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FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 a follow-up survey on 06/19/25 to 06/20/25.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment free of hazards related to bed bugs being in residents' rooms on the 400 Hall in the assisted living side of the facility. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed with a capacity of 96 beds including 56 beds for the assisted living (AL) side of the facility and 40 beds for a special care unit (SCU). Review of the facility's census report provided on 06/19/25 revealed:	D 079		

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-The facility's in-house census was 64 residents.
-There were 33 residents residing in the SCU.
-There were 31 residents residing in the AL side of the facility.

Review of the facility's Pest Control / Bed Bug Treatment Policy revised on 05/12/23 revealed:
-The purpose of the policy was to establish greater efficiencies in the control and treatment of observed pests and bed bugs.
-Observation, reporting, treatment, eradication, and maintaining preventive measures was the responsibility of the entire facility team.
-Any staff member who was told by a resident, family member, or guest that they believed bed bugs were present in the facility, would immediately notify the Executive Director (ED).
-The ED would make their own assessment as soon as possible.
-If the ED suspected bed bugs, they would immediately move the resident to a clean, unoccupied room.
-The resident would be given a shower and a skin assessment would be conducted.
-Two sets of the resident's clothing should be placed in a plastic bag, then washed and dried on hot.
-This would allow the resident to put on fresh clothing after showering.
-If a resident appeared to have any skin lesions resembling bed bug bites, the resident's provider would be notified and asked to evaluate and treat the resident.
-The resident's room with suspected bed bugs would be locked.
-The ED would call corporate and request immediate attention and the ED would enter the bed bug concern into the maintenance work order system.
-After the resident was moved to a clean room,

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the ED with the help of maintenance, housekeeping, and other staff, would oversee pre-treatment procedures.
-Corporate would schedule a visit by the maintenance bed bug detection canine group and an inspector from the contracted pest control expert.
-If the presence of bed bugs was confirmed, the contracted pest control company would be scheduled by the corporate office.
-Prior to treatment, the ED would oversee the implementation of the pre-treatment steps.
-After the room (or rooms) had been treated, the pest control contractor would conduct a follow-up visit within 14 days to confirm successful eradication.
-If there was no evidence of bed bugs, the work order ticket would be closed and the resident may move back into their room.

Review of the facility's Preparation For Bed Bug Treatment form (undated) from the facility's contracted pest control company revealed:
-Remove all bedding and place in plastic bags (seal them tightly) for transport to laundry area.
-Wash and dry all bedding on the highest possible setting (120 degrees F is lethal to bed bugs).
-After washing, place all clean bedding in new plastic bags and seal them tightly.
-Discard old plastic bags outside for garbage removal and do not re-use.
-Remove all loose articles from the floors and underneath the beds.
-Thoroughly vacuum all floors, bed frames, mattresses, box springs, upholstery, shoes, and curtains.
-Place vacuum bag in a sealed plastic bag and discard outside.
-Shoes must be vacuumed and washed as well.
-Empty all closets, dressers, bookshelves, wall

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units, breakfronts, hutches, etc. throughout the room.
-All items that have been removed should be inspected, cleaned, and put into plastic bags and sealed tightly.
-All of the above areas must be vacuumed once emptied to help eliminate any live bed bugs or eggs.
-These areas should be left emptied until after treatment.
-Remove all items that are mounted to the walls such as framed pictures, mirrors, light fixtures, and decorative items.
-Do not remove these items from the room as they need treatment.
-Remove outlet and switch plate covers.
-Do not remove any items of furniture from the room to be treated.
-Seal tightly all exposed food items and cover up.
-Wash all clothes prior to treatment.
-After washing, place clean clothes in new plastic bags and seal tightly.
-Discard old plastic bags outside for garbage removal.
-All infested mattresses should be discarded or fumigated.
-The room must be vacant for a minimum of 4 hours following treatment or until the chemical is completely dry.
-Residents must be out of the room for a minimum of 48 hours.
Interview with a resident on 06/19/25 at 9:01am revealed bed bugs were found about 2 days ago in 3 or 4 resident rooms on the 400 Hall.

Observation of resident room 403 on 06/19/25 at 10:23am revealed:
-The room appeared vacant.
-There were no mattresses on the beds.
-There were multiple full black trash bags sitting

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on the floor with residents' names labeled on them.
-There was a laundry cart with folded linens.

Observation of resident rooms 407, 410, and 412 during the tour of the facility on 06/19/25 between 10:45am - 10:55am revealed:
-In room 407, there were no sheets on the mattresses; multiple large black trash bags with belongings labeled with residents' names on the floor; 5 plastic totes stacked up against the wall beside a night stand; and a folded bed linen on top of a mattress.
-In room 410, there were no sheets on the mattresses; multiple large black trash bags with belongings labeled with residents' names on the floor; a plastic container against the wall near a night stand; a clothes hanger and holiday decorations on the floor; opened night stand drawers full of personal items; and a pile of unbagged clothing on the floor near the closet.
-In room 412, there was one bed frame with no mattresses; a second bed with no sheets on the mattresses; two clear bags with belongings labeled with residents' names; a decorative pillow unbagged on the floor; a walker, a portable air conditioner, and a laundry basket.

Interview with a resident on 06/19/25 at 10:15am revealed:
-He usually resided in resident room 410 but had been moved 2 days ago to another room.
-This was the third time he had been moved out of room 410 because of bed bugs.
-The exterminator had sprayed before, but it was not killing the bed bugs.
-He did not see bed bugs in his room 2 days ago but was told he had to move out.

Interview with a resident on 06/19/25 at 10:56am

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revealed:
-He was moved out of room 412 and into another room yesterday, 06/18/25.
-A man came with a dog 2 days ago and found bed bugs in room 412 in the bed frame.
-He did not see the bed bugs.

Interview with two residents on 06/19/25 at 11:12am revealed:
-They were moved out of room 407 yesterday, 06/18/25.
-A man came with a dog and found bed bugs in their room this week.
-They had not seen any bed bugs in their room this week.
-They had to take a shower and change clothes before they moved into the temporary room.

Review of the facility's canine Bed Bug Inspection report dated 06/16/25 revealed:
-All areas of the facility were inspected.
-The facility was positive for bed bugs.
-The identified areas of concern were rooms 407, 410, and 412.
-Pest control was notified and there would be a re-check in 30 - 45 days.

Interview with the Administrator on 06/19/25 at 2:31pm revealed:
-She had worked at the facility as the Administrator / ED since February 2025.
-A live bed bug was found on a pillowcase in resident room 410 on 06/12/25.
-She contacted the corporate pest control and was told the corporate canine bed bug would come to the facility for an inspection.
-The corporate bed bug canine came to the facility on 06/16/25 and identified bed bug activity in resident rooms 407, 410, and 412.
-She emailed the corporate pest control on

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D 079	Continued From page 6 06/16/25 with the results. -The facility's contracted pest control company was contacted on 06/17/25 and were scheduled to treat those 3 rooms today, 06/19/25. -She was also notified via third shift staff yesterday, 06/18/25, that a bed bug was found on a pillow in room 414. -The facility's protocol was to remove all bed linens and clothing to be processed including washed, dried, and bagged up. -Some clothing was to be separated and washed and dried for the resident to wear. -It was to be placed in a room with no bed bug activity. -Nothing else was to be moved in the room with bed bug activity. -The residents were to be moved to temporary rooms without bed bug activity. -The residents were showered and put on clean clothes before being moved into the temporary rooms. -After the pest control treatment, there was a follow-up inspection by the pest control company in 2 weeks. -If there was no bed bug activity found during the 2-week follow-up, the residents could move back to their rooms. -The bed bug activity found on 06/12/25 was the first activity found since April 2025. -She requested from corporate for heat treatments to be done in March 2025 because of the history of bed bugs but it was not approved by corporate. -The bed bug activity in the past had mostly been on 300 Hall and 400 Hall since she started in February 2025. Interview with an exterminator from the facility's pest control company on 06/19/25 at 3:30pm revealed:	D 079		

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D 079	Continued From page 7 -Chemical treatment would work to kill bed bugs but heat treatment was more efficient. -Chemical treatment was not as efficient in treating bed bugs if they were in the walls. -They talked with the facility about doing heat treatments months ago, but it was not approved by the facility, so they were currently treating the bed bugs with chemical sprays. -If there was live activity, they vacuumed and put powdered chemicals in the wall outlets. -They treated only the rooms noted on the work order ticket. -They only treated the baseboards for adjoining bathrooms and bedrooms unless otherwise specified by the work ticket. -Once the room was treated, no one should be in the room for 4.5 hours. -They came back in 2 weeks to recheck the rooms. -There were not supposed to be any resident belongings left in the rooms. -The facility was supposed to follow the pest control company protocol prior to treatment. -The facility should not leave bags of clothing or other belongings in the rooms that needed treatment. -If there was a bag with a hole in it; there could be recontamination of the room. -Their last visit to the facility to treat bed bugs was in April 2025. -She was previously coming to the facility 2 to 3 times a week to treat bed bug activity. -The rooms she treated today were rooms she had treated in the past. -The facility was not following the pre-treatment protocol, and she had talked with the Administrator multiple times about the rooms not being cleaned out prior to treatment. -Every time she came to treat for bed bugs, rooms were not prepared for treatment.	D 079		

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D 079	Continued From page 8 -This could contribute to recontamination of the rooms. Observation on 06/19/25 at 3:33pm revealed the exterminator was wearing gloves and had live bed bug crawling on her gloved hand. Second interview with the exterminator from the facility's contracted pest control company on 06/19/25 at 3:33pm revealed: -She found a live bed bug in resident room 410 today, 06/19/25. -The bed bug was on the mattress on the bed near the door. Interview with a personal care aide (PCA) on 06/19/25 at 4:38pm revealed: -If bed bugs were found in a resident room, the resident was given a shower, their clothes were washed, and the resident was moved to another room. -The cleaned items were bagged up and taken to a temporary room. -Some of the bags in the vacant rooms were bags that had not been washed yet because there was not enough room to store them in the laundry room. -She was not sure which rooms had bags with clean clothing, and which had bags with clothing that had not been washed. Interview with Maintenance on 06/19/25 at 4:30pm revealed: -The PCAs and housekeepers were responsible for bagging up clothing and items and getting the rooms ready for bed bug treatment. -He was not aware of any issues with bed bug pre-treatment preparation. Interview with a housekeeper on 06/20/25 at	D 079		

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D 079	Continued From page 9 8:13am revealed: -Bed bug activity had just started again on Monday or Tuesday of this week. -They had bed bugs in the past that were treated by the pest control company but the bed bugs kept coming back. -Their protocol was to wash the resident's clothing, walker and wheelchair. -The resident was moved to another room without bed bug activity. -All clothing and bed linens were bagged up in trash bags and taken to the laundry room to be washed and dried and then they were stored in a vacant room. -The trash bags of clothes and linens were usually left in the room with bed bugs until they could get them washed because they did not want to take the contaminated bags and mix them with other clothing in the laundry room. -She did not vacuum or clean out drawers in the bed bug rooms because she did not realize she needed to. Second interview with the Administrator on 06/19/25 at 4:46pm revealed: -The facility staff was in-serviced on the bed bug policy prior to her starting at the facility in February 2025. -She had discussed with staff during all staff training what to do if bed bug activity was found. -She had instructed staff on how to process the bagged items. -She followed up by asking housekeeping staff if the protocol had been done and by doing walk throughs to check. -The Maintenance and housekeeping staff were responsible for making sure the bed bug protocol was followed. -There had been issues in the past with staff not knowing which clothing was in the plastic bags,	D 079		

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D 079	Continued From page 10 contaminated or clean clothing. -The Maintenance and housekeeping were responsible for cleaning and preparing the rooms for treatment. -The PCAs were responsible for showering the residents and doing the laundry. -She was not aware staff had left items unbagged in the rooms with bed bug activity. -Bed mattresses should either be discarded or cleaned with rubbing alcohol. -Drawers should be emptied. -She had not done a walk through yet that morning, 06/19/25, prior to the pest control company coming to treat the affected rooms.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the HVAC (heating, ventilation, and air conditioning) system that controlled the library and the hallway on the 400 Hall was maintained in an operating condition. The findings are: Observation of the library and hallway outside of the library on the 400 Hall on 06/19/25 at 2:03pm	D 105		

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revealed:
-The temperature in the library and hallway on the 400 Hall was 79 degrees Fahrenheit.
-There was no air blowing from the vents in the library and hallway on the 400 Hall.

Interview with a resident residing on the 400 Hall on 06/19/25 at 4:25pm revealed:
-The air conditioning unit on that hall had been broken for about a year.
-A new unit was put in a couple of months ago, but he did not think it was working properly.
-It was hot and uncomfortable on the 400 Hall.

Interview with Maintenance on 06/19/25 at 2:20pm revealed:
-He had worked as maintenance at the facility for about 3 months.
-The HVAC (heating, ventilation, and air conditioning) for the library on the 400 Hall had been short cycling for some reason.
-He noticed it was warm in the library last week, but he thought it was because he had been working outside in the heat.
-The library was for the residents to use but he rarely saw any residents use the library.
-He called the Corporate Maintenance Director today, 06/19/25, for assistance.

Second interview with Maintenance on 06/19/25 at 4:25pm revealed:
-Up until today, he thought the HVAC unit that controlled the library (Unit #9) and the hallway on the 400 Hall had been working.
-He noticed today, 06/19/25, that the air was not blowing out of the vents in the library and the hallway of the 400 Hall.

Interview with the Administrator on 06/19/25 at 2:18pm revealed:

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-She was not aware of any issues with the air conditioning unit for the library on the 400 hall or the hallway on 400 Hall prior to today.
-She just called the Regional Vice President of Operations (RVPO) and they were going to get someone to come check the air conditioning unit for the library on the 400 Hall.

Observation of the hallway of the 400 Hall on 06/20/25 at 7:00am revealed there were floor fans at the entrance of the 400 hallway blowing air down the hallway of the 400 Hall.

Interview with a housekeeper on 06/20/25 at 8:13am revealed:
-The air conditioning in the library on 400 Hall had not worked for about a year.
-It was hard to tell if it was not working until it got real hot outside, like it was today.
-Residents occasionally used the library.
-It was also warm on the hallway of the 400 Hall from about midway down all the way to the end of the hallway.

Interview with Corporate Maintenance on 06/19/25 at 5:00pm revealed:
-Unit #9 had been switched off outside and the thermostat for that unit was stuck.
-He may have to put in a new thermostat.

Third interview with Maintenance on 06/20/25 at 7:05am revealed:
-After further inspection, the air handler in the attic for the library and the hallway of the 400 Hall was melted/burned out.
-The air handler was over 20 years old, so it was being phased out.
-He was not sure if they would be able to get a new one of the same type or if they would have to install a whole new system.

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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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a medication for congestion and cough (#6) and a vitamin supplement (#7); and for 3 of 5 residents (#2, #4, #5) sampled for record review including errors with a blood thinner (#2), an antibiotic for infection (#2), a topical pain reliever (#4), and a vitamin supplement (#5). The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 32 opportunities during the 8:00am medication pass on 06/20/25. a. Review of Resident #6's current FL-2 dated 10/22/24 revealed: -Diagnoses included essential hypertension, decreased white blood cell count, major	D 358		

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depressive disorder, hypothyroidism, anxiety disorder, and osteoporosis.
-There was an order for Mucus Relief 600mg ER 1 tablet twice a day as needed (prn) for cough. (Mucus Relief ER is used to treat cough and congestion.)

Review of Resident #6's clarification order dated 10/22/24 revealed:
-There was an order to discontinue Mucus Relief 600mg ER 1 tablet twice a day prn for cough.
-There was an order for Mucus Relief 600mg ER 1 tablet twice a day as directed scheduled.

Review of Resident #6's physician's order sheet dated 04/03/25 revealed:
-There was an order for Mucus Relief 600mg ER 1 tablet twice a day prn for cough.
-There was no order for Mucus Relief 600mg ER 1 tablet twice a day scheduled.

Observation of the 8:00am medication pass on 06/20/25 revealed:
-Resident #6's medications were packaged in multi-dose packs (MDPs).
-The medication aide (MA) prepared and administered medications in the morning MDP, including one Mucus Relief 600mg ER tablet to Resident #6 at 7:24am.
-The MA did not ask the resident if she needed a Mucus Relief 600mg ER tablet and the resident did not request or indicate that she needed one.
-Mucus Relief 600mg ER was administered as a scheduled medication instead of a prn medication as ordered.

Review of Resident #6's June 2025 electronic medication administration record (eMAR) dated 06/01/25 - 06/20/25 revealed:
-There was an entry for Mucus Relief 600mg ER

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1 tablet twice daily as directed prn cough.
-No Mucus Relief 600mg ER was documented as administered in June 2025.
-There was no other entry for Mucus Relief 600mg ER on the June 2025 eMAR.

Observation of Resident #6's medications on hand on 06/20/25 at 12:11pm revealed:
-There was a MDP printed on 06/12/25 and labeled Week 1.
-Each morning MDP included one Mucus Relief 600mg ER tablet packaged with other morning medications.
-The instructions on the label included Mucus Relief 600mg ER take 1 tablet twice daily as directed.

Interview with the MA on 06/20/25 at 12:14pm revealed:
-She thought the order for Mucus Relief 600mg ER had been clarified in the past (could not recall date).
-She thought it was supposed to be administered as a scheduled medication.
-She had not noticed the order on the eMAR was for prn administration and did not match the instructions on the medication label.
-Either the pharmacy or the Resident Care Coordinator (RCC) entered orders into the eMAR system.
-The RCC approved orders in the eMAR system.

Interview with Resident #6 on 06/20/25 at 12:04pm revealed:
-She did not receive any medication for cough or congestion.
-She was just getting over a cold, and she did not currently have any congestion or cough.
-If she needed something for cough or congestion, she would have to get her doctor to

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prescribe something.

Telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm revealed:
-The pharmacy had an order on file dated 10/08/24 for Mucus Relief 600mg ER 1 tablet twice a day.
-The pharmacy did not have Resident #6's FL-2 dated 10/22/24 or physician's order sheet dated 04/03/25.
-If the pharmacy had received an order for prn Mucus Relief, they would have packaged the prn medication in a bubble card, not the MDPs.
-The pharmacy usually entered any orders they received into the eMAR system.
-The facility had to verify and approve orders in the eMAR system.
-The facility also had access to enter orders into the eMAR system.

Interview with the RCC on 06/20/25 at 12:58pm revealed:
-She was unable to locate a clarification order for Resident #6's Mucus Relief 600mg ER after the order dated 04/03/25 for the medication to be administered prn.
-The MAs, RCC, or Special Care Coordinator (SCC) were responsible for clarification of orders.
-The MAs should double check orders, contact the pharmacy, and notify her if something did not match.

Interview with the Administrator on 06/20/25 at 1:12pm revealed:
-If a medication order did not match on the eMAR and medication label, the MAs should notify the RCC or SCC.
-The SCC position was currently vacant.
-The RCC would get clarification for any discrepancies.

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Telephone interview with Resident #6's primary care provider (PCP) on 06/20/25 at 2:08pm revealed:
-Resident #6's Mucus Relief 600mg ER should be administered prn.
-Resident #6 had chronic allergies and should take Mucus Relief 600mg ER prn for cough related to her allergies.
-Taking Mucus Relief 600mg ER on a scheduled basis could potentially cause elevations in blood pressure.

b. Review of Resident #7's current FL-2 dated 12/11/24 revealed:
-Diagnoses included Alzheimer's dementia, multiple sclerosis, stroke, seizures, depression, anxiety, chronic insomnia, hypertension, and paranoia.
-There was an order for Vitamin B12 1000mcg 1 tablet once daily. (Vitamin B12 is a vitamin supplement used to treat Vitamin B12 deficiency.)

Review of Resident #7's primary care provider (PCP) visit note dated 01/09/25 revealed:
-The resident's Vitamin B12 level was 836 (reference range 213 - 816) on 01/07/25.
-There was an order to discontinue Vitamin B12 supplement.

Review of Resident #7's June 2025 electronic medication administration record (eMAR) revealed there was no entry for Vitamin B12 1000mcg 1 tablet daily.

Observation of the 8:00am medication pass on 06/20/25 revealed:
-Resident #7's medications were packaged in multi-dose packs (MDPs).
-The medication aide (MA) prepared and

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administered medications in the morning MDP, including one Vitamin B12 1000mcg tablet to Resident #7 at 7:59am.
-The resident was administered Vitamin B12 1000mcg after it was discontinued on 01/09/25.

Observation of Resident #7's medications on hand on 06/20/25 at 12:35pm revealed:
-There was a MDP printed on 06/16/25 and labeled Week 1.
-Each morning MDP included one Vitamin B12 1000mcg tablet packaged with other morning medications.
-The instructions on the label included Vitamin B12 1000mcg 1 tablet once daily.

Interview with the MA on 06/20/25 at 12:38pm revealed:
-She was not aware Resident #7's Vitamin B12 had been discontinued.
-She did not notice Vitamin B12 was not on the eMAR that morning when she administered medications to Resident #7.
-If a medication was discontinued and still in the MDP, the MAs were supposed to remove that tablet and dispose of it in the sharp's container.
-The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) were responsible for faxing orders to the pharmacy and removing orders from the eMAR.

Interview with Resident #7 on 06/20/25 at 12:53pm revealed:
-She usually received medications for her diagnosis of multiple sclerosis.
-She did not think she received any vitamins.
-She denied any side effects from her medications.

Telephone interview with a certified pharmacy

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technician on 06/20/25 at 3:08pm revealed:
-Vitamin B12 100mcg tablet had been included in the MDPs for weekly cycle fills since January 2025.
-They did not receive an order to discontinue Vitamin B12 dated 01/09/25.
-The pharmacy usually entered orders, including discontinue orders, into the eMAR system.
-The facility had to verify and approve orders in the eMAR system.
-The facility also had access to enter orders into the eMAR system.
-It appeared the facility may have discontinued Vitamin B12 in their eMAR system but the discontinue order never reached the pharmacy so they continued to dispense Vitamin B12.

Interview with the RCC on 06/20/25 at 12:58pm revealed:
-She was unsure why Resident #7 was receiving Vitamin B12 after it had been discontinued.
-The MAs should double check orders, contact the pharmacy, and notify her if something did not match.
-The MAs also had access to contact the PCP's office 24 hours a day if needed.

Interview with the Administrator on 06/20/25 at 1:15pm revealed:
-If a medication order did not match on the eMAR and medication label, the MAs should not administer the medication and notify the RCC or SCC.
-The RCC or SCC would check the order, clarify if needed, and communicate the information with the MAs.
-The RCC or SCC were responsible for verifying orders and then filing orders in the residents' records.
-The SCC position was currently vacant.

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D 358	Continued From page 20 Telephone interview with Resident #7's PCP on 06/20/25 at 2:08pm revealed: -She did not want Resident #7 to receive Vitamin B12. -Resident #7's Vitamin B12 was discontinued because her Vitamin B12 levels were too high when checked in January 2025. -She had not rechecked the resident's Vitamin B12 level because she thought the resident had stopped taking it. -Excess Vitamin B12 could cause stomach upset or a sense of malaise (a general feeling of being sick or having no energy). -The resident had not presented with any of those symptoms during her visits with the resident. 2. Review of Resident #2's current FL-2 dated 05/29/25 revealed diagnoses included history of cerebrovascular accident (stroke), history of placement of prosthetic heart valve, anticoagulation, hypertension, diabetes mellitus type 2, hyperlipidemia, altered mental status, electrolyte abnormality, falls, and fracture of left arm in 2021. a. Review of Resident #2's primary care provider (PCP) visit note dated 04/10/25 revealed: -The resident's current order was Warfarin 10mg on Saturday through Wednesday, and Warfarin 7.5mg on Thursdays and Fridays. (Warfarin is a blood thinner used to prevent blood clots.) -The resident's therapeutic INR range was 2.5 - 3.5. [International Normalized Ratio (INR) is a lab value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations. The target INR range is generally recommended to be 2.5 - 3.5 for those with mechanical heart valves.]	D 358		

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D 358	Continued From page 21 Review of Resident #2's lab results dated 04/15/25 revealed: -The PCP's handwritten note on the bottom of the page was "INR therapeutic 2.0 to 3.0 goal" dated 04/17/25. -The resident's INR was 2.31 (within therapeutic goal range). Review of Resident #2's PCP visit note dated 04/17/25 revealed there was an order to continue current Warfarin regimen until further notice. Review of Resident #2's PCP visit note dated 05/08/25 revealed: -The resident's INR was 1.77 (below therapeutic range) on 05/06/25. -There was an order for an additional Warfarin 2mg tablet to be given for 1 dose in addition to the existing regimen. Review of Resident #2's PCP visit note dated 05/27/25 revealed: -The resident was seen via televisit due to complaint of upper thigh pain, mild redness, reportedly with warmth. -There was evidence of two dried blood spots inside the resident's pants. -There was some point of contact or pressure to the thigh with faint bruising. -The resident had a contusion (bruise) on the upper part of the thigh with mild red discoloration and warmth to touch. -There was no break in skin but old dried blood was noted on her clothes. -No falls were reported and the resident was not complaining of pain. -Due to the resident's use of Warfarin, there was an increased risk of bleeding complications. -There was an order to hold Warfarin temporarily; hold Warfarin 10mg today, 05/27/25.	D 358		

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D 358	Continued From page 22 -Labs were ordered to be done on 05/28/25. -An ultrasound was also ordered to rule out blood clot. -The resident was to follow-up in 2 days to review lab and imaging results. Review of Resident #2's PCP visit note dated 05/29/25 revealed: -The resident's Warfarin was currently on hold due to elevated INR of 3.85. -The PCP would resume Warfarin at a lower dose starting Monday, 06/02/25. -There was an order to resume Warfarin at a reduced dose of 3mg starting on Monday, 06/02/25, for one week, followed by re-evaluation. Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Warfarin 10mg 1 tablet once daily on Saturdays, Sundays, Mondays, Tuesdays, and Wednesdays scheduled at 5:00pm. -There was no entry for an additional dose of Warfarin 2mg to be administered as ordered on 05/08/25. -Warfarin 10mg was documented as administered on Tuesday, 05/27/25; Wednesday, 05/28/25; and Saturday, 05/31/25 when it should have been held. -There was an entry for Warfarin 7.5mg 1 tablet once daily on Thursdays and Fridays scheduled at 5:00pm. -Warfarin 7.5mg was documented as administered on Thursday, 05/29/25, and Friday, 05/30/25 when it should have been held. -There were 5 doses of Warfarin administered from 05/27/25 - 05/31/25 when it was ordered to be held.	D 358		

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Review of Resident #2's PCP visit note dated 06/03/25 revealed:
-The resident's INR was 3.85 (above therapeutic range) on 05/28/25.
-There was an order to hold Warfarin until further notice.

Review of Resident #2's PCP visit note and orders dated 06/05/25 revealed:
-The resident's INR was 5.81 (above therapeutic range) on 06/03/25.
-There was an order to hold Warfarin 3mg 1 tablet once a day until further notice.
-There was an order to repeat INR on 06/09/25.
-The resident's goal INR was 2.5 - 3.5.

Review of Resident #2's PCP visit note dated 06/11/25 revealed:
-The resident's INR was 1.07 (below therapeutic range) on 06/09/25.
-There was an order to restart Warfarin 3mg 1 tablet every evening.

Review of Resident #2's PCP clarification order dated 06/13/25 revealed:
-There was an order to discontinue Warfarin 7.5mg and Warfarin 10mg doses.
-The current dose was Warfarin 3mg every evening.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry for Warfarin 10mg 1 tablet once daily on Saturdays, Sundays, Mondays, Tuesdays, and Wednesdays scheduled at 5:00pm.
-Warfarin 10mg was documented as administered on Sunday, 06/01/25 when it should have been held.
-There was an entry for Warfarin 3mg 1 tablet

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once daily scheduled at 8:00am.
-Warfarin 3mg was documented as not being administered on 06/02/25 due to given in pm.
-There was no entry for Warfarin 3mg to be administered in the pm.
-Warfarin 10mg was documented as administered on 06/02/25 instead of 3mg as ordered.
-Warfarin was not held as ordered on 06/03/25, 06/04/25, and 06/10/25 instead 10mg was documented as administered on those days.
-Warfarin 10mg was documented as administered on 06/11/25, 06/15/25, and 06/17/25 instead of Warfarin 3mg as ordered.
-No Warfarin was documented as administered on 06/12/25, 06/14/25, 06/16/25, 06/18/25, and 06/19/25, but the resident should have received Warfarin 3mg on those days as ordered.

Observation of Resident #2's medications on hand on 06/20/25 at 2:58pm revealed:
-There was a supply of Warfarin 7.5mg dispensed on 05/23/25 with 4 of 4 tablets remaining.
-There was a supply of Warfarin 10mg dispensed on 06/05/25 with 9 of 10 tablets remaining.
-There was a supply of Warfarin 10mg dispensed on 06/18/25 with 10 of 10 tablets remaining.
-There was a supply of Warfarin 3mg dispensed on 05/30/25 with 9 of 14 tablets remaining.
-There was a supply of Warfarin 3mg dispensed on 06/19/25 with 14 of 14 tablets remaining.

Telephone interview with a certified pharmacy technician at the facility's contracted pharmacy on 06/20/25 at 3:08pm revealed:
-The pharmacy received medication orders either through electronic prescriptions from providers or via fax from the facility.
-The pharmacy usually entered orders into the

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eMAR system, but the facility had to approve the orders before the orders became active in the eMAR system.
-The facility staff also had access to enter orders into the eMAR system.
-The last order the pharmacy received for Warfarin was dated 05/30/25 for Warfarin 3mg 1 tablet daily.
-The pharmacy never received an order dated 05/08/25 for an additional Warfarin 2mg tablet to be administered for a one-time dose so they never dispensed Warfarin 2mg.
-They never received an order dated 05/27/25 to hold Warfarin so they did not enter a hold order into the eMAR system until they received a hold order dated 06/05/25.
-The pharmacy never received an order to discontinue Warfarin 10mg or Warfarin 7.5mg until that morning on 06/20/25 and the order to discontinue them was dated 06/13/25.
-They dispensed 14 Warfarin 3mg tablets each on 05/30/25 and 06/19/25.
-They dispensed 4 Warfarin 7.5mg tablets on 05/23/25.
-They dispensed 10 Warfarin 10mg tablets each on 05/12/25, 05/23/25, 06/05/25, and 06/18/25.

Interview with Resident #2 on 06/20/25 at 5:50pm revealed:
-She usually received Warfarin every day, but she did not recall what strength of the medication she usually received.
-She did not recall if the Warfarin had been held on any days.
-She denied any current symptoms of bleeding or bruising.

Interview with a medication aide (MA) on 06/20/25 at 2:58pm revealed:
-She did not administer Warfarin 3mg to Resident

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#2 on 06/02/25 because it was on the eMAR to be administered at 8:00am and she thought it was supposed to be administered in the evening.
-She was not sure why the resident was administered the wrong doses at times.
-Warfarin would not have been held if it was listed on the eMAR to be administered.

Interview with the Resident Care Coordinator (RCC) on 06/20/25 at 3:57pm revealed:
-Warfarin orders should be handled the same as other medication orders.
-She usually checked for unverified medication orders in the eMAR system daily to make sure orders were sent to the pharmacy and the medications had been received by the facility.
-If the facility received orders to hold medications, either she or the MAs would put the hold order into the eMAR system.
-She thought she had tried to put the Warfarin order on hold in the eMAR system at some point (could not recall when) but it must have disappeared.
-She recalled getting a clarification order on 06/13/25 to discontinue Warfarin 10mg and 7.5mg because a MA had asked her if they were supposed to still be administering Warfarin 10mg with the restart of Warfarin 3mg.
-The MAs should notify the provider of any medication errors.

Interview with the Administrator on 06/20/25 at 4:15pm revealed:
-She was not aware of any errors with Resident #2's Warfarin.
-The MAs were supposed to communicate with the RCC, if there were medication discrepancies immediately.
-The RCC was supposed to communicate with the PCP and the pharmacy about any medication

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issues.

Telephone interview with Resident #2's PCP on 06/20/25 at 2:08pm revealed:
-She was not aware Resident #2's Warfarin was not held or the wrong doses were administered.
-Not receiving or holding Warfarin as ordered could cause the resident's heart valve to be dysfunctional; cause bleeding; or put the resident at risk for blood clots which could lead to heart attack, stroke, or death.

b. Review of Resident #2's primary care provider (PCP) visit note dated 05/27/25 revealed:
-The resident was seen via televisit due to complaint of upper thigh pain, mild redness, reportedly with warmth.
-There was evidence of two dried blood spots inside the resident's pants.
-There was some point of contact or pressure to the thigh with faint bruising.
-The resident had a contusion (bruise) on the upper part of the thigh with mild red discoloration and warmth to touch.
-There was no break in skin, but old dried blood was noted on her clothes.
-The resident was to follow-up in 2 days to review lab and imaging results.

Review of Resident #2's PCP order dated 05/29/25 revealed an order for Doxycycline 100mg 1 tablet twice a day for 7 days. (Doxycycline is an antibiotic for infection.)

Review of Resident #2's May 2025 and June 2025 electronic medication administration records (eMARs) revealed:
-There was an entry for Doxycycline 100mg 1 tablet twice daily for 7 days scheduled at 12:00pm and 8:00pm on the May 2025 eMAR.

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D 358	Continued From page 28 -The first dose of Doxycycline was documented as administered at 12:00pm on 05/31/25. -There was no reason documented for the delay in starting Doxycycline as ordered on 05/29/25. -There was a total of 2 doses of Doxycycline documented as administered on 05/31/25. -There was an entry for Doxycycline 100mg 1 tablet twice daily for 7 days scheduled at 12:00pm and 8:00pm on the June 2025 eMAR. -Doxycycline was documented as administered from 12:00pm on 06/01/25 - 8:00pm on 06/06/25, for a total of 12 doses. Telephone interview with a certified pharmacy technician at the facility's contracted pharmacy on 06/20/25 at 3:08pm revealed: -The pharmacy received an order for Doxycycline for Resident #2 on 05/29/25 at 8:27pm, after the cut off time. -They pharmacy dispensed 14 Doxycycline 100mg tablets on 05/30/25 and were delivered to the facility in the early morning hours on 05/31/25. -The facility could contact the pharmacy if they needed medication the same day or they could contact them and ask to use the backup pharmacy to get medication the same day. -The facility did not contact the pharmacy to request the Doxycycline on the same day. Interview with Resident #2 on 06/20/25 at 5:50pm revealed: -She did not recall when she started the antibiotic for the hip wound. -She denied any signs of infection on her hip but stated it hurt occasionally. Observation of Resident #2 on 06/20/25 at 6:17pm revealed there were no open areas, redness, or bruising on either hip.	D 358		

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Interview with the Resident Care Coordinator (RCC) on 06/20/25 at 3:57pm revealed:
-Antibiotics should be started within 24 hours of receiving the order.
-She was not sure why there was a delay in getting Resident #2's Doxycycline.
-The medication aides (MAs) could call and get the medication through the backup pharmacy.

Interview with the Administrator on 06/20/25 at 4:15pm revealed:
-She was not aware of the delay in starting Resident #2's Doxycycline.
-Antibiotics should usually be started within 24 hours of receiving the order.
-The MAs or RCC should immediately let the pharmacy know when there was an order for an antibiotic or they could use the backup pharmacy.

Telephone interview with Resident #2's PCP on 06/20/25 at 2:08pm revealed:
-Doxycycline was ordered on 05/29/25 for Resident #2 because she had a boil on her hip that was bleeding.
-She expected the antibiotic to be started at least by the next day.
-If the facility had asked her, she could have sent the order to the backup pharmacy so they could get it sooner.
-She ordered the antibiotic to make sure there was not any infection or minimal infection.
-A delay in starting the antibiotic could increase the risk of infection.

3. Review of Resident #4's current FL-2 dated 04/24/25 revealed:
-Diagnoses included mood disorder, hypertension, major depressive disorder, anxiety disorder, Behcet's disease (inflammation of blood vessels), and unspecified pain.

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-There was an order for Diclofenac Sodium Gel 1% apply 2 grams topically to left knee twice a day. (Diclofenac Sodium is a topical gel used to treat pain associated with arthritis.)
-There was an order for Diclofenac Sodium Gel 1% apply 2 grams topically to bilateral hands/fingers 3 times daily.

Review of Resident #4's May 2025 and June 2025 electronic medication administration records (eMARs) revealed:
-There was an entry for Diclofenac Sodium Gel 1% apply 2 grams topically to left knee twice a day on the May 2025 eMAR scheduled at 8:00am and 8:00pm.
-Diclofenac Sodium Gel 1% to the left knee was documented as administered from 05/01/25 - 05/14/25 then noted to be a duplicate and discontinued on 05/15/25.
-There was no entry for Diclofenac Sodium Gel 1% apply 2 grams topically to left knee twice a day on the June 2025 eMAR.

Review of Resident #4's physician's orders revealed no documentation of an order to discontinue Diclofenac Sodium Gel 1% apply 2 grams topically to the left knee twice a day.

Observation of Resident #4's medications on hand on 06/20/25 at 6:02pm revealed:
-There was a 100gram tube of Diclofenac Sodium Gel 1% dispensed on 03/27/25.
-The instructions were to apply topically 2 grams to left knee twice daily.
-There was a handwritten note on the box that it was opened on 05/26/25.
-The tube was approximately half full.
-There was no other supply of Diclofenac Sodium Gel 1% on hand.

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Interview with a medication aide (MA) on 06/20/25 at 6:02pm revealed:
-She did not know why the order for Resident #4's Diclofenac Sodium Gel to the left knee was not included on the June 2025 eMAR.
-If the medication did not pop up on the eMAR, the MAs would not know to administer it.

Interview with Resident #4 on 06/20/25 at 6:10pm revealed:
-The MAs usually put Diclofenac Sodium Gel on her hands.
-They did not usually put any gel on either of her legs.
-She had pain in her left knee and thigh area.

Interview with the Resident Care Coordinator (RCC) on 06/20/25 at 6:25pm revealed:
-She was not aware Resident #4's Diclofenac Sodium Gel order to be applied to her left knee was not included on the June 2025 eMAR.
-She did not know why the Diclofenac Sodium Gel order to the left knee was stopped on 05/15/25 on the May 2025 eMAR.
-She did not see an order to discontinue it.
-The MAs should notify her of any discrepancies.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/20/25 at 6:58pm was unsuccessful.

4. Review of Resident #5's current FL-2 dated 10/15/24 revealed diagnoses included seizures and shaking.

Review of Resident #5's care plan dated 08/02/24 revealed diagnoses included type 2 diabetes mellitus without complications (primary admission), unspecified urinary incontinence, anxiety disorder due to known physiological

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condition, other history of seizures and restlessness and agitation.

Review of Resident #5's progress note dated 12/12/24 revealed there was an order to discontinue Vitamin B-Complex. (Vitamin B-Complex is a vitamin supplement.)

Review of the Resident #5's physician order report dated 06/19/25 revealed there was not an order for Vitamin B-Complex.

Observation of Resident #5's medications on hand on 06/20/25 at 12:57pm revealed:
-There was a multi-dose pack (MDP) of medication with Vitamin B-Complex 1 tablet once daily on Monday, Wednesday and Friday.
-The MDP was dated 06/12/25 with an expiration date of 08/11/25.

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was not an entry for Vitamin B-Complex.
-There was no documentation of Vitamin B-Complex administered on 05/01/25 to 05/31/25.

Review of Resident #5's June 2025 eMAR revealed:
-There was not an entry for Vitamin B-Complex.
-There was no documentation of Vitamin B-Complex administered on 06/01/25 to 06/20/25.

Interview with the medication aide (MA) on 06/20/25 at 12:57pm revealed:
-Resident #5 had an order for Vitamin B-Complex 1 tablet in the morning on Monday, Wednesday and Friday.
-She had administered the Vitamin B-Complex to Resident #5 as ordered on the multi bubble pack.

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D 358	Continued From page 33 -She last administered the Vitamin B-Complex during the morning medication pass on 06/20/25. -There was not a discontinue order for the Vitamin B-Complex. -The Resident Care Coordinator (RCC) was responsible for sending all orders to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/20/25 at 2:02pm revealed: -Resident #5's order for Vitamin B-Complex started on 05/29/24 for 3 times weekly on Monday, Wednesday and Friday. -The Vitamin B-Complex was filled on 06/12/25 and 7 pills were dispensed. -The Vitamin B-Complex was last filled on 06/19/25 and 7 pills were dispensed. -The order for Vitamin B-Complex was active. Interview with Resident #5's primary care provider (PCP) on 06/20/25 at 2:44pm revealed: -Resident #5's Vitamin B-complex was discontinued around 11/07/24 due to elevated levels. -She had not prescribed a new order for Vitamin B-Complex. -She did not know why the Vitamin B-Complex was showing as an active order. -Most of her orders are completed electronically. -She was concerned with Resident #5 continuing to take the medication because it could harm the liver, cause upset stomach and could lead to acute elevation of the organs until the Vitamin B-Complex was completely out of Resident #5's system. _____ The facility failed to ensure medications were administered as ordered for 3 of 5 residents reviewed. Resident #2 had multiple errors with	D 358		

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D 358	Continued From page 34 Warfarin, a blood thinner, including not implementing hold orders and/or not administering the correct dosage of medication putting the resident at risk of bleeding or blood clots that could lead to stroke, heart attack, and death. Resident #2 had a delay in receiving an antibiotic for a hip wound that put the resident at increased risk of infection. Resident #4, who complained of left knee pain, did not receive Diclofenac Sodium Gel 1% to her left knee twice a day as ordered from 05/15/25 - 06/20/25. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/25 for this violation.	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	D 367		

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omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 7 sampled residents (#5, #6, #7) including documentation for a medication for cough and congestion (#6) and vitamin supplements (#5, #7).

The findings are:

1. Review of Resident #6's current FL-2 dated 10/22/24 revealed:
-Diagnoses included essential hypertension, decreased white blood cell count, major depressive disorder, hypothyroidism, anxiety disorder, and osteoporosis.
-There was an order for Mucus Relief 600mg ER 1 tablet twice a day as needed (prn) for cough. (Mucus Relief ER is used to treat cough and congestion.)

Review of Resident #6's clarification order dated 10/22/24 revealed:
-There was an order to discontinue Mucus Relief 600mg ER 1 tablet twice a day prn for cough.
-There was an order for Mucus Relief 600mg ER 1 tablet twice a day as directed scheduled.

Review of Resident #6's physician's order sheet dated 04/03/25 revealed:

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-There was an order for Mucus Relief 600mg ER 1 tablet twice a day prn for cough.
-There was no order for Mucus Relief 600mg ER 1 tablet twice a day scheduled.

Observation of the 8:00am medication pass on 06/20/25 at 7:24am revealed Mucus Relief 600mg ER was administered as a scheduled medication instead of a prn medication as ordered without asking if it was needed or the resident requesting the medication.

Review of Resident #6's June 2025 electronic medication administration record (eMAR) dated 06/01/25 - 06/20/25 revealed:
-There was an entry for Mucus Relief 600mg ER 1 tablet twice daily as directed prn cough.
-No Mucus Relief 600mg ER was documented as administered in June 2025, including the dose observed to be administered on 06/20/25 at 7:24am.
-There was no other entry for Mucus Relief 600mg ER on the June 2025 eMAR.

Observation of Resident #6's medications on hand on 06/20/25 at 12:11pm revealed:
-Resident #6's medications were packaged in multi-dose packs (MDPs).
-There was a MDP printed on 06/12/25 and labeled Week 1.
-Each morning MDP included one Mucus Relief 600mg ER tablet packaged with other morning medications.
-The instructions on the label included Mucus Relief 600mg ER take 1 tablet twice daily as directed.
-There was no supply of prn Mucus Relief 600mg ER tablets.

Interview with the medication aide (MA) on

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D 367	Continued From page 37 06/20/25 at 12:14pm revealed: -She had not noticed the order on the eMAR was for prn administration and did not match the instructions on the medication label. -Either the pharmacy or the Resident Care Coordinator (RCC) entered orders into the eMAR system. -The RCC approved orders in the eMAR system. Telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm revealed: -The pharmacy had an order on file dated 10/08/24 for Mucus Relief 600mg ER 1 tablet twice a day. -The pharmacy did not have Resident #6's FL-2 dated 10/22/24 or physician's order sheet dated 04/03/25. -If the pharmacy had received an order for prn Mucus Relief, they would have packaged the prn medication in a bubble card, not the MDPs. Refer to telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/20/25 at 12:58pm. Refer to interview with the Administrator on 06/20/25 at 1:12pm. 2. Review of Resident #7's current FL-2 dated 12/11/24 revealed: -Diagnoses included Alzheimer's dementia, multiple sclerosis, stroke, seizures, depression, anxiety, chronic insomnia, hypertension, and paranoia. -There was an order for Vitamin B12 1000mcg 1 tablet once daily. (Vitamin B12 is a vitamin supplement used to treat Vitamin B12 deficiency.)	D 367		

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Review of Resident #7's primary care provider (PCP) visit note dated 01/09/25 revealed:
-The resident's Vitamin B12 level was 836 (reference range 213 - 816) on 01/07/25.
-There was an order to discontinue Vitamin B12 supplement.

Observation of the 8:00am medication pass on 06/20/25 at 7:59am revealed Resident #7 was administered one Vitamin B12 1000mcg tablet after it was discontinued on 01/09/25.

Review of Resident #7's June 2025 electronic medication administration record (eMAR) revealed there was no entry for Vitamin B12 1000mcg 1 tablet daily and none was documented as administered, including the dose observed to be administered on 06/20/25.

Observation of Resident #7's medications on hand on 06/20/25 at 12:35pm revealed:
-Resident #7's medications were packaged in multi-dose packs (MDPs).
-There was a MDP printed on 06/16/25 and labeled Week 1.
-Each morning MDP included one Vitamin B12 1000mcg tablet packaged with other morning medications.
-The instructions on the label included Vitamin B12 1000mcg 1 tablet once daily.

Interview with the medication aide (MA) on 06/20/25 at 12:38pm revealed:
-She did not notice Vitamin B12 was not on the eMAR that morning when she administered medications to Resident #7.
-If a medication was discontinued and still in the MDP, the MAs were supposed to remove that tablet and dispose of it in the sharp's container.
-The Resident Care Coordinator (RCC) and

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	HAL051060	A. BUILDING: _____ B. WING _____	R 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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
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Special Care Coordinator (SCC) were responsible for faxing orders to the pharmacy and removing orders from the eMAR.

Telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm revealed:
-Vitamin B12 100mcg tablet had been included in the MDPs for weekly cycle fills since January 2025.
-They did not receive an order to discontinue Vitamin B12 dated 01/09/25.
-It appeared the facility may have discontinued Vitamin B12 in their eMAR system but the discontinue order never reached the pharmacy, so they continued to dispense Vitamin B12.

Refer to telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/20/25 at 12:58pm.

Refer to interview with the Administrator on 06/20/25 at 1:12pm.

3. Review of Resident #5's current FL-2 dated 10/15/24 revealed diagnoses included seizures and shaking.

Review of Resident #5's care plan dated 08/02/24 revealed diagnoses included type 2 diabetes mellitus without complications (primary admission), unspecified urinary incontinence, anxiety disorder due to known physiological condition, other history of seizures and restlessness and agitation.

Review of Resident #5's progress note dated 12/12/24 revealed there was an order to discontinue Vitamin B-Complex. (Vitamin

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B-Complex is a vitamin supplement.)

Review of the Resident #5's physician order report dated 06/19/25 revealed there was not an order for Vitamin B-Complex.

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was not an entry for Vitamin B-Complex.
-There was no documentation of Vitamin B-Complex administered on 05/01/25 to 05/31/25.

Review of Resident #5's June 2025 eMAR revealed:
-There was not an entry for Vitamin B-Complex.
-There was no documentation of Vitamin B-Complex administered on 06/01/25 to 06/20/25.

Interview with the medication aide (MA) on 06/20/25 at 12:57pm revealed:
-Resident #5 had an order for Vitamin B-Complex 1 tablet in the morning on Monday, Wednesday and Friday.
-She had administered the Vitamin B-Complex to Resident #5 as indicated on the multi-dose pack (MDP).
-She last administered the Vitamin B-Complex during the morning medication pass on 06/20/25.
-She had not seen a discontinue order for the Vitamin B-Complex.
-She had documented on the eMAR but did not know why it was not showing up when the eMAR was printed.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/20/25 at 2:02pm revealed:
-Resident #5 had an order for Vitamin B-Complex on 05/29/24 for 3 times weekly on Monday,

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D 367	Continued From page 41 Wednesday and Friday. -There were 7 pills dispensed on 06/12/25. -There were 7 pills dispensed on 06/19/25. -The order for Vitamin B-Complex was active. -The Vitamin B-Complex was placed on the eMAR by the pharmacy. Refer to telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/20/25 at 12:58pm. Refer to interview with the Administrator on 06/20/25 at 1:12pm. _____ Telephone interview with a certified pharmacy technician on 06/20/25 at 3:08pm revealed: -The pharmacy usually entered any orders they received into the eMAR system. -The facility had to verify and approve orders in the eMAR system. -The facility also had access to enter orders into the eMAR system. Interview with the RCC on 06/20/25 at 12:58pm revealed: -The MAs should double check orders, contact the pharmacy, and notify her if something did not match or was not accurate on the eMARs. -The facility's contracted pharmacy usually entered orders into the eMAR system. -She or the SCC (currently vacant position) had access to and were responsible for verifying orders in the eMAR system prior to the orders becoming active. Interview with the Administrator on 06/20/25 at 1:12pm revealed: -If a medication order did not match on the eMAR	D 367		

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D 367	Continued From page 42 and medication label, the MAs should notify the RCC or SCC. -The RCC and SCC were responsible for weekly cart audits, including comparing the medications to the eMARs to make sure the eMARs were accurate. -The MAs should be comparing the orders and eMARs daily to make sure the eMARs were accurate. -The SCC position was currently vacant. -The MAs should have notified the RCC of any discrepancies with the eMARs.	D 367		