Received 7/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044040	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY CLYDE, NC 28721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey June 04, 2025.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 04/25/25 revealed: -Diagnoses included heart failure, diabetes, and anxiety. -Resident #1 had occasional urinary incontinence. a. Review of Resident #1's current physician's orders dated 04/16/25 revealed an order for gemtesa (used to treat overactive bladder) 75mg daily. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for gemtesa 75mg daily at	D 358	D358 Meeting with all Med Techs stating "They must always follow MAR's at all times when passing out all Medication with all residents. If medication are not in building You are to call facility Contracted Pharmacy to get meds to the facility ASAP If not able to obtain meds call PCP for orders	6/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy Vonderhorst | TITLE: RCA | (X6) DATE: 7/11/25

STATE FORM 6899 9MT011 If continuation sheet 1 of 10

Reviewed + acknowledged JMJ 7/14/25

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D 358	Continued From page 1 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 04/17/25 through 04/30/25. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for gemtesa 75mg daily at 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 05/01/25 through 05/31/25. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for gemtesa 75mg daily at 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 06/01/25 through 06/04/25. Observation of Resident #1's medications on hand on 06/04/25 at 2:19pm revealed there was no gemtesa available for administration. Interview with the medication aide (MA) on 06/04/25 at 2:19pm revealed: -He was unsure why the gemtesa was not available for administration. -He reviewed the pharmacy delivery sheets for Resident #1 for April, May, and June 2025. -He was unable to locate any documentation that verified the gemtesa was delivered to the facility. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/25 at 2:40pm revealed: -They received an order for Resident #1 from the facility on 04/16/25 for gemtesa 75mg daily. -They requested prior authorization twice for	D 358		

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D 358	Continued From page 2 payment for the gemtesa, but it was never received. -Due to not receiving prior authorization, the prescription was never filled and delivered to the facility. Second interview with the MA on 06/04/25 at 3:04pm revealed: -Before he administered a medication to a resident, he always compared the eMAR to the medication bubble pack to ensure the resident would be receiving the correct medication. -He was not sure why he documented he administered Resident #1's gemtesa 75mg daily since it was not available. Interview with a second MA on 06/04/25 at 3:25pm revealed: -She administered medications to Resident #1 several times a month. -She did not realize Resident #1's gemtesa had not been delivered to the facility. -She thought she was probably "going too fast" during her medication pass and did not realize the gemtesa was never available for administration for Resident #1. Refer to interview with the Resident Care Coordinator (RCC) on 06/04/25 at 3:38pm. Telephone interview with the physician representative from Resident #1's physician office on 06/04/25 at 4:02pm revealed they were not made aware the gemtesa was not started on the day it was ordered. b. Review of Resident #1's current physician's orders dated 04/25/25 revealed an order for vitamin D2 (used to increase bone health) 50,000-unit capsule weekly.	D 358		

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D 358	Continued From page 3 Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D2 50,000-unit capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered weekly at 8:00am on 04/07/25, 04/14/25, 04/21/25, and 04/28/25. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for vitamin D2 50,000-unit capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered weekly at 8:00am on 05/05/25, 05/12/25, 05/19/25, and 05/26/25. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for vitamin D2 50,000-unit capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered at 8:00am on 06/02/25. Observation of Resident #1's medications on hand on 06/04/25 at 2:19pm revealed there was no vitamin D2 50,000-unit capsule available for administration. Interview with a medication aide (MA) on 06/04/25 at 2:19pm revealed: -He was unsure why Resident #1's vitamin D2 was not available for administration. -There was no vitamin D2 50,000-unit capsules in the facility's overstock medication storage available for administration to Resident #1.	D 358		

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D 358	Continued From page 4 Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/04/25 at 2:40pm revealed: -The facility last requested a refill for Resident #1's vitamin D2 50,000-unit capsules on 04/21/25. -The refill requested on 04/21/25 was enough to last until 05/21/25. -The facility would have a shortage of two doses based on the weekly vitamin D2 50,000-unit capsule dose. -Refer to interview with the Resident Care Coordinator (RCC) on 06/04/25 at 3:38pm. Telephone interview with Resident #1's Primary Care Provider (PCP) on 06/04/25 at 4:14pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 06/04/25 at 3:38pm revealed: -The MAs were responsible for re-ordering medication a few days before the resident would be out of medication. -If a medication was not at the facility, she expected the MAs to call the pharmacy and ask when the medication would be delivered to the facility. -The MAs should inform her if there was a problem getting medication from the pharmacy so she could assist. -When removing medications from the medication cart for administration, the MAs were not comparing the label on the medication bubble pack to what was listed on the eMAR.	D 358	D358 Staff informed if medications not in facility to call Contracted pharmacy to deliver meds immediately. Also staff (med Techs) educated to always compare the medication labels with MAR in the computer to make sure proper meds.	6/16/25
D 367	10A NCAC 13F .1004 (j) Medication Administration	D 367		

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D 367	Continued From page 5 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to accurately document the administration of medications on the electronic medication administration record (eMAR) for 1 of 3 sampled residents (Resident #1) related to a medication used to treat overactive bladder and a medication used for bone health. The findings are: Review of Resident #1's current FL2 dated 04/25/25 revealed: -Diagnoses included heart failure, diabetes, and	D 367	D367 All med Teens were educated when doing medication administration to always follow appropriate residents, MrtR. Check residents name, med, route and quantity to be administered Instructed Med Teens to check this 3 times before before each medication administration on each individual resident medication pass. Also make sure all documentation is done properly.	6/11/25

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D 367	Continued From page 6 anxiety. -Resident #1 had occasional urinary incontinence. a. Review of Resident #1's current physician's orders dated 04/16/25 revealed an order for gemtesa (used to treat overactive bladder) 75mg daily. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for gemtesa 75mg daily at 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 04/17/25 through 04/30/25. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for gemtesa 75mg daily at 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 05/01/25 through 05/31/25. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for gemtesa 75mg daily at 8:00am. -There was documentation gemtesa 75mg was administered daily at 8:00am from 06/01/25 through 06/04/25. Observation of Resident #1's medications on hand on 06/04/25 at 2:19pm revealed there was no gemtesa available for administration. Interview with a medication aide (MA) on 06/04/25 at 2:19pm NS 3:04pm revealed: -He was unsure why the gemtesa was not	D 367		

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D 367	Continued From page 7 available for administration. -He reviewed the pharmacy delivery sheets for Resident #1 for April, May, and June 2025. -He was unable to locate any documentation that verified the gemtesa was delivered to the facility. -Before he administered a medication to a resident, he always compared the eMAR to the medication to ensure the resident would be receiving the correct medication. -He was not sure why he documented he admnistered Resident #1's gemtesa 75mg daily. -He thought he must have been mixing up the gemtesa for another medication and was documenting on the eMAR incorrectly. Interview with a second MA on 06/04/25 at 3:25pm revealed: -She administered medications to Resident #1 several times a month. -She did not realize she was documenting administration of a medication for Resident #1 that had not been delivered to the facility. -She thought she was just "going too fast" during her medication pass and did not realize the gemtesa was never available for administration for Resident #1. Refer to interview with the Resident Care Coordinator (RCC) on 06/04/25 at 3:38pm and 4:32pm. b. Review of Resident #1's current physician's orders dated 04/25/25 revealed an order for vitamin D2 (used to increase bone health) 50,000-unit capsule weekly. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D2 50,000-unit	D 367		

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D 367	Continued From page 8 capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered weekly at 8:00am on 04/07/25, 04/14/25, 04/21/25, and 04/28/25. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for vitamin D2 50,000-unit capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered weekly at 8:00am on 05/05/25, 05/12/25, 05/19/25, and 05/26/25. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for vitamin D2 50,000-unit capsule weekly at 8:00am. -There was documentation vitamin D2 50,000-unit capsule was administered at 8:00am on 06/02/25. Observation of Resident #1's medications on hand on 06/04/25 at 2:19pm revealed there were no vitamin D2 50,000-unit capsules available. Interview with a medication aide (MA) on 06/04/25 at 2:19pm revealed: -He was unsure why Resident #1's vitamin D2 was not available for administration. -He could not find any vitamin D2 50,000-unit capsules available for administration to Resident #1. Refer to interview with the Resident Care Coordinator (RCC) on 06/04/25 at 3:38pm and 4:32pm revealed. Interview with the Resident Care Coordinator	D 367		

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D 367	Continued From page 9 (RCC) on 06/04/25 at 3:38pm and 4:32pm revealed the MAs should not be documenting administration of medications on the eMAR when a medication was not available for administration.	D 367	D367 In staff meeting educated Med Techs to always make sure all medication are in carts at all times and matched up with MAR's. If out of Medication Call pharmacy or PCP to get medication. Do not sign off that you gave medication. If its not in med cart. Also document correctly.	6/6/25