vice Regulation

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL059032	A. BUILDING: _____ B. WING _____	05/29/2025

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LAKE JAMES LODGE	63 LAKEVIEW DRIVE MARION, NC 28752

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D 000	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted an annual survey on May 28 to May 29, 2025.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 3 sampled residents (Resident #3) who had a referral for physical therapy (PT). The findings are: Review of Resident #3's current FL2 dated 05/14/25 revealed: -Diagnoses included hypertension, hyperlipidemia, hypothyroidism, type 2 diabetes, history of chronic obstructive pulmonary disease (COPD), chronic pain with neuropathy, anxiety, and vitamin D deficiency. -Resident #3 was oriented. -Resident #3 was semi-ambulatory. Review of Resident #3's Resident Register dated 05/20/25 revealed an admission date of 05/20/25. Review of Resident #3's hospital discharge summary dated 05/20/25 revealed there was a PT referral was sent to a home health agency for the resident to be seen within 24 hours.	D 273 .0902B	Regarding rule .0902B Follow up on referrals From hospital discharges, new admits and/or current residents We have added a new referral tracking log with space to note details of referrals ie: PT, RN, OT, ST or any other specialty group/ physician. The resident care coordinator will be in charge of tracking these referrals & follow ups. Director will check referral tracking log + notes following any hospital discharge,	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 7/3/25

STATE FORM 6899 ICX211 If continuation sheet 1 of 27

Reviewed and acknowledged

by on 07/08/25

DMS

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 1 Telephone interview with a Registered Nurse (RN) from the home health agency on 05/29/25 at 9:19am revealed the agency did not receive a PT referral for Resident #3. Interview with the Resident Care Coordinator (RCC) on 05/28/25 at 4:00pm revealed: -She knew Resident #3's hospital discharge summary dated 05/20/25 had an order for a PT evaluation. -She thought the discharging hospital was responsible for sending the home health PT referral to the home health agency. -She did not know if the home health PT referral had been made. -She did not follow up with the hospital discharge planner or the home health agency to see if a PT referral had been made. -She thought home health agencies usually waited a week after the referral had been received to see residents. -There was no follow up process in place to ensure all orders and referrals had been processed or implemented. Review of Resident #3's PCP text message dated 05/29/25 at 10:47am revealed: -Resident #3 was a new patient and was due to be seen on 06/04/25. -No one at the facility had contacted her for a PT referral for Resident #3. -She expected the facility to ensure all orders and referrals were processed and implemented. -Resident #3 not getting PT could have caused possible further deconditioning and weakness. Interview with the Administrator on 05/29/25 at 9:46am revealed: -She did not know Resident #3 had an order for a PT evaluation.	D 273 .0928	Cont. from page 1 . . . new admits as well as following after provider appointments.	7/9/25

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D 273	Continued From page 2 -She did not know why the referral for Resident #3 to have PT was not sent to the home health agency. -She expected the RCC to implement all physician orders and referrals. -She expected RCC to follow up with all referrals to ensure services were in place. -She expected the RCC to check to ensure all physician orders and referrals were processed correctly. -There was no process in place to ensure all orders and referrals had been processed or implemented correctly.	D 273	.1002A Regarding rule .1002A The RCC & Director will work in conjuction with admissions or readmissions to insure all orders have been checked using the discharge orders comparing to medications + enter system. This includes checking to ensure all medications are correct + in facility or are en-route from pharmacy. If medications needed to be clarified from the pharmacist or	7/1/25
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 4 sampled residents (Resident #3) regarding a medication order to treat shortness of breath that was ordered every four hours.	D 344		

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D 344	Continued From page 3 The findings are: Review of the facility's undated Resident Medication Orders policy revealed: -All medication orders would include, the date, medication name, strength of the medication, dosage of the medication, route of the medication, frequency of administration, and the reason for use. -Any medication order that was not clear or incomplete were to be verified with the prescribing practitioner. Review of Resident #3's current FL2 dated 05/14/25 revealed: -Diagnoses included hypertension, type 2 diabetes, history of chronic obstructive pulmonary disease, and vitamin D deficiency. -Resident #3 was oriented. Review of Resident #3's Resident Register dated 05/20/25 revealed an admission date of 05/20/25. Review of Resident #3's hospital discharge summary dated 05/20/25 revealed there was an order for albuterol (used to treat shortness of breath) 90mcg, 2 puffs, by mouth, every 4 hours. Review of Resident #3's May 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for albuterol 90mcg inhaler, 2 puffs by mouth, every 4 hours as needed for shortness of breath. -There was no documentation albuterol 90mcg was administered. -There was no entry for albuterol 90mcg/inhalation, 2 puffs, by mouth, every 4 hours.	D 344 .1002A	Cont from page 3 . . . the orders themselves, the RCC or Director will reach out to provider to get clarification + this will be documented in the residents chart. If the admission was done by RCC the Director will be the second set of eyes to insure the items listed above have been double checked. If Director completes admission the RCC will do the same double check/ review.	7/1/25

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D 344	Continued From page 4 Observation of Resident #3's medications on hand on 05/28/25 revealed there was no albuterol 90mcg available on the medication cart. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 05/28/25 at 1:09pm revealed: -The pharmacy received Resident #3's FL2 dated 05/14/25 from the facility on 05/19/25. -The FL2 did not list albuterol 90mcg as a medication. -The pharmacy received Resident #3's hospital discharge summary dated 05/20/25 from the facility on 05/20/25. - There was an order on the hospital discharge summary for albuterol 90mcg/inhalation, 2 puffs, by mouth, every 4 hours. -The pharmacy entered Resident #3's albuterol order incorrectly onto the eMAR as, as needed and not scheduled. -The facility had to approve or decline medication orders entered by the pharmacy into the eMAR and the facility did approve the incorrect order for PRN albuterol. -The pharmacy made a mistake and did not dispense Resident #3's albuterol 90mcg. -The pharmacy was contacted by the RCC today (05/28/25) about the incorrect albuterol order and corrected the order on the eMAR. -Albuterol was used to treat wheezing, coughing and shortness of breath and without using albuterol as ordered, the resident could have tightness in the chest, wheezing, and shortness of breath. Interview with Resident #3 on 05/28/25 at 12:40pm revealed: -She thought she was supposed to be on two inhalers. -She was administered two inhalers daily.	D 344		

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D 344	Continued From page 5 -She used the inhalers when the MA administered them to her. -She did not know which inhalers were ordered for her to use. -She had shortness of breath since she moved into the facility. Interview with the medication aide (MA) on 05/28/25 at 12:23pm revealed: -She did not know Resident #3's albuterol was not on the medication cart. -She administered Resident #3's mometasone duroate 100mcg/5mcg (a long-acting steroidal inhaler used to treat COPD) she found on the medication cart. -She thought she administered Resident #3's albuterol 90mcg inhaler. -She was responsible for comparing medications and mediation labels to the eMAR but did not prior to administering medications to Resident #3. -The Resident Care Coordinator (RCC) was responsible for sending medication orders to the pharmacy. -The RCC was responsible for approving or declining medication orders entered by the pharmacy. -MAs were responsible for calling the pharmacy or notifying the RCC if there was a medication not available on the medication cart. -The RCC or Administrator completed medication cart audits which included reviewing medication orders, medication on hand and eMAR's, but she did not know how often or when medication cart audits were completed. Interview with the RCC on 05/28/25 at 3:20pm revealed: -She did not know Resident #3 had an order for albuterol or that the albuterol was not available. -She did not know Resident #3's albuterol was	D 344 .1002A .1004A	.1002A The RCC will be doing weekly cart/med audits on Wednesdays. The third Thursday of the month the Director will do a detailed audit of resident orders comparing with emar system & checking over medication carts.	7/9/25 weekly start 7/17/25 monthly start

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D 344	Continued From page 6	D 344		

entered incorrectly on the eMAR.
-She and the Administrator were responsible for completing new admission paperwork including medication orders.
-New admission medication orders were faxed to the pharmacy for the pharmacy to add to the eMAR.
-When the pharmacy added all medication orders to the eMAR, the pharmacy sends the orders to the facility for verification, where the facility approved or declined the medication orders entered by the pharmacy.
-She was out of the facility when Resident #3 was admitted on 05/20/25, and the Administrator completed Resident #3's admission orders.
-The Administrator faxed Resident #3's hospital discharge summary dated 05/20/25 to the pharmacy.
-She did not verify Resident #3's medication orders from the pharmacy or ensure the orders were correct upon her return to the facility on 05/21/25.
-She completed a medication cart audit every several weeks but could not recall the date of her last medication cart audit.
-There was no documentation available for any medication cart audits.

Interview with the Administrator on 05/29/25 at 1:50pm revealed:
-She completed Resident #3's admission orders.
-She faxed Resident #3's hospital discharge summary dated 05/20/25 to the pharmacy.
-She and/or the RCC were responsible for comparing the hospital discharge summary to the eMAR for accuracy.
-She did not compare Resident #3's hospital discharge summary to the orders entered into the eMAR.
-She had approved the orders entered by the

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D 344	Continued From page 7 pharmacy. -She did not know Resident #3's albuterol order was entered incorrectly into the eMAR or that the albuterol was not available. -She and the RCC completed a medication cart audit every month or every other month and the last one was completed in January 2025. -She did not have documentation available for any medication cart audits completed January 2025.	D 344		
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 2 of 4 sampled residents (#3 and #4) related to medications used to treat chronic obstructive pulmonary disease (COPD) (#3 and #4). Review of the facility's undated policy on Medication Administration revealed medications were to be administered according to the prescribing practitioner's orders. The findings are:	D 358 .1004A	.1004A The RCC will not decline or approve any orders without the actual order in hand to double check & compare the actual order to the emar before approvals. Director will also review & double check RCC & compare order to emar.	7/3/25

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D 358	Continued From page 8 1. Review of Resident #4's current FL2 dated 12/04/24 revealed: -Diagnoses included COPD. -An order for ipratropium/albuterol (a medication used to treat COPD) 0.5-3mg/2.5ml two times daily. -An order for ipratropium/albuterol 0.5-3ml, every six hours as needed for shortness of breath/wheezing. Review of Resident #4's signed physician's order dated 04/02/25 revealed: -There was an order for ipratropium/albuterol 0.5mg-2.5mg/3ml two times daily. -There was an order for ipratropium/albuterol 0.5mg-2.5mg/3ml every six hours as needed for shortness of breath/wheezing. Observation of Resident #4's medication available for administration on (date) at (time) revealed: -There was a plastic bag tabled with Resident #4's name, containing ipratropium/albuterol labeled 0.5mg-2.5mg/3ml two times daily and every six hours as needed for shortness of breath and/or wheezing and a dispense date of 04/08/24, with 120 doses left to administer. -There was a second plastic bag tabled with Resident #4's name, containing ipratropium/albuterol labeled 0.5mg-2.5mg/3ml two times daily and a dispense date of 11/19/24, with 28 doses left to administer. Review of Resident #4's October 2024 electronic Medication Record (eMAR) revealed: -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24. -There was documentation the ipratropium/albuterol was administered 10/01/24 to 10/31/24 at 8:00am and 8:00pm.	D 358		

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-There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with an start date of 04/09/24 as needed for shortness of breath and/or wheezing.
-There was no documentation the ipratropium/albuterol was administered 10/01/24 to 10/31/24.

Review of Resident #4's November 2024 eMAR revealed:
-There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24.
-There was documentation the ipratropium/albuterol was administered 11/01/24 to 11/30/24 at 8:00am and 8:00pm.
-There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing.
-There was no documentation the ipratropium/albuterol was administered 11/01/24 to 11/30/24.

Review of Resident #4's December 2024 eMAR revealed:
-There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24.
-There was documentation the ipratropium/albuterol was administered 12/01/24 to 12/14/24 at 8:00am and 8:00pm and on 12/15/24 at 8:00am.
-On 12/15/24 at 8:00pm, the ipratropium/albuterol was documented as refused.
-There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing.
-There was no documentation the ipratropium/albuterol was administered 12/01/24 to 12/30/24.

Review of Resident #4's January 2025 eMAR

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D 358	Continued From page 10 revealed: -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24. -There was documentation the ipratropium/albuterol was administered 01/01/24 to 01/31/24 at 8:00am and 8:00pm. -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing. -There was documentation the ipratropium/albuterol was administered on 01/17/25 at 7:12am for cough and congestion. Review of Resident #4's February 2025 eMAR revealed: -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24. -There was documentation the ipratropium/albuterol as administered 02/01/24 to 02/28/24 at 8:00am and 8:00pm. -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing. -There was no documentation the ipratropium/albuterol was administered 02/01/24 to 02/28/24. Review of Resident #4's March 2025 eMAR revealed: -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24. -There was documentation the ipratropium/albuterol was administered 03/01/24 to 03/31/25 at 8:00am and 8:00pm. -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing. -There was no documentation the ipratropium/albuterol was administered 03/01/24 to 03/31/24.	D 358		

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D 358	Continued From page 11 Review of Resident #4's April 2025 eMAR revealed: -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24. -There was documentation the ipratropium/albuterol was administered 04/01/24 at 8:00am and 8:00pm and on 04/02/25 at 8:00pm. -On 04/02/25 at 8:00pm the ipratropium/albuterol was documented as discontinued. -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing. -There was no documentation the ipratropium/albuterol was administered 04/01/24 to 04/30/24. Review of Resident #4's May 2025 eMAR revealed: -There was no entry for ipratropium/albuterol 0.5mg-2.5mg/3ml to be administered two times daily. -There was an entry for ipratropium/albuterol 0.5mg-2.5mg/3ml with a start date of 04/09/24 as needed for shortness of breath and/or wheezing. -There was no documentation the ipratropium/albuterol was administered 05/01/24 to 05/28/24. Telephone/Interview with a Pharmacist from the facility's contracted pharmacy on 05/28/25 at 4:24pm revealed: -The original order date for ipratropium/albuterol 0.5mg-2.5mg/3ml to be administered two times daily was 04/09/24. -On 04/08/25, the facility faxed a signed physician's orders dated 04/02/25 for ipratropium/albuterol 0.5mg-2.5mg/3ml two times daily.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 -The ipratropium/albuterol was documented as active in their records but was when the orders were entered into the eMAR system for the facility staff to approve, the ipratropium/albuterol was accidentally discontinued. -The facility was responsible for reviewing the order and matching it with the original signed physician's order and approve the order as it was entered into the eMAR system before administration to make sure the order was correct. -The pharmacy dispensed ipratropium/albuterol 0.5mg-2.5mg/3ml, 120 doses, a 60-day supply on 10/11/24, 30 doses could be used for the "as needed" order. -The pharmacy dispensed ipratropium/albuterol 0.5mg-2.5mg/3ml, 120 doses, a 60-day supply on 11/19/24, 30 doses could be used for the "as needed" order. -The pharmacy dispensed ipratropium/albuterol 0.5mg-2.5mg/3ml, 120 doses, a 60-day supply on 11/30/24, 30 doses could be used for the "as needed" order. -The pharmacy dispensed ipratropium/albuterol 0.5mg-2.5mg/3ml, 120 doses, a 60-day supply on 04/08/24, 30 doses could be used for the "as needed" order. -The pharmacy dispensed a total of 480 doses of the ipratropium/albuterol and if there was no "as needed" ipratropium/albuterol administered then Resident #4 would have enough ipratropium/albuterol to last from 10/11/24 to 06/08/25. -If Resident #4 was not getting the ipratropium/albuterol as ordered, his oxygen saturation could drop and start having breathing difficulties such as shortness of breath and or wheezing. After observations of Resident #4's	D 358		

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	HAL059032	A. BUILDING: _____ B. WING _____	05/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 ipratropium/albuterol 0.5mg-2.5mg/3ml available for administration, review of Resident #4's October 2024 to May 2025 eMARs and interview with the pharmacist, there were 134 doses that were not administered as ordered. Interview with a medication aide (MA) on 05/28/25 at 3:59pm revealed: -Resident #4 did not have an order to administer the ipratropium/albuterol 0.5mg-2.5mg/3ml after 04/02/25 at 8:00am populated on the eMAR. -He only administered medication that populated on the eMAR when it was time to administer medications. -The MAs did not completed medication cart audits and he was not sure who did. Interview with the Resident Care Coordinator (RCC) on 05/28/25 at 3:48pm revealed: -On 04/02/25 she faxed the signed physician's orders which contained the ipratropium/albuterol 0.5mg-2.5mg/3ml, two times daily and every 6 hours as needed for shortness of breath/wheezing, to the pharmacy. -When the pharmacy entered the signed physician's orders for the ipratropium/albuterol 0.5mg-2.5mg/3ml into the eMAR system, she was responsible to go into the eMAR system and approve the new orders after reviewing them with the signed physician's orders for accuracy. -She must have missed the ipratropium/albuterol 0.5mg-2.5mg/3ml two times daily order was discontinued by accident and approved the order so the order for ipratropium/albuterol 0.5mg-2.5mg/3ml two times daily did not populate on the eMAR for administration. -She did not completed a medication cart audit since January 2025. Telephone interview with Resident #4's Primary	D 358 .1004A .1002A	See page 6 regarding weekly + monthly cart audits weekly audits by RCC 7/9/25 monthly audits by Director 7/17/25	

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D 358	Continued From page 14 Care Provider (PCP) on 05/29/25 at 9:00am revealed: -The ipratropium/albuterol 0.5mg-2.5mg/3ml was ordered to help prevent COPD exacerbation. -She last saw Resident #4 on 05/14/25 and there were no issues with his COPD. -She did not know Resident #4 was not getting his ipratropium/albuterol 0.5mg-2.5mg/3ml as ordered. -She expected the facility staff to administered the medications as ordered. Interview with the Administrator on 05/29/25 at 9:46am revealed: -The RCC was responsible to approve medication order in the eMAR once the pharmacy entered the information, and after the order on the eMAR and signed physician's order matched. -She and the RCC were responsible to complete medication cart audits on a quarterly basis. -The audits were completed by verifying the medications on the cart with the eMAR but they did not check to make sure they matched with the orders. -Every Thursday night, the RCC was responsible to check the medications that were delivered by the pharmacy matched the eMAR but not matching with the orders as well. -The last medication cart audit was completed by the RCC in January 2025 and there were no issues reported. -She did not know Resident #4's ipratropium/albuterol 0.5mg-2.5mg/3ml two times daily order to discontinue was approved by instead of verifying it with the signed physician's order. 2. Review of Resident #3's current FL2 dated 05/14/25 revealed diagnoses included hypertension, type 2 diabetes, and history of	D 358		

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D 358	Continued From page 15 chronic obstructive pulmonary disease (COPD). Review of Resident #3's Resident Register dated 05/20/25 revealed an admission date of 05/20/25. a. Review of Resident #3's hospital discharge summary dated 05/20/25 revealed there was an order for albuterol (used to treat shortness of breath) 90mcg, 2 puffs, by mouth, every 4 hours for shortness of breath. Review of Resident #3's May 2025 electronic Medication Administration Record (eMAR) revealed: -There was no entry for albuterol 90mcg, 2 puffs, by mouth, every 4 hours. -There was an entry for albuterol 90mcg, 2 puffs by mouth, every 4 hours as needed. -There was no documentation albuterol 90mcg was administrated. Observation of Resident #3's medications on hand on 05/28/25 revealed there was no albuterol 90mcg inhaler available on the medication cart. Interview with a medication aide (MA) on 05/28/25 at 12:23pm revealed: -She could not find Resident #3's albuterol 90mcg inhaler was not on the medication cart. -She thought she administered the albuterol 90mcg inhaler to Resident #3 during the morning medication pass today (05/20/25). -She administered Resident #3's mometasone duroate 100mcg/5mcg (a long-acting steroidal inhaler used to treat COPD) she found on the medication cart. -The Resident Care Coordinator (RCC) was responsible for entering all medication orders into the eMAR. -She was responsible for comparing medications	D 358	•100% Meeting will be held with med techs to go over new policy + procedure manual. We will also be covering that MT's are scanning medications + comparing the actual medication + labels to the emars prior to administration of medications Director + RCC will evaluate med techs medication pass monthly	7/9/25

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D 358	Continued From page 16 and mediation labels to the eMAR but did not prior to administering medications to Resident #3. -MAs were responsible for calling the pharmacy or notifying the RCC if a medication was not available on the medication cart. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 05/28/25 at 1:09pm revealed: -The pharmacy received Resident #3's hospital discharge summary dated 05/20/25 from the facility on 05/20/25 with an order for albuterol 90mcg inhaler, 2 puffs, by mouth, every 4 hours. -The pharmacy entered Resident #3's albuterol 90mcg inhaler incorrectly onto the eMAR as, as needed and not scheduled. -When the pharmacy added a medication onto the eMAR, the facility approved or declined the order. -The facility approved the incorrect albuterol order for as needed. -The pharmacy made a mistake and did not dispense Resident #3's albuterol 90mcg inhaler. -Albuterol was used to treat wheezing, coughing and shortness of breath and without albuterol being administered as ordered, the resident could experience tightness in the chest, wheezing, and shortness of breath. Interview with the RCC on 05/28/25 at 12:40pm revealed: -She did not know Resident #3 did not have an albuterol inhaler available or that the order for the albuterol was incorrect. -The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications. -She and the Administrator were responsible for completing new admission paperwork including any orders or referrals.	D 358		

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D 358	Continued From page 17 -The pharmacy adds all medication orders onto the eMAR and sends orders to the facility for verification, where the facility approved or declined the medication orders entered by the pharmacy. -She was out of the facility when Resident #3 was admitted 05/20/25, and the Administrator had completed Resident #3's admission paperwork. -The Administrator faxed Resident #3's hospital discharge summary dated 05/20/25 to the pharmacy. -She did not verify Resident #3's medication orders from the pharmacy or ensure the orders were correct upon her return to the facility on 05/21/25. Interview with the Administrator on 05/29/25 at 1:50pm revealed: -She completed the admission for Resident #3. -Resident #3 was sent with medications from the hospital. -The RCC was responsible for completing a medication release form where any medications brought into the facility for Resident #3 should have been counted, documented, and compared to the current medications orders prior to placing medications on the medication cart for administration. -She did not check the bag of medications sent with Resident #3 from the hospital. -She faxed the hospital discharge summary dated 05/20/25 to the pharmacy. -The expectation was that she or the RCC check the eMAR to the hospital discharge summary for accuracy. -She did not check the eMAR orders to the hospital discharge summary. -She did not know Resident #3 had an order for albuterol or that the albuterol was not available. -She did not know Resident #3's albuterol was	D 358		

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D 358	Continued From page 18	D 358		

entered incorrectly on the eMAR.
-The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications.
-She did not know Resident #3's albuterol order was entered incorrectly into the eMAR or that the albuterol was not available.
-She and the RCC completed a medication cart audit every month or every other month and the last one was completed in January 2025.
-She did not have documentation available for any medication cart audits completed January 2025.

Refer to the interview with Resident #3 on 05/28/25 at 12:40pm.

Refer to the review of Resident #3's PCP text message dated 05/29/25 at 10:47am.

b. Observation of Resident #3's medications on hand on 05/28/25 revealed fluticasone furoate (used to treat COPD) 100/25mcg, inhale one puff, twice daily, with a label from Resident #3's discharging hospital was found on the medication cart.

Review of Resident #3's record on 05/28/25 revealed there was no order for fluticasone furoate 100/25mcg, inhale one puff, twice daily.

Review of Resident #3's May 2025 eMAR revealed there was no entry for fluticasone furoate 100/25mcg, inhale one puff, twice daily.

Interview with a MA on 05/28/25 at 12:23pm revealed:
-She administered Resident #3 the fluticasone furoate 100/25mcg, inhale one puff, twice daily every morning.

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D 358	Continued From page 19 -The fluticasone furoate 100/25mcg inhaler came from the discharging hospital. -She was responsible for comparing medications and mediation labels to the eMAR but did not prior to administering fluticasone furoate 100/25mcg inhaler to Resident #3. -The RCC was responsible for sending medication orders to the pharmacy. -The MAs were responsible for calling the pharmacy or notifying the RCC if medications were not available on the medication cart. -The RCC or Administrator completed medication cart audits, but she did not know how often or when medication cart audits were completed. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 05/28/25 at 1:09pm revealed: -The pharmacy received a hospital discharge summary dated 05/20/25 from the facility on 05/20/25. -There was not an order on Resident #3's discharge summary for fluticasone furoate 100/25mcg inhaler but there was an order for mometasone duroate (a long-acting steroidal inhaler used to treat COPD) 100mcg/5mcg inhaler. -Fluticasone furoate 100/25mcg inhaler was used to treat COPD symptoms such as wheezing, coughing, and shortness of breath. Interview with the RCC on 05/28/25 at 12:40pm revealed: -She did not know Resident #3 had fluticasone furoate 100/25mcg inhaler was on the medication cart, or that there was no order for the fluticasone furoate 100/25mcg inhaler. -She did not know Resident #3 had been administered fluticasone furoate 100/25mcg inhaler without a physician's order.	D 358		

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D 358	Continued From page 20 -The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications. -She and the Administrator were responsible for completing new admission paperwork including any orders or referrals. -The pharmacy adds all medication orders onto the eMAR and sends orders to the facility for verification, where the facility approved or declined the medication orders entered by the pharmacy. -She was out of the facility when Resident #3 was admitted 05/20/25, and the Administrator had completed Resident #3's admission paperwork. -The Administrator faxed Resident #3's hospital discharge summary dated 05/20/25 to the pharmacy. -She did not verify Resident #3's medication orders from the pharmacy or ensure the orders were correct upon her return to the facility on 05/21/25. Interview with the Administrator on 05/29/25 at 1:50pm revealed: -She completed the admission for Resident #3. -Resident #3 was sent with medications from the hospital. -The RCC was responsible for completing a medication release form where any medications brought into the facility for Resident #3 should have been counted, documented, and compared to the current medications orders prior to placing medications on the medication cart for administration. -She did not check the bag of medications sent with Resident #3 from the hospital. -She faxed the hospital discharge summary dated 05/20/25 to the pharmacy. -The expectation was that she or the RCC check the eMAR to the hospital discharge summary for	D 358		

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D 358	Continued From page 21 accuracy. -She did not check the eMAR orders to the hospital discharge summary. -She did not know there was a fluticasone furoate 100/25mcg inhaler on the medication cart. -The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications. -She and the RCC completed a medication cart audit every month or every other month and the last one was completed in January 2025. -She did not have documentation available for any medication cart audits completed January 2025. Refer to the interview with Resident #3 on 05/28/25 at 12:40pm. Refer to the review of Resident #3's PCP text message dated 05/29/25 at 10:47am. Interview with Resident #3 on 05/28/25 at 12:40pm revealed: -She thought she was supposed to be on two inhalers. -She was administered two inhalers daily. -She used the inhalers when the MA administered them to her. -She did not know which inhalers were ordered for her to use. -She had shortness of breath since she moved into the facility. Review of Resident #3's PCP text message dated 05/29/25 at 10:47am revealed: -Resident #3 was a new patient. -Resident #3 was due to be seen on 06/04/25. -She expected the facility to ensure all orders and referrals were processed and implemented correctly.	D 358			

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D 412	10A NCAC 13F .1010 (e) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide pharmaceutical services that ensured accurate records of the receipt of medications were maintained in the facility for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 05/14/25 revealed: -Diagnoses included hypertension, hyperlipidemia, hypothyroidism, type 2 diabetes, history of chronic obstructive pulmonary disease, chronic pain with neuropathy, anxiety, and vitamin D deficiency. Review of Resident #3's Resident Register dated 05/20/25 revealed an admission date of 05/20/25. a. Review of Resident #3's hospital discharge summary dated 05/20/25 revealed there was an order for vitamin D3 (used to treat softening and weakening of the bones) 25mcg, 4 tabs, daily. Observation of Resident #3's medications on hand on 05/28/25 revealed there was no vitamin D3 available on the medication cart.	D 412		

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D 412	Continued From page 23 Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 25mcg, 4 tabs, daily. -Vitamin D3 was documented as administered from 05/21/25 through 05/28/25. Interview with Resident #3 on 05/28/25 at 12:40pm revealed she knew of two inhalers administered daily but did not know what other medications the MA gave her. Interview with a MA on 05/28/25 at 12:23pm revealed: -The vitamin D3 came from Resident #3's discharging hospital. -She thought she had administered Resident #3's vitamin D3 during the morning medication pass. -She did not know Resident #3 did not have vitamin D3 available on the medication cart. -She was responsible for comparing medications and mediation labels to the eMAR but did not prior to administering medications to Resident #3. -The RCC or Administrator completed medication cart audits, but she did not know how often or when medication cart audits were completed. Interview with the RCC on 05/28/25 at 3:20pm revealed: -She was out of the facility when Resident #3 was admitted on 05/20/25, and the Administrator completed Resident #3's admission orders. -She did not know Resident #3 did not have vitamin D3 available on the medication cart. -The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications. -She completed a medication cart audit every	D 412	.1010E The facility will ensure any paperwork +/or medications coming in with residents/ new admits will be kept + filed in residents file. This also includes any receipts & medications brought into facility. 7/1/25 All pharmacy receipts are filed + kept in RCC office. RCC handles medications + new admissions. Director will oversee.	

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several weeks but could not recall the date of her last medication cart audit.
-There was no documentation available for any medication cart audits.

Refer to the interview with the Administrator on 05/29/25 at 1:50pm.

b. Observation of Resident #3's medications on hand on 05/28/25 revealed fluticasone furoate (used to treat COPD) 100/25mcg, inhale one puff, twice daily, with a label from Resident #3's discharging hospital was found on the medication cart.

Review of Resident #3's record on 05/28/25 revealed there was not an order for fluticasone furoate 100/25mcg inhaled once daily.

Review of Resident #3's May 2025 eMAR revealed there was no entry for fluticasone furoate 100/25mcg inhaled once daily.

Interview with Resident #3 on 05/28/25 at 12:40pm revealed:
-She thought she was supposed to be on two inhalers.
-She used the inhalers when the MA administered them to her.
-She did not know which inhalers or medications were ordered for her to use.
-She had shortness of breath since she moved into the facility.

Interview with a MA on 05/28/25 at 12:23pm revealed:
-The fluticasone furoate inhaler came from Resident #3's discharging hospital.
-She had been giving Resident #3 the fluticasone furoate inhaler every morning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059032	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JAMES LODGE	63 LAKEVIEW DRIVE MARION, NC 28752

(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 412	Continued From page 25 -She did not know the process was when the facility received medications from anywhere other than a pharmacy. Interview with the RCC on 05/28/25 at 3:20pm revealed: -She was out of the facility when Resident #3 was admitted on 05/20/25, and the Administrator completed Resident #3's admission orders. -She did not know Resident #3 had a fluticasone furoate 100/25mcg inhaler on the medication cart. -She did not know Resident #3 had been administered fluticasone furoate 100/25mcg inhaler without a physician's order. -She did not know Resident #3 did not have vitamin D3 available on the medication cart. -The MAs were responsible for comparing medications and mediation labels to the eMAR prior to administering any medications. -She completed a medication cart audit every several weeks but could not recall the date of her last medication cart audit. -There was no documentation available for any medication cart audits. Refer to the interview with the Administrator on 05/29/25 at 1:50pm Interview with the Administrator on 05/29/25 at 1:50pm revealed: -She completed the admission for Resident #3. -Resident #3 was sent with medications from the hospital and she did not check or document the medications sent from the hospital. -The RCC was responsible for completing a medication release form where any medications brought into the facility for Resident #3 should have been counted, documented, and compared to the current medications orders prior to placing medications on the medication cart for	D 412		

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 412	Continued From page 26 administration.	D 412		