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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 07/15/25 to 07/17/25.	D 000		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations	D 259		

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warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure 6 of 6 sampled residents had a care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (Resident #1, #2, #3, #4, #5 and #6).

The findings are:

1. Review of Resident #2's current FL2 dated 04/16/25 revealed diagnoses included muscle weakness, Parkinson's disease and prostate cancer.

Review of Resident #2's record revealed an admission date of 04/16/25.

Review of Resident #2's care plan dated 05/21/25 revealed:
-Resident #2 required limited assistance with toileting, ambulation, bathing, dressing, grooming and transfers.
-Resident #2 was independent with eating.
-The care plan was not signed by Resident #2's Primary Care Physician (PCP).

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D 259	Continued From page 2 Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 2. Review of Resident #5's current FL2 dated 05/15/25 revealed: -Diagnoses included left hip fracture, heart failure, muscle weakness and glaucoma. -Resident #2 was semi-ambulatory. -Resident #2 required assistance with bathing and dressing. Review of Resident #5's record revealed a re-admission date of 05/16/25. Review of Resident #5's care plan dated 05/16/25 revealed: -Resident #5 required assistance with toileting and setup with bathing. -Resident #5 utilized a wheelchair for locomotion. -The care plan was not signed by Resident #5's Primary Care Physician (PCP). Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 3. Review of Resident #1's current FL2 dated 02/19/25 revealed: -Diagnoses included hypertension, prostate cancer and hearing loss. -He was oriented to person, place and time. -He was independent for ambulation. Review of Resident #1's Resident Register	D 259		

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revealed he was admitted on 02/19/25.

Review of Resident #1's Care Plan dated 04/04/25 revealed:
-He was independent for ambulation, grooming and toileting.
-He was continent of bowel and bladder.
-Resident #1's Care Plan was not signed and dated by his PCP.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

4. Review of Resident #4's current FL2 dated 07/15/25 revealed:
-Diagnoses included alcohol abuse, anxiety, chronic pain and Parkinson's Disease
-She was semi-ambulatory.
-She was continent of bowel and bladder.
-There was not an orientation on the FL2.

Review of Resident #4's Resident Register revealed she was admitted on 03/01/24.

Review of Resident #4's Care Plan dated 03/17/25 revealed:
-She was semi-ambulatory with a wheelchair.
-She was alert and oriented to person, place and time.
-Resident #4's Care Plan was not signed and dated by her PCP.

Refer to interview with the HWD on 07/17/25 at 4:51pm.

Refer to interview with the Administrator on 07/17/25 at 6:01pm.

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D 259	Continued From page 4 5. Review of Resident #3's current FL2 dated 01/21/25 revealed diagnoses included diabetes, hypertension, depression, osteoarthritis, and urinary incontinence. Review of Resident #3's Resident Register revealed an admission date of 06/04/24. Review of Resident #3's care plan dated 03/19/25 revealed: -Resident #3 was independent with dressing, grooming, bathroom assistance. -Resident #3 required had insulin-dependent diabetes. -Resident #3's care plan was not signed by Resident #3's PCP. Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 6. Review of Resident #6's current FL2 dated 03/24/25 revealed diagnoses included acute cerebral infarct (stroke), coronary artery disease and depression. Review of Resident #6's Resident Register revealed an admission date of 12/19/24. Review of Resident #6's care plan dated 12/17/24 revealed: -Resident #6 required one person assistance with ambulation, dressing, toileting and grooming. -Resident #6 had memory loss and cognitive impairment. -Resident #6's care plan was not signed by Resident #6's PCP.	D 259		

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D 259	Continued From page 5 Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. _____ Interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm revealed: -She was responsible for completing the care plan assessment. -She was not informed resident care plans required the signature of the Primary Care Physician (PCP). Interview with the Administrator on 07/17/25 at 6:01pm revealed: -The HWD was responsible for completing resident care plans. -He was not aware resident care plans needed to be signed by the residents PCP.	D 259		
D 263	10A NCAC 13F .0802 (f) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled residents (Resident #6) who had a significant change, and diagnoses of dementia had an assessment	D 263		

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D 263	Continued From page 6 completed 10 days following the significant change. The findings are: Review of Resident #6's current FL2 dated 03/24/25 revealed diagnoses of cardiovascular accident (stroke), delirium, mood disorder and depression. Review of Resident #6's Resident Register revealed: -He was admitted on 12/19/24. -He came from Independent Living where he lived with his wife. Review of Resident #6's care plan dated 12/17/24 revealed: -He needed the assistance of one person when ambulating, dressing and grooming. -He had memory loss and cognitive impairment. -He did not wander or try to leave the facility when he was in independent living. -There was no significant changed noted on the care plan after Resident #6 eloped from the building on 07/14/25. Interview with the Health and Wellness Director (HWD) on 09/17/25 at 4:51pm revealed: -She was responsible for the care plans being completed and updated in a timely manner. -The Care Plan was not revised after Resident #6 eloped from the building and that was her responsibility. -The Care Plan was not revised when Resident #6 went with his wife to the Neurologist's office on 06/05/25 and came back with a diagnosis of dementia as she did not see any difference in him or a change of condition.	D 263		

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D 263	Continued From page 7 Interview with the Administrator on 07/17/25 at 6:00pm revealed: -He was not aware the care plan had not been changed after the 06/05/25 visit with the Neurologist when Resident #6 received the diagnoses of dementia or when Resident #6 eloped from the facility on 07/14/25. -The HWD was responsible for care plans being completed. -The care plan should have been updated after the 06/05/25 Neurologist visit and 07/14/25 when Resident #6 eloped.	D 263		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#6) related to a resident who was intermittently disoriented with a diagnosis of dementia left the facility during third shift without staff knowledge. The findings are:	D 270		

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D 270	Continued From page 8 Review of Resident #6's current FL2 dated 12/23/24 revealed: -Diagnoses included stroke, depression and history of falls. -Resident #6 required personal care assistance with bathing and dressing. -Resident #6 was intermittently disoriented and semi-ambulatory. -The recommended level of care was other (assisted living). Review of Resident #6's resident register revealed: -He was admitted to the facility on 12/19/24. -His memory status was forgetful, needed reminders. Review of Resident #6's personal service assessment dated 12/17/24 revealed: -Resident #6 had memory loss. -Resident #6 required assistance with dressing, grooming, toileting and showering. Review of Resident #6's staff progress note dated 05/01/25 at 7:52am revealed: -Resident #6 was confused throughout the night and restless. -Resident #6 was trying to get out of bed and go meet a family. Review of Resident #6's staff progress note dated 05/12/25 at 3:47am revealed Resident #6 had a fall. Review of Resident #6's May 2025 electronic medication administration record (eMAR) revealed resident was hospitalized the morning of 05/12/25.	D 270		

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Review of Resident #6's private personal care aide task reports revealed he had a private sitter on third shift (11:00pm-7:00am) on 05/14/25, 05/16/25-06/11/25, 06/13/25-06/23/25, and 07/14/25-07/15/25.

Review of Resident #6 's Neurology Visit Note dated 06/05/25 revealed:
-Family reported frequent sundowning and confusion, beginning about two years ago.
-Resident #6 had evidence of dementia, likely moderate in severity.
-Diagnosis for the visit was primary dementia.

Review of an incident accident report dated 07/14/25 revealed:
-Resident #6 was found outside of the assisted living facility.
-Resident #6 was returned to the assisted living facility with no injuries or harm.
-Resident #6's family and provider were notified.

Review of a 24-hour initial report revealed:
-Resident #6 eloped in his wheelchair, leaving the facility through a secondary exit/entrance.
-The incident occurred on 07/15/25 at 4:15am.
-Another staff member on campus found Resident #6 on the cart path and returned him to the assisted living facility.

Interview with a personal care aide (PCA) on 07/17/25 at 9:15am revealed:
-She was on duty when Resident #6 was brought back to the facility on 07/15/25.
-She checked on Resident #6 at 4:00am in his room and he was brought back to the facility at 4:25am when he was found outside.
-Resident #6 did not get too far from the building, just outside the door on the cart path.
-Staff checked on him every 30 minutes after he

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was found outside.
-Resident #6 never left the building during the day.
-Resident #6 had days when he was confused and other days when he was not.

Interview with Resident #6's family member on 07/17/25 at 9:15am revealed:
-Resident had episodes of confusion at night and the episodes could be sundowners.
-The private sitters were no longer providing services because of the cost and because it had been a while since Resident #6 had tried to leave the facility.
-The family wanted to get a bed alarm for Resident #6 but the facility did not allow them.
-A family member took Resident #6 to a neurologist and he was diagnosed with dementia.

Interview with second family member on 07/17/25 at 10:35am revealed:
-There was a monitor placed in Resident #6's room so family could check on him.
-Resident #6 pushed his wheelchair by himself and he used it as a walker.
-On 07/14/25 Resident #6 pushed his wheelchair out the back door, got it stuck in the grass and he fell on the grass.
-After the incident on 07/14/25, the family hired private sitters again.

Interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm revealed:
-Resident #6 received a new diagnosis of dementia on 06/04/25.
-Private sitters were cancelled due to financial issues and Resident #6 had a long span of time where he was not trying to leave.

Interview with the Administrator on 07/17/25 at

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D 270	Continued From page 11 6:00pm revealed: -Resident #6 at times needed redirected to return to bed. -He is checked every 30 minutes or more often until his discharge to memory care on 07/18/25. Based on observations, record reviews and interviews it was determined Resident #6 was not interviewable. _____ The facility failed to provide supervision for Resident #3 who had a history of exit-seeking behaviors which resulted in the resident eloping from the facility and found 25 minutes later and brought back to the facility. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/25 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 31, 2025	D 270		
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:	D 358		

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D 358	Continued From page 12 TYPE B VIOLATION The facility failed to administer medications as ordered for 3 of 6 sampled residents (#2, #5 and #6) related to medications for Parkinson's disease, high blood pressure, elevated cholesterol levels (#2), glaucoma, low potassium levels, nerve pain (#5), elevated cholesterol levels and mental health issues (#6). The findings are: 1. Review of Resident #2's current FL2 dated 04/16/25 revealed diagnoses included Parkinson's disease, hypertension, and hyperlipidemia. a. Review of Resident #2's current FL2 dated 04/16/25 revealed there was an order for carbidopa-levodopa (a combination medication to treat Parkinson's disease) 25-100mg, one tablet twice daily. Review of Resident #2's neurology consult date 04/29/25 revealed: -Neurology was consulted for Resident #2 for evaluation and establishment of care for his Parkinson's disease. -Resident #2 was to begin carbidopa-levodopa-entacapone 50-200-200mg one tablet three times daily. -If carbidopa-levodopa-entacapone 50-200-200mg was available from the pharmacy, Resident #2's carbidopa-levodopa 25-100mg was to be discontinued. Review of a prescription for Resident #2 dated 04/29/25 revealed: -The prescription was electronically printed. -Resident #2 was prescribed	D 358		

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carbidopa-levodopa-entacapone 50-200-200mg one tablet three times a day.
-On the bottom of the prescription there was a handwritten note stating to stop the carbidopa-levodopa 25-100mg three times daily if the above medication was started.

Review of Resident #2 May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry with a start date of 05/01/25 for carbidopa-levodopa-entacapone 50-200-200mg one tablet three times a day.
-There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered at 8:00am, 2:00pm and 8:00pm on 89 of 93 opportunities.
-There was no documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered on 05/13/25 at 2:00pm and on 05/14/25 at 8:00pm with no explanation.
-There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was not administered on 05/19/25 at 8:00pm due to the medication on order and on 05/30/25 at 8:00pm because the resident refused the medication.
-There was an entry with a start date of 04/16/25 for carbidopa-levodopa 25-100mg one tablet twice daily.
-There was documentation carbidopa-levodopa 25-100mg one tablet was administered at 8:00am and 7:00pm/8:00pm on 51 of 62 opportunities.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry with a start date of 05/01/25 for carbidopa-levodopa-entacapone 50-200-200mg one tablet three times a day.

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D 358	Continued From page 14 -There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered at 8:00am, 2:00pm and 8:00pm on 84 of 90 opportunities. -There was no documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered on 06/26/25 and 06/28/25 at 2:00pm and on 06/10/25, 06/15/25 and 06/17/25 at 8:00pm with no explanation. -There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was not administered on 06/01/25 at 2:00pm because the resident refused the medication. -There was an entry with a start date of 04/16/25 for carbidopa-levodopa 25-100mg one tablet twice daily. -There was documentation carbidopa-levodopa 25-100mg one tablet was administered at 8:00am and 8:00pm on 57 of 62 opportunities. Review of Resident #2's July 2025 eMAR revealed: -There was an entry with a start date of 05/01/25 for carbidopa-levodopa-entacapone 50-200-200mg one tablet three times a day. -There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered at 8:00am, 2:00pm and 8:00pm on 41 of 44 opportunities. -There was no documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was administered on 07/13/25 at 2:00pm and on 07/12/25 at 8:00pm with no explanation. -There was documentation carbidopa-levodopa-entacapone 50-200-200mg one tablet was not administered on 07/10/25 at 8:00am because the resident was out of the facility.	D 358		

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D 358	Continued From page 15 -There was an entry with a start date of 04/16/25 for carbidopa-levodopa 25-100mg one tablet twice daily. -There was documentation carbidopa-levodopa 25-100mg one tablet was administered at 8:00am and 8:00pm on 27 of 29 opportunities. Observation of medication on hand for Resident #2 on 07/16/25 at 9:15am revealed: -There was a bubble pack of carbidopa-levodopa-entacapone 50-200-200 containing 30 tablets with a fill date of 06/09/25 and labeled "3 of 3". -There was a bubble pack of carbidopa-levodopa-entacapone 50-200-200 containing 30 tablets with a fill date of 07/02/25 and labeled "2 of 3". -There was a second bubble pack of carbidopa-levodopa-entacapone 50-200-200 containing 30 tablets with a fill date of 07/02/25 and labeled "2 of 3". -There was a third bubble pack of carbidopa-levodopa-entacapone 50-200-200 containing 18 tablets with a fill date of 07/02/25 and labeled "3 of 3". -There was a bubble pack of carbidopa-levodopa 25-100mg containing seven tablets with a fill date of 06/16/25 and labeled "1 of 2". Interview with a medication aide (MA) on 07/16/25 at 9:34am revealed: -She administered medications to Resident #2 that morning (07/16/25). -According to the eMAR system, Resident #2 had an active order for both carbidopa-levodopa-entacapone 50-200-200mg one tablet three times daily and carbidopa-levodopa 25-100mg one tablet twice daily. -She administered	D 358		

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D 358	Continued From page 16 carbidopa-levodopa-entacapone 50-200-200mg one tablet and carbidopa-levodopa 25-100mg one tablet to Resident #2 that morning. -She was aware the medication names were similar but thought Resident #2 had orders for both medications. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed: -The pharmacy put orders into the eMAR system when they received them. -The facility was capable of entering orders into the eMAR system also. -Carbidopa-levodopa-entacapone 50-200-200mg 49 tablets were dispensed for Resident #2 on 05/01/25. -Carbidopa-levodopa-entacapone 50-200-200mg 90 tablets were dispensed for Resident #2 on 05/16/25, 06/09/25 and 07/02/25. -Carbidopa-levodopa 25-100mg 60 tablets were dispensed for Resident #2 on 04/20/25. -The pharmacy tried to dispense Carbidopa-levodopa 25-100mg for Resident #2 on 07/15/25 but his insurance rejected it. -When insurance rejects a medication it could be due to the resident filling the prescription at another pharmacy. -There was a note in the pharmacy's records that a prescription for a different medication for Resident #2 was filled at another pharmacy and it was possible they dispensed carbidopa-levodopa 25-100mg for Resident #2. -If Resident #2 received both carbidopa-levodopa-entacapone 50-200-200mg one tablet three times daily and carbidopa-levodopa 25-100mg one tablet twice daily he could experience dizziness, drowsiness and trouble concentrating.	D 358		

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Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:25am revealed carbidopa-levodopa 25-100mg 60 tablets were dispensed for Resident #2 on 05/21/25, 06/16/25 and 07/12/25.

Telephone interview with Resident #2's neurologist on 07/16/25 at 11:20am revealed:
-Resident #2's carbidopa-levodopa 25-100mg was to be discontinued if carbidopa-levodopa-entacapone 50-200-200mg one tablet three times daily was started.
-Resident #2 could be more lethargic (lack of energy) if he received both medications.
-Because Resident #2 was on both medications since May 2025, the carbidopa-levodopa 25-100mg should be gradually reduced and not just stopped.

Interview with Resident #2 on 07/15/25am at 9:52am revealed:
-He was not sure what medications he was prescribed.
-The MAs brought his medications to him a couple times each day.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

b. Review of Resident #2's current FL2 dated 04/16/25 revealed there was an order for

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metoprolol succinate (a medication to treat high blood pressure) ER (extended release) 25mg one tablet once daily.

Review of Resident #2's primary care provider's orders dated 05/27/25 and 06/03/25 revealed there was an order for metoprolol succinate ER 25mg one tablet once daily.

Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol succinate ER 25mg one tablet daily.
-There was documentation metoprolol succinate ER 25mg one tablet was not administered on 05/22/25, 05/23/25, 05/28/25 and 05/31/25 due to the medication was not available to administer.
-There were 4 of 31 opportunities metoprolol succinate 25mg one tablet was not administered.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry for metoprolol succinate ER 25mg one tablet daily.
-There was documentation metoprolol succinate ER 25mg one tablet was not administered on 06/01/25, 06/27/25, 06/29/25 and 06/30/25 due to the medication was not available to administer.
-There was no documentation metoprolol succinate ER 25mg one tablet was administered on 06/28/25 with no explanation.
-There were 5 of 30 opportunities metoprolol succinate 25mg one tablet was not administered.

Observation of medication on hand for Resident #2 on 07/16/25 at 9:15am revealed there was a bubble pack of metoprolol succinate ER 25mg containing 5 tablets with a fill date of 06/29/25.

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Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed:
-Metoprolol succinate ER 25mg 30 tablets were dispensed for Resident #2 on 04/20/25 and 07/15/25.
-Metoprolol succinate ER 25mg 21 tablets were dispensed for Resident #2 on 06/29/25.
-Resident #2 would have run out of his metoprolol succinate ER 25mg in May 2025 or June 2025 if he did not get the medication from another pharmacy.
-If Resident #2 did not receive his metoprolol succinate ER 25mg as prescribed he could experience elevated blood pressures and/or elevated heart rates.

Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:25am revealed metoprolol succinate ER 25mg 30 tablets were dispensed for Resident #2 on 06/06/25 and 07/12/25.

Interview with Resident #2 on 07/15/25am at 9:52am revealed:
-He was not sure what medications he was prescribed.
-The MAs brought his medications to him a couple times each day.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on

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D 358	Continued From page 20 07/17/25 at 6:01pm. c. Review of Resident #2's current FL2 dated 04/16/25 revealed there was an order for atorvastatin (a medication to treat elevated cholesterol levels) 10mg one tablet at bedtime. Review of Resident #2's primary care provider's orders dated 05/27/25 and 06/03/25 revealed there was an order for atorvastatin 10mg one tablet at bedtime. Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was documentation atorvastatin 10mg one tablet was not administered on 05/20/25, 05/22/25, 05/23/25, and from 05/29/25 to 05/31/25 due to the medication was not available to administer. -There were 6 of 31 opportunities atorvastatin 10mg one tablet was not administered. Review of Resident #2's June 2025 eMAR revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was documentation atorvastatin 10mg one tablet was not administered on 06/01/25, 06/02/25, 06/04/25, 06/10/25, 06/12/25, 06/15/25 and 06/17/25 due to the medication was not available to administer. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was no documentation atorvastatin 10mg	D 358		

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one tablet was administered on 07/12/25 with no explanation.
-There were 1 of 14 opportunities atorvastatin 10mg one tablet was not administered.

Observation of medication on hand for Resident #2 on 07/16/25 at 9:15am revealed there was a bubble pack of atorvastatin 10mg containing 2 tablets with a fill date of 06/16/25.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed:
-Atorvastatin 10mg 30 tablets were dispensed for Resident #2 on 04/16/25 and 06/16/25.
-Resident #2 would have run out of atorvastatin 10mg around 05/16/25 if he did not get the medication from another pharmacy.
-If Resident #2 did not receive his atorvastatin 10mg as prescribed he could experience elevated cholesterol levels.

Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:25am revealed atorvastatin 10mg 30 tablets were dispensed for Resident #2 on 07/09/25.

Interview with Resident #2 on 07/15/25am at 9:52am revealed:
-He was not sure what medications he was prescribed.
-The MAs brought his medications to him a couple times each day.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

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D 358	Continued From page 22 Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 2. Review of Resident #5's current FL2 dated 05/15/25 revealed diagnoses included glaucoma (an eye disease that can cause vision loss and blindness), neuropathy, atrial fibrillation and hypertensive heart disease. a. Review of Resident #5's current FL2 dated 05/15/25 revealed there was an order for latanoprost ophthalmic solution (medicated eye drops to treat glaucoma) 0.005% instill one drop to each eye at bedtime. Review of Resident #5's Primary Care Physician's (PCP) orders dated 05/22/25 and 07/10/25 revealed there was an order for latanoprost eye drops 0.005% instill one drop to each eye at bedtime. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for latanoprost eye drops 0.005% instill one drop in both eyes at bedtime. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 05/19/25 and 05/27/25 because the medication was not available. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 05/17/25, 05/24/25, 05/25/25 and 05/28/25 with no explanation. -There were 6 of 16 opportunities latanoprost eye drops 0.005% one drop in both eyes were not administered.	D 358		

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D 358	Continued From page 23 Review of Resident #5's June 2025 eMAR revealed: -There was an entry for latanoprost eye drops 0.005% instill one drop in both eyes at bedtime. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 06/03/25 and 06/21/25 because the medication was not available. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 06/05/25, 06/07/25, 06/08/25, 06/11/25, 06/22/25, 06/23/25 and 06/25/25 with no explanation. -There were 9 of 30 opportunities latanoprost eye drops 0.005% one drop in both eyes were not administered. Review of Resident #5's July 2025 eMAR revealed: -There was an entry for latanoprost eye drops 0.005% instill one drop in both eyes at bedtime. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 07/03/25, 07/04/25, 07/06/25, 07/11/25 and 07/14/25 because the medication was not available. -There was documentation latanoprost eye drops 0.005% one drop in both eyes were not administered on 07/02/25 and 07/05/25 with no explanation. -There was no documentation latanoprost eye drops 0.005% one drop in both eyes were administered on 07/08/25 with no explanation. -There were 8 of 14 opportunities latanoprost eye drops 0.005% one drop in both eyes were not administered. Observation of medication on hand for Resident #5 on 07/16/25 at 2:18pm revealed there were no	D 358		

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latanoprost eye drops 0.005% available for administration for Resident #5.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed:
-Latanoprost eye drops 0.005% one 2.5ml bottle were dispensed for Resident #5 on 05/19/25, 06/23/25 and 07/08/25.
-Each 2.5ml bottle of latanoprost eye drops should last approximately one month.
-Latanoprost eye drops 0.005% should be on the medication cart and available for Resident #5.
-If Resident #5 did not receive his latanoprost eye drops as prescribed he could have increased eye pressures.

Interview with Resident #5's Primary Care Provider (PCP) on 07/17/25 at 12:15pm revealed:
-Latanoprost eye drops were prescribed for Resident #5 to treat his glaucoma and lower his eye pressures.
-Resident #5 could experience eye pain if he did not receive the latanoprost eye drops.
-She was not notified Resident #5 was not receiving his latanoprost eye drops as prescribed.
-She expected to be notified if Resident #5 did not receive medications after the second missed dose.

Interview with a medication aide (MA) on 07/17/25 at 11:35am revealed:
-Resident #5's latanoprost eye drops were not available for administration.
-The MAs were responsible for requesting medication refills and for contacting the pharmacy if a medication was not available for administration.
-If the MAs had problems getting medication from the pharmacy, they were to notify the Health and

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Wellness Director (HWD).

Interview with Resident #5 on 07/17/25am at 3:00pm revealed
-He was not sure what medications he was prescribed.
-The MAs handled his medications.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

b. Review of Resident #5's current FL2 dated 05/15/25 revealed there was an order for potassium chloride (mineral supplement to treat low potassium levels) ER (extended release) 20meq one tablet twice daily.

Review of Resident #5's PCP's orders dated 05/22/25 and 07/10/25 revealed there was an order for potassium chloride ER 20meq one tablet twice daily.

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for potassium chloride ER 20meq one tablet twice daily.
-There was documentation potassium chloride ER 20meq one tablet was not administered at 8:00am on 05/18/25 and 7:00pm on 05/18/25, 05/20/25, 05/22/25 and 05/23/25 because the

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medication was not available.
-There was documentation potassium chloride ER 20meq one tablet was not administered at 8:00am 05/17/25, 05/20/25 through 05/23/25 and at 7:00pm on 05/17/25 with no explanation.
-There were 11 of 31 opportunities potassium chloride ER 20meq one tablet was not administered.

Review of Resident #5's June 2025 eMAR revealed:
-There was an entry for potassium chloride ER 20meq one tablet twice daily.
-There was documentation potassium chloride ER 20meq one tablet was not administered at 8:00am on 06/24/25 and at 7:00pm on 06/04/25, 06/10/25, 06/12/25, 06/13/25, 06/15/25 and 06/21/25 because the medication was not available.
-There was documentation potassium chloride ER 20meq one tablet was not administered at 7:00pm on 06/05/25, 06/07/25, 06/08/25 and 06/22/25 with no explanation.
-There were 11 of 60 opportunities potassium chloride ER 20meq one tablet was not administered.

Review of Resident #5's July 2025 eMAR revealed:
-There was an entry for potassium chloride ER 20meq one tablet twice daily.
-There was documentation potassium chloride ER 20meq one tablet was not administered at 7:00pm on 07/14/25 because the medication was not available.
-There was no documentation potassium chloride ER 20meq one tablet was administered at 7:00pm on 07/08/25 with no explanation.
-There were 2 of 29 opportunities potassium chloride ER 20meq one tablet was not

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D 358	Continued From page 27 administered. Observation of medication on hand for Resident #5 on 07/16/25 at 2:18pm revealed: -There was a bubble pack of potassium chloride ER 20meq containing 3 tablets with a fill date of 06/28/25. -There was a second bubble pack of potassium chloride ER 20meq containing 25 tablets with a fill date of 06/28/25. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed: -Potassium chloride ER 20meq 60 tablets were dispensed for Resident #5 on 06/28/25. -The pharmacy had a fill request for Resident #5's potassium chloride ER 20meq on 05/23/25 but was unable to fill it because he had it filled at another pharmacy. -There was a note in the pharmacy system that another pharmacy dispensed potassium chloride ER 20meq for Resident #5 on 04/21/25 but did not indicate the quantity. -If Resident #5 did not receive his potassium chloride as prescribed he could experience muscle cramping and irregular heart rhythms. Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:07am revealed potassium chloride ER 20meq 180 tablets were dispensed for Resident #2 on 04/21/25. Interview with Resident #5's Primary Care Provider (PCP) on 07/17/25 at 12:15pm revealed: -Potassium chloride ER 20meq was prescribed for Resident #5 to treat low potassium blood levels. -Resident #5 could experience irregular heart	D 358		

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rhythms if he did not receive the potassium chloride as prescribed.
-She was not notified Resident #5 missed doses of his potassium chloride ER.
-She expected to be notified if Resident #5 did not receive medications after the second missed dose.

Interview with Resident #5 on 07/17/25am at 3:00pm revealed
-He was not sure what medications he was prescribed.
-The MAs handled his medications.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

c. Review of Resident #5's current FL2 dated 05/15/25 revealed there was an order for gabapentin (medication to treat nerve pain) 300mg one capsule at bedtime.

Review of Resident #5's PCP's orders dated 05/22/25 and 07/10/25 revealed there was an order for gabapentin 300mg one capsule once daily.

Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 300mg one

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capsule once daily.
-There was documentation gabapentin 300mg one capsule was not administer at 10:00pm on 06/22/25 with no explanation.
-There was no documentation gabapentin 300mg one capsule was administered from 06/10/25 to 06/12/25, 06/15/25, 06/17/25, 06/20/25, 06/24/25, 06/26/25 and 06/28/25 with no explanation.
-There were 10 of 30 opportunities gabapentin 300mg one capsule was not administered.

Review of Resident #5's July 2025 eMAR revealed:
-There was an entry for gabapentin 300mg one capsule once daily.
-There was documentation gabapentin 300mg one capsule was not administered on 07/05/25, 07/07/25 and 07/14/25 because the medication was not available.
-There was no documentation gabapentin 300mg one capsule was administered on 07/08/25 with no explanation.
-There were 4 of 14 opportunities gabapentin 300mg one capsule was not administered.

Observation of medication on hand for Resident #5 on 07/16/25 at 2:18pm revealed there was a bubble pack of gabapentin 300mg containing 30 tablets with a fill date of 07/14/25.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed:
-Gabapentin 300mg 30 tablets were dispensed for Resident #5 on 05/19/25 and 07/14/25.
-Resident #5 would have run out of his gabapentin 300mg around 06/19/25.
-If Resident #5 did not receive his gabapentin as prescribed he could experience nerve pain.

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D 358	Continued From page 30 Interview with Resident #5's PCP on 07/17/25 at 12:15pm revealed: -Gabapentin 300mg was prescribed for Resident #5 to treat nerve pain. -Resident #5 could experience increased pain if he did not receive the gabapentin as prescribed. -She was not notified Resident #5 missed doses of his potassium chloride ER. -She expected to be notified if Resident #5 did not receive medications after the second missed dose. Interview with Resident #5 on 07/17/25am at 3:00pm revealed -He was not sure what medications he was prescribed. -The MAs handled his medications. Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm. Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am. Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 3. Review of Resident #6's current FL2 dated 12/23/24 revealed diagnoses included acute cerebral infarct (stroke), coronary artery disease and depression. a. Review of Resident #6's PCP's orders dated 06/03/25 revealed there was an order for quetiapine (a medication to treat chemical imbalances in the brain) 25mg one tablet at bedtime.	D 358		

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D 358	Continued From page 31 Review of Resident #6's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 25mg one tablet at bedtime. -There was documentation quetiapine 25mg one tablet was not administered from 06/14/25 to 06/21/25, from 06/23/25 to 06/26/25, on 06/28/25 and 06/30/25 because the medication was not available. -There were 14 of 30 opportunities quetiapine 25mg one tablet was not administered. Review of Resident #6's July 2025 eMAR revealed: -There was an entry for quetiapine 25mg one tablet at bedtime. -There was documentation quetiapine 25mg one tablet was not administered 07/03/25, 07/05/25, 07/08/25 and 07/09/25 because the medication was not available. -There was documentation quetiapine 25mg one tablet was not administered on 07/06/25 with no explanation. -There were 5 of 14 opportunities quetiapine 25mg one tablet was not administered. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 10:45am revealed: -Quetiapine 25mg 30 tablets were dispensed for Resident #6 on 03/12/25 and 04/04/25. -Quetiapine 25mg 10 tablets were dispensed for Resident #6 on 07/10/25. -Resident #6 could have sleeplessness at night if he did not receive his quetiapine as prescribed. Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.	D 358		

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D 358	Continued From page 32 Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am. Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. b. Review of Resident #6's current FL2 dated 12/23/24 revealed there was an order for atorvastatin 20mg one tablet at bedtime. Review of Resident #6's PCP's orders dated 06/03/25 revealed there was an order for atorvastatin 20mg one tablet at bedtime. Review of Resident #6's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg one tablet at bedtime. -There was documentation atorvastatin 20mg one tablet was not administered on 06/01/25, 06/02/25, 06/04/25 06/10/25, from 06/12/25 to 06/20/25, from 06/23/25 to 06/26/25, on 06/29/25 and 06/30/25 because the medication was not available. -There were 19 of 30 opportunities atorvastatin 20mg one tablet was not administered. Review of Resident #6's July 2025 eMAR revealed: -There was an entry for atorvastatin 20mg one tablet at bedtime. -There was documentation atorvastatin 20mg one tablet was not administered on 07/01/25, 07/08/25, 07/09/25, 07/11/25, 07/12/25 and 07/15/25 because the medication was not	D 358		

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available.
-There were 6 of 15 opportunities atorvastatin 20mg one tablet was not administered.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 10:45am revealed:
-Atorvastatin 20mg 30 tablets were last dispensed for Resident #6 on 03/25/25.
-There were no refills left for Resident #6's atorvastatin 20mg after 03/25/25.
-The pharmacy received signed physician orders dated 06/03/25 for Resident #6 but it appeared there were pages missing.
-Resident #6 could have increased lipid levels if he did not receive his atorvastatin as prescribed.

Refer to the interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am.

Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

Interview with a medication aide (MA) on 07/17/25 at 11:35am and 4:16pm revealed:
-The MAs were responsible for reordering residents' medications when there were five to seven doses remaining.
-If the MA had issues with getting medications from the pharmacy they were to notify the Health and Wellness Director (HWD).
-If the MA contacted the pharmacy, they should document in the electronic medication

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administration record (eMAR) system the details of the call and should report it to the next MA coming on duty.
-The MAs on third shift were responsible for auditing the medication carts to ensure resident medications were available for administration.

Interview with the Resident Care Coordinator (RCC) on 07/16/25 at 11:20am revealed:
-The MAs were to follow up with the pharmacy if a medication was not available for administration.
-The MAs and nurses were to notify her and the HWD if medications needed to be reordered.

Interview with the HWD on 07/17/25 at 4:51pm revealed:
-The MAs were responsible for reordering medications when there were two to three days left.
-The MAs were responsible for notify her if there were issues getting medications from the pharmacy.
-She and the RCC performed random "spot checks" of resident eMARs.
-She did not know if the eMAR system was capable of printing a missed medications report.

Interview with the Administrator on 07/17/25 at 6:01pm revealed:
-The MAs were responsible to contact pharmacy when medications needed refilled.
-The MAs were to report any issues with medications to the HWD.
-The MAs were responsible contacting residents' PCPs or the HWD if a resident missed medications.
-The pharmacy did cart audits monthly.
-The MAs on third shift were responsible for auditing the medication carts nightly and notifying the HWD if a medication could not be located.

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D 358	Continued From page 35 The facility failed to ensure medications were administered as ordered related to medications for Parkinson's disease, elevated blood pressure, elevated cholesterol levels (Resident #2), glaucoma, low potassium levels, nerve pain (Resident #5), elevated cholesterol levels and sleeplessness (Resident #6). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 31, 2025	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 electronic Medication Administration Records (eMARs) were accurate for 2 of 6 residents (#2 and #6) related to documentation of medications to lower blood pressure (#2), lower cholesterol levels (#2 and #6) and to treat chemical imbalances in the brain (#6).

The findings are:

1. Review of Resident #2's current FL2 dated 04/16/25 revealed diagnoses included hypertension and hyperlipidemia.

a. Review of Resident #2's current FL2 dated 04/16/25 revealed an order for metoprolol succinate (a medication to treat high blood pressure) ER (extended release) 25mg, one tablet daily.

Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol succinate ER 25mg one tablet daily.
-There was documentation metoprolol succinate ER 25mg one tablet was administered daily at 8:00am except on 05/22/25, 05/23/25, 05/28/25 and 05/31/25 because the medication was not

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D 367	Continued From page 37 available to administer. Review of Resident #2's June 2025 eMAR revealed: -There was an entry for metoprolol succinate ER 25mg one tablet daily. -There was documentation metoprolol succinate ER 25mg one tablet was administered daily at 8:00am except on 06/01/25, 06/27/25, 06/29/25 and 06/30/25 because the medication not available to administer. -There was no documentation metoprolol succinate ER 25mg one tablet was administered on 06/28/25 with no explanation. Observation of medication on hand for Resident #2 on 07/16/25 at 9:15am revealed there was a bubble pack of metoprolol succinate ER 25mg containing 5 tablets with a fill date of 06/29/25. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed: -Metoprolol succinate ER 25mg 30 tablets were dispensed for Resident #2 on 04/20/25 and 07/15/25. -Metoprolol succinate ER 25mg 21 tablets were dispensed for Resident #2 on 06/29/25. -Resident #2 would have run out of his metoprolol succinate ER 25mg around 05/20/25 if he did not get the medication from another pharmacy. Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:25am revealed metoprolol succinate ER 25mg 30 tablets were dispensed for Resident #2 on 06/06/25 and 07/12/25. Interview with a medication aide (MA) on 07/17/25 at 4:16pm revealed:	D 367		

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D 367	Continued From page 38 -She was unsure why she documented she administered Resident #2's metoprolol succinate ER 25mg when Resident #2 should have been out of the medication. -She may have located a bubble pack of Resident #2's metoprolol succinate ER 25mg in another resident's medications or she may have documented she administered the medication by accident. -She did not know if there were any audits completed of residents' eMARs for accurate documentation. Refer to the interview with a MA on 07/17/25 at 4:16pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. b. Review of Resident #2's current FL2 dated 04/16/25 revealed there was an order for atorvastatin (a medication to treat elevated cholesterol levels) 10mg one tablet at bedtime. Review of Resident #2's primary care provider's orders dated 05/27/25 and 06/03/25 revealed there was an order for atorvastatin 10mg one tablet at bedtime. Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was documentation atorvastatin 10mg one tablet was administered daily at 7:00pm except on 05/20/25, 05/22/25, 05/23/25, and from	D 367		

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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 367	Continued From page 39 05/29/25 to 05/31/25 due to the medication was not available to administer. Review of Resident #2's June 2025 eMAR revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was documentation atorvastatin 10mg one tablet was administered daily at 7:00pm or 8:00pm except on 06/01/25, 06/02/25, 06/04/25, 06/10/25, 06/12/25, 06/15/25 and 06/17/25 due to the medication was not available to administer. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for atorvastatin 10mg one tablet at bedtime. -There was no documentation atorvastatin 10mg one tablet was administered on 07/12/25 with no explanation. Observation of medication on hand for Resident #2 on 07/16/25 at 9:15am revealed there was a bubble pack of atorvastatin 10mg containing 2 tablets with a fill date of 06/16/25. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 8:58am revealed: -Atorvastatin 10mg 30 tablets were dispensed for Resident #2 on 04/16/25 and 06/16/25. -Resident #2 would have run out of atorvastatin 10mg around 05/16/25 if he did not get the medication from another pharmacy. Telephone interview with a representative with a second pharmacy on 07/17/25 at 10:25am revealed atorvastatin 10mg 30 tablets were dispensed for Resident #2 on 07/09/25.	D 367		

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	HAL060016	A. BUILDING: _____ B. WING _____	07/17/2025

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D 367	Continued From page 40 Refer to the interview with a medication aide (MA) on 07/17/25 at 4:16pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. 2. Review of Resident #6's current FL2 dated 12/23/24 revealed diagnoses included acute cerebral infarct (stroke), coronary artery disease, and depression. Review of Resident #6's Resident Register revealed an admission date of 12/19/24. a. Review of Resident #6's primary care provider's orders dated 06/03/25 revealed there was an order for quetiapine (a medication to treat chemical imbalances in the brain) 25mg one tablet at bedtime. Review of Resident #6's June 2025 eMAR revealed: -There was an entry for quetiapine 25mg one tablet at bedtime. -There was documentation quetiapine 25mg one tablet was not administered from 06/14/25 to 06/21/25, from 06/23/25 to 06/26/25, on 06/28/25 and 06/30/25 because the medication was not available. -There was documentation quetiapine 25mg one tablet was administered on 06/22, 06/27 and 06/29 although the medication was not available. Review of Resident #6's July 2025 eMAR revealed: -There was an entry for quetiapine 25mg one tablet at bedtime.	D 367		

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D 367	Continued From page 41 -There was documentation quetiapine 25mg one tablet was not administered on 07/01/25 (refused), 07/03/25 (medication not available/pharmacy), 07/05/25 and 07/06/25 (see med note), 07/08/25 and 07/09/25 (medication not available/pharmacy). -There was documentation quetiapine 25mg one tablet was administered on 07/02/25, 07/04/25, 07/07/25 and 07/10 to 07/15/25. Observation of medications available for administration for Resident #6 on 07/16/25 at 4:30pm revealed there were quetiapine 25mg 10 tables available for administration with a label dispense date of 07/10/25. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 10:45am revealed: -The pharmacy did not have any issues with availability of quetiapine. -Resident #6's quetiapine 25mg has to be requested by the facility before it is dispensed. -Quetiapine 25mg 30 tablets were dispensed for Resident #6 on 03/12/25 and 04/04/25. -The facility did not request Resident #6's quetiapine 25 mg (30 tablets) in May 2025. -On 06/11/25 the pharmacy sent a note to the facility that a refill prescription for quetiapine was needed, per the pharmacy's weekly report. -On 06/11/25 the pharmacy received a faxed copy of the physician order summary dated 06/03/25 and pages were missing. -Quetiapine 25mg 10 tablets were last dispensed for Resident #6 on 07/10/25 as a count down to the next cycle refill date of 07/18/25 (30 tablets). -Resident #6 could have sleeplessness at night if he did not receive his quetiapine as prescribed. Interview with the RCC on 0717/25 at 11:20am	D 367		

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revealed:
-MAs were expected to inform her or the HWD if they could not get a medication refilled and document an explanation when medications were not given.
-She noticed Resident #6 did not have any quetiapine available and contacted the pharmacy to request it.
-She did not know why MAs documented Resident #6's quetiapine was given if it was not available in the facility.

Interview with the HWD on 07/17/25 at 4:50pm revealed:
-She did not know why MAs documented Resident #6's quetiapine was given on 06/22, 06/27/25 and 06/29/25 if the medication was not available.
-She was aware Resident #6's quetiapine was last dispensed to the facility on 07/10/25 for 10 tablets.
-She did not know why there was a lapse in communication between the facility and the pharmacy as it relates to refill requests.

Refer to the interview with the RCC on 07/17/25 at 11:20am.

Refer to the interview with the HWD on 07/17/25 at 4:51pm.

Refer to the interview with the Administrator on 07/17/25 at 6:01pm.

b. Review of Resident #6's current FL2 dated 12/23/24 revealed there was an order for atorvastatin 20mg one tablet at bedtime.

Review of Resident #6's primary care provider's orders dated 06/03/25 revealed there was an

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order for atorvastatin (a medication to lower cholesterol levels in the blood) 20mg one tablet at bedtime.

Review of Resident #6's June 2025 eMAR revealed:
-There was an entry for atorvastatin 20mg one tablet at bedtime.
-There was documentation atorvastatin 20mg one tablet was not administered on 06/01/25, 06/02/25, 06/04/25 06/10/25, from 06/12/25 to 06/20/25, from 06/23/25 to 06/26/25, 06/29/25 and 06/30/25 because the medication was not available.
-There was documentation atorvastatin 20mg one tablet was administered on 06/11/25, from 06/21/25 to 06/22/25, and from 06/27/25 to 06/28/25.

Review of Resident #6's July 2025 eMAR revealed:
-There was an entry for atorvastatin 20mg one tablet at bedtime.
-There was documentation atorvastatin 20mg one tablet was not administered on 07/01/25, 07/08/25, 07/09/25, 07/11/25, 07/12/25 and 07/15/25 because the medication was not available.

Observation of medications available for administration for Resident #6 on 07/16/25 at 4:30pm revealed atorvastatin 20mg was not available for administration.

Interview with the MA on 07/16/25 at 4:30pm revealed she documented on Resident #6's medication as code "20" (not available/pharmacy action) because the medication was not on the cart and at times the medications could have been delivered to another building on the

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premises.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/17/25 at 10:45am revealed:
-Atorvastatin 20mg 30 tablets were last dispensed for Resident #6 on 03/25/25.
-There were no refills left for Resident #6's atorvastatin 20mg after 03/25/25.
-The pharmacy received signed physician orders dated 06/03/25 for Resident #6 but it appeared there were pages missing.
-Resident #6 could have increased lipid levels if he did not receive his atorvastatin as prescribed.

Interview with the RCC on 0717/25 at 11:20am revealed:
-MAs were expected to inform her or the HWD if they could not get a medication refilled and document an explanation when medications were not given.
-She did not know why MAs documented Resident #6's atorvastatin was given if it was not available in the facility.

Interview with the HWD on 07/17/25 at 4:50pm revealed:
-She did not know why MAs documented Resident #6's atorvastatin was given on 06/21 to 06/22/25 and 06/27/25 to 06/28/25 if the medication was not available.

Refer to the interview with the RCC on 07/17/25 at 11:20am.

_____

Interview with the RCC on 07/17/25 at 11:20am revealed Resident #6 received all of his medications from one pharmacy.

Refer to the interview with a MA on 07/17/25 at

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D 367	Continued From page 45 4:16pm. Refer to the interview with the HWD on 07/17/25 at 4:51pm. Refer to the interview with the Administrator on 07/17/25 at 6:01pm. _____ Interview with a MA on 07/17/25 at 4:16pm revealed: -The MAs were to compare the label on the medication with the order on the resident's eMAR when administering medications. -MAs were responsible for documenting medications administered on the residents' eMARs. -If a medication was unavailable for administration to a resident, the MA was to document the medication was not administered and the reason the medication was not available. -She checked all areas of the medication cart if she could not find a resident's medication because sometimes MAs put medications back in the cart in another resident's section. -She did not know if there were any audits completed of residents' eMARs for accurate documentation. Interview with the HWD on 07/17/25 at 4:51pm. -The MAs were responsible to accurately documenting medications administered to residents on the eMAR. -If the MA was unable to administer a medication for any reason, there should be documentation on the eMAR the medication was not administered and the reason it was not administered. -The MAs were expected to make a note in the eMAR software whenever medications were not administered and follow up with pharmacy when needed.	D 367		

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D 367	Continued From page 46 -She and the RCC performed random "spot check" audits of resident eMARs. -She did not know if the eMAR system was able to run a "missed medications" report. Interview with the Administrator on 07/17/25 at 6:01pm revealed: -The MAs were responsible to document on the eMAR if a medication was not available for administration and contact the pharmacy. -The MAs were to report any issues with medications to the HWD. -Inaccurate documentation of the eMARs was unacceptable.	D 367		