STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049030	A. BUILDING: _____ B. WING _____	R 08/27/2025

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SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from August 26, 2025 to August 27, 2025.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency; the Statement of Deficiency is prepared solely as a matter of compliance with State Law	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 sampled residents related to notifying their Primary Care Provider (PCP) about medications that could not be crushed (#2). The findings are: Review of the facility's Policy and Procedure for Crushing Medications dated 08/01/24 revealed the staff were responsible to notify the PCP who gave the order to crush a medication that the manufacturer stated should not be crushed to get an alternative medication and/or dosage form or provide documentation of why it would not adversely affect the resident. Observation of the medication pass on 08/26/25 at 8:40am revealed: -The medication aide (MA) was administering Resident #2's morning medications. -Resident #2's Anastrozole (used to treat breast cancer) 1mg every day was administered whole.	D 273	10A NCAC 13F .0902 (b) Health Care Training completed on how to review medication orders for completeness. If a resident has orders from the Provider to crush medications, the Wellness Director and/or Pearl Director is responsible for obtaining specific orders on medications that are allowed to be crushed and obtaining orders for alternative medications if necessary. The updated orders will be sent to the pharmacy and added to the eMAR system per the Provider's orders. Training was completed on 9/18/2025 by Sandra Thorson, RN with the Executive Director, Pearl Director and Medication Technicians on medication orders, administration and refusals, cart audits, and health care referral and follow-up. To ensure compliance, the Executive Director or designee will conduct weekly audits of physician orders of resident files and review results with nursing leadership until 1/9/2026. Any discrepancies will be addressed immediately.	10/9/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 09/25/2025

Faheemah Jones Reviewed and acknowledged 9/29/25

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D 273	Continued From page 1 -Resident #2's duloxetine (used to treat depression) 30mg capsule every day was administered whole. -Resident #2's omega-3 (used for heart health) 1000mg, take 3 capsules every day was administered whole. -Resident #2's medications were administered one medication at a time. -Resident #2 moved the medications around in her mouth for about 30-seconds before she could swallow the medications. -Resident #2 displayed facial grimacing while trying to swallow the medications. -After three medications were administered, Resident #2 had a slight cough. -There was an entry on the electronic Medication Administration Record (eMAR) documented as "may crush medications unless contraindicated" that displayed on the computer screen. Interview with the medication pass medication aide (MA) on 08/26/25 at 8:45am revealed: -There was no order to crush Resident #2's medications but there was an entry on the electronic Medication Administration Record (eMAR) Resident #2's medications could be crushed if she needed. -She attempted to crush Resident #2's medications on other occasions but Resident #2 would not take the medications, so she did not crush them anymore. Interview with Resident #2's family member on 08/25/25 at 8:55am revealed: -He lived in the same room with Resident #2. -He saw staff administer Resident #2's medications and they did not crush them. -Resident #2 had a hard time swallowing her medications and he thought there was an order to crush all of her medications every time.	D 273		

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D 273	Continued From page 2 Review of Resident #2's FL2 dated 03/30/25 revealed: -Diagnoses included dementia, breast cancer and hypertension. -There was an order for Anastrozole 1mg every day. -There was an order for duloxetine 30mg every day. -There was an order for omega-3 1000mg, take 3 capsules every day. Review of Resident #2's signed physician's order dated 04/15/25 revealed: -There was an order for Anastrozole 1mg every day. -There was an order for duloxetine 30mg every day. -There was an order for omega-3 1000mg, take 3 capsules every day. Review of Resident #2's signed physician's order dated 04/22/25 revealed Resident#2's medications were to be crushed. Review of Resident #2's progress note dated 04/22/25 revealed at 11:00pm a MA documented Resident #2's PCP wrote an order for speech therapy (ST) to evaluate and treat for dysphagia and to crush all medications. Review of Resident #2's ST consult note dated 04/30/25 revealed: -Resident #2 was referred to ST due to a new onset of coughing/choking during oral intake, decreased safety awareness and cognitive impairment indicating the need for ST to provide speech services. -ST recommended medications to be crushed and administered in applesauce or pudding.	D 273		

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D 273	Continued From page 3 Review of Resident #2's PCP communication sheet dated 05/12/25 revealed: -A MA requested a change to a liquid or a form of omega-3, duloxetine and docusate (a stool softner) that could be crushed. -The PCP replied on 05/13/25, with an order to "change medications that were available to change formulation". Review of Resident #2's June 2025 eMAR revealed: -There was an entry documented as "may crush medications unless contraindicated". -There was an entry for Anastrozole 1mg every day and there were instructions to "do not crush" documented as administered 06/01/25 to 06/06/25, and 06/11/25 to 06/30/25 at 8:30am. -There was an entry for duloxetine 30mg capsules every day and there were instructions to "do not crush" documented as administered 06/01/25 to 06/06/25, and 06/11/25 to 06/30/25 at 8:30am. -There was an entry for omega-3 300mg capsules, take 3 capsules every day and there were instructions to "do not crush" documented as administered 06/01/25 to 06/06/25, and 06/11/25 to 06/30/25 at 8:30am. Review of Resident #2's July 2025 eMAR revealed: -There was an entry documented as "may crush medications unless contraindicated". -An entry for Anastrozole 1mg every day and there were instructions to "do not crush" documented as administered 07/01/25 to 07/31/25 at 8:30am. -There was an entry for duloxetine 30mg capsules every day and there were instructions to "do not crush" documented as administered	D 273		

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07/01/25 to 07/31/25 at 8:30am.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day and there were instructions to "do not crush" documented as administered 07/01/25 to 07/05/25 and 07/07/25 to 07/31/25 at 8:30am.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry documented as "may crush medications unless contraindicated".
-An entry for Anastrozole 1mg every day and there were instructions to "do not crush" documented as administered 08/01/25 to 08/26/25 at 8:30am.
-There was an entry for duloxetine 30mg capsules every day and there were instructions to "do not crush" documented as administered 08/01/25 to 08/26/25 at 8:30am.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day and there were instructions to "do not crush" documented as administered 08/01/25 to 08/26/25 at 8:30am.

Interview with Resident #2's family member on 08/26/25 at 11:01am revealed:
-Resident #2 had issues with choking on medications and food in April 2025.
-It was his understanding that Resident #2's PCP wrote an order to crush all the medications and for Resident #2 to see a ST.
-It took at least 30 minutes for Resident #2 to take her 8:30am medications every morning because they were administered whole.
-The omega-3, was the hardest because they were very large gel-filled capsules and she had to take three.
-Resident #3's medications were not crushed 90% of the time.

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D 273	Continued From page 5 Interview with Resident #2's ST on 08/26/25 at 11:31am revealed on 04/30/25, Resident #2 was evaluated by ST and recommended to crush all medication and administer with applesauce or pudding to help prevent choking. Telephone interview with Resident #2's previous PCP on 08/26/25 at 1:41pm revealed: -In April, Resident #2 was having issues with swallowing and choking on her medications. -On 04/22/25, she wrote an order for a ST evaluation and treatment for dysphagia and to crush all of Resident #2's medications. -On 04/30/25, the ST recommended Resident #2's medications to be crushed and administered with applesauce or pudding. -She saw Resident #2 on 04/29/25 and 05/06/25 and there was no mention about Resident #2 having any difficulty taking her crushed medications. -On 05/12/25, she received a physician communication from the facility asking for omega-3 and duloxetine to be changed to a liquid or a different medication that could be crushed. -On 05/13/25, she replied to that communication with an order to change those medications to a form that could be crushed and did not hear anything more about the medications. -She was not notified that the omega-3, duloxetine and Anastrozole were still on the eMAR as "do not crush". -If she been notified, she could have written a order to crush the Anastrozole while wearing gloves because of the cytotoxic (something that was toxic to cells) agents, sprinkle the contents of the duloxetine contents and order a gummy for the omega-3. -Resident #2's dementia had worsened and along with Resident #2's weakness due to increased hospitalizations for other medical issues resulted	D 273		

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in Resident #2's swallowing issues becoming worse.
-Resident #2 taking her medications whole instead of crushing them put Resident #2 at a increased risk for a choking episode that could lead to aspiration pneumonia and medication non-compliance.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/25 at 8:57am revealed:
-On 05/13/25, the facility faxed a physician communication sheet signed by Resident #2's PCP with an order to change omega-3 1000mg capsules, duloxetine 30mg capsules and docusate sodium 100mg capsules to a crushed or a liquid version.
-The docusate sodium capsules were changed to tablets.
-Because of the manufacture's recommendations, the duloxetine and Anastrozole had to be listed on the eMAR as "do not crush".
-The omega-3 was provided by Resident #2's family and was in their records as profile only.
-It was the facility's responsibility to notify Resident #2's PCP for an order to "sprinkle" the duloxetine 30mg capsules, "crush" the Anastrozole and order a "gummy" for the omega-3 and let Resident #2's family know.
-According to their records, the entry for "may crush medications unless contraindicated" was entered by the facility's previous Health and Wellness Director (HWD) on 05/12/25 at 10:22am.

Interview with the current HWD on 08/26/25 at 4:30pm revealed:
-She began working at the facility a week ago.
-The MAs were responsible for completing weekly

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medication cart audits on all residents where the MA would compare the medications on hand with the eMAR and physician's orders.
-She and the Administrator were responsible for monthly medication cart audits.
-The medication cart audits did not cover the orders for crushing medications so the order to crush Resident #2's medications was not realized.
-She did not know there was an order to crush Resident #2's medications just an order to crush if needed.
-The previous HWD was responsible to fax the signed physician's order dated 04/22/25 to crush Resident #2's medications and place the order on Resident #2's eMAR.
-It was the previous HWD's responsibility to follow-up with the Resident #2's PCP after 05/13/25, because the pharmacy still listed "do not crush" for the Anastrozole and duloxetine and get a new order.
-It was the previous HWD's responsibility to notify Resident #2's PCP to get an order for omega-3 gummies.

Interview with the Administrator on 08/26/25 at 4:37pm revealed:
-The MAs were responsible to complete weekly medication cart audits on all residents where the MA would compare the medications on hand with the eMAR and physician's orders but it would not have alerted them about the medications that still needed to be crushed.
-The previous HWD was responsible to review the eMAR at the end of the month to verify all of the medications listed matched the orders.
-The previous HWD was responsible to follow-up with Resident #2's PCP when the pharmacy still had the Anastrozole, duloxetine and the omega-3 listed on the eMAR as "do not crush" after the

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D 273	Continued From page 8 05/13/25 order was faxed to the pharmacy. _____ The facility failed to ensure referral and follow up with a physician when an order was not obtained from Resident #2's PCP to crush Anastrozole and sprinkle the duloxetine after the pharmacy continued to list the two medications on the eMAR as "do not crush" medications. Also, the facility failed to notify Resident #2's PCP when the omega-3 needed a new order for gummies because the pharmacy did not supply the omega-3. This failure resulted in Resident #2's increased risk of a choking episode that could lead to aspiration pneumonia and medication non-compliance. This failure was detrimental to the health, safety and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on August 27, 2025 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 11, 2025.	D 273		
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	D 358		

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D 358	Continued From page 9 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to administer medications as ordered during the medication pass for 1 of 5 sampled residents (#2). The findings are: Observation of the medication pass on 08/26/25 at 8:40am revealed: -The medication aide (MA) was administering Resident #2's morning medications. -Resident #2's Anastrozole (used to treat breast cancer) 1mg every day was administered whole. -Resident #2's duloxetine (used for depression) 30mg capsule every day was administered whole. -Resident #2's omega-3 (used for cardiac health) 1000mg, take 3 capsules every day was administered whole. -Resident #2's Nutrilite joint health take 2 tablets every day was administered whole. -Resident #2's Nutrilite fruit and veggies take 2 tablets every was administered whole. -Resident #2's calcium/magnesium/zinc (essential minerals for bones and immunity) three times a day was administered whole. -Resident #2's Vitamin D3 (used for bone health) 2000 units every morning was administered whole. -Resident #2's metformin (used to treat diabetes) 1000mg two times a day was administered whole. -Resident #2's spironolactone (used to treat excess fluid in the body) 50mg every day was administered whole. -Resident #2's memantine (used to treat dementia) 10mg two times a day was	D 358	10A NCAC 13F .1004 (a) Medication Administration All residents with orders to crush medications were reviewed by the Wellness Director for accuracy. Clarification was obtained from the Provider, and orders were revised from "May crush medications unless otherwise contraindicated" to specific instructions such as "Crush medications, place in applesauce, pudding, or ice cream unless otherwise contraindicated." Each individual medication was reviewed, and explicit provider orders regarding administration were entered into the eMAR. Training was completed on 9/18/2025 by Sandra Thorson, RN with the Executive Director, Pearl Director and Medication Technicians on medication orders, proper administration and refusals, cart audit procedures, and health care referral and follow-up. To ensure ongoing compliance, the Executive Director or designee will conduct weekly audits of physician orders in resident files and review findings with the nursing leadership team. Any variances will be addressed immediately with corrective action. This process will remain in effect until at least January 9, 2026 to ensure ongoing compliance.	10/9/2025

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administered whole.
-Resident #2's Nutrilite double X multivitamin two times a day was administered whole.
-Resident #2's acetaminophen (used to treat pain) 325mg, take 2 tablets every day was administered whole.
-Resident #2's docusate sodium (a stool softener) 125mg, take 2 tablets every day was administered whole.
-Resident #2's medications were administered one medication at a time.
-Resident #2 moved the medications around in her mouth for about 30-seconds before she could swallow the medications.
-Resident #2 displayed facial grimacing while trying to swallow the medications.
-After three medications were administered, Resident #2 had a slight cough.
-There was an entry on the electronic Medication Administration Record (eMAR) documented as "may crush medications unless contraindicated" on the computer screen.

Interview with the medication aide (MA) on 08/26/25 at 8:45am revealed:
-There was no order to crush Resident #2's medications but there was an entry on the electronic Medication Administration Record (eMAR) that she could crush Resident #2's medications if she needed.
-She attempted to crush Resident #2's medications before but then Resident #2 would not take the medications, so she did not crush them anymore.

Interview with Resident #2's family member on 08/25/25 at 8:55am revealed:
-He lived in the same room with Resident #2.
-He saw staff administer Resident #1's medications and they did not crush them.

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D 358	Continued From page 11 -Resident #2 had a hard time swallowing her medications and he thought there was an order to crush all of her medications every time. Review of Resident #2's FL2 dated 03/30/25 revealed diagnoses included dementia, invasive ductal carcinoma of the left breast and hypertension. Review of Resident #2's signed physician's order dated 04/15/25 revealed: -There was an order for Anastrozole 1mg every day. -There was an order for duloxetine 30mg every day. -There was an order for omega-3 1000mg, take 3 capsules every day. -There was an order for Nutrilite joint health take 2 tablets every day. -There was an order for Nutrilite fruit and veggies take 2 tablets every. -There was an order for calcium/magnesium/zinc three times a day. -There was an order for Vitamin D3 2000 units every morning. -There was an order for metformin 1000mg two times a day. -There was an order for spironolactone 50mg every day. -There was an order for memantine 10mg two times a day. -There was an order for Nutrilite double X multivitamin two times a day. -There was an order for acetaminophen 325mg, take 2 tablets every day. -There was an order for docusate sodium 125mg, take 2 tablets every day. Review of Resident #2's signed physician's order dated 06/11/25 revealed an order for a	D 358		

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multivitamin every day.

Review of Resident #2's signed physician's order dated 04/22/25 revealed Resident #2's medications were to be crushed.

Review of Resident #2 ST consult note dated 04/30/25 revealed:
-Resident #2 was referred to ST due to a new onset of coughing/choking during oral intake, decreased safety awareness and cognitive impairment indicating the need for ST to provide speech services.
-ST recommended medications to be crushed and administered in applesauce or pudding.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry documented as "may crush medications unless contraindicated".
-There was an entry for Anastrozole 1mg every day documented as administered for 26 out of 30 opportunities.
-There was an entry for duloxetine 30mg capsules every day documented as administered for 26 out of 30 opportunities.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 26 out of 30 opportunities.
-There was an entry for Nutrilite joint health take 2 tablets two time a day documented as administered for 50 out of 60 opportunities.
-There was an entry for Nutrilite fruit and veggies take 2 tablets every day documented as administered for 26 out of 30 opportunities.
-There was an entry for calcium/magnesium/zinc three times a day documented as administered for 73 out of 90 opportunities.
-There was an entry for Vitamin D3 2000 units every morning documented as administered for

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D 358	Continued From page 13 26 out of 30 opportunities. -There was an entry for metformin 1000mg two times a day documented as administered for 51 out of 60 opportunities. -There was an entry for spironolactone 50mg every day documented as administered for 26 out of 30 opportunities. -There was an entry for memantine 10mg two times a day documented as administered for 26 out of 30 opportunities. -There was an entry for a multivitamin every day documented as administered for 11 out of 19 opportunities. -There was an entry for Nutrilite double X multivitamin (take 1 tablet from each of the three foil packs) two times a day documented as administered for 50 of 60 opportunities. -There was an entry for acetaminophen 325mg, take 2 tablets every day documented as administered for 26 out of 30 opportunities. -There was an order for docusate sodium 125mg, take 2 tablets every day documented as administered for 26 out of 30 opportunities. Review of Resident #2's July 2025 eMAR revealed: -There was an entry documented as "may crush medications unless contraindicated". -There was an entry for Anastrozole 1mg every day documented as administered for 31 out of 31 opportunities. -There was an entry for duloxetine 30mg capsules every day documented as administered for 31 out of 31 opportunities. -There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 30 out of 31 opportunities. -There was an entry for Nutrilite joint health take 2 tablets two times a day documented as	D 358		

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administered for 62 out of 62 opportunities.
-There was an entry for Nutrilite fruit and veggies take 2 tablets every day documented as administered for 31 out of 31 opportunities.
-There was an entry for calcium/magnesium/zinc three times a day documented as administered for 93 out of 93 opportunities.
-There was an entry for Vitamin D3 2000 units every morning documented as administered for 31 out of 31 opportunities.
-There was an entry for metformin 1000mg two times a day documented as administered for 62 out of 62 opportunities.
-There was an entry for spironolactone 50mg every day documented as administered for 31 out of 31 opportunities.
-There was an entry for memantine 10mg two times a day documented as administered for 31 out of 31 opportunities.
-There was an entry for a multivitamin every day documented as administered for 31 out of 31 opportunities.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry documented as "may crush medications unless contraindicated".
-There was an entry for Anastrozole 1mg every day documented as administered for 26 out of 26 opportunities.
-There was an entry for duloxetine 30mg capsules every day documented as administered for 26 out of 26 opportunities.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 26 out of 26 opportunities.
-There was an entry for Nutrilite joint health take 2 tablets two times a day documented as administered for 50 out of 51 opportunities.
-There was an entry for Nutrilite fruit and veggies

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take 2 tablets every day documented as administered for 26 out of 26 opportunities.
-There was an entry for calcium/magnesium/zinc three times a day documented as administered for 76 out of 77 opportunities.
-There was an entry for Vitamin D3 2000 units every morning documented as administered for 26 out of 26 opportunities.
-There was an entry for metformin 1000mg two times a day documented as administered for 50 out of 51 opportunities.
-There was an entry for spironolactone 50mg every day documented as administered for 26 out of 26 opportunities.
-There was an entry for memantine 10mg two times a day documented as administered for 26 out of 26 opportunities.
-There was an entry for a multivitamin every day documented as administered for 26 out of 26 opportunities.

Interview with Resident #2's family member on 08/26/25 at 11:01am revealed:
-Resident #2 had issues with choking on medications and food in April 2025.
-It was his understanding that Resident #2's PCP wrote an order to crush all the medications and for Resident #2 to see a speech therapist (ST).
-It took at least 30 minutes for Resident #2 to take her 8:30am medications every morning because they were administered whole.
-The omega-3 was the hardest because they were very large gel-filled capsules and she had to take three of those.
-Resident #3's medications were not crushed 90% of the time.

Telephone interview with Resident #2's previous PCP on 08/26/25 at 1:41pm revealed:
-In April, Resident #2 was having issues with

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swallowing and choking on her medications.
-On 04/22/25, she wrote an order to crush all of Resident #2's medications.
-Resident #2's dementia had worsened and along with Resident #2 already weak due to increased hospitalizations for other medical issues resulted in Resident #2's swallowing issues becoming worse.
-Resident #2 taking her medications whole instead of crushing them put Resident #2 at an increased risk for a choking episode that could lead to aspiration pneumonia and medication non-compliance.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/25 at 8:57am revealed:
-On 04/22/25, the facility faxed a signed physician's order to crush all medications.
-The facility was responsible for adding the order to the eMAR to crush all medications.
-According to their eMAR records, on 04/22/25, the previous HWD added the entry "may crush medications unless contraindicated".

Interview with the current HWD on 08/26/25 at 4:30pm revealed:
-She began working at the facility a week ago.
-The MAs were responsible for completing weekly medication cart audits on all residents where the MA would compare the medications on hand with the eMAR and physician's orders.
-She and the Administrator were responsible for monthly medication cart audits.
-The medication cart audits did not cover the orders for crushing medications so the order to crush Resident #2's medications was not realized.
-The previous HWD added the entry "may crush medications unless contraindicated" instead of

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D 358	Continued From page 17 the order to crush Resident #2's medications. Interview with the Administrator on 08/26/25 at 4:37pm revealed: -The previous HWD was responsible for reviewing the eMAR at the end of the month to verify all of the medications listed matched the orders. -She did not know the HWD entered added the entry "may crush medications unless contraindicated" instead of the order to crush Resident #2's medications. _____ The facility failed to ensure medications were administered as ordered during the medication pass resulting in Resident #2 taking her medications whole instead of crushing them putting Resident #2 at an increased risk for a choking episode that could lead to aspiration pneumonia and medication non-compliance. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on August 29, 2025 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 11, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 18 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#2) related to medications administered during the medication pass. The findings are: Review of Resident #2's current FL2 dated 03/30/25 revealed diagnoses included dementia, breast cancer and hypertension. Review of Resident #2's signed physician's order dated 04/15/25 revealed: -There was an order for Anastrozole 1mg every	D 367	10 NCAC 13F .1004 (j) Medication Administration If a resident refuses to take a prescribed medication the Med Tech will notify the Wellness Director or Pearl Director on each occasion and document the medication refusal on the MAR. The Wellness Director or designee will then notify the prescribing physician and family member or responsible party of the refusal and document the notification in the resident's progress notes. Training was completed on 9/18/2025 by Sandra Thorson, RN with the Executive Director, Pearl Director and Medication Technicians on medication orders, administration and refusals, cart audits, and health care referral and follow-up. To ensure ongoing compliance the Wellness Director and/or Pearl Director will review the Medication Exception Report daily to ensure that refusals and follow-up actions are documented accurately and promptly. The Executive Director will review the Medication Exceptions report weekly to ensure compliance and accountability. This process will remain in effect and be maintained until at least January 9, 2026.	10/9/2025

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day.
-There was an order for duloxetine 30mg every day.
-There was an order for omega-3 1000mg, take 3 capsules every day.
-There was an order for Nutrilite joint health take 2 tablets every day.
-There was an order for Nutrilite fruit and veggies take 2 tablets every.
-There was an order for calcium/magnesium/zinc three times a day.
-There was an order for Vitamin D3 2000 units every morning.
-There was an order for metformin 1000mg two times a day.
-There was an order for spironolactone 50mg every day.
-There was an order for memantine 10mg two times a day.
-There was an order for Nutrilite double X multivitamin two times a day.
-There was an order for acetaminophen 325mg, take 2 tablets every day.
-There was an order for docusate sodium 125mg, take 2 tablets every day.

Review of Resident #2's signed physician's order dated 06/11/25 revealed an order for a multivitamin every day.

Review of Resident #2's signed physician's order dated 04/22/25 revealed Resident #2's medications were to be crushed.

Review of Resident #2 ST consult note dated 04/30/25 revealed:
-Resident #2 was referred to ST due to a new onset of coughing/choking during oral intake, decreased safety awareness and cognitive impairment indicating the need for ST to provide

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speech services.
-ST recommended medications to be crushed and administered in applesauce or pudding.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry documented as "may crush medications unless contraindicated".
-There was an entry for Anastrozole 1mg every day documented as administered for 26 out of 30 opportunities.
-There was an entry for duloxetine 30mg capsules every day documented as administered for 26 out of 30 opportunities.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 26 out of 30 opportunities.
-There was an entry for Nutrilite joint health take 2 tablets two time a day documented as administered for 50 out of 60 opportunities.
-There was an entry for Nutrilite fruit and veggies take 2 tablets every day documented as administered for 26 out of 30 opportunities.
-There was an entry for calcium/magnesium/zinc three times a day documented as administered for 73 out of 90 opportunities.
-There was an entry for Vitamin D3 2000 units every morning documented as administered for 26 out of 30 opportunities.
-There was an entry for metformin 1000mg two times a day documented as administered for 51 out of 60 opportunities.
-There was an entry for spironolactone 50mg every day documented as administered for 26 out of 30 opportunities.
-There was an entry for memantine 10mg two times a day documented as administered for 26 out of 30 opportunities.
-There was an entry for a multivitamin every day documented as administered for 11 out of 19

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D 367	Continued From page 21 opportunities. -There was an entry for Nutrilite double X multivitamin (take 1 tablet from each of the three foil packs) two times a day documented as administered for 50 of 60 opportunities. -There was an entry for acetaminophen 325mg, take 2 tablets every day documented as administered for 26 out of 30 opportunities. -There was an entry for docusate sodium 125mg, take 2 tablets every day documented as administered for 26 out of 30 opportunities. Review of Resident #2's July 2025 eMAR revealed: -There was an entry documented as "may crush medications unless contraindicated". -There was an entry for Anastrozole 1mg every day documented as administered for 31 out of 31 opportunities. -There was an entry for duloxetine 30mg capsules every day documented as administered for 31 out of 31 opportunities. -There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 30 out of 31 opportunities. -There was an entry for Nutrilite joint health take 2 tablets two times a day documented as administered for 62 out of 62 opportunities. -There was an entry for Nutrilite fruit and veggies take 2 tablets every day documented as administered for 31 out of 31 opportunities. -There was an entry for calcium/magnesium/zinc three times a day documented as administered for 93 out of 93 opportunities. -There was an entry for Vitamin D3 2000 units every morning documented as administered for 31 out of 31 opportunities. -There was an entry for metformin 1000mg two times a day documented as administered for 62	D 367		

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out of 62 opportunities.
-There was an entry for spironolactone 50mg every day documented as administered for 31 out of 31 opportunities.
-There was an entry for memantine 10mg two times a day documented as administered for 31 out of 31 opportunities.
-There was an entry for a multivitamin every day documented as administered for 31 out of 31 opportunities.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry documented as "may crush medications unless contraindicated".
-There was an entry for Anastrozole 1mg every day documented as administered for 26 out of 26 opportunities.
-There was an entry for duloxetine 30mg capsules every day documented as administered for 26 out of 26 opportunities.
-There was an entry for omega-3 300mg capsules, take 3 capsules every day documented as administered for 26 out of 26 opportunities.
-There was an entry for Nutrilite joint health take 2 tablets two times a day documented as administered for 50 out of 51 opportunities.
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-There was an entry for calcium/magnesium/zinc three times a day documented as administered for 76 out of 77 opportunities.
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-There was an entry for metformin 1000mg two times a day documented as administered for 50 out of 51 opportunities.
-There was an entry for spironolactone 50mg

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D 367	Continued From page 23 every day documented as administered for 26 out of 26 opportunities. -There was an entry for memantine 10mg two times a day documented as administered for 26 out of 26 opportunities. -There was an entry for a multivitamin every day documented as administered for 26 out of 26 opportunities. Interview with the current HWD on 08/26/25 at 4:30pm revealed: -She began working at the facility a week ago. -The previous HWD added the entry "may crush medications unless contraindicated" instead of the order to crush Resident #2's medications. Interview with the Administrator on 08/26/25 at 4:37pm revealed: -The previous HWD was responsible for reviewing the eMAR at the end of the month to verify all of the medications listed matched the orders. -She did not know the HWD entered added the entry "may crush medications unless contraindicated" instead of the order to crush Resident #2's medications.	D 367		