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WAKE ASSISTED LIVING	2800 KIDD ROAD RALEIGH, NC 27610

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up, and a complaint investigation on July 22, 2025, through July 23, 2025. The complaint investigation was initiated by the Wake County Department of Social Services on July 10, 2025.	D 000		
D 128	10A NCAC 13f .0404 (1) Qualifications Of Activity Director 10A NCAC 13F .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (1) The activity director hired after September 30, 2022 shall meet a minimum educational requirement by being a high school graduate or certified under the GED Program. This Rule is not met as evidenced by: Based on interviews, the facility failed to employ a qualified activity director. The findings are: Interview with a personal care aide (PCA) on 07/23/25 at 2:40pm revealed: -The facility did not have an activity director. -The PCAs would do activities with residents.	D 128		

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D 128	Continued From page 1 Interview with a medication aide (MA) on 07/23/25 at 2:45pm revealed: -The facility did not have an activity director. -The activity director stopped working at the facility about a week prior. -All the staff helped to do some activities with the residents. Interview with the Executive Director on 07/23/25 at 2:50pm revealed: -He was aware the facility needed an activity director. -The facility did not have an activity director. -The activity director was terminated on 07/18/25. -The activity director had been working at the position about two weeks. -The facility was seeking to hire an activity director. -It was important for the facility to employ an activity director in order to plan activities to enrich the lives of the residents. Interview with the Resident Care Coordinator (RCC) on 07/23/25 at 3:00pm revealed: -She was aware the facility needed a qualified activity director. -The facility did not have an activity director. -The facility had not had an activity director for about a week. -The facility needed an activity director to ensure the residents were being mentally and physically stimulated. -The facility was actively interviewing to hire an activities director. Interview with the Administrator on 07/23/25 at 3:10pm revealed: -She was aware the facility needed a qualified activity director. -The facility did not have an activity director.	D 128		

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D 128	Continued From page 2 -The facility had not had an activity director for about a week. -The facility needed an activity director to provide daily activities for residents. -The facility was actively attempting to hire an activity director.	D 128		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications;	D 253		

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D 253	Continued From page 3 (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10)skin integrity; (11)memory, orientation and cognition; (12)vision and hearing; (13)speech and communication; (14)assistive devices needed; and (15)a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253		

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D 253	Continued From page 4 This Rule is not met as evidenced by: Based on interviews, and record review, the facility failed to ensure 2 of 5 sampled residents (#2 and #4) had assessments completed within 30 days of admission and annually. The findings are: 1. Review of Resident #2's current FL2 dated 02/05/25 revealed: -Diagnoses included senile degeneration of the brain, vascular dementia, congestive heart failure, and hypertension. -His level of care was documented as assisted living facility memory care. Review of resident #2's Resident Register revealed she was admitted to the facility on 02/05/25. Review of Resident #2's records revealed she did not have a completed care plan. Refer to interview with the Resident Care Coordinator (RCC) on 07/23/25 at 9:40am. Refer to interview with the Executive Director (ED) on 07/23/25 at 9:55am. Refer to interview with the Administrator on 07/23/25 at 10:15am. 2. Review of Resident #4's current FL2 dated 03/07/25 revealed: -Diagnoses included dementia and hypertension. -Her level of care was documented as special care unit. Review of Resident #4's Resident Register	D 253		

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D 253	Continued From page 5 revealed she was admitted to the facility on 02/05/24. Review of Resident #4's care plan dated 01/23/24 revealed: -She required extensive assistance with bathing. -She required limited assistance with dressing and personal hygiene. -She had confusion and short-term memory problems. Review of #4's record revealed there were no care plans completed after 01/23/24. Refer to interview with the Resident Care Coordinator (RCC) on 07/23/25 at 9:40am. Refer to interview with the Executive Director (ED) on 07/23/25 at 9:55am. Refer to interview with the Administrator on 07/23/25 at 10:15am. _____ Interview with the Resident Care Coordinator (RCC) on 07/23/25 at 9:40am revealed: -He was aware that care plans need to be completed for each resident upon admission and annually. -He was responsible for ensuring all residents in the facility had care plans updated annually and when significant changes occurred. -He kept a spreadsheet on his computer when all care plans were due to be updated annually. -He audited residents information quarterly to ensure care plan were updated. -Resident #2's care plan was completed within 30 days of admission but, they were waiting on hospice to sign and return the care plan. -He had not gotten around to completing Resident #4's care plan.	D 253		

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D 253	Continued From page 6 -Having updated care plans was important so that staff would know the level of care for each resident. Interview with the ED on 07/23/25 at 9:55am revealed: -The RCC was responsible for completing resident care plans. -Care plans should be completed upon admission, annually, and if there was a change in level of care. -Resident #4 should have had an updated care plan January of 2025. -Resident #2 should have had a care plan completed upon admission. -She should have followed up and made sure resident care plans were done. Interview with the Administrator on 07/23/25 at 10:15am revealed: -The RCC was responsible for completing the care plans timely for all residents. -The RCC kept a spreadsheet of when all residents were due for their care plan to be updated. -The RCC should have completed a care plan for Resident #2 upon admission. -Resident #4's care plan should have been updated January of 2025.	D 253		
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	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 3 of 4 residents (#2, #7, #8) observed during the medication pass including errors with medications used to treat anxiety (#7, #8), macular degeneration and lactose intolerance (#7), hypertension (#2, #7), mood and pain (#8), and dry skin, agitation, and glaucoma (#2); and for 1 of 5 sampled for record review related to a medication used for vitamin deficiencies (#5).

The findings are:

Review of the facility's undated medication administration policy revealed:
-Medications will be administered within one hour before or after the prescribed or scheduled time unless an emergency situation precludes the administration.
-The electronic medication administration record (eMAR) will be updated and changed when medication or treatment orders from the primary care provider (PCP) changes.
-In the event of medication errors, the facility staff will notify the provider, Administrator, and Resident Care Coordinator (RCC), document any orders or instructions from the PCP and actions taken by the facility to comply and document the cause that led to the error for example documentation error, unavailable medication, or resident refusal.

The medication error rate was 45% as evidenced by 14 errors of 31 opportunities during the

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D 358	Continued From page 8 8:00am medication pass on 07/22/25. 1. Review of Resident #7's current FL-2 dated 06/17/25 revealed diagnoses included dementia and right hip fracture. a. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Buspirone 5mg, take one three times daily. (Buspirone is used to treat anxiety). Observation of 8:00am medication pass on 07/22/25 revealed: -Buspirone 5mg was administered to Resident #7 at 9:50am. -Buspirone 5mg was administered thirty-five minutes beyond the allowed time frame. Review of Resident #7's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Buspirone 5mg, take three times daily at 8:00am, 12:00pm, and 4:00pm. -Buspirone was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and 12:00pm and 07/01/25 to 07/21/25 at 4:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm	D 358		

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D 358	Continued From page 9 b. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Preservision AREDS 2 take one capsule twice daily. (Preservision AREDS is used to reduce the risk of progression of age-related macular degeneration). Observation of 8:00am medication pass on 07/22/25 revealed: -Preservision AREDS 2 was administered to Resident #7 at 9:50am. -Preservision AREDS 2 was administered thirty-five minutes beyond allowed time frame. Review of Resident #7's July 2025 eMAR revealed: -There was an entry for Preservision AREDS 2 take twice daily at 8:00am and 8:00pm. -Preservision AREDS 2 was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm c. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Lactaid 3000 unit three times daily. (Lactaid is used to help those with lactose intolerance digest dairy products).	D 358		

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D 358	Continued From page 10 Observation of 8:00am medication pass on 07/22/25 revealed: -Lactaid 3000 unit was administered to Resident #7 at 9:50am. -Lactaid 3000 unit was administered thirty-five minutes beyond the allowed time frame. Review of Resident #7's July 2025 eMAR revealed: -There was an entry for Lactaid 3000 unit take one tablet before meals. -Lactaid 3000 unit was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and 12:00pm and from 07/01/25 to 07/21/25 at 5:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm d. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Lactaid 3000 units three times daily. (Lactaid is used to help lactose intolerance digest dairy products). Observation of 8:00am medication pass on 07/22/25 revealed: -Lactaid 3000 unit was to be administered before meals. -Lactaid 3000 unit was administered to Resident #7 at 9:50am beyond the allowed time frame.	D 358		

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D 358	Continued From page 11 Review of Resident #7's July 2025 eMAR revealed: -There was an entry for Lactaid 3000 unit take one tablet before meals. -Lactaid 3000 unit was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and 12:00pm and from 07/01/25 to 07/21/25 at 5:00pm. Interview with the medication aide (MA) on 07/22/25 at 9:48am revealed: -The medication should have been administered before Resident #7 ate breakfast. -She was unable to administer medications to Resident #7 before breakfast. -She was administering Resident #7's medications late this morning, 07/22/25. Refer to second interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm e. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Metoprolol Tartrate 25mg. (Metoprolol Tartrate is used to treat hypertension). Observation of 8:00am medication pass on 07/22/25 Metoprolol Tartrate 25mg was administered at 9:50am beyond the allowed time frame.	D 358		

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D 358	Continued From page 12 Review of Resident #7's July 2025 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg take twice daily. -Metoprolol Tartrate 25mg was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm f. Review of Resident #7's signed physician orders dated 06/17/25 revealed there was an order for Metoprolol Tartrate 25mg hold for systolic blood pressure less than 110 and/or heart rate less than 60. (Metoprolol Tartrate is used to treat hypertension). Observation of the 8:00am medication pass on 07/22/25 revealed: -There were parameters for the Metoprolol Tartrate 25mg hold for systolic blood pressure less than 110 and/or heart rate less than 60. -Vital signs were not taken prior to administering Metoprolol Tartrate 25mg. -Metoprolol Tartrate 25mg was administered to Resident #7 at 9:50am beyond the allowed time frame. Review of Resident #7's July 2025 eMAR	D 358		

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revealed:
-There was an entry for Metoprolol Tartrate 25mg take twice daily.
-Metoprolol Tartrate 25mg was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm.

Interview with the MA on 07/22/25 at 9:48am revealed:
-She did not take Resident #7's blood pressure or pulse before administering medications.
-She thought the vital signs were ordered after administering the medication.
-She did not compare the eMAR and the medication card to see the parameters.
-She did not know what she would have done if parameters were outside of the parameters.

Refer to second interview with the medication aide (MA) on 07/22/25 at 1:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm.

Refer to interview with the Administrator on 07/23/25 at 9:20am.

Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm

2. Review of Resident #8's current FL-2 dated 01/08/25 revealed diagnoses included severe dementia, acute cystitis without hematuria, heart failure, cerebral vascular accident, hypertension, and acute encephalopathy.

a. Review of Resident #8's signed physician orders dated 01/08/25 revealed there was an order for Buspirone 5mg, take one three times daily. (Buspirone is used to treat anxiety).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 Observation of the 8:00am medication pass on 07/22/25 revealed: -Buspirone 5mg was administered to Resident #8 at 10:27am. -Buspirone 5mg was administered 1 hour and 12 minutes beyond the allowed time frame. Review of Resident #8's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Buspirone 5mg, take three times daily at 8:00am, 12:00pm, and 4:00pm. -Buspirone was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 12:00pm and 07/01/25 to 07/21/25 at 4:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm b. Review of Resident #8's signed physician orders dated 01/08/25 revealed there was an order for Divalproex Sodium DR 500mg take one twice daily. (Divalproex Sodium DR 500mg is used for mood). Observation of the 8:00am medication pass on 07/22/25 revealed: -Divalproex Sodium DR 500mg was administered	D 358		

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to Resident #8 at 10:27am.
-Divalproex Sodium DR 500mg was administered 1 hour and 12 minutes beyond the allowed time frame.

Review of Resident #8's July 2025 eMAR revealed:
-There was an entry for Divalproex Sodium DR 500mg, take twice daily at 8:00am and 8:00pm.
-Divalproex Sodium DR 500mg was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm.

Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm.

Refer to interview with the Administrator on 07/23/25 at 9:20am.

Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm

c. Review of Resident #8's signed physician orders dated 12/17/24 revealed there was an order for Tylenol 1000mg take three times daily. (Tylenol is used to treat pain).

Review of Resident #8's July 2025 eMAR revealed:
-There was an entry for Tylenol 1000mg, take three times daily at 8:00am, 12:00pm, and 4:00pm.
-Tylenol 1000mg was documented as administered daily from 07/01/25 to 07/21/25 at 4:00pm and from 07/01/25 to 07/22/25 at 8:00am and 12:00pm.

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D 358	Continued From page 16 Observation of the 8:00am medication pass on 07/22/25 revealed: -Tylenol 1000mg was administered to Resident #8 at 10:27am. -Tylenol 1000mg was administered 1 hour and 12 minutes beyond the allowed time frame. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm 3. Review of Resident #2's current FL-2 dated 11/19/24 revealed diagnoses included dementia and hypertension. a. Review of Resident #2's signed physician orders dated 12/17/24 revealed there was an order for Metoprolol Tartrate 25mg take ½ tablet twice daily. (Metoprolol Tartrate is used to treat hypertension). Observation of 8:00am medication pass on 07/22/25 revealed: -Metoprolol Tartrate 25mg ½ was administered to Resident #2 at 10:05am. -Metoprolol Tartrate was administered fifty minutes beyond the allowed time frame. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 17 -There was an entry for Metoprolol Tartrate 25mg take twice daily at 8:00am and 8:00pm. -Metoprolol Tartrate 25mg was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm b. Review of Resident #2's signed physician orders dated 12/17/24 revealed there was an order for Risperidone 1mg take twice daily. (Risperidone 1mg is used to treat agitation). Observation of the 8:00am medication pass on 07/22/25 revealed: -Risperidone 1mg was administered to Resident #2 at 10:05am. -Risperidone 1mg was administered fifty minutes beyond the allowed time frame. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for Risperidone 1mg take twice daily at 8:00am and 8:00pm -Risperidone 1mg was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 8:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm.	D 358		

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D 358	Continued From page 18 Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm c. Review of Resident #2's signed physician orders dated 12/17/24 revealed there was an order for Eucerin Cream take twice daily. (Eucerin Cream is used to treat dry skin). Observation of the 8:00am medication pass on 07/22/25 revealed: -Eucerin Cream was administered to Resident #2 at 10:07am. -Eucerin Cream was administered fifty-two minutes beyond the allowed time frame. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for Eucerin Cream apply twice daily to legs, abdomen, chest, and back at 8:00am and 7:00pm. -Eucerin Cream was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 7:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am.	D 358		

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D 358	Continued From page 19 Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm d. Review of Resident #2's signed physician orders dated 12/17/24 revealed there was an order for Brimonidine Solution 0.2% take twice daily. (Brimonidine Solution is used to treat glaucoma). Observation of the 8:00am medication pass on 07/22/25 revealed: -Brimonidine Solution 0.2% was administered to Resident #2 at 10:14am. -Brimonidine Solution 0.2% was administered fifty-nine minutes beyond the allowed time frame. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for Brimonidine Solution 0.2% at 8:00am and 7:00pm. -Brimonidine Solution 0.2% was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 7:00pm. Refer to interview with the medication aide (MA) on 07/22/25 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm e. Review of Resident #2's signed physician orders dated 12/17/24 revealed there was an order for Brimonidine Solution 0.2% take twice daily. (Brimonidine Solution is used to treat	D 358		

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D 358	Continued From page 20 glaucoma). Observation of the 8:00am medication pass on 07/22/25 revealed: -Brimonidine Solution 0.2% was administered to Resident #2 at 10:14am. -Brimonidine Solution 0.2% was dated as opened on 05/09/25. -Brimonidine Solution 0.2% was dated as expired on 06/09/25. -Brimonidine Solution 0.2% had been expired for 44 days when administered on 07/22/25. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for Brimonidine Solution 0.2% at 8:00am and 7:00pm. -Brimonidine Solution 0.2% was documented as administered daily from 07/01/25 to 07/22/25 at 8:00am and from 07/01/25 to 07/21/25 at 7:00pm. Interview with the MA on 07/22/25 at 10:18am revealed: -She should have reviewed the open and expired dates before administering the eye drops not afterwards. -She should not administer expired medications. Interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm revealed: -He had worked at the facility for 5 months. -Eye drops were dated when they were opened and they were good for 30 days. -The open and expired date should be reviewed before administering eye drops. -This was a medication error and a medication error document should be completed and the provider should be notified. Refer to second interview with the medication	D 358		

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D 358	Continued From page 21 aide (MA) on 07/22/25 at 1:00pm. Refer to second interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm. Refer to interview with the Administrator on 07/23/25 at 9:20am. Refer to interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm _____ Interview with a medication aide (MA) on 07/22/25 at 1:00pm revealed: -She had one hour prior and one hour after scheduled time to administer medications. -She knew that she was administering medications late. -She had not been trained on what to do if medications were passed late. -She had not notified the RCC or provider that medications were administered late. -She did not compare the eMAR to the medications card before administering medications. Interview with the Resident Care Coordinator (RCC) on 07/22/25 at 2:20pm revealed: -He had worked at the facility for 5 months. -He did know that that medications were administered late today (07/22/25). -Medications could be administered one hour before or one hour after scheduled administration time. -Late medications must have documentation stating why they were administered late. -The MA was responsible for notifying the PCP when medications are administered late. -The MA should notify the RCC when medications were passed late. -Breakfast was served at 8:00am today	D 358		

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(07/22/25).
-Medications ordered to be administered before meals should be administered before the resident ate.
-Expired medications should not be administered.
-He was not sure who performed medication cart audits or when.

Interview with the Administrator on 07/23/25 at 9:20am revealed:
-The MA should notify the RCC and her when medications were passed late.
-She did not know medications were passed late.
-Expired medications should not be administered due to the efficacy of the medication.
-If medications were ordered to be administered prior to a meal then they should be administered before the resident ate not after their meal.
-Medication cart audits were performed by the RCC and she was not sure of the date of the last audit.
-MAs were trained during their MA course that medications were to be administered one hour prior or one hour after scheduled time.
-MAs had been trained to review the open and expired dates during their MA course.

Interview with the facility's primary care provider (PCP) on 07/23/25 at 1:23pm revealed:
-She did not know that medications were administered late yesterday, (07/22/25).
-Medications should be administered at the time they were ordered.
-Parameters should be followed as ordered.
-Expired medications should not be administered.
-Medications could cause dizziness or stomach pain if administered to close together.

4). Review of Resident #5's current FL-2 dated 09/17/24 revealed diagnoses included vascular

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D 358	Continued From page 23 dementia, hypertension, kidney disease, congestive heart failure and asthma. Review of Resident #5's signed physician orders dated 04/29/25 revealed there was an order to stop cholecalciferol (Vitamin D3) 125mcg capsule, take 1 capsule every day. (Vitamin D3 is used to prevent bone disease). Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 125mcg capsule, take 1 capsule every day. -Vitamin D3 125mcg was documented as administered from 05/01/25 to 05/08/25 and from 05/13/25 to 05/31/25. Review of Resident #5's June 2025 eMAR revealed: -There was an entry for Vitamin D3 125mcg capsule, take 1 capsule every day. -Vitamin D3 125mcg was documented as administered from 06/01/25 to 06/30/25. Review of Resident #5's July 2025 eMAR revealed: -There was an entry for Vitamin D3 125mcg capsule, take 1 capsule every day. -Vitamin D3 125mcg was documented as administered from 07/01/25 to 07/22/25. Review of Resident #5's medications on hand on 07/22/25 at 2:37pm revealed: -The Vitamin D3 125mcg capsule was in the medication cart. -There were 7 capsules remaining from a 30-day supply bubble pack. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 24 07/22/25 at 2:37pm revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring medications that were discontinued were removed from the eMAR. -The MAs were responsible for ensuring medications that were discontinued were removed from the medication cart. -The MAs had no way of knowing if a medication was discontinued therefore if it was on the eMAR it would continue to be administered. Interview with the RCC on 07/22/25 at 2:45pm revealed: -The contracted pharmacy removed discontinued medications from the eMAR. -He was responsible for reviewing the eMAR to determine if the medication that was discontinued had been removed. -He had to approve the discontinued medication in the eMAR system before it would be removed from the eMAR. -He was not aware Resident #5 had a medication order to discontinue Vitamin D3. -The primary care provider's (PCP) notes were emailed to him for review. -He would notify the MAs when a medication had been discontinued, and they would remove the medication from the medication cart. Interview with Resident #5's PCP on 07/23/25 at 1:21pm revealed: -She felt Resident #5's Vitamin D level was more than sufficient, and she no longer needed the supplement. -She discontinued Resident #5's Vitamin D3 because her level was 79. -She did not want Resident #5's Vitamin D level to rise above 100 because it would cause toxicity with symptoms of nausea, vomiting, constipation and confusion.	D 358		

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D 358	Continued From page 25 Interview with the Administrator on 07/22/25 at 3:00pm revealed: -It was the RCC's responsibility to ensure medications that were discontinued were removed from the eMAR and the medication cart. -It was the RCC's responsibility to review the PCP's progress notes and follow up on any new orders.	D 358		