

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/22/2025
NAME OF PROVIDER OR SUPPLIER HOMEPLACE OF NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1309 MCCARTHY BLVD NEW BERN, NC 28562			
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 21, 2025 and July 22, 2025.	D 000			
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on the findings, the previous Type B violation was not abated. Based on interviews and record reviews, the facility failed to administer medications according to provider orders for 1 of 3 sampled residents (#1) including 3 medications used to treat high blood pressure and elevated heart rate. The findings are: Review of Resident #1's current FL2 dated 07/05/25 revealed: -Diagnoses included hypertension (high blood pressure), hyperlipidemia and osteoporosis. -There was an order for Losartan (used to treat hypertension) potassium 50mg, take 1 tablet twice daily. -There was an order for Propranolol (used to treat	D 358	Care Services Director/Designee will review the New Order Tracking form and verify medication is located on the Medication Cart daily for 4 weeks and weekly audits for the next 90 days. Director of Health and Wellness/ Designee will pull a sample of the New Order Tracking Form daily for 4 weeks and weekly for the next 90 days to verify the resident has the medication located on the medication cart and address any issues. Facility's Pharmacy conducted a Medication Cart to Resident eMAR audit for all residents in the facility to verify all medication was active and in the facility.	8/25/25 8/25/25 8/12/25	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

JHYJ11

If continuation sheet 1 of 11

Reviewed and Acknowledged

08/26/25

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D 358	Continued From page 1 hypertension and to slow the heart rate) 10mg, take one tablet at bedtime. -There was an order for Verapamil (used to treat hypertension and to slow the heart rate) 240 mg ER, take one at bedtime. Review of Resident #1's signed physicians order sheet dated 06/16/25 revealed: -There was an order for Losartan potassium 50mg, take one tablet twice a day. -There was an order for Propranolol 10mg, take one tablet at bedtime. -There was an order for Verapamil 240 mg ER, take one capsule at bedtime. Review of Resident #1's previous FL2 dated 07/08/24 revealed: -Diagnoses included essential hypertension, hyperlipidemia, and osteoporosis. -There was an order for Losartan Potassium 50mg, take one tablet twice daily. -There was an order for Propranolol 10mg. take one tablet twice daily. -There was an order for Verapamil ER 120mg, take one tablet at bedtime. Review of a signed subsequent physician's order for Resident #1 dated 07/10/24 revealed: -There was an order to discontinue Verapamil 120mg SR. 24-hour capsule at bedtime. -There was an order to start Verapamil 240 mg ER, take one capsule at bedtime. -There was an order to discontinue Propranolol 10mg, one tablet twice a day. -There was an order to start Propranolol 10mg, take one tablet every evening. Review of Resident #1's signed physicians order sheet dated 09/12/24 revealed: -There was an order for Losartan potassium	D 358	Medication Aide training to include Medication Pass, New Order Tracking Form Medication Policy and Procedures.	7/23/25	

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D 358	Continued From page 2 50mg, take one tablet twice daily every night at bedtime. -There was an order for Propranolol 10mg, take one tablet at bedtime. -There was an order for Verapamil 240 mg ER, take one capsule every night at bedtime. Review of Resident #1's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Losartan potassium 50mg, take one tablet twice a day, scheduled at 8:00am and 8:00pm. -Losartan potassium 50mg was documented as not administered on 06/11/25 at 8:00pm with the exception documented as other/see progress notes. -There was an entry for Propranolol 10mg, take one tablet at bedtime, scheduled for 8:00pm. -Propranolol 10mg was documented as not administered on 06/11/25 at 8:00pm with the exception documented as other/see progress notes. -There was an entry for Verapamil 240 mg ER, take one capsule at bedtime, scheduled for 8:00pm. -Verapamil 240 mg ER was documented as not administered on 06/11/25 at 8:00pm with the exception documented as other/see progress notes. Review of Resident #2's staff progress notes revealed: -There was an entry by the medication aide (MA) on 06/11/25 at 7:37pm, Losartan Potassium 50mg, take one tablet twice a day, "on order". -There was an entry by the MA on 06/11/25 at 7:39pm, Verapamil 240 mg ER, take one capsule at bedtime, "on order". -There was an entry by the MA on 06/11/25 at	D 358		

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D 358	Continued From page 3 7:39pm, Propranolol 10mg, take one tablet at bedtime, "on order". -There was an entry by a second MA on 06/12/25 at 3:00pm, the resident was sent out to the hospital for high blood pressure and pulse, blood pressure was documented as 165/101, and her pulse was documented as 118. Review of Resident #1's emergency department (ED) after visit summary (AVS) dated 06/12/25 revealed: -Chief complaint, the patient presents with hypertension, complains of high heart rate and high blood pressure, did not receive Verapamil dose last night per patient, blood pressure was 175/103. -History of present illness, patient reports she had been taking her blood pressure and saw it was higher than normal. -She reported she did not get her night time dose of Verapamil, propranolol and several other medications as the facility did not have the evening dose. -She denied chest pain or shortness of breath. -She endorsed a history of sinus tachycardia and was tachycardic (tachycardia is a rapid heart beat) on initial evaluation. -Her vital signs were documented as pulse 93, blood pressure 175/103. -She had asymptomatic hypertension, she was notably tachycardic, however, she reported she had a history of sinus tachycardia and reported that her tachycardia was because the facility did not have her Propranolol or Verapamil available at that time. -Her medications were reviewed at length, and she may need some adjustments to her medications and should resume her regular nighttime dose of Verapamil and Propranolol which will better control her known tachycardia.	D 358		

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D 358	Continued From page 4 -She agreed and understood that she may need some further blood pressure management over time was not an emergent process today. Review of Resident #1's primary care provider (PCP) visit notes dated 06/16/25 revealed: -The resident was seen for a follow-up visit after being transferred to the ED for tachycardia, elevated blood pressure and weakness. -She reported she had missed some doses of routine blood pressure medications. -The evening of 06/11/25 she was found to be weak and had a rapid heart of 116 and her blood pressure was 169/109 and she was transferred to the ED for evaluation and treatment. -Her ED evaluation was unremarkable for electrocardiogram, chest x-ray and labs. -After treating her blood pressure, she returned to the facility and has been stable. -She self-monitored her blood pressure, and they had been a bit higher than her usual baseline. -Her current systolic blood pressure was 150 or greater and her current diastolic blood pressure was in the 80s or higher. -She usually had systolic blood pressure in the 120s and diastolic blood pressure in the 80s or less. -Under Treatment Plan/Orders, treatment plan, ED transfer for brief tachycardia and blood pressure elevation from dosing of blood pressure medications. -She was stable with improving blood pressure back on her regimen. -The plan was to continue to monitor and continue her regular blood pressure regimen. Interview with Resident #1 during the initial tour of the facility on 07/21/25 at 9:11am revealed: -Staff administered her medications daily. -The facility had run out of some of her	D 358			

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D 358	Continued From page 5 medications sometime last month and she had to go to the hospital because her blood pressure went "sky high". Second interview with Resident #2 on 07/22/25 at 8:51am revealed: -The facility ran out of her medications when she first moved to the facility about a year ago. -She had a history of high blood pressure and sinus tachycardia. -She took medications for her blood pressure and heart rate. -She was a registered nurse for 46 years and checked her blood pressure twice a day. -Her systolic blood pressure was usually 120-130 and her diastolic blood pressure was less than 90. -The facility ran out of her evening medications on one occasion last month. -The following day, her blood pressure and heart rate were higher than normal, she could not remember exactly what the readings were, but they were very high. -She went to the ED and was there for about three hours and after testing and lab work, was told everything looked ok and was sent back to the facility. -She has been following up her PCP in the facility since the June 2025 ED visit about her blood pressure. -She was not sure why the facility ran out of her medications. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 07/22/25 at 9:06am revealed: -An order was received for Resident #1's Losartan Potassium 50mg to take twice daily on 07/10/24. - 56 tablets of Losartan Potassium 50mg, take	D 358			

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D 358	Continued From page 6 one twice a day for a 28-day supply each were dispensed for Resident #1 on 05/08/25, 06/05/25, and 07/03/25. -An order was received for Resident #1's Propranolol 10mg to take one tablet at bedtime on 07/12/24. -28 tablets of Propranolol 10mg, to take one a bedtime, for a 28-day supply each were dispensed for Resident #1 on 05/08/25, 06/05/25, and 07/03/25. -An order was received for Resident #1's Verapamil 240 mg ER, to take one a bedtime on 07/12/24. -28 capsules of Verapamil 240 mg ER, take one at bedtime, for a 28-day supply each were dispensed for Resident #1 on 05/08/25, 06/05/25 and 07/03/25. Review of a packing slip from the facility's contracted pharmacy revealed: -The packing slip was dated 06/09/25. -56 tablets of Losartan Potassium 50mg were included for Resident #1. -28 tablets of Propranolol 10mg were included for Resident #1. -28 capsules of Verapamil 240 mg ER were included for Resident #1. Interview with the Administrative Assistant (AA) on 07/22/25 at 1:30pm revealed: -Batch filled medications were received from the pharmacy on 06/09/25. -The batch fill cycle for June 2025 was started 06/12/25. -The night shift MA placed the June 2025 batch filled medications on the medication cart on the 11:00pm to 7:00am shift on 06/12/25. -Resident #1's Losartan, Propranolol and Verapamil were in the facility on 06/11/25.	D 358			

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D 358	Continued From page 7 Interview with a MA on 07/22/25 at 10:05am revealed: -The facility received batch filled medications for the residents monthly. -The MAs were responsible for ordering medication refills for the residents from the pharmacy. Second interview with a MA on 07/22/25 at 1:42pm revealed: -The MAs performed medication cart audits weekly. -Medication cart audits consisted of looking for expired or discontinued medications, making sure medications were available for the residents and making sure the medication cart was clean and organized. -There was a form the MAs completed for the medication cart audits, once the medication cart audits were completed, the medication cart audit form was given to the Administrator. -Scheduled medications for the residents were batch filled monthly from the pharmacy. -If a resident ran low on a medication before the batch fill cycle was to start, the MAs were responsible to request additional medication from the pharmacy to cover the resident until the batch fill cycle started. -The batch filled medications were delivered to the facility a few days before the new batch fill cycle started. -The new batch cycle was held in a tote until the new cycle was to start, and the new cycle medications were placed on the medication cart by the night shift MA on the day the new cycle was to start. -She was not sure why Resident #1 ran out of medications last month. Interview with the Administrative Assistant (AA)	D 358		

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D 358	Continued From page 8 on 07/22/25 at 1:48pm revealed: -The MAs were responsible for ordering medications for the residents. -Medication cart audits were performed by the MAs or the Care Services Assistant. -Medication cart audits included looking for expired or discontinued medications and making sure all medications were available for the residents. -Medications were matched to the eMAR for accuracy and make sure all medications were there. -Medications were received from the facility's pharmacy every 28 days. -There was a posted batch cycle start schedule on the back of the door in the medication room for the MAs. -On the day the new batch cycle was to start, the night shift MA compared the medications to the residents' eMAR and placed the medications on the medication cart. -If a resident ran low on a medication before the new batch cycle started, the MAs could either request additional medication from the facility's contracted pharmacy, contact the facility's back up pharmacy for additional medications or pull from the new batch cycle. -The facility's previous Health and Wellness Director (HWD) had told the MAs they were not to pull medications from the batch fill medications before the scheduled start date. -She was not sure why the previous HWD told the MAs they could not pull medications from the new batch cycle. Interview with the Administrator on 07/22/25 at 2:04pm revealed: -The MAs were responsible for ordering medications for the residents. -The MAs performed medication cart audits	D 358		

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D 358	Continued From page 9 weekly which included removing expired or discontinued medications and making sure all medications were available on the medication cart for the residents. -The residents' scheduled medications were batch-filled by the pharmacy on a 28-day cycle. -The batch filled medications were received 2 or 3 days prior to the cycle fill start date to ensure all the medications were available. -Ideally, if a resident ran short of medication before the new batch started, the MAs called the contracted pharmacy for additional doses to last until the new batch cycle started or they could contact the back-up pharmacy for additional doses, and if there was no medication available for a resident, then they should pull medications from the new batch cycle. -It had come to her attention that the facility's previous HWD had erroneously told the MAs, they were not to pull from the new batch cycle medications prior to the cycle start date, -Resident #1's Losartan, Propranolol and Verapamil were in the facility on 06/11/25 and should have been pulled from the new batch and administered to Resident #1 as ordered. Attempted telephone interview with the 3:00pm to 11:00pm MA on 07/22/25 at 1:38pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 07/22/25 at 11:55am was unsuccessful. The facility's failure to ensure medications were administered as ordered to Resident #1 who was prescribed 3 medications to treat high blood pressure and heart rate. Resident #1 missed her evening dose of all 3 medications and was sent to the ED the next day after checking her own blood pressure and finding it to be elevated. Resident	D 358			

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D 358	Continued From page 10 #1 arrived at the hospital with a pulse of 93 and blood pressure 175/103. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 07/29/25 for this violation.	D 358			