STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL087009	A. BUILDING: _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYSON SENIOR LIVING	314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 06/30/25 through 07/03/25. The complaint was initiated by the Swain County Department of Social Services on 06/18/25.	D 000	Responses to the cited deficiences do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state laws.	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B, MA) had completed the 5, 10, or 15 hour MA training and MA Clinical Skills Competency Validation prior to administering medications and pass the State MA written examination within 60 days of employment. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide/Supervisor (MA) on 04/28/25. -Staff B completed the MA Clinical Skills	D 125	Executive Director and his/her designee will audit employee files to ensure all required have the appropriate clinical skills training documented as completed by Clinical Nurse Consultant, RN. Community Business Office Coordinator and/or Executive Director will audit no less than 5 employee files monthly including new hires for 60 days than quarterly thereafter to ensure check-offs and state tests are completed within the approriate timeframe. Executive Director, Business Office Coordinator and Care Coordinator were in-serviced on the importance of staff competency check-offs for all employees upon hire and prior to being scheduled alone. In-service conducted by Clinical Nurse Consultant, RN.	08/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Brooks | TITLE: Executive Director | (X6) DATE: 08/15/2025

LSB Reviewed & acknowledged 08/18/25

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D 125	Continued From page 1 Competency Validation checklist on 07/01/25. -Staff B completed the MA 15-hour training course on 07/01/25. -There was no documentation Staff B had passed the State written MA examination. Review of a resident's Controlled Substance Count Sheets (CSCS) dated 04/18/25-06/26/25 revealed: -There was documentation Staff B administered lorazepam (used to treat anxiety) 0.5mg on 04/25/25, 04/30/25, 05/01/25, 05/08/25, 05/09/25, 05/10/25, 05/14/25, 05/15/25, 06/24/25, and 06/26/25. -There was documentation Staff B administered hydrocodone/acetaminophen (used to treat pain) 5-325mg on 04/25/25, 04/30/25, 05/01/25, 05/27/25, 05/28/25, 05/30/25, 06/03/25, 06/24/25, and 06/26/25. Interview with the Business Office Manager (BOM) on 07/02/25 at 10:10am revealed: -She was aware MAs were required to have a MA Clinical Skills Competency Validation checklist and a least 5 hours of the 15 hour MA training course completed prior to administering medications. -She and the Administrator were responsible for notifying the Licensed Health Professional Support (LHPS) Registered Nurse (RN) when new MAs were hired and the training they required. -The LHPS RN would then scheduled and complete the training with the MA. -She and the Administrator were responsible for making sure new MAs had the required training before they administered medications. Interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on	D 125		

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D 125	Continued From page 2 07/02/25 at 11:03am revealed: -He did not know Staff B documented administration of controlled substances in April, May, and June 2025. -He initiated Staff B's MA 15-hour training course "last week." -He did not complete a 5 or 10-hour MA training with Staff B prior to 07/01/25. -He completed Staff B's 15-hour training on 07/01/25. -He completed Staff B's MA Clinical Skills Competency Checklist on 07/01/25. Interview with a MA on 07/02/25 at 11:11am revealed Staff B used the Facility Manager's credentials to document the administration of medications in the resident's electronic administration records (eMARs). Interview with the Facility Manager on 07/02/25 at 1:47pm revealed the BOM and the Administrator were responsible for letting her know when staff had their required qualifications and were cleared to administer medications. Telephone interview with Staff B on 07/02/25 at 2:50pm revealed: -She completed the MA Clinical Skills Competency Validation and 15 hour MA training on 07/01/25. -She had not taken the State MA written examination, but was told by the LHPS RN she had 60 days from 07/01/25 to pass the State MA written examination. -She administered medications in the facility prior to 07/01/25. -She used the Facility Manager's login credentials to document medications she administered to the residents in the electronic medication administration records.	D 125		

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D 125	Continued From page 3 -The Facility Manager gave her the login credentials to use to documented medication administration. -She had administered medications to residents when the Facility Manager was not present in the facility. Interview with the Facility Manager on 07/02/25 at 3:08pm revealed she had given the MA her personal sign in for the computer so the MA could administer medications during the night shift. Interview with a MA on 07/03/25 at 9:05am revealed: -She was aware Staff B used the Facility Manager's credentials to document medication administration in resident's eMARs. -She had told the Administrator on multiple occasions Staff B was using the Facility Manager's credentials for medication administration on the eMARs. -The Administrator told her each time "we'll get it fixed." -Staff B had continued to use the Facility Manager's credentials for several weeks when documenting medication administration on the eMARs. Interview with the Facility Manager on 07/03/25 at 2:45pm revealed: -She knew Staff B had not completed all the required training to administer medications. -She did not have any other MA staff to cover third shift. -She was required to work as a MA when there was not enough MA staff to cover the schedule which often lead to her working consecutive day and night shifts. The facility failed to ensure Staff B, MA,	D 125		

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D 125	Continued From page 4 completed the 5, 10, or 15 hour MA training and MA Clinical Skills Competency Validation prior to administering medications and pass the State MA written examination within 60 days of employment resulting in Staff B administering medications to residents for over two months without the required training. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2025.	D 125		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff B) was tested for tuberculosis (TB) disease upon employment in compliance with control measures adopted by the Commission for Public Health.	D 131	Executive Director and his/her designee will audit employee files to ensure all staff have appropriate Tuberculosis test documentation. Community Business Office Coordinator and/or Executive Director will audit no less than 5 employee files monthly including new hires for 60 days than quarterly thereafter to ensure Tuberculosis testing has been completed in accordance with .0406(a) regulation. Executive Director, Business Office Coordinator and Care Coordinators were in-serviced on the importance of staff having the appropriate Tuberculosis test documentation and follow up.	08/17/2025

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D 131	Continued From page 5 The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide/Supervisor (MA) on 04/28/25. -There was a TB screening form dated 04/25/25 completed by Staff B and signed by the facility Business Office Manager (BOM). -Staff B documented no to all TB risk questions on the form. -Staff B documented no to all TB symptom questions on the form. -There was no documentation a step 1 TB skin test was completed. -There was no documentation a step 2 TB skin test was completed. -There was no documentation of a Interferon Gamma Release Assay (a blood test used to detect latent TB infection). -There was no documentation of a chest x-ray read for TB infection with a negative result was completed. Interview with the BOM on 07/02/25 at 10:10am and 10:34am revealed: -She, and the Administrator and the Licensed Health Support Professional (LHPS) Registered Nurse (RN) were responsible for ensuring staff received TB testing upon employment. -The facility was out of TB skin test serum when Staff B was hired. -The pharmacy had the TB serum available, however the Administrator did not reorder the TB serum. -She was instructed by the Administrator and LHPS RN to do the TB screening form instead. -She and Staff B completed a TB screening form instead of a one step TB skin test. -She let the LHPS RN know "today" (07/02/25) Staff B needed two step TB skin testing.	D 131		

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D 131	Continued From page 6 Interview with the Facility Manager on 07/02/25 at 1:47pm revealed: -The BOM and the Administrator were responsible for letting her know when staff had their required qualifications and were cleared to work. -She did not know the facility did not have documentation of TB testing for Staff B.	D 131		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there was at least one staff person on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 2 of 5 sampled staff (Staff B and D).	D 167	Executive Director and his/her designee will audit employee files to ensure appropriate staff have CPR training. Community Business Office Coordinator and/or Executive Director will audit no less than 5 employee files monthly including new hires for 60 days than quarterly thereafter to ensure appropriate staff have a CPR certification to meet state requirements and to ensure it remains valid. Executive Director, Business Office Coordinator and Care Coordinators were in-serviced on the importance of no less that one employee per shift is CPR certified and that it is notated on the scheduled. Executive Director and his/her designee will review the staffing schedule no less than weekly for 60 days to ensure appropriate CPR coverage is scheduled.	08/17/2025

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D 167	Continued From page 7 The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide/Supervisor (MA) on 04/28/25. -There was no documentation of CPR training. Interview with the Business Office Manager (BOM) on 07/02/25 at 10:10am revealed: -She was responsible for maintaining personnel records. -Staff B was hired on 04/28/25 as a MA/Supervisor. -Staff B told her when she was hired that she was current with CPR training. -Staff B was supposed to bring in a copy of her current CPR card. -She could not find a CPR training card for Staff B. Review of the facility's schedule for 06/15/25-06/28/25 revealed: -Staff B was scheduled for eight 8:00PM-8:00AM shifts (06/16/25, 06/17/25, 06/18/25, 06/19/25, 06/23/25, 06/24/25, 06/25/25, and 06/26/25). -Staff B worked six out of the eight shifts (06/16/25, 06/17/25, 06/18/25, 06/223/25, 06/24/25 and 06/25/25) when no staff on the premises were CPR certified. Telephone interview with Staff B on 07/02/25 at 2:50pm revealed: -She had CPR and first aid training within the last year and she knew it was still valid. -She "forgot" to bring a copy of the CPR card and turn it in to the BOM. Refer to the interview with the Facility Manager on 07/02/25 at 1:47pm.	D 167		

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D 167	Continued From page 8 2. Review of Staff D's personnel record revealed: -Staff D was hired as a personal care aide (PCA) on 01/07/25. -There was no documentation of CPR training. Review of the facility's schedule for 06/15/25-06/28/25 revealed: -Staff D was scheduled for six 7:00PM-7:00AM shifts (06/15/25, 06/18/25, 06/19/25, 06/25/25, 06/26/25, and 06/28/25). -Staff D worked two out of the six shifts (06/18/25 and 06/25/25) when no staff on the premises were CPR certified. Interview with the Business Office Manager (BOM) on 07/02/25 at 10:10am revealed: -She was responsible for maintaining personnel records. -She could not find a CPR training card for Staff D. Refer to the interview with the Facility Manager on 07/02/25 at 1:47pm. Interview with the Facility Manager on 07/02/25 at 1:47pm revealed: -She was responsible for ensuring at least one CPR trained staff was available on each shift. -A heart next to the employee's name on the staff schedule indicated the employee was current with CPR training. -Staff B and Staff D did not have a heart next to their name which meant they were not CPR certified.	D 167		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities-	D 177		

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D 177	Continued From page 9 General Administrator and Manager Responsibilities (b) An adult care home manager shall be responsible for carrying out the day-to-day operations and all required duties of an adult care home in the absence of an administrator. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to have a manager on duty to carry out the day to day operations and all required duties in the absence of the Administrator related to a night shift personal care aide who was left alone in the facilty when the night shift medication aide left campus for an unspecificed amount of time. The findings are: Review of the census provided upon entry revealed there were 34 residents. A confidential interview with a resident revealed: -There were usually 2 staff who worked through the night. -Sometimes one of the staff would sleep in an empty room. -One evening last week the medication aide (MA) left the building for a couple of hours and the	D 177	Executive Director, Care Coordinator and/or designee will ensure there is a Supervisor in Charge at the facility at all times. Executive Director will in-service Supervisor's in Charge on their job duties and expectations. Executive Director will in-service staff on the propper chain of command including the responsibilities of the Supervisor's in Charge and the Administrator's in Charge. Facility Managment staff will conduct random visits on shifts to ensure adequate coverage of Supervisor's in Charge no less than weekly for 60 days.	08/17/2025

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personal care aide (PCA) was asleep in an unoccupied resident's room.
-Two residents were standing at the nurse's station and a call light in room 301 was ringing but no staff could be found.
-One of the residents at the nurse's station wanted pain medication.
-This resident made a 911 call and a law enforcement officer (LEO) came to the building to check on the residents around midnight.
-The PCA that was asleep in a room came out and told the LEO she was doing laundry.

Interview with another resident on 06/30/25 at 5:00pm revealed:
-One day last week his leg was hurting so he went to the nurse's station around midnight to request pain medication, but he could not find the MA or the PCA that were supposed to be working.
-The call light in room 301 was ringing and no one was answering it.
-Staff that work at night usually went outside and sat in their car during their break, so he assumed that was where one of them was.
-While he was standing at the nurse's station he heard someone at the front door and he saw that it was a LEO.
-He opened the door for the LEO who told him they had been called because there was a report there were no staff in the building.
-He told the LEO that the staff were on break, and he returned to his room.

Telephone interview with a PCA on 07/01/25 at 4:05pm revealed:
-She started working at the facility as a PCA on night shift about 6 months ago.
-She was in a resident's room last week when the LEO came.
-She was in the resident's room for about 10 or

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15 minutes.
-When she left the resident's room about midnight and returned to the nurse's station there were two residents standing around and the call light in room 301 was ringing.
-The telephone started ringing and when she answered it was the hospital informing her a LEO was at the facility's front door.
-She spoke with the LEO who told her he had already been inside the facility and could not locate any employees.
-The LEO left after she informed him she had been helping a resident and the other employee was on her break.
-The MA she was working with that evening left the property when she went on her break.
-While she was helping the resident in her room she called the MA who was on break because the resident needed pain medication.
-The MA told her she was on her way back to the facility, but she did not actually return until 1:30 or 2:00am.

Telephone interview with the MA (who worked when a LEO came to the facility) on 07/02/25 at 2:37pm revealed:
-She started working at the facility in April 2025 as a MA.
-She was working as an MA last week when a LEO came to the facility but she was on her break at the time they came to the facility.
-She went on her break about midnight and she left the property in her car and drove down the street.
-The PCA called her while she was on her break and told her a LEO came to the facility due to a report that no staff were in building.
-She thought she was out of the facility for about 45 minutes.

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Review of the MA's personnel record revealed:
-The MA was hired as a Medication Aide/Supervisor (MA) on 04/28/25.
-The MA did not complete the MA Clinical Skills Competency Validation checklist on 07/01/25.
-The MA did not complete the MA 15-hour training course on 07/01/25.
-There was no documentation the MA had passed the State written MA examination.

Interview with the Assistant Chief at the local Law Enforcement office on 07/01/25 at 10:11am revealed:
-A LEO responded to a 911 call last week reporting there were no staff in the building.
-The final report was not available for review because it was not complete, but he was told by the LEO that there was one employee at the facility, and she was asleep in a room when he arrived at the facility.
-The LEO left the facility after speaking with the employee because he determined the 911 call was a staffing issue and not a law enforcement issue.

Review of the 911 call report dated 06/24/25 revealed:
-The initial 911 call was received on 06/24/25 at 11:35pm.
-The caller reported there was no one was at the facility to take care of people and everyone's car was gone.
-At 11:58pm the LEO who responded to the call reported he walked the whole place and was unable to locate anyone in the building.
-At 12:05am the LEO reported the 911 call could be disregarded.
-At 12:12am the LEO called in reporting he found a worker and also reported that a call alarm that had a timer had been alerting for 22 minutes.

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BRYSON SENIOR LIVING	314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713

(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 177	Continued From page 13 Attempted interview with the local LEO on 07/02/25 at 8:30am was unsuccessful. Interview with the Facility Manager on 07/01/25 at 4:45pm revealed: -She was not aware the MA who worked on the evening of 06/24/25 left the property when she was on break. -Staff were not supposed to leave the property when they were on break. The facility failed to ensure a manager was on duty in the facility on 06/24/25 to carry out day to day operations and all required duties in the absernce of an Administrator resulting in a resident calling 911 because no staff could be found to provide care. One resident needed pain medication and a call bell had been sounding for 22 minutes when a LEO arrived and could not locate any staff in the building. The LEO eventually located one staff that was asleep in a resident's room. This failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/01/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2025.	D 177		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information:	D 352		

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D 352	Continued From page 14 (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a pain medication for 1 of 1 sampled resident (#10) drawn up into syringes by staff were labeled with the name of the resident for whom the medication was prescribed, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name of the dispensing pharmacist. The findings are: Review of Resident #10's current FL2 dated 02/18/25 revealed diagnoses included dysphagia,	D 352	Care coordinator and/or designee will conduct medication cart audits no less than weekly for 30 days to ensure all medications are labeled appropriately and remain in original packaging. Clinical Nurse Consultant, RN will conduct "spot checks" during visits for 60 days to ensure medications are labeled and remain in its original packaging. Clinical Nurse Consultant, RN will inservice medication staff and management team on the importance of ensuring medications are labeled appropriately and remain in the original packaging.	08/17/2025

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D 352	Continued From page 15 partial intestinal obstruction, and unsteadiness on feet. Review of Resident #10's record revealed the resident was deceased as of 06/27/25. Review of Resident #10's physician's prescription dated 06/22/25 revealed: -There was an order for hydromorphone (used to treat pain and trouble breathing) 1mg/1ml every six hours scheduled. -There was an order for hydromorphone 1mg/1ml may take an additional 1ml every two hours as needed for pain and trouble breathing. -Please send in prefilled syringes. -The prescription quantity was 50mls. Review of Resident #10's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydromorphone 1mg/1ml give 1ml four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 06/23/25 and an end date of 06/27/25. -There was an entry for hydromorphone 1mg/1ml every two hours as needed with a start date of 06/23/25 and an end date of 06/27/25. -The hydromorphone 1mg was documented as administered four times daily on 06/25/25 and 06/26/25. -There were no documented administrations of scheduled hydromorphone 1mg on 06/23/25, 06/24/25, or 06/27/25. -There were no documented administrations of as needed hydromorphone on the eMAR. Review of Resident #10's hydromorphone 1mg/1ml controlled substance count sheet (CSCS) dated 06/22/25-06/27/25 revealed: -There were 50mls of hydromorphone 1mg/1ml	D 352		

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documented as received on 06/22/25.
-The first documented administration was on 06/22/25 at 7:00pm.
-The last documented administration was on 06/27/25 at 1:00am.
-There was a remaining balance of 1ml.

Observation of Resident #10's hydromorphone 1mg/1ml on hand on 07/03/25 at 10:53am revealed:
-There was 0.55mls of pink solution remaining in the bottom of a 2 oz bottle with a pharmacy label.
-The label directions were hydromorphone 1mg/1ml take one ml every six hours scheduled may take additional one ml every two hours as needed.
-The dispense date was 06/22/25 with a quantity of 50mls.

Telephone interview with a pharmacist from the facility's backup pharmacy on 07/02/25 at 10:40am revealed:
-They received an electronic prescription for Resident #10 dated 06/22/25.
-The prescription was for hydromorphone 1mg/1ml take 1ml every six hours scheduled may take additional 1ml every two hours as needed for pain and trouble breathing.
-Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility on 06/22/25 in a 2oz. bottle with a quantity of 50mls.
-The prescription requested prefilled syringes, however the pharmacy did not provide prefilled syringes.
-The pharmacy sent two or three empty reusable syringes to be used to draw up the hydromorphone at the time of administration.

Telephone interview with Resident #10's Hospice Registered Nurse (RN) on 07/02/25 at 3:55pm

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D 352	Continued From page 17 revealed: -Prefilled syringes were requested for the hydromorphone prescription for Resident #10. -She did not measure the hydromorphone 1mg/1ml into syringes for the facility for administration. Interview with the Facility Manager on 07/03/25 at 9:41am and 10:55am revealed: -Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility in a bottle. -The pharmacy did not provide prefilled appropriately labeled syringes of hydromorphone 1mg/1ml for Resident #10. -The facility had some new syringes in storage. -She used the new syringes to draw up Resident #10's hydromorphone 1mg/1ml solution into doses. -She did not label the syringes of hydromorphone she drew up for Resident #10.	D 352		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#3) related to an oral medication used	D 358	RN Consultant will provide training on the importance of administering physician prescribed medications as directed. Resident Care Corrdinator or designee will conduct MAR to cart audits no less than once weekly for 30 days to ensure physician ordered medications are administered per physician instructions. Resident Care Coordinator will observed no less than 10 medication administrations per week for 60 days to ensure medications are being administered as ordered by the residents physician.	08/17/2025

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D 358	Continued From page 18 to treat itching. The findings are: Review of Resident #3's current FL2 dated 02/18/25 revealed diagnoses included amnesia and Parkinson's disease with dyskinesia (a movement disorder characterized by involuntary, repetitive, and sometimes erratic muscle movements). Review of Resident #3's physician's orders dated 05/20/25 revealed: -An order for hydroxyzine (used to relieve itching skin) 25mg twice daily. -An order for hydroxyzine 25mg daily as needed. Review of Resident #3's May 20-31, 2025, electronic medication administration record (eMAR) revealed: -There was documentation hydroxyzine 25mg daily "as needed" was administered 05/24/25, 05/25/25, and 05/26/25. -The hydroxyzine 25 mg twice daily was not listed on the eMAR. Review of Resident #3's June 2025 eMAR revealed: -There was no documentation hydroxyzine 25mg daily "as needed" was administered during June 2025. -The hydroxyzine 25 mg twice daily was not listed on the eMAR. Observation of medications available for administration on 07/01/25 at 4:38pm revealed: -A bubble pack of hydroxyzine with a dispense date of 05/21/25 with 13 of 18 tablets remaining. -A bubble pack of hydroxyzine with a dispense date of 06/09/25 with 18 of 18 tablets remaining.	D 358		

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-Two bubble packs of hydroxyzine with a dispense date of 06/27/25 with 9 of 9 tablets remaining on each bubble pack.

Interview with a medication aide (MA) on 07/01/25 at 2:24pm revealed:
-Resident #3 had itching on her back, buttocks and the upper back of her legs.
-Resident #3 tended to scratch wherever she could.

Interviews with the Facility Manager on 07/01/25 at 2:41pm revealed Resident #3 would "pick and dig" at the skin on her back.

Interview with the facility's Pharmacy Representative on 07/01/25 at 3:28pm revealed:
-They received an order on 05/20/25 for Resident #3 that included hydroxyzine 25mg twice daily and hydroxyzine 25mg daily as needed.
-The order was typed into the computer and verified by a pharmacist.
-Facility staff verified the medication was correct before it was placed on the resident's eMAR.
-Only the hydroxyzine 25mg daily prn had been verified by the facility staff on Resident #3's eMAR.
-Only medications that were verified would be placed on the eMAR.

Interview with the Facility Manager on 07/01/25 at 4:10pm revealed:
-Resident #3's medication should be in a weekly cycle dose, but her hydroxyzine had come in a bubble pack instead and she was unsure why.
-No facility staff were able to modify the eMAR as that could only be done through the pharmacy.
-She had verified the hydroxyzine on 05/22/25 for both the scheduled and the as needed dose.
-Both the scheduled and the as needed

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D 358	Continued From page 20 hydroxyzine should have been visible on the eMAR for Resident #3. -She was responsible for cart audits and had not realized the hydroxyzine was not being given twice daily per the physician's order. Attempted interview on 07/01/25 at 11:41am revealed Resident #3 was not interviewable.	D 358		
D 365	10A NCAC 13F .1004 (h) Medication Administration 10A NCAC 13F .1004 Medication Administration (h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure procedures were implemented for 1 of 1 sampled residents (#10) to identify the staff person who prepared doses of a schedule II (drugs with high potential for abuse) pain medication for administration and the staff who administered the medication.	D 365	Executive Director and/or Resident Care Coordinator will conduct cart reviews no less than weekly for 60 days to ensure there is no medication removed from its original packaging and prepared for another staff member to administer. Clinical Nurse Consultant, RN will inservice medication staff to include facility managers on the importance of not administering a medication that has previously been removed from its original packaging by other facility staff. RN will also inservice on the importance of not preparing medication for other staff members to administer.	08/17/2025

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D 365	Continued From page 21 The findings are: Review of Resident #10's current FL2 dated 02/18/25 revealed diagnoses included dysphagia, partial intestinal obstruction, and unsteadiness on feet. Review of Resident #10's record revealed the resident was deceased as of 06/27/25. Review of Resident #10's physician's prescription dated 06/22/25 revealed: -There was an order for hydromorphone (a schedule II drug used to treat pain and trouble breathing) 1mg/1ml every six hours scheduled. -There was an order for hydromorphone 1mg/1ml may take an additional 1ml every two hours as needed for pain and trouble breathing. -Please send in prefilled syringes. -The prescription quantity was 50mls. Review of Resident #10's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydromorphone 1mg/1ml give 1ml four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 06/23/25 and an end date of 06/27/25. -There was an entry for hydromorphone 1mg/1ml every two hours as needed with a start date of 06/23/25 and an end date of 06/27/25. -The hydromorphone 1mg was documented as administered four times daily on 06/25/25 and 06/26/25. -There were no documented administrations of scheduled hydromorphone 1mg on 06/23/25, 06/24/25, or 06/27/25. -There were no documented administrations of as needed hydromorphone on the eMAR.	D 365		

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D 365	Continued From page 22 Review of Resident #10's hydromorphone 1mg/1ml controlled substance count sheet (CSCS) dated 06/22/25-06/27/25 revealed: -There were 50mls of hydromorphone 1mg/1ml documented as received on 06/22/25. -The first documented administration was on 06/22/25 at 7:00pm. -The last documented administration was on 06/27/25 at 1:00am. -There was a remaining balance of 1ml. Observation of Resident #10's hydromorphone 1mg/1ml on hand on 07/03/25 at 10:53am revealed: -There was 0.55mls of pink solution remaining in the bottom of a 2 oz bottle with a pharmacy label. -The label directions were hydromorphone 1mg/1ml take one ml every six hours scheduled may take additional one ml every two hours as needed. -The dispense date was 06/22/25 with a quantity of 50mls. Interview with a medication aide (MA) on 07/02/25 at 11:11am revealed: -Resident #10's hydromorphone was delivered to the facility on 06/22/25 between 3:00pm and 4:00pm. -The hydromorphone was delivered in a "cough syrup size" bottle. Telephone interview with a pharmacist from the facility's backup pharmacy on 07/02/25 at 10:40am revealed: -They received an electronic prescription for Resident #10 dated 06/22/25. -The prescription was for hydromorphone 1mg/1ml take 1ml every six hours scheduled may take additional 1ml every two hours as needed for	D 365		

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D 365	Continued From page 23	D 365		

pain and trouble breathing.
-Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility on 06/22/25 in a 2oz. bottle with a quantity of 50mls.
-The prescription requested prefilled syringes, however the pharmacy did not provide prefilled syringes.
-The pharmacy sent two or three empty reusable syringes to be used to draw up the hydromorphone at the time of administration.

Telephone interview with Resident #10's Hospice Registered Nurse (RN) on 07/02/25 at 3:55pm revealed:
-Resident #10 was changed to hydromorphone for pain on 06/20/25 due to an inability to swallow pain medication in tablet form.
-Prefilled syringes were requested for the hydromorphone prescription for Resident #10.
-She assisted with the change of tablet pain medication to hydromorphone solution right before she left on leave.
-She did not prefill the hydromorphone 1mg/1ml into syringes for the facility, because she was not back from leave.

Interview with the Facility Manager on 07/03/25 at 9:41am and 10:55am revealed:
-Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility in a bottle.
-The pharmacy did not provide prefilled appropriately labeled syringes of hydromorphone 1mg/1ml for Resident #10.
-The facility had some new syringes in storage.
-She used the new syringes to draw up Resident #10's hydromorphone 1mg/1ml solution into doses.
-She did not know how many syringes of the hydromorphone 1mg/1ml she drew up.
-She left the syringes of hydromorphone 1mg/1ml

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D 365	Continued From page 24 stored in a clear plastic zip top bag with the pharmacy provided labeled 2 oz bottle of hydromorphone. -The pharmacy provided bottle of hydromorphone had the directions on the label on how to administer the hydromorphone to Resident #10. -She did not label the syringes of hydromorphone she drew up for Resident #10. -She did not have labels to use on the syringes she measured of hydromorphone for Resident #10. The facility staff transferred prescription hydromorphone 1mg/1ml solution into unlabeled syringes for use by multiple medication aides to administer to Resident #10. This was detrimental to the health, safety, and welfare of Resident #10 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2025.	D 365		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	D 366		

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D 366	Continued From page 25 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations interviews and record reviews the facility failed to accurately document on the electronic medication administration record (eMAR) who actually administered medications for 2 of 7 sampled residents (#1 & #7) related to an anti-seizure medication, a medication to treat elevated cholesterol, an anti-fungal and and antibiotic (#1) and a medication to treat anxiety and a pain medication (#7). The findings are: Review of the facility's work schedule revealed: -An employee, who was hired on 04/28/25 as a medication aide (MA) who did not complete her training as a MA until 07/01/25 worked as an MA from 8:00pm to 8:00am on 06/17-19/25, 06/24/25 and 06/26/25. -The Facility Manager did not work from 8:00pm to 8:00am on 06/17-19/25, 06/24/25 and 06/26/25. 1.Review of Resident #1's current FL2 dated 02/03/25 revealed diagnoses included mixed dementia, seizure disorder and hyperlipidemia (elevated cholesterol). a. Review of Resident #1's current FL2 dated 02/03/25 revealed there was an order for levetiracetam (used to treat seizures), 500mg twice daily. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for levetiracetam 500mg	D 366	Executive Director and/or Resident Care Coordinator will monitor and compare eMAR documentation with staff schedule/ timesheets to ensure the appropriate staff on shift is documenting medication administrations no less than once weekly for 60 days. Executive Director will conduct an audit to ensure staff have personal logins with the appropriate functions to efficiently complete their assigned tasks Clinical Nurse Consultant, RN will inservice medication staff to include facility managers on the importance of documenting medication administrations under their own assigned eMAR logins to be in compliance with rule area .1004(h)	08/17/2025

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twice daily.
-There was documentation the Facility Manager administered levetiracetam on 06/17-19/25, 06/24/25 and 06/26/25 at 8:00am.
-There was documentation the Facility Manager administered levetiracetam on 06/24/25 at 8:00pm.

b. Review of Resident #1's current FL2 dated 02/03/25 revealed there was an order for rosuvastatin (used to treat elevated cholesterol), 5mg at bedtime.

Review of Resident #1's June 2025 eMAR revealed:
-There was an entry for rosuvastatin 5mg at bedtime.
-There was documentation the Facility Manager administered rosuvastatin on 06/24/25 at 8:00pm.

c. Review of Resident #1's physician's orders dated 06/19/25 revealed clotrimazole 1% (used to treat a fungal infection) apply twice daily.

Review of Resident #1's June 2025 eMAR revealed:
-There was an entry for clotrimazole 1% apply twice daily.
-There was documentation the Facility Manager administered clotrimazole 1% on 06/24/25 and 06/26/25 at 8:00am and on 06/24/25 at 8:00pm

d. Review of Resident #1's physician's orders dated 06/19/25 revealed nitrofurantoin (an antibiotic) 100mg twice daily for 7 days.

Review of Resident #1's June 2025 eMAR revealed:
-There was an entry for nitrofurantoin 100mg twice daily.

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D 366	Continued From page 27 -There was documentation the Facility Manager administered nitrofurantoin 100mg on 06/20/25, 06/24/25 and 06/26/25 at 8:00am and on 06/24/25 at 8:00pm. Refer to Telephone interview with an employee (Staff B) on 07/02/25 at 2:50pm. Refer to interview with a MA on 07/02/25 at 11:11am. Refer to interview with a second MA on 07/03/25 at 9:05am. Refer to interview with the Facility Manager on 07/02/25 at 1:47pm and 3:08pm. 2. Review of Resident #7's current FL2 dated 02/18/25 revealed: -Diagnoses included osteoarthritis, generalized anxiety disorder, and epileptic seizures. -There was an order for alprazolam (used to treat anxiety) 0.5mg at bedtime. -There was an order for oxycodone (used to treat moderate to severe pain) 0.5mg at bedtime. a. Review of Resident #7's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for alprazolam 0.5mg at bedtime. -There was documentation the Facility Manager administered alprazolam on 06/18/25 at 8:00pm, 06/23/25 at 8:00pm, 06/24/25 at 8:00pm, 06/25/25 at 8:00pm. b. Review of Resident #7's June 2025 eMAR revealed: -There was an entry for oxycodone 0.5mg at bedtime.	D 366		

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D 366	Continued From page 28 -There was documentation the Facility Manager administered oxycodone on 06/18/25 at 8:00pm, 06/23/25 at 8:00pm, 06/24/25 at 8:00pm, 06/25/25 at 8:00pm. Refer to Telephone interview with an employee (Staff B) on 07/02/25 at 2:50pm. Refer to interview with a MA on 07/02/25 at 11:11am. Refer to interview with a second MA on 07/03/25 at 9:05am. Refer to interview with the Facility Manager on 07/02/25 at 1:47pm and 3:08pm. _____ Telephone interview with an employee (Staff B) on 07/02/25 at 2:50pm revealed: -She completed the MA Clinical Skills Competency Validation and 15 hour MA training on 07/01/25. -She administered medications in the facility prior to 07/01/25. -She used the Facility Manager's login credentials to document medications she administered to the residents in the eMAR. -She had administered medications to residents when the Facility Manager was not present in the facility. Interview with a MA on 07/02/25 at 11:11am revealed a night shift employee used the Facility Manager's credentials to document the administration of medications in the resident's eMARs. Interview with a second MA on 07/03/25 at 9:05am revealed: -She was aware an employee used the Facility	D 366		

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D 366	Continued From page 29 Manager's credentials to document medication administration in resident's eMARs. -She had told the Administrator on multiple occasions the employee was using the Facility Manager's credentials for medication administration on the eMAR. -The Administrator told her each time "we'll get it fixed." -The employee continued to use the Facility Manager's credentials for several weeks when documenting medication administration on the eMARs. Interview with the Facility Manager on 07/02/25 at 1:47pm and 3:08pm revealed: -She was responsible for preparing the staff schedule. -She had given the employee her personal sign in for the computer so the employee could administer medications during the night shift. -The employee was not signed off to give medications until 07/01/25 by the Licensed Health Professional Health Support RN.	D 366		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the	D 375		

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D 375	Continued From page 30 medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a resident had a physician's order and assessment to self-administer medications for 1 of 5 sampled residents (#7) related to an inhaled medication used to treat allergies. The findings are: Review of Resident #7's current FL2 dated 02/18/25 revealed diagnoses included alcohol induced persisting dementia, depressive disorder, generalized anxiety disorder, high blood pressure, and epileptic seizures. Observation of Resident #7's room at 11:54am on 06/30/25 revealed a bottle of Fluticasone Propionate nasal spray on his bedside table. Interview with Resident #7 at 11:54am on 06/30/25 revealed: -He had very bad sinus problems and used the Fluticasone Propionate nasal spray for treatment. -The medication aide (MA) brought the nasal spray to his room the morning of 06/30/25 and administered the nasal spray to him. Review of Resident #7's primary care provider (PCP) order dated 02/18/25 revealed an order for Fluticasone Propionate nasal spray 50 mcg - instill 1 spray both nostrils every day. Review of Resident #7's medical record revealed there was no PCP order to self-administer the	D 375	Resident Care Coordinator will identify any residents with medications on their person and remove until a self-administration evaulation is completed and an order for self-administration is obtained by the residents physician. Executive Director and/or Resident Care Coordinator will educate identified residents and/or their responsible parties on the importance of bringing medications into the facility without prior consulting facility management to ensure orders and assessments are obtained. Clinical Nurse Consultant, RN will inservice facility staff on the importance or notifying management when medications are found in a residents room to ensure self-administration orders and assessments have been completed. RN will also inservice staff on the importance of not leaving medications in a residents room unless appropriate documentation has been obtained.	08/17/2025

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Fluticasone Propionate nasal spray, and no assessment had been completed to determine if Resident #7 was able to self-administer the Fluticasone Propionate.

Review of Resident #7's electronic medication administration record (eMAR) from April 2025 revealed Fluticasone Propionate 50mcg 1 spray both nostrils every day was administered to Resident #7 daily at 9:00am.

Review of Resident #7's electronic medication administration record (eMAR) from May 2025 revealed Fluticasone Propionate 50mcg 1 spray both nostrils every day was administered to Resident #7 daily at 9:00am.

Review of Resident #7's electronic medication administration record (eMAR) from June 2025 revealed Fluticasone Propionate 50mcg 1 spray both nostrils every day was administered to Resident #7 daily at 9:00am.

A second interview with Resident #7 on 06/30/25 at 3:43pm revealed:
-He used the Fluticasone Propionate nasal spray around 2:00pm on 06/30/25.
-He needed it again even though the MA had administered it to him that morning.

Interview with the MA on 06/30/25 at 3:57pm revealed:
-She administered Resident #7 's Fluticasone Propionate nasal spray at 9:00am on 06/30/25.
-Resident #7 could not self-administer medications.
-She forgot and accidentally left the Fluticasone Propionate in Resident #7's room on 06/30/25.

Observation of medications available for

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D 375	Continued From page 32 administration to Resident #7 on 06/30/25 at 3:57pm revealed there was a box of Fluticasone Propionate on the medication cart, but it was empty. Interview with the Facility Manager 06/30/25 at 4:10pm revealed: -Resident #7 had no physician's order to self-administer any medications. -Resident #7 had not had an evaluation to determine if he could safely administer his medications. -Resident #7 was not supposed to have medication in his room that he was self-administering.	D 375		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure a record of controlled substances that reconciled the receipt, administration, and disposition of controlled medications for 2 of 3 sampled residents (#10 and #4) related to Schedule II controlled pain relievers (#10 and #4), and a Schedule IV controlled anti-anxiety medication (#10).	D 392	Executive Director and/or Resident Care Coordinator will review narctoic count records no less than weekly for 60 days to ensure accurate reconciliation of controlled substances are maintained. Clinical Nurse Consultant, RN and other Support Center staff will conduct controlled substance audits and reconciliations during visits for 60 days to ensure compliance with rule area .1008(a) Clinical Nurse Consultant, RN will inservice facility medication staff to include facility managers on the importance of reconciliation of controlled substances to maintain compliance.	08/17/2025

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D 392	Continued From page 33 The findings are: Review of the facility's Controlled Substances policy revealed: -Each controlled substance medication received be maintained on the electronic medication administration record (eMAR). -Staff must follow accurate documentation practices when charting the use of controlled substances. -Another staff member must witness the disposition of a controlled substance and initial the count sheet. -A controlled substance medication count must be completed at the end of each shift, or anytime controlled substance keys are exchanged. -The medication destruction record is completed for any medication and/or controlled substance requiring facility destruction. 1. Review of Resident #10's current FL2 dated 02/18/25 revealed diagnoses included dysphagia, partial intestinal obstruction, and unsteadiness on feet. Review of Resident #10's record revealed the resident was deceased as of 06/27/25. a. Review of Resident #10's physician's prescription dated 06/22/25 revealed: -There was an order for hydromorphone (used to treat pain and trouble breathing) 1mg/1ml every six hours scheduled. -There was an order for hydromorphone 1mg/1ml may take an additional 1ml every two hours as needed for pain and trouble breathing. -Please send in prefilled syringes. -The prescription quantity was 50mls. Review of Resident #10's June 2025 electronic	D 392		

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medication administration record (eMAR) revealed:
-There was an entry for hydromorphone 1mg/1ml give 1ml four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 06/23/25 and an end date of 06/27/25.
-There was an entry for hydromorphone 1mg/1ml every two hours as needed with a start date of 06/23/25 and an end date of 06/27/25.
-The hydromorphone 1mg was documented as administered four times daily on 06/25/25 and 06/26/25.
-There were no documented administrations of scheduled hydromorphone 1mg on 06/23/25, 06/24/25, or 06/27/25.
-There were no documented administrations of as needed hydromorphone on the eMAR.

Observation of Resident #10's hydromorphone 1mg/1ml on hand on 07/03/25 at 10:53am revealed:
-There was 0.55mls of pink solution remaining in the bottom of a 2 oz bottle with a pharmacy label.
-The label directions were hydromorphone 1mg/1ml take one ml every six hours scheduled may take additional one ml every two hours as needed.
-The dispense date was 06/22/25 with a quantity of 50mls.

Review of Resident #10's hydromorphone paper controlled substance count sheet (CSCS) revealed:
-There were 50mls of hydromorphone 1mg/1ml documented as received on 06/22/25.
-There were entries dated 06/22/25-06/27/25.
-The first entry on the CSCS was 06/22/25 at 7:00pm.
-There were two entries for hydromorphone 1mg documented as administered on 06/23/25 at

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D 392	Continued From page 35 9:00pm and the balance declined by two from the CS count. -There were two entries for hydromorphone 1mg documented as administered on 06/23/25 at 11:00pm and the balance declined by two from the CS count. -There were two entries for hydromorphone 1mg documented as administered on 06/24/25 at 1:00am and the balance declined by two from the CS count. -There were two entries for hydromorphone 1mg documented as administered on 06/24/25 at 3:00am and the balance declined by two from the CS count. -There were two entries for hydromorphone 1mg documented as administered on 06/24/25 at 5:00am and the balance declined by two from the CS count. -There were two entries for hydromorphone 1mg documented as administered on 06/24/25 at 7:00am and the balance declined by two from the CS count. -The last entry on the CSCS was 06/27/25 1:00am with a balance of 1ml remaining. Review of Resident #10's hydromorphone electronic CSCS (eCSCS) revealed: -There were entries dated 06/25/25 at 10:29am to 06/26/25 at 8:02pm. -There was no documentation of the starting count of hydromorphone 1mg/1ml on 06/25/25 at 10:29am. -There was no documentation of the ending count of hydromorphone 1mg/1m on 06/26/25 at 8:02pm. -On 06/26/25 at 7:01am, the medication aide (MA) who documented administration in the eCSCS did not match the MA who documented administration on the paper CSCS.	D 392		

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D 392	Continued From page 36 Telephone interview with a pharmacist from the facility's backup pharmacy on 07/02/25 at 10:40am revealed: -Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility on 06/22/25 in a 2oz. bottle with a quantity of 50mls. -The pharmacist received a call from a staff at the facility on 06/24/25 requesting to refill the hydromorphone for Resident #10. -He and another pharmacist "did the math" and the original prescription should have covered a three day supply if administered as ordered including all as needed doses. -The pharmacy did not dispense the new prescription "early." Interview with a MA on 07/03/25 at 8:39am revealed: -She documented administering hydromorphone 1mg to Resident #10 on the eMAR on 06/25/25 at 8:00am, 12:00pm, 4:00pm, and at 8:00pm. -Her name was documented on Resident #10's paper CSCS entries on 06/25/25 at 9:00am, 11:00am, 1:00pm, 3:00pm, 5:00pm, and 7:00pm as having administered hydromorphone 1mg to Resident #10. -She did not remember giving Resident #10 hydromorphone 1mg on 06/25/25 at 9:00am. -She thought Resident #10's hydromorphone paper CSCS had been rewritten by someone. -The signatures documented on Resident #10's hydromorphone paper CSCS that were supposed to be hers did not look like her signature. Interview with the Facility Manager on 07/03/25 at 9:41am and 10:55am revealed: -Resident #10's hydromorphone 1mg/1ml solution was delivered to the facility in a bottle. -They used a paper CSCS for Resident #10's hydromorphone 1mg because the backup	D 392		

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pharmacy did not supply a CSCS with the hydromorphone.
-The facility's contracted pharmacy delayed entering Resident #10's hydromorphone orders into the eMAR.
-That was why there were no entries in the eMAR and eCSCS for Resident #10's hydromorphone until 06/25/25.
-Resident #10's hydromorphone should have been entered into the eCSCS.
-All MAs had the ability to enter receipt of CS into the eMAR.
-When a MA administered hydromorphone to Resident #10, the eCSCS was updated automatically with the eMAR if the orders were in the eMAR.
-The paper CSCS was required to be documented by the MA with each administration.
-All controlled substances for all residents were supposed to be counted and entered into the eMAR before transfer of keys to the oncoming shift MA.
-She was responsible for CS audits.
-She tried to audit all resident CS on the cart "every week" to obtain refills and ensure residents did not run out of their CS medications.

b. Review of Resident #10's lorazepam (used to treat anxiety) prescriptions dated 05/30/25 revealed:
-Lorazepam 0.5mg one tablet twice daily scheduled quantity 30 tablets with 0 refills.
-Lorazepam 0.5mg one tablet every four hours as needed for anxiety quantity 45 with 0 refills.

Review of Resident #10's June 2025 eMAR revealed:
-There was an entry for lorazepam 0.5mg one tablet twice daily scheduled at 8:00am and 8:00pm with a start date of 05/30/25 and

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	HAL087009	A. BUILDING: _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYSON SENIOR LIVING	314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713

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discontinue date of 06/27/25.
-There was an entry for lorazepam 0.5mg one tablet every four hours as needed with a start date of 05/31/25 and discontinue date of 06/27/25.
-The lorazepam 0.5mg one tablet twice daily was documented as administered 52 occurrences out of 52 opportunities.
-The lorazepam 0.5mg one tablet every four hours as needed was documented as administered on 4 occurrences on 06/20/25 at 11:54am, on 06/21/25 at 9:53am, on 06/21/25 at 5:54pm, and on 06/22/25 at 3:53pm.

Review of a packing slip dated 05/31/25 revealed:
-There were 45 tablets of lorazepam 0.5mg RX#1 delivered to the facility for Resident #10.
-There were 30 tablet of lorazepam 0.5mg RX#2 delivered to the facility for Resident #10.

Observation of Resident #10's lorazepam 0.5mg on hand on 07/03/25 at 10:20am revealed:
-The lorazepam 0.5mg 30 tablets RX#2 documented on the packing slip as received on 05/31/25 were not available.
-There was one bubble pack of lorazepam 0.5mg RX#1 with 34 tablets remaining.
-The label directions were lorazepam 0.5mg take one tablet every four hours as needed for anxiety with a dispense date of 05/30/25 and quantity dispensed 45 tablets.
-There was one bubble pack of lorazepam 0.5mg RX#3 with 22 tablets remaining.
-The label directions were lorazepam 0.5mg take one tablet every four hours as needed for anxiety with a dispense date of 02/01/25 and quantity dispensed 30 tablets.
-The lorazepam 0.5mg 30 tablets RX#2 documented on the packing slip as received on 05/31/25 was not .

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D 392	Continued From page 39 Review of Resident #10's lorazepam 0.5mg electronic CSCS (eCSCS) dated 05/01/25-05/31/25 revealed: -There was an entry on 05/31/25 at 2:51pm for receipt of 30 lorazepam. -The strength of the lorazepam received was not documented. -The RX# of the lorazepam prescription received into the supply was not documented. Review of Resident #10's lorazepam 0.5mg eCSCS dated 06/01/25-06/30/25 revealed: -There was an entry on 06/01/25 at 8:07am for receipt of 44 lorazepam. -The strength of the lorazepam was not documented. -The RX# of the lorazepam prescription received into the supply was not documented. Review of Resident #10's record revealed there was no paper Controlled Substance Count Sheet (CSCS) for lorazepam 0.5mg RX#2 30 tablets delivered on 05/31/25. Review of Resident #10's lorazepam 0.5mg paper Controlled Substance Count Sheet (CSCS) RX #3 revealed: -There were 30 doses of lorazepam 0.5mg documented as received on 06/04/25. -The directions on the pharmacy labeled CSCS were lorazepam 0.5mg one tablet every four hours as needed with a dispense date of 02/01/25 quantity 30. -The entries were dated 06/08/25-06/22/25. -There was an entry on 06/08/25 with no time documented and the count was increased by one instead of declined by one to total 31. -There was an entry on 06/12/25 at 3:00pm with no corresponding entry on the eMAR.	D 392		

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D 392	Continued From page 40 -There was an entry on 06/22/25 at 12:00pm with no corresponding entry on the eMAR. -There was an entry on 06/22/25 at 4:00pm with no corresponding entry on the eMAR. -There was an entry on 06/22/25 at 8:00pm balance declined by one which was a duplicate entry on the CSCS RX#1 same date and time. Review of Resident #10's lorazepam 0.5mg paper CSCS RX #1 revealed: -There were 45 doses of lorazepam 0.5mg documented as received on 05/31/25. -The directions on the pharmacy labeled CSCS were lorazepam 0.5mg one tablet every four hours as needed with a dispense date of 05/30/25 quantity 45. -The entries were dated 06/22/25-06/26/25. -There was an entry dated 06/22/25 at 8:00pm balance declined by one which was a duplicate entry on the CSCS RX#3 same date and time. -The entry documented on 06/23/25 at 8:00am was followed by two entries without a date and time with "borrowed" and a declining balance of two. -There was no documented corresponding entry on 06/23/25 on Resident #10's eMAR for documented administratin of as needed doses. -The "borrowed" entries were followed by an entry documented on 06/23/25 at 8:00pm. Interview with the Facility Manager on 07/03/25 at 2:45pm revealed: -A "borrowed" entry on the paper CSCS meant the medication aide did not have a scheduled dose and they borrowed a dose from the as needed supply of the medication. -The MAs were responsible for receiving controlled substances received from the pharmacy and entering the receipt of the supply into the eCSCS.	D 392		

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D 392	Continued From page 41 -The MAs opened the eMAR when they were ready to administer a controlled substance to a resident. -The MAs removed the controlled substance from double lock storage and scanned it into the eMAR. -The MAs prepped the controlled substance for administration and then administered it to the resident. -The MA documented the administration in the eMAR which automatically documented the administration on the eCSCS. -The MA then documented an entry on the paper CSCS including the date and time of administration, the amount administered, update the declining balance, and sign as having administered the CSCS. -All controlled substances were counted off at the end of each shift prior to exchange of keys by the MAs. -She audited controlled substances for all residents every week to make sure residents did not run out of their medications. 2. Review of Resident #4's current FL2 dated 02/18/25 revealed diagnoses included dementia, asthma and chronic obstructive pulmonary disease (COPD). Review of Resident #4's physician's order dated 03/04/25 revealed an order for morphine sulfate solution (used to treat shortness of breath), 100mg/5ml, take 0.25ml every 4 hours as needed. Review of Resident #4's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for morphine sulfate solution, 100mg/5ml, take 0.25ml every 4 hours as	D 392		

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D 392	Continued From page 42 needed. -There was no documentation the morphine sulfate was administered in May 2025. Review of Resident #4's controlled substance count sheet (CSCS) for morphine sulfate solution 100mg/5ml revealed: -Thirty doses were dispensed on 03/04/25 and delivered to the facility on 03/06/25. -There was documentation one dose of morphine was administered on 03/07/25 and 03/28/25. -There was documentation three doses of morphine were borrowed for another resident on 05/13/25, two doses were borrowed on 05/14/25 and six doses were borrowed on 05/15/25. -There was documentation two doses were deducted from the CSCS but there was no date, time, amount given or signature documented; only the declining balance was documented. -There was documentation 15 doses remained. Observation of Resident #4's medications on hand on 06/30/25 at 4:27pm revealed there were 15 doses of morphine sulfate 100mg/5ml available. Interview with a medication aide (MA) on 06/330/25 at 4:27pm revealed: -Resident #4 refused to take morphine sulfate recently. -There was another resident who was ordered the same strength and dose of morphine but it had not been delivered from the pharmacy so she borrowed it from Resident #4 on two different days. -She always documented on the CSCS when she borrowed medications. -She did not know who removed 2 doses but did not document their signature or the date, time or amount given.	D 392		

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D 392	Continued From page 43 Based on observation, interview and record review it was determined Resident #4 was not interviewable. ._____ The facility failed to maintain a readily available record that reconciled the receipt, administration, and disposition of controlled medications resulting in a missing 0.5ml dose of hydromorphone and 30 tablets of lorazepam 0.5mg delivered on 05/31/25. This was detrimental to the health, safety, and welfare of the residents and constituted a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 17, 2025.	D 392		