound until hospice arrived later this morning.
-She notified hospice that the dressings were missing to Resident #3's feet this morning.
-The resident was known to pick at wounds and bandages.

Interview with a medication aide (MA) on 05/29/25 at 2:30pm revealed:
-Hospice staff dressed the wounds on Resident #3's feet.
-If the dressings on his feet came off, the facility staff would call hospice and report.
-The hospice nurse had educated her to call hospice if the dressings were not present.

Interview with Resident #3's hospice nurse on 05/29/25 at 8:55am revealed:
-She most recently visited the resident on 05/26/25; she did not visit on 05/28/25.
-The facility should dress any new skin tears that occurred per their standing orders.
-Facility staff were supposed to call hospice if the

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D 273	Continued From page 15 dressings to the resident's feet came off in between her scheduled visits. -She did not want the wound to the left inner side of the resident's foot left open to air. -If the dressing was off, she expected a call from the facility notifying her that the dressing was not intact. Interview with the Administrator on 05/29/25 at 2:55pm revealed: -She did not know Resident #3's left foot dressing was missing all day on 05/28/25. -The resident handed her bandages this morning and she noticed the left foot was not dressed at that time. -The facility staff should have notified her if the dressings were missing from the resident's feet and she would have called hospice and applied a wrap to cover them until hospice arrived. Interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed: -The wounds on the inner side of the resident's left and right feet should always be covered with a dressing to prevent infection. -Hospice staff should dress the wounds and if the dressing came off, the facility staff should contact hospice.	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	D 276		

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D 276	Continued From page 16 Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure implementation and documentation of orders for 1 of 5 sampled residents (#3) related to standing orders for wound care. The findings are: Review of Resident #3's current FL-2 dated 05/06/25 revealed: -Diagnosis included encephalopathy, unspecified. -There was an order for Santyl ointment 200 unit/gram apply topically to the left 4th toe one time a day (Santyl ointment is a topical enzyme medication used to remove damaged skin which promotes the growth of healthy skin). Review of Resident #3's previous FL-2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy. Review of Resident #3's Standing Physician Orders dated 12/11/24 revealed there was a standing orders sheet dated 12/11/24 to cleanse area with normal saline then apply Neosporin Ointment as needed to area every day until healed, cover with non-adhesive dressing/Bandaid and notify the physician if not healed in 7 days (Neosporin is an antibacterial ointment used to prevent infection). Review of Resident #3's Patient Care Order (Verbal Order) dated 05/28/25 revealed there was	D 276		

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an order from hospice to cleanse skin tears with wound cleanser, allow to dry, apply polymem (a type of non-adhesive dressing), wrap with thick roll gauze and secure with tape, change dressing 3 times a week and as needed for drainage/lifting.

Observation of Resident #3 on 05/28/25 at 10:03am revealed there were two unsigned, undated, and untimed dressings on his right forearm and one unsigned, undated dressing on his left hand near his thumb.

Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Santyl ointment to apply to left 4th toe topically daily for irritation scheduled for 8:00am.
-The Santyl was documented as administered on the eMAR 13 out of 17 daily opportunities.
-There were no additional orders on the eMAR for wound care.

Interview with Resident #3's hospice nurse on 5/29/25 at 8:55am revealed:
-Hospice staff had not started to dress skin tear wounds on both arms because the ordered supplies had not been delivered yet.
-Facility staff were responsible for all arm wound dressings until supplies arrived for the new hospice order and facility staff were supposed to use the facility standing orders for wound care to perform the task.
-She discussed resident needs, changes, and instructions with the Administrator at each of her visits to facility.

Observation of Resident #3 on 05/29/25 from 9:15am to 10:12am revealed:
-The hospice nurse and the medication aide (MA)

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D 276	Continued From page 18 were in the resident's room. -There was one gauze dressing on the resident's right forearm that was removed by the hospice nurse with no wound or drainage present under the dressing. -There was an uncovered cluster on the resident's right arm of 3 shallow wounds that were partially scabbed and partially wet with a small amount of pink drainage. -The hospice nurse stated she thought the dressing must have slid down the arm from the cluster of wounds. -The dressing was removed from a second skin tear to the right forearm, the hospice nurse assessed the wound, and the MA applied the standing order wound care. -There was a dressing of dry gauze on a wound on the resident's left hand near his thumb. -The MA attempted to remove this dressing on the left hand and discovered the dressing was stuck to the resident's quarter-sized, scabbed, and dark red wound. -The MA reported that this wound did not have the required nonadhesive dressing covering it to prevent injury to the resident when the dressing was removed. -The MA used skin cleanser provided by the hospice nurse to remove the dressing which took over 15 minutes because the gauze was embedded into and stuck to the wound. -Resident #3 moaned, cried out, and verbalized having pain during dressing removal because gauze fibers were stuck into the wound and scab. Interview with the MA on 05/29/25 at 2:30pm revealed: -She used standing orders for any skin tears. -She had no place to document the wound care she performed that morning because the standing order for wounds was not activated on	D 276		

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D 276	Continued From page 19 the eMAR. -She knew that the standing order should be activated on the eMAR. -The wound that was dressed without the non-adhesive bandage on the resident's left hand was not dressed per standing orders. -The removal of the left hand dressing caused pain to the resident even though she used wound cleanser to moisten the gauze to aid in more gentle removal. Interview with the Assistant Resident Care Coordinator on 05/29/25 at 11:45am revealed: -The facility standing orders were in the eMAR and must be activated and moved from the standing order inactive list to the active list for staff to use a standing order and document it. -Any activated standing orders remained active for 3 days in order for staff to know that an ordered task should be performed and then document performing it. -No standing order was activated and documented as done for Resident #3's upper arm wounds and his left hand wound. Interview with the Administrator on 05/29/25 at 2:55pm revealed: -Any MA that discovered a skin tear wound should have activated the standing order for wound care on the eMAR and documented that the wound was dressed per that standing order. -The standing orders for wound care included application of a nonadherent dressing to prevent injury from dressing removal. -The left hand wound near the resident's left thumb should have had a nonadherent dressing on it to prevent injury. _____ The facility failed to provide wound care per facility standing orders to Resident #3's left thumb	D 276		

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D 276	Continued From page 20 and right arm wounds. The absence of a nonadherent dressing caused Resident #3 pain and distress when the incorrectly applied dressing was removed on 05/29/25. The wound care for all wounds that the facility was responsible for was not on the medication administration record. This failure was detrimental to the health, safety, and welfare of the resident which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/13/25.	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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 12 residents (#6) observed during the medication pass including errors with a medication used to treat gastroesophageal reflux and medications used for dietary supplements and for 1 of 5 sampled residents (#3) including a medicated eye	D 358		

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drops used to treat macular degeneration, a pain patch and a medication to be taken as needed used to treat nausea .

The findings are:

1.The medication error rate was 13% as evidenced by 4 errors out of 29 opportunities during the 12:00pm medication pass on 05/28/25 and the 8:00am medication pass on 05/29/25.

Review of Resident #6's current FL-2 dated 05/06/25 revealed diagnoses included muscle weakness, rheumatic mitral valve disease and fibromyalgia.

Review of Resident #6's Resident Register revealed she was admitted to the facility on 05/27/25 from a local rehabilitation facility.

a. Review of Resident #6's current FL-2 dated 05/06/25 revealed there was an order for omeprazole delayed release 20mg to be administered each morning. (Omeprazole is medication used to indigestion.)

Observation of the 8:00am medication pass on 05/29/25 revealed omeprazole delayed release 20mg was not administered.

Review of Resident #6's electronic medication administration record (eMAR) for May 2025 revealed there was no entry for omeprazole delayed release 20mg to be administered each morning.

Observation of medications on hand for Resident #6 on 05/29/25 at 11:39am revealed there was no omeprazole delayed release 20mg available for administration.

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D 358	Continued From page 22 Interview with Resident #6 on 05/29/25 at 3:52pm revealed she experienced pain and was unable to sit or stand for very long but had not experienced any indigestion for quite some time. Telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm revealed: -Omeprazole delayed release 20mg to be administered each morning was an active order and had not been dispensed for Resident #6. -Omeprazole was used to decrease stomach acid and would not be as effective if not taken as prescribed. Refer to telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm. Refer to telephone interview with a medication aide (MA) on 05/29/25 at 10:50am. Refer to interview with a second MA on 05/29/25 at 3:40pm. Refer to interview with the Administrator on 05/29/25 at 11:15am. b. Review of Resident #6's current FL-2 dated 05/06/25 revealed there was an order for magnesium oxide 250mg to be administered one time a day. (Magnesium Oxide is a supplement used to support magnesium levels in the blood.) Observation of the 8:00am medication pass on 05/29/25 revealed magnesium oxide 250mg was not administered. Review of Resident #6's electronic medication administration record (eMAR) for May 2025	D 358		

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D 358	Continued From page 23 revealed there was no entry for magnesium oxide 250mg to be administered one time a day. Observation of medications on hand for Resident #6 on 05/29/25 at 11:39am revealed there was no magnesium oxide 250mg available for administration. Telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm revealed -Magnesium oxide 250mg to be administered each day was an active order and had not been dispensed for Resident #6. -Magnesium was a vitamin supplement to support adequate magnesium in the blood. Refer to telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm. Refer to telephone interview with a medication aide (MA) on 05/29/25 at 10:50am. Refer to interview with a second MA on 05/29/25 at 3:40pm. Refer to interview with the Administrator on 05/29/25 at 11:15am. c. Review of Resident #6's current FL-2 dated 05/06/25 revealed there was an order for cyanocobalamin 1000mcg to be administered once a day. (Cyanocobalamin is a B12 vitamin used to support Vitamin B12 levels in the blood.) Observation of the 8:00am medication pass on 05/29/25 revealed cyanocobalamin 1000mcg was not administered. Review of Resident #6's electronic medication	D 358		

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administration record (eMAR) for May 2025 revealed there was no entry for cyanocobalamin 1000mcg to be administered one time a day.

Observation of medications on hand for Resident #6 on 05/29/25 at 11:39am revealed there was no cyanocobalamin 1000mcg available for administration.

Telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm revealed:
-Cyanocobalamin 1000mcg to be administered each day was an active order and had not been dispensed for Resident #6.
-Cyanocobalamin was a vitamin supplement to support adequate B vitamins in the blood.

Refer to telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm.

Refer to telephone interview with a medication aide (MA) on 05/29/25 at 10:50am.

Refer to interview with a second MA on 05/29/25 at 3:40pm.

Refer to interview with the Administrator on 05/29/25 at 11:15am.

d. Review of Resident #6's current FL-2 dated 05/06/25 revealed there was an order for vitamin D3 5000 units to be administered one time a day. (Vitamin D3 is a supplement used to support vitamin D levels in the blood.)

Observation of the 8:00am medication pass on 05/29/25 revealed the medication aide (MA) administered 3 tablets from a bottle labeled vitamin D3 2000 units at 9:11am to Resident #6.

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D 358	Continued From page 25 Review of Resident #6's electronic medication administration record (eMAR) for May 2025 revealed: -There was no entry for vitamin D3 5000 units to be administered one time a day. -There was an entry for vitamin D2 2,000units, 3 tablets (6,000 units) to be administered daily and scheduled for 8:00am and was documented as administered on 05/29/25. Observation of medications on hand for Resident #6 on 05/29/25 at 11:39am revealed: -There was no vitamin D3 5000 units available for administration. -There was an over-the-counter (OTC) bottle of vitamin D2 2,000 units available for administration. Telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm revealed: -The copy of Resident #6's FL-2 dated 05/06/25 was blurry but looked like vitamin D3 was ordered as 6,000 units to be administered each day. -Vitamin D3 was entered into the eMAR to administer 3 tablets of 2,000 units to equal 6,000 units each day but none had been dispensed for Resident #6. -Vitamin D3 was used to support vitamin D levels which affect immune and muscle health. Attempted telephone interview with Resident #6's Power of Attorney on 05/29/25 at 12:05pm was unsuccessful. Refer to telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm. Refer to telephone interview with a medication	D 358		

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D 358	Continued From page 26 aide (MA) on 05/29/25 at 10:50am. Refer to interview with a second MA on 05/29/25 at 3:40pm. Refer to interview with the Administrator on 05/29/25 at 11:15am. _____ Telephone interview with Resident #6's pharmacist on 05/29/25 at 10:14am and 4:18pm revealed: -They received a call from an MA at the facility on 5/27/25 requesting they hold dispensing of medications at that time because Resident #6's family was going to bring some medications in later that day. -They had not received a call from the facility with a request to dispense medications since 05/27/25. Telephone interview with a medication aide (MA) on 05/29/25 at 10:50am revealed: -Resident #6 was admitted to the facility on 05/27/25 from a local rehabilitation facility. -No medications were brought to the facility from the local rehabilitation facility for Resident #6. -She faxed Resident #6's FL-2 dated 05/06/25 to the pharmacy but told the pharmacy she would let them know if medications were needed. -She verbally passed on the information to the on-coming MA staff, but she did not call the pharmacy back and she was not sure if anyone had called the pharmacy with a dispensing request. Interview with a second MA on 05/29/25 at 3:40pm revealed: -The MA was responsible for checking medication against the FL-2 for newly admitted residents if they or family brought medications into the facility.	D 358		

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D 358	Continued From page 27 -The MA was responsible for faxing the FL-2 to the pharmacy and the pharmacy staff entered the medication orders onto the eMAR and the MA must approve the medication order on the eMAR for it to be administered. -MAs were expected to compare the medication label with the eMAR and the FL-2 prior to approving the order on the eMAR to be sure it was entered correctly. -Medications should always be requested from the pharmacy even if family were bringing medications in because medication orders may have changed and the family may bring in medications that were not ordered. Interview with the Administrator on 05/29/25 at 11:15am revealed: -MAs were responsible for approving medication orders on the eMAR when the medication arrived in the facility. -MAs should compare the medication label, the order on the eMAR and the FL-2 or other provider order prior to approving the medication for administration. -Resident #6's family brought in some medication late on 05/27/25 after Resident #6 was admitted. -She reconciled medications that came in with new admission residents but had not had an opportunity to reconcile Resident #6's medications. 2. Review of Resident #3's current FL-2 dated 05/06/25 revealed diagnosis included encephalopathy, unspecified. a. Review of Resident #3's current FL-2 dated 05/06/25 revealed there was an order for prednisolone acetate (AC) 1% drops instill 1 drop in both eyes two times a day (prednisolone AC is	D 358		

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D 358	Continued From page 28 a steroid medication used to treat eye inflammation and relieve symptoms of itching, swelling, and redness). Review of Resident #3's May 2025 electronic medical administration record (eMAR) revealed: -There was an order for prednisolone AC 1% eye drops instill 1 drop into both eyes two times a day at 8:00am and 8:00pm. -Prednisolone AC 1% was documented as administered 27 out of 34 opportunities. -Prednisolone AC 1% was not documented as administered at 8:00am on 05/13/25, 8:00pm on 05/18/25, 8:00am on 05/19/25, 8:00pm on 05/23/25, and 8:00pm on 05/27/25 with a note that it was not in the building/not in cart. -Prednisolone AC 1% was not documented as administered at 8:00pm on 05/22/25 and 8:00pm on 5/26/25 with a note that it had to be reordered from the pharmacy. Observation of medications on hand for Resident #3 on 05/28/25 at 11:00am revealed that prednisolone acetate 1% eye drops were not in the medication cart. Interview with a medication aide (MA) on 05/28/25 at 3:17pm revealed: -She reordered Resident #3's prednisolone acetate eye drops today, 05/28/25, from the facility pharmacy after administering the morning dose at 8:00am because it was the last dose on hand at the facility. -The eye drops were due to arrive at the facility from the pharmacy that same afternoon. Interview with Resident #3 on 05/29/25 at 8:10am revealed he received eye drops but he could not remember what the drops treated or how many eye drops he received.	D 358		

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D 358	Continued From page 29 Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/28/25 at 3:34pm revealed: -The last dispensed date of prednisolone AC eye drops for Resident #3 was 02/06/25. -The eye drops would have lasted and/or expired 28 days from 02/06/25. -The pharmacy did not receive any request from the facility to refill the prednisolone eye drops, including the refill the MA said was requested today, 05/28/25. Interview with a MA on 05/29/25 at 2:30pm revealed: -She documented administration of Resident #3's prednisolone AC eye drops for 8:00am today, 05/29/25, but she did not administer them. -Resident #3's eye drops were still not in stock on the cart for the resident. -She placed a request to refill the eye drops today to the facility pharmacy and they should arrive this evening. -She should have documented that the medication was not administered and placed a note as to why in the eMAR. Interview with the Administrator on 05/29/25 at 2:55pm revealed: -She did not know that Resident #3's prednisolone AC eye drops were not refilled and delivered on 05/28/25. -MAs could and should request refills for any missing medication. Interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed: -She did not know that the resident was not receiving prednisolone AC eye drops and that the pharmacy had not been contacted for refills of	D 358		

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D 358	Continued From page 30	D 358		

this medication since February of 2025.
-The eye drops were prescribed for macular degeneration but she was not sure of the consequences of not having the eye drops.

b. Review of Resident #3's Patient Care Orders (Verbal Order) revealed there was an order from hospice dated 05/15/25 for prochlorperazine 10 mg tablet give 1 tablet every 6 hours as needed for nausea (prochlorperazine is used to treat nausea).

Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed there was no entry for prochlorperazine.

Observation of medications on hand for Resident #3 on 05/28/25 at 11:00am revealed prochlorperazine was not in the medication cart.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/28/25 at 3:34pm revealed that the pharmacy had no record of prochlorperazine ever being ordered or dispensed for Resident #3.

Interview with Resident #3's hospice nurse on 05/28/25 at 3:54pm revealed she wanted the prochlorperazine ordered and on hand for the resident in case he developed nausea.

Interview with the Administrator on 05/29/25 at 2:55pm revealed:
-Resident #3's prochlorperazine should have arrived from the pharmacy the evening it was ordered, 05/15/25, and the medication should have been profiled on the eMAR that same evening.
-Evening shift was responsible for comparing orders to received medications from the

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pharmacy and ensuring the entry was added to the eMAR.
-Evening shift failed to ensure Resident #3's prochlorperazine arrived and was added to the eMAR.

Interview with Resident #3's primary care provider (PCP) on 05/29/25 at 4:10pm revealed:
-She was not concerned that prochlorperazine was not on hand because Resident #3 had no nausea since his return to the facility.
-She wanted the order on hand in case the resident developed nausea at some point in time.

c. Review of Resident #3's current FL-2 dated 05/06/25 revealed there was no order for Lidocaine pain relief 4% patch topically to right hip at bedtime and remove in the morning after 12 hours for pain (Lidocaine pain relief 4% patch is a topical medication that works by blocking nerve signals at the nerve endings in the skin to reduce pain).

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/29/25 at 9:05am revealed:
-When a resident was on a leave of absence from the facility, all medication orders remained active unless there was a discontinue order.
-The order for Lidocaine patches was previously written on 12/02/24 with instructions to apply to right hip each night and remove in the morning.
-The order remained active in their system and a refill could be requested at any time.

Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 4% pain relief patch apply 1 patch topically to right hip at

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bedtime (8:00pm) and remove in the morning after 12 hours (8:00am) for pain (Lidocaine 4% pain relief patch relieves pain by blocking pain nerve signals).
-Lidocaine 4% pain relief patch was documented as administered to right hip at 8:00pm on 05/28/25.
-Lidocaine 4% pain relief patch was documented as removed at 8:00am on 05/29/25.

Observation of Resident #3 on 05/29/25 at 9:30am revealed:
-There was an intact Lidocaine patch applied to the resident's left flank instead of to the ordered right hip dated 05/28/25 and timed for 8:31pm.
-There were no additional Lidocaine patches on the resident, including no patch on the right hip as ordered.

Interview with a medication aide (MA) on 05/29/25 at 2:30pm revealed:
-She documented removal of Resident #3's Lidocaine patch for 05/29/25 at 8:00am but she did not actually remove the patch.
-She did not know the Lidocaine patch was applied to the wrong part of the resident's body (left flank instead of right hip).

Interview with a second MA on 05/29/25 at 3:40pm revealed:
-She placed the Lidocaine patch on Resident #3 at bedtime on 05/28/25.
-She knew the order read to apply the patch on his right side.
-If the patch was on his left side, she must have applied the patch based on her right and not his right instead.

Interview with the Administrator on 05/29/25 at 2:55pm revealed the MA notified her of the error

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D 358	Continued From page 33 in location of the Lidocaine patch and of the fact that it was not removed this morning at 8:00am as ordered.	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). This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 2 of 5 sampled residents (#1,#3) including an eye drop and removal of a pain patch (#3) and a medication used to treat a thyroid	D 367		

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D 367	Continued From page 34 disorder (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 05/06/25 revealed diagnosis included encephalopathy, unspecified. a. Review of Resident #3's current FL-2 dated 05/06/25 revealed an order for prednisolone acetate (AC) 1% drops instill 1 drop in both eyes two times a day (Prednisolone AC is a steroid medication used to treat eye inflammation and relieve symptoms of itching, swelling, and redness). Review of Resident #3's previous FL-2 dated 12/02/22 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, hyperlipidemia, depression, spondylopathy, and arthropathy. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for prednisolone AC 1% eye drops instill 1 drop into both eyes two times a day at 8:00am and 8:00pm. -Prednisolone AC 1% was documented as administered 27 out of 34 opportunities. -Prednisolone AC 1% was not documented as administered at 8:00am on 05/13/25, 8:00pm on 05/18/25, 8:00am on 05/19/25, 8:00pm on 05/23/25, and 8:00pm on 05/27/25 with a note that it was not in the building/not in cart. -Prednisolone AC 1% was not documented as administered at 8:00pm on 05/22/25 and 8:00pm on 05/26/25 with a note that it had to be reordered from the pharmacy.	D 367		

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D 367	Continued From page 35 Observation of Resident #3's medications on hand on 05/28/25 at 11:00am revealed the prednisolone acetate 1% eye drops were not in the medication cart and available for administration. Interview with a medication aide (MA), on 05/28/25 at 3:17pm revealed: -She reordered Resident #3's prednisolone acetate eye drops today, 05/28/25, from the facility pharmacy after administering the morning dose because it was the last dose on hand at the facility. -The eye drops should arrive this afternoon. Interview with a pharmacist at the facility's contracted pharmacy on 05/28/25 at 3:34pm revealed: -The last dispensed date of Resident #3's prednisolone AC eye drops was 02/06/25. -The eye drops would have lasted and/or expired 28 days from the date of dispense. -The pharmacy did not receive any request from the facility to refill the prednisolone eye drops as of this interview. Interview with a MA on 05/29/25 at 2:30pm revealed: -She documented administration of Resident #3's prednisolone AC eye drops for 8:00am today but she did not administer them. -The eye drops were still not in stock on the cart. -She placed a request to refill the eye drops today, 05/29/25, to the facility pharmacy and they should arrive this evening. -She should have documented that the medication was not administered and placed a note as to why in the eMAR. Telephone interview with a second shift	D 367		

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medication aide on 05/29/25 at 3:40pm revealed:
-She worked and administered medications to Resident #3 during the evening shift on 05/25/25.
-She administered Resident #3 an eye drop but was unsure what kind because he received two different types.
-She was not aware there were no Prednisolone AC 1% eye drops on the medication cart available for administration.

Interview with the Administrator on 05/29/25 at 2:55pm revealed:
-She did not know Resident #3's Prednisolone AC 1% eye drops were not refilled and delivered on 05/28/25.
-Staff initials on the eMAR indicated the administration of a medication as ordered and an omission should be documented with a note attached as to why the medication was omitted.

b. Review of Resident #3's current FL-2 dated 05/06/25 revealed there was no order for Lidocaine pain relief 4% patch topically to right hip at bedtime and remove in the morning after 12 hours for pain (Lidocaine pain relief 4% patch is a topical medication that works by blocking nerve signals at the nerve endings in the skin to reduce pain).

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/29/25 at 9:05am revealed:
-When a resident was on a leave of absence from the facility, all medication orders remained active unless there was a discontinue order.
-The order for Lidocaine patches was previously written on 12/02/24 with instructions to apply to right hip each night and remove in the morning.
-The order remained active in their system and a refill could be requested at any time.

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D 367	Continued From page 37 Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lidocaine 4% pain relief patch apply 1 patch topically to right hip at bedtime (8:00pm) and remove in the morning after 12 hours (8:00am) for pain. -The Lidocaine patch was documented as removed on 05/29/25 at 8:00am. Observation of Resident #3 on 05/29/25 at 9:30am revealed there was an intact Lidocaine patch applied to the resident's left flank dated 05/28/25 and timed for 8:31pm. Observation of Resident #3 on 05/29/25 at 11:59am revealed the Lidocaine patch was still applied to the resident's left flank and dated 05/28/25 and timed for 8:31pm. Interview with a medication aide (MA) on 05/29/25 at 2:30pm revealed: -She documented removal of Resident #3's Lidocaine patch for 05/29/25 at 8:00am but she did not actually remove the patch. -She did not know the Lidocaine patch was applied to the wrong part of the resident's body (left flank instead of right hip or shoulder). Interview with the facility Administrator on 05/29/25 at 2:55pm revealed that the MA notified her that she documented removal of the Lidocaine patch but did not remove it. 2. Review of Resident #1's current FL2 dated 12/11/24 revealed: -Diagnoses included hypothyroidism (low thyroid level), dementia, atrial fibrillation and hypertension.	D 367		

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D 367	Continued From page 38 -His level of care was Special Care Unit. -There was an order for levothyroxine (levothyroxine is a synthetic thyroid hormone used to treat low thyroid levels) 50mcg, take one daily. Review of Resident #1's signed physicians order sheet dated 12/11/24 revealed an order for levothyroxine 50mcg, take one tablet daily at 6:30am. Review of Resident #1's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 50mcg, take one tablet daily, scheduled at 6:30am. -There was documentation that levothyroxine 50mcg was administered on 05/01/25 through 05/16/25 at 6:30am. -There was documentation levothyroxine 50mcg was not administered on 05/17/25 at 6:30am, with the exception documented as "none left". -There was documentation levothyroxine 50mcg was administered on 05/18/25 at 6:30am. -There was documentation levothyroxine 50mcg was not administered on 05/19/25 at 6:30am, with the exception documented as "not on cart". -There was documentation levothyroxine was administered on 05/20/25 through 05/28/25 at 6:30am. Observation of Resident #1's medications on hand on 05/28/25 at 4:04pm revealed a bubble card of levothyroxine 50mcg tablets, take one tablet daily at 6:30am for thyroid, with a dispense date of 05/18/25 for a quantity of 30 tablets, with 20 tablets remaining. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at	D 367		

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	HAL074045	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR - GREENVILLE	2097 WEST ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 367	Continued From page 39 8:41am revealed: -An order was received for Resident #1's levothyroxine 50mcg, take one daily on 10/30/24. -A new prescription for Resident #1's levothyroxine 50mcg, take one tablet daily at 6:30am was received on 05/09/25 for a quantity of 30 tablets with 11 refills. -Levothyroxine 50mcg was last dispensed for Resident #1 on 05/09/25, to take 1 daily for a quantity of 30 tablets for a 30-day supply. -Levothyroxine 50mcg, 30 tablets were sent to the facility for Resident #1 on 05/14/25. -Levothyroxine 50mcg was batch filled for Resident #1, and the batch started on 05/18/25. -Levothyroxine 50mcg should have been in the facility and available for Resident #1 on 05/17/25 and 05/19/25. Interview with the Administrator on 05/29/25 at 9:31am revealed: -Batch filled medications including Resident #1's levothyroxine were delivered to the facility on 05/18/25. -She had the dispensing sheets for the May 2025 batch medications that included Resident #1's levothyroxine. -Batch medications were delivered to the facility in the evening or at night. Review of the pharmacy dispensing sheet on 05/28/25 at 9:31am revealed levothyroxine 50mcg, 30 tablets delivered on 05/18/25 but there was not a delivery time documented. Interview with the lead MA on 05/29/25 at 9:36am revealed: -She was not sure why Resident #1's levothyroxine was documented as not available on 05/17/25, documented as administered on 05/18/25, and documented as "not on cart" on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 40 05/19/25. -She thought Resident#1's levothyroxine was pulled early from this month's (May 2025) batch and placed on the medication cart, and when the night shift MA placed all the new batch medications on the medication cart on the batch start date, she mistakenly pulled Resident #1's new levothyroxine medication card from the medication cart. Interview with a third MA on 05/29/25 at 10:56am revealed: -She worked the 11:00pm to 7:00am shift on 05/17/25, 05/18/25, and 05/19/25. -She could not remember for certain but thought the batch medications including Resident #1's levothyroxine were in the facility on 05/17/25 but the batch was not due to start until 05/18/25 so she could not administer Resident #1's levothyroxine until the new batch date. -She thought levothyroxine was available for Resident #1 on 05/18/25 and on 05/19/25 but could not explain why Resident #1's levothyroxine was documented as administered on 05/18/25 and documented as not available on 05/19/25. Interview with the Administrator on 05/29/25 at 3:38pm revealed: -The MAs were to always document if a medication was not administered and list a reason why it was not administered. -MAs should never document that a medication was administered if it was not available.	D 367		