STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VALLEY LIVING CENTER	1135 TAYLOR ROAD WESTFIELD, NC 27053

(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 conducted an annual and a follow-up survey on 06/04/25 to 06/05/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including a beta blocker, an antidiabetic combination, a cardiovascular agent, an antidepressant, a topical anesthetic, and a gastrointestinal agent (Resident #1); and a medication to treat an overactive bladder (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 04/11/25 revealed diagnoses included dementia, syncope, and hypokalemia. a. Review of Resident #1's current FL2 dated 04/11/25 revealed there was an order for carvedilol (a medication used to treat hypertension) 6.25mg take 1 tablet twice daily, hold if systolic blood pressure (SBP) less than	D 358		

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D 358	Continued From page 1 110, diastolic blood pressure (DBP) less than 60 or pulse less than 50. Review of Resident #1's hospice physician orders dated 04/29/25 revealed there was an order for carvedilol 6.25mg take 1 tablet twice daily, hold if BP less than 100/50. Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/01/25 to 04/30/25 revealed: -There was an entry for carvedilol 6.25mg take one tablet twice daily, hold if SBP less than 110, DBP less than 60 or pulse less than 50, scheduled for administration at 9:00am and 9:00pm. -There was documentation carvedilol was held when it should have been administered on 04/14/25 at 9:00pm. -There was documentation Resident #1's BP was 118/63 on 04/14/25 at 9:00pm. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed: -There was an entry for carvedilol 6.25mg take one tablet twice daily, hold if SBP less than 110, DBP less than 60 or pulse less than 50, scheduled for administration at 9:00am and 9:00pm. -There was documentation carvedilol was administered when it should have been held on 05/04/25 at 9:00pm and 05/21/25 at 9:00am. -Resident #1's BP values were documented as 89/61 on 05/04/25 at 9:00pm and 93/48 on 05/21/25 at 9:00am. -There was documentation carvedilol was held when it should have been administered on 05/05/25 at 9:00pm, 05/07/25 at 9:00am, 05/08/25 at 9:00pm, 05/15/25 at 9:00pm, 05/22/25 at 9:00pm, 05/24/25 at 9:00am,	D 358		

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05/29/25 at 9:00pm, and 05/31/25 at 9:00am.
-Resident #2's blood pressure BP values were documented as 101/58 on 05/05/25 at 9:00pm, 130/53 on 05/07/25 at 9:00am, 107/62 on 05/08/25 at 9:00pm, 108/58 on 05/15/25 at 9:00pm, 108/52 on 05/22/25 at 9:00pm, 108/53 on 05/24/25 at 9:00am, 105/52 on 05/29/25 at 9:00pm, and 132/57 on 05/31/25 at 9:00am.

Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed:
-There was an entry for carvedilol 6.25mg take one tablet twice daily, hold if systolic SBP less than 110, DBP less than 60 or pulse less than 50, scheduled for administration at 9:00am and 9:00pm.
-There was documentation carvedilol was administered when it should have been held on 06/01/25 at 9:00pm.
-There was documentation Resident #1's BP was 76/57 on 06/01/25 at 9:00pm.

Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm revealed:
-There was a medication card with 20 of 28 carvedilol 6.25mg tablets scheduled for administration at 9:00am with a dispensed date of 05/28/25 available for administration on the medication cart.
-There was a medication card with 21 of 28 carvedilol 6.25mg tablets scheduled for administration at 9:00pm with a dispensed date of 05/28/25 available for administration on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed:
-There was a current order on file for carvedilol 6.25mg take one tablet twice daily, hold if SBP

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less than 110, DBP less than 60 or pulse less than 50.
-Resident #1's carvedilol was dispensed on 03/26/25, 04/23/25, and 05/21/25 for a quantity of 56 tablets each.

Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/05/25 at 2:17pm was unsuccessful.

Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful.

Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed:
-She checked Resident #1's BP value before administering medication.
-She did not know there was a hospice order dated 04/29/25 with a lower BP hold parameter than what was on the eMAR.
-She followed the orders on the eMAR for medication hold parameters, including carvedilol.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed she did not know there was a hospice order dated 04/29/25 with a lower hold parameter for Resident #1's carvedilol.

Interview with the Administrator on 06/05/25 at 4:00pm revealed:
-She did not know Resident #1's carvedilol was administered when it should have been held twice in May 2025, and once in June 2025.
-She did not know Resident #1's carvedilol was

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held when it should have been administered for 8 of 62 opportunities in May 2025.
-She expected the MAs to follow hold parameters for medication orders.

b. Review of Resident #1's current FL2 dated 04/11/25 revealed there was an order for sitagliptin/metformin (a medication used to treat diabetes) 100/1000mg take 1 tablet daily with a meal, hold if blood sugar (BS) less than 150.

Review of Resident #1's hospice physician orders dated 04/29/25 revealed there was an order for sitagliptin/metformin 100/1000mg tablet daily with no hold parameter.

Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/01/25 to 04/30/25 revealed:
-There was an entry for sitagliptin/metformin 100/1000mg tablet daily with a meal, hold if BS less than 150 scheduled for administration at 8:00am.
-There was documentation sitagliptin/metformin was administered when it should have been held on 04/07/25, 04/12/25, 04/22/25, 04/28/25 and 04/29/25.
-There was documentation Resident #1's BS was 121 on 04/07/25, 95 on 04/12/25, 120 on 04/22/25, 116 on 04/28/25 and 108 on 04/29/25.

Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed:
-There was an entry for sitagliptin/metformin 100/1000mg tablet daily with a meal, hold if BS less than 150 scheduled for administration at 8:00am.
-There was documentation sitagliptin/metformin was held when it should have been administered on 05/15/25, 05/23/25 and 05/30/25.

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-There was documentation Resident #1's BS was 216 on 05/15/25, 230 on 04/23/25 and 186 on 05/30/25.

Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed:
-There was an entry for sitagliptin/metformin 100/1000mg tablet daily with a meal, hold if BS less than 150 scheduled for administration at 8:00am.
-There was documentation sitagliptin/metformin was held when it should have been administered on 06/02/25, 06/03/25 and 06/04/25.
-There was documentation Resident #1's BS was 155 on 06/02/25, 143 on 06/03/25 and 129 on 06/04/25.

Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm revealed there was a medication card with 22 of 28 sitagliptin/metformin 100/1000mg tablets with a dispensed date of 05/28/25 available for administration on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed:
-There was an order on file for sitagliptin/metformin 100/1000mg tablet daily with a meal, hold if BS less than 150.
-Resident #1's sitagliptin/metformin was dispensed on 03/26/25, 04/23/25, and 05/21/25 for a quantity of 28 tablets each.

Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/05/25 at

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D 358	Continued From page 6 2:17pm was unsuccessful. Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful. Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed she did not know Resident #1's hospice order dated 04/29/25 changed Resident #1's sitagliptin/metformin to no hold parameter. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed: -She thought there was a problem with the eMAR documentation for Resident #1's sitagliptin/metformin. -She did not know why Resident #1's sitagliptin/metformin was documented as administered when it should have been held for 5 of 30 opportunities in April 2025, 3 of 31 opportunities in May 2025, and 3 of 4 opportunities in June 2025. Interview with the Administrator on 06/05/25 at 4:00pm revealed: -She was aware Resident #1's sitagliptin/metformin was administered when it should have been held for 5 of 30 opportunities in April 2025. -She did not know Resident #1's sitagliptin/metformin was held when it should have been administered for 3 of 31 opportunities in May 2025 and 3 of 4 opportunities in June 2025. -She expected the MAs to follow hold parameters for medication orders. c. Review of Resident #1's current FL2 dated 04/11/25 revealed there was an order for	D 358		

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midodrine (a medication used to prevent syncope) 5mg take 1 tablet as needed (PRN) for blood pressure (BP) less than 100/60.

Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/01/25 to 04/30/25 revealed:
-There was an entry for midodrine 5mg 1 tablet PRN for BP less than 100/60.
-There was documentation midodrine was not administered when it should have been on 04/12/25, 04/13/25, 04/14/25, 04/15/25, 04/21/25, 04/24/25 and 04/28/25.
-There was documentation Resident #1's BP was 85/52 on 04/12/25 at 9:00am, 67/47 on 04/13/25 at 9:00am, 86/48 on 04/14/25 at 9:00am, 83/43 on 04/15/25 at 9:00am, 98/48 on 04/21/25 at 9:00am, 70/48 on 04/24/25 at 9:00am and 88/58 on 04/28/25 at 9:00am.

Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed:
-There was an entry for midodrine 5mg 1 tablet PRN for BP less than 100/60.
-There was documentation midodrine was not administered when it should have been on 05/12/25 and 05/21/25.
-There was documentation Resident #1's BP was 86/52 on 05/12/25 at 9:00am and 93/48 on 05/21/25 at 9:00am.

Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed:
-There was an entry for midodrine 5mg 1 tablet PRN for BP less than 100/60.
-There was documentation midodrine was not administered when it should have been on 06/01/25.
-There was documentation Resident #1's BP was 76/57 on 06/01/25 at 9:00pm.

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D 358	Continued From page 8 Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm revealed: -There was a medication card with 19 of 30 midodrine tablets with a dispensed date of 10/15/24 available for administration on the medication cart. -There was a medication card with 60 of 60 midodrine tablets with a dispensed date of 10/14/24 available for administration on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed: -There was an order on file for midodrine 5mg 1 tablet PRN for BP less than 100/60. -Resident #1's midodrine was dispensed on 10/15/24 for a quantity of 30 tablets. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/05/25 at 2:17pm was unsuccessful. Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful. Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed: -She knew Resident #1 had an order for midodrine 5mg 1 tablet PRN for BP less than 100/60. -She had not administered midodrine to Resident #1 because Resident #1's BP had not met the parameter for administration when she checked	D 358		

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D 358	Continued From page 9 Resident #1's BP. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed: -She knew Resident #1 had an order for midodrine 5mg 1 tablet PRN for BP less than 100/60. -She did not know Resident #1's midodrine was not administered when it should have been. Interview with the Administrator on 06/05/25 at 4:00pm revealed: -She did not know Resident #1's midodrine was not administered when it should have been twice in May 2025 and twice in June 2025. -She expected the MAs to follow parameters for medication orders. d. Review of Resident #1's hospice physician orders dated 04/29/25 revealed there was an order for sertraline 25mg take 1 tablet daily. Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/29/25 to 04/30/25 revealed: -There was no entry for sertraline 25mg take 1 tablet daily. -There was no documentation sertraline was administered on 04/29/25 and 04/30/25. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed: -There was no entry for sertraline 25mg take 1 tablet daily. -There was no documentation sertraline was administered from 05/01/25 to 05/31/25. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed: -There was no entry for sertraline 25mg take 1	D 358		

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tablet daily.
-There was no documentation sertraline was administered from 06/01/25 to 06/04/25.

Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm there was no sertraline 25mg available for administration on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed:
-There was no active order on file for Resident #1 for sertraline 25mg take 1 tablet daily.
-There was a previous order for Resident #1 for sertraline 25mg take 1 tablet daily that was discontinued by Resident #1's primary care provider (PCP) on 02/06/25.

Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's PCP on 06/05/25 at 2:17pm was unsuccessful.

Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful.

Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed:
-She did not know Resident #1 had an order for sertraline 25mg take 1 tablet daily.
-Sertraline 25mg was not on Resident #1's eMAR and she administered medications according to the eMAR.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed:

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-She did not know Resident #1 had an order for sertraline 25mg take 1 tablet daily.
-She normally reviewed new medication orders.
-She and the MAs faxed new medication orders to the pharmacy.
-She thought Resident #1's hospice agency faxed all of Resident #1's medication orders to the pharmacy.

Interview with the Administrator on 06/05/25 at 4:00pm revealed:
-She did not know Resident #1 had an order for sertraline 25mg take 1 tablet daily.
-She expected staff to combine Resident #1's PCP and hospice physician orders when new orders were written and administer medications as ordered.

e. Review of Resident #1's hospice physician orders dated 04/29/25 revealed there was an order for lidocaine 5% topical patch daily, remove patch after 12 hours.

Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/29/25 to 04/30/25 revealed:
-There was no entry for lidocaine 5% topical patch daily, remove patch after 12 hours.
-There was no documentation lidocaine was administered on 04/29/25 and 04/30/25.

Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed:
There was no entry for lidocaine 5% topical patch daily, remove patch after 12 hours.
-There was no documentation lidocaine was administered from 05/01/25 to 05/31/25.

Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed:

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D 358	Continued From page 12 There was no entry for lidocaine 5% topical patch daily, remove patch after 12 hours. -There was no documentation lidocaine was administered from 06/01/25 to 06/04/25. Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm there was no lidocaine 5% patch available for administration on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed: -There was no active order on file for Resident #1 for lidocaine 5% topical patch daily, remove patch after 12 hours. -There was a previous order for Resident #1 for lidocaine 5% take 1 tablet daily that was discontinued by Resident #1's primary care provider (PCP) in December 2024. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 06/05/25 at 2:17pm was unsuccessful. Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful. Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed: -She did not know Resident #1 had an order for lidocaine 5% topical patch daily, remove patch after 12 hours. -Lidocaine 5% patch was not on Resident #1's eMAR and she administered medications according to the eMAR.	D 358		

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	HAL085011	A. BUILDING: _____ B. WING _____	R 06/05/2025

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D 358	Continued From page 13 Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed: -She did not know Resident #1 had an order for lidocaine 5% topical patch daily, remove patch after 12 hours. -She normally reviewed new medication orders. -She and the MAs faxed new medication orders to the pharmacy. -She thought Resident #1's hospice agency faxed all of Resident #1's medication orders to the pharmacy. Interview with the Administrator on 06/05/25 at 4:00pm revealed: -She did not know Resident #1 had an order for lidocaine 5% topical patch daily, remove patch after 12 hours. -She expected staff to combine Resident #1's PCP and hospice physician orders when new orders were written and administer medications as ordered. f. Review of Resident #1's hospice physician orders dated 04/29/25 revealed there was an order for sucralfate 100mg/mL take 10mL before meals and at bedtime. Review of Resident #1's April 2025 electronic medication administration record (eMAR) from 04/29/25 to 04/30/25 revealed: -There was no entry for sucralfate 100mg/mL take 10mL before meals and at bedtime. -There was no documentation sucralfate was administered on 04/29/25 and 04/30/25. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/31/25 revealed: -There was no entry for sucralfate 100mg/mL take 10mL before meals and at bedtime.	D 358		

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D 358	Continued From page 14 -There was no documentation sucralfate was administered from 05/01/25 to 05/31/25. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/04/25 revealed: -There was no entry for sucralfate 100mg/mL take 10mL before meals and at bedtime. -There was no documentation sucralfate was administered from 06/01/25 to 06/04/25. Observation of the medications on hand for Resident #1 on 06/05/25 at 12:06pm there was no sucralfate 10mL available for administration on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:52pm revealed: -There was no active order on file for Resident #1 for sucralfate 100mg/mL take 10mL before meals and at bedtime. -There was a previous order for Resident #1 for sucralfate 100mg/mL take 10mL before meals and at bedtime that was discontinued by Resident #1's primary care provider (PCP) in February 2025. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 06/05/25 at 2:17pm was unsuccessful. Attempted telephone interview with a representative of Resident #1's hospice agency on 06/05/25 at 2:42pm was unsuccessful. Interview with a medication aide (MA) on 06/05/25 at 3:30pm revealed:	D 358		

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D 358	Continued From page 15 -She did not know Resident #1 had an order for sucralfate 100mg/mL take 10mL before meals and at bedtime. -Sucralfate 10mL was not on Resident #1's eMAR and she administered medications according to the eMAR. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:08pm revealed: -She did not know Resident #1 had an order for sucralfate 100mg/mL take 10mL before meals and at bedtime. -She normally reviewed new medication orders. -She and the MAs faxed new medication orders to the pharmacy. -She thought Resident #1's hospice agency faxed all of Resident #1's medication orders to the pharmacy. Interview with the Administrator on 06/05/25 at 4:00pm revealed: -She did not know Resident #1 had an order for sucralfate 100mg/mL take 10mL before meals and at bedtime. -She expected staff to combine Resident #1's PCP and hospice physician orders when new orders were written and administer medications as ordered. 2. Review of Resident #3's current FL2 dated 03/06/25 revealed: -Diagnoses included gastroesophageal reflux, chronic pain, dysphagia, cognitive communication, insomnia, bipolar disorder and asthma. -There was an order for mirabegron, used to treat overactive bladder, 25mg one tablet daily. Review of Resident #3's record on 06/04/25 at 9:30am revealed there was an order dated	D 358		

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05/15/25 to discontinue mirabegron 25mg one tablet daily on 05/15/25.

Review of Resident #3's May 2025 medication administration record (eMAR) revealed:
-There was an entry for mirabegron 25mg scheduled administration time of 8:00am.
-There was documentation mirabegron 25mg was administered from 05/16/25 to 05/30/25 at 8:00am.

Review of Resident #3's June 2025 medication administration record (eMAR) revealed:
-There was an entry for mirabegron 25mg scheduled administration time of 8:00am.
-There was documentation mirabegron 25mg was administered from 06/01/25 to 06/04/25 at 8:00am.

Observation of Resident #3's medications on hand on 06/05/25 at 11:00am revealed:
-There was a bubble pack of mirabegron 25mg one tablet daily available for administration.
-The bubble pack was dispensed on 05/28/25 with 28 tablets.
- There were 21 of 28 mirabegron25mg tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 06/05/25 at 1:45pm revealed:
-The pharmacy had an order for mirabegron 25mg one tablet daily.
-The pharmacy did not have an order to discontinue the mirabegron 25mg.
-The pharmacy dispensed 28 mirabegron 25mg tablets on 05/27/25.

Interview with Resident #3's primary care provider (PCP) on 06/05/25 2:00pm revealed:

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D 358	Continued From page 17 -She was not aware Resident #3 was still taking the mirabegron 25 mg. -She wrote the order to discontinue the mirabegron 25mg on 03/15/25. -She would like the facility to discontinue medications as ordered and remove them from the eMAR and cart. Interview with the Medication Aide (MA) on 06/05/25 at 2:20pm revealed: -She administered Resident #3's mirabegron 25mg one tablet daily. -She was not aware the mirabegron 25mg was discontinued. -The Resident Care Coordinator (RCC) was responsible for sending new orders to the pharmacy. -The RCC was responsible for removing discontinued medication from the cart Interview with the RCC on 06/05/25 at 2:30pm revealed: -She was not aware resident #3 received a mirabegron 25mg that was discontinued on 05/15/25. -She was responsible for faxing new and discontinued orders to the pharmacy. -She and the administrator were responsible for cart audits and comparing the medications on hand to the orders. -She would expect for the discontinued order to be faxed to the pharmacy and discontinued medications to be removed from the cart. Interview with the Administrator on 06/05/25 at 2:35pm revealed: -She was made aware by the RCC on today 06/04/24 that Resident #3 received mirabegron 25mg from 05/16/25 to 06/04/25 after it was discontinued on 05/15/25.	D 358		

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D 358	Continued From page 18 -The RCC was responsible for faxing all orders to the pharmacy. -She would expect the discontinued order to be faxed to the pharmacy and the medication be removed from the cart.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass. The findings are: Observation of the morning medication pass on 06/05/25 between 7:56am and 8:30am revealed: -The Resident Care Coordinator (RCC) administered medications to the residents. -Two oral medications fell on top of the medication cart as the RCC was popping the oral medications from the medication cards into a medication cup. -The RCC was not wearing gloves and picked up the two oral medications with her bare hand and put them into the medication cup. -The RCC administered 20 and a half oral medications to a resident at 8:00am, including the	D 371		

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two oral medications that fell on top of the medication cart.
-Hand hygiene was performed after the first resident was administered medication.
-Between 8:25am and 8:29am, the RCC prepared medications for a second resident.
-One oral medication fell on top of the medication cart.
-The RCC was not wearing gloves and picked up the oral medication with her bare hand and put it into the medication cup.
-The RCC popped six oral medications from medication cards into her bare hand and then dropped them into a medication cup one at a time.
-The RCC administered seven oral medications to the second resident at 8:30am.

Interview with the RCC on 06/05/25 at 2:41pm revealed:
-When she popped oral medications into a medication cup, the oral medications sometimes fell on top of the medication cart.
-She popped the oral medications into her bare hand during the morning medication pass and dropped the oral medications into a medication cup so they would not fall on top of the medication cart.

Interview with the Administrator on 06/05/25 at 4:00pm revealed:
-She expected the MAs and the RCC to pop oral medications directly into a medication cup for medication administration.
-Oral medications should not be handled with bare hands.
-If an oral medication touched the medication cart or a bare hand, the medication should be disposed, tracked on a sheet for wasted medications, and a new oral medication should

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D 371	Continued From page 20 be popped into a medication cup for administration.	D 371		