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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 on 10/01/25 through 10/03/25.	D 000		
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 observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#2, #5) including failing to immediately notify the primary care provider (PCP) when a resident was found to have an injury of unknown origin (#2) and failing to notify the PCP of blood sugar readings greater than 400 as ordered (#5). The findings are: 1. Review of Resident #5's current FL2 dated 06/02/25 revealed: -Diagnoses included type 2 diabetes, hypertension, generalized anxiety, irritable bowel syndrome, pancreatitis, and gastroesophageal reflux disease. -There was an order for insulin lispro (lispro is a rapid acting insulin used to treat elevated blood glucose levels), check fingerstick blood sugars before meals and at bedtime, and inject per sliding scale insulin (SSI), for FSBS of 150-199= 2 units, 200-249= 4 units, 250-299=6 units, 300-349= 8 units, 350-399=10units, if greater	D 273		

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than 400=12 units and notify primary care provider (PCP).

Review of Resident #5's signed physicians order sheet dated 07/14/25 revealed an order for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm.
-Resident #5's FSBS was documented as 413 at 4:00pm on 08/09/25 and 12 units of insulin lispro documented as administered with no documentation the PCP was notified.
-Resident #5's FSBS was documented as 476 at 7:00am on 08/28/25 and 12 units of insulin lispro documented as administered with no documentation the PCP was notified.

Review of Resident #5's progress notes revealed there was no documentation of primary care provider (PCP) notification of FSBSs greater than 400 on 08/09/25 and 08/28/25.

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units,

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D 273	Continued From page 2 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm. -Insulin lispro was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep" and there was no documentation of a FSBS. -Resident #5's FSBS was documented as 405 at 11:00am on 09/02/25 and 12 units of insulin lispro was documented as administered with no documentation the PCP was notified. -Resident #5's FSBS was documented as 425 at 4:00pm on 09/02/25 and 12 units of insulin lispro was documented as administered with no documentation the PCP was notified. -Resident #5's FSBS was documented as 533 at 4:00pm on 09/04/25 and 12 units of insulin lispro was documented as administered with no documentation the PCP was notified. -Resident #5's FSBS was documented as 421 at 4:00pm on 09/06/25 and 12 units of insulin lispro was documented as administered with no documentation the PCP was notified. -Resident #5's FSBS was documented as 447 at 7:00pm on 09/21/25 and 12 units of insulin lispro was documented as administered with no documentation the PCP was notified. Review of Resident #5's progress notes revealed there was no documentation of PCP notification of FSBSs greater than 400 on 09/02/25, 09/04/25, 09/06/25, and 09/21/25. Documentation of PCP notification of FSBSs greater than 400 for Resident #5 on 08/09/25, 08/28/25, 09/02/25, 09/04/25, 09/06/25, and 09/21/25 were requested on 10/02/25 at 3:53pm and was not provided prior to survey exit.	D 273		

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Interview with a medication aide (MA) on 10/03/25 at 4:20pm revealed:
-The MAs notified the facility's contracted PCP of FSBSs outside of parameters using telemedicine.
-The MAs should always contact the residents' PCP if FSBS were greater than 400 unless there were other parameters ordered.
-Telemedicine was like texting.
-Telemedicine notes could be printed and provided documentation of PCP notification of FSBSs outside of parameters.

Interview with a second MA on 10/03/25 at 4:20pm revealed:
-The MAs used telemedicine to communicate with the facility's contracted provider.
-She always reported Resident #5's FSBSs outside of parameters.
-She did not always use telemedicine because it was easier to call the facility's contracted PCP because she did not always have time to log on to the computer and use the telemedicine system.
-She did not document her phone calls to the facility's PCP because she was very busy but she was certain she notified the PCP of Resident #5's elevated FSBSs above 400 on 09/02/25, 09/04/25, 09/06/25, and 09/21/25.

Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm revealed:
-The MAs notified the facility's contracted PCP of elevated FSBSs via telemedicine.
-If the MA did not utilize telemedicine and called instead, they were to complete an Incident/Accident report for the phone call.
-The facility's contracted PCP should have been notified each time Resident #5's FSBS was greater than 400 as ordered.

Interview with the Administrator on 10/03/25 at

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D 273	Continued From page 4 7:40pm revealed: -The MAs were to review all orders for the residents three times and compare to the resident's eMAR, this included parameters for notifying the facility's contracted PCP. -The MAs were to always use telemedicine to contact the facility's contracted PCP or the on-call PCP of FSBSs outside of parameters. -If the MA was unable to utilize telemedicine and called the PCP or notified her verbally while in the facility, they were to document the conversation in the progress notes. -Any contact with the PCP was to be documented either via telemedicine or documenting on a charting note. -The facility's contracted PCP should have been notified of Resident #5's FSBSs greater than 400 in August 2025 and September 2025. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am revealed: -She was not notified of Resident #5's FSBSs above 400 in August and September at the time they occurred. -She was notified later usually when she was at the facility to see Resident #5 or by reviewing his FSBSs on the eMAR. -She expected to be notified at the time the elevated FSBS occurred so she could give orders to cover the elevated FSBSs. -It was frustrating to her that staff did not notify her immediately of Resident #5's elevated FSBSs. -The telemedicine system was a very easy and convenient communication system for staff to use to report FSBSs outside of parameters for Resident #5 immediately. -She could not order additional insulin units for Resident #5 when his FSBSs were above 400 if	D 273		

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she was not notified at the time it occurred.
-Short term effects of hyperglycemia or elevated blood sugar included sweating, lethargy, drooling, frequent urination, excessive thirst, and blurred vision.
-Long term effects of elevated blood sugars put Resident #5 at risk for damage to his organs such as the kidneys, heart, and eyes and neuropathy.

2. Review of Resident #2's current FL-2 dated 03/26/25 revealed:
-Diagnoses included vascular dementia, generalized anxiety and insomnia.
-She was constantly disoriented.
-She was semi-ambulatory with the use of a wheelchair.

Observation of Resident #2 on 10/02/25 at 8:07am revealed:
-She was sitting in the TV room in her wheelchair.
-She was constantly reaching out to a resident that was seated beside her wheelchair.
-She was scooting her wheelchair by using her feet.
-Her right foot/ankle was in a brace secured by gauze padding and wrap.

Review of a communication thread between the facility and Resident #2's primary care provider (PCP) dated 08/20/25 revealed:
-There was a picture sent from the facility with a complaint stating Resident #2's foot was swollen and warm to the touch at 2:01pm.
-The response from the PCP at 5:28pm stated she was calling the facility.

Review of Resident #2's nursing notes revealed:
-On 08/21/25 at 8:48am, staff discovered Resident #2 had swelling and discoloration of her

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right lower leg, the primary care provider (PCP) was notified and an x-ray was ordered.
-On 08/21/25 at 11:51am, the order for x-ray was sent to the mobile x-ray company.
-On 08/21/25 at 11:54pm, Resident #2 was sent to the local hospital emergency department (ED) for right foot swelling, pain and discoloration.

Review of Resident #2's accident and incident report dated 08/21/25 revealed:
-Resident #2 was found in the dayroom with swelling and discoloration to her right lower leg at 11:30am.
-The provider was notified and x-ray of the right tibia and fibula were ordered.

Review of Resident #2's second accident and incident report dated 08/21/25 revealed:
-Resident #2 was found in her bedroom at 8:00pm with her right foot swollen and discolored.
-Resident #2 cried when her right foot was touched.
-She was sent to the local hospital ED via ambulance.

Review of a second communication thread between the facility and Resident #2's PCP dated 08/21/25 revealed:
-The facility notified the PCP that Resident #2 was being sent out to the local hospital ED for evaluation of the right foot swelling and redness at approximately 9:16pm.
-The response from the PCP at 09:17pm stated she was aware and requested that she be alerted when Resident #2 returned to the facility.

Review of Resident #2's x-ray report dated 08/21/25 revealed:
-There was a mildly displaced fracture involving the right tibia and fibula noted with overlying mild

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soft tissue swelling.
-The final report for the x-ray was dictated at 10:05pm.

Review of Resident #2's after visit summary from the local hospital emergency department (ED) dated 08/21/25 revealed:
-She was seen for leg swelling.
-She was diagnosed with a closed fracture of the shaft of the right tibia and torus fracture of the right fibula. (Torus fractures are a type of incomplete bone fracture that usually result from falls onto outstretched limb.)

Review of Resident #2's orthopedic provider visit note dated 08/28/25 revealed:
-The orthopedic doctor reviewed the x-ray from the ED visit on 08/21/25.
-There was a mildly displaced spiral type fracture through he mid to distal tibia shaft. (A spiral fracture occurs when a twisting force is applied to the bone causing a corkscrew type fracture and are most common in long bones such as the tibia and fibula.)
-There was a mildly displaced and minimally angulated oblique type fracture there the distal fibular shaft. (Oblique fractures typically occur due to direct impact or shearing force.)

Telephone interview with Resident #2's family member on 10/03/25 at 8:51am revealed:
-Resident #2 had always been very active and scoots her wheelchair around.
-The facility contacted her regarding the injury to Resident #2's leg but she did not remember what day or time she was contacted.
-The facility called her quickly for any concerns.

Interview with a personal care aide (PCA) on 10/03/25 at 9:26am revealed:

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-She worked the 7:00am-3:00pm shift on 08/21/25.
-She saw Resident #2 that morning in the TV room sitting in her wheelchair at approximately 9:00am.
-Resident #2's pants leg was pulled up and she noticed Resident #2's right leg was red and swollen so she reported it to the Resident Care Coordinator (RCC).
-There had been no report of injury by the prior shift during morning hand-off.
-Resident #2 was known to scoot her wheelchair using her feet; sometimes getting the right side unlocked and scooting around in a circle to the left.
-She never saw anyone be aggressive with Resident #2 but would have reported it immediately if she had.

Telephone interview with a medication aide (MA) on 10/03/25 at 10:26am and 10:52am revealed:
-She was a medication aide (MA) but was working on the floor as an personal care aide on the 11:00pm-7:00am shift on 08/21/25.
-There were no concerns to Resident #2's leg reported to her by the previous shift.
-She and another MA were in Resident #2's bedroom together and were getting the residents out of bed for the day.
-She was assisting Resident #2's roommate when she noticed the other MA had put Resident #2's bedroom shoes on the wrong feet.
-She then noticed "red spots" on Resident #2's right leg.
-She described the red spots as "splotchy" and "red sparkle".
-She did not notice any swelling to Resident #2's but she did not go over to inspect.
-The red spots were not reported to the MA in-charge during her shift because she did not

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think there was anything wrong with Resident #2's leg since Resident #2 was acting normal.
-She should have reported to findings to the MA in-charge that night.
-She thought the other MA reported the redness on Resident #2's leg to the on-coming personal care aide (PCA) and MA but she did not.

Interview with a second MA on 10/02/25 at 3:32pm revealed:
-Resident #2 was able to scoot her wheelchair around with her feet and continued to do so despite the fracture.
-Resident #2 was always reaching out to grab people.
-Resident #2 would grab hold of staff and not let go when staff were completing personal care.
-Resident #2 never tried to hurt or kick at staff.
-She thought the redness and swelling in Resident #2's leg was discovered on first shift (7:00am-3:00pm) on 08/21/25.
-She remembered letting the mobile x-ray company in the facility but did not recall what day or time; She thought it was possibly around 3:30pm.

Interview with Resident #2's primary care provider (PCP) on 10/03/25 at 12:47pm and 3:05pm revealed:
-She received notification on 08/20/25 from the facility informing her that Resident #2's leg was red and swollen.
-She thought Resident #2 may have had a deep vein thrombosis (a blood clot in a deep vein) due to Resident #2's history.
-She considered ordering a doppler study but decided to order an xray.
-Resident #2's leg continued to get worse over the next couple of days and she was sent out to the local hospital ED for evaluation.

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D 273	Continued From page 10 -X-ray results showed a fracture at the local hospital ED and the facility received the same results from the mobile x-ray later the same day (08/21/25). -Resident #2 was unable to walk or stand and used a wheelchair for mobility. -Immediate reporting of injuries was important to ensure a quick response from the provider. -A delay in reporting put Resident #2 at risk for a blood clot dislodging and causing a pulmonary embolus or a stroke and continued pain and to ensure x-rays orders are obtained timely. Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 7:22pm revealed: -She became aware of the redness and swelling to Resident #2's leg on Wednesday 08/21/25 when a first shift PCA reported it to her at approximately 8:30am. -The Special Care Unit Coordinator (SCC) came in at approximately 9:00am and they looked at Resident #2's leg together. -Resident #2 did not appear to be in pain but the leg was red and swollen. -An x-ray was ordered on 08/21/25 and was completed at approximately 3:00pm-4:00pm. -Resident #2 appeared to be worse on second shift and she sent a picture to Resident #2's PCP at approximately 6:30pm. -Resident #2 was sent out for evaluation at the local hospital ED before results of the x-ray were received. Interview with the Administrator on 10/03/25 at 7:38pm revealed: -Staff should have informed the MA on duty immediately with any concerns. -An MA working the floor as a PCA told her she saw it at 3:00am or 4:00am that morning but did not report it to the MA in-charge or the PCP	D 273		

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D 273	Continued From page 11 during the shift. -The MAs had access to a notification system 24 hours a day and should have reported concerns immediately to the PCP and complete an accident and incident report. -Staff were trained annually about immediate reporting of accidents and incidents. Resident #2's records were requested from the local EMS on 10/03/25 but were not provided. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable. _____ The facility failed to ensure the acute health care needs were met for Resident #5 who had an order to notify the primary care provider of blood sugar readings greater than 400, there were two occasions in August and five occasions in September in which his blood sugar was over 400 and as high as 533, placing Resident #5 at risk for damage to the kidneys, heart, and eyes. The failure of the facility to provide health care coordination and follow-up was detrimental to 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 10/03/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration	D 358		

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D 358	Continued From page 12 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: TYPE A2 VIOLATION Based on observations, record review, and interviews, the facility failed to administer medications as ordered for 2 of 3 (#3 and #6) residents observed during the morning medication pass and for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) pertaining to medications used to treat high blood pressure (#3, #5), manage movement disorders, treat seizure disorder, a blood thinner (#3), vitamin supplements (#1, #3, #5), a stool softener (#3, #5), medications used to treat anxiety (#1, #3, #5), medications used to treat dementia (#1, #3, #5) medications used to treat type 2 diabetes (#3, #5), a medication used to treat low sodium levels (#3), a medication used to treat gastroesophageal reflux disease (#6), a digestive enzyme, a medication used treat irritable bowel syndrome, a medication used to treat constipation, a medication used to treat dry eyes (#5), a medications used to treat depression and insomnia (#1, #2, #5), medication used to treat schizophrenia, and medications used to treat Type one diabetes (#5), and a medication used to treat bacterial infections (#4). The findings are:	D 358		

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D 358	Continued From page 13 Review of the facility's undated Medication Administration policy revealed: -As new orders are received, read the order confirming all elements of the order is present, the medication name, the strength of the medication, the dosage of the medication to be administered, the route of administration, the specific directions for use, including frequency of administration, and if ordered on an as-needed basis, a stated indication for use. -When a medication is not given as prescribed by the MD, a medication error has occurred. -Errors are the opposite of the Five Rights and thus can be referred to as the Five Wrongs. -They are the wrong resident, the wrong medication, the wrong dose, the wrong time, a medication was given at the wrong time or not at all, and the wrong route. 1. The medication error rate was 7% as evidenced by 2 errors out of 28 opportunities during the 7:00am/8:00am medication pass on 10/01/25. a. Review of Resident #3's current FL2 dated 04/16/25 revealed: -Diagnoses included unspecified dementia, diabetes type 2, and hyperlipidemia. -Her level of care was special care unit. Review of Resident #3's hospital discharge summary dated 07/31/25 revealed there was an order to start amlodipine (amlodipine is used to treat high blood pressure) 5mg, take one daily, hold for systolic blood pressure of less than 110, to start on 08/01/25. Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed:	D 358		

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-There was an entry for amlodipine 5mg, take one tablet every day, hold for systolic blood pressure of less than 110.
-Amlodipine 5mg tablet was documented as administered at 8:00am on 08/01/25 through 08/10/25.
-Amlodipine 5mg tablet was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep".
-Amlodipine 5mg tablet was documented as administered at 8:00am on 08/12/25 through 08/31/25
-There was no entry to record the resident's blood pressure on 08/01/25 through 08/31/25.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for amlodipine 5mg, take one tablet every day, hold for systolic blood pressure of less than 110.
-Amlodipine 5mg tablet was documented as administered at 8:00am on 09/01/25 through 09/14//25.
-Amlodipine 5mg tablet was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep".
-Amlodipine 5mg tablet was documented as administered at 8:00am on 09/16/25 through 09/30/25
-There was no entry to record the resident's blood pressure on 09/01/25 through 09/30/25.

Review of Resident #3's October 2025 eMAR revealed:
-There was an entry for amlodipine 5mg, take one tablet every day, hold for systolic blood pressure of less than 110.
-Amlodipine 5mg tablet was documented as administered at 8:00am on 10/01/25.
-There was no entry to record the resident's blood

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pressure.

Observation of the morning medication pass on 10/01/25 revealed:
-The medication aide (MA) prepared Resident #3's morning mediations that included one amlodipine 5mg tablet.
-The MA administered Resident #3's morning medications which included amlodipine 5mg at 9:02am.
-The MA did not check Resident #3's blood pressure prior to administering the resident's morning medications.

Observation of Resident #3's medication on hand on 10/01/25 at 11:59am revealed:
-There was a bubble pack of amlodipine 5mg, take one tablet every day, hold for systolic blood pressure less than 110, with a dispense date of 09/25/25 for 28 tablets.
-There were 21 remaining tablets of amlodipine 5mg for Resident #3 in the bubble pack.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was received for Resident #3 on 07/31/25 for amlodipine 5mg, take one tablet daily, hold for systolic blood pressure less than 110.
-Amlodipine 5mg, take one tablet daily hold for systolic blood pressure less than 110 was dispensed for Resident #3 on 07/31/25 for a quantity of 28 tablets, on 08/21/25 for a quantity of 28 tablets and on 09/18/25 for a quantity of 28 tablets.

Interview with the MA on 10/01/25 at 12:00pm revealed:
-She checked Resident #3's blood pressure when

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D 358	Continued From page 16 it popped up in the eMAR. -Resident #3 did not have an order for daily blood pressure checks so it would not pop up on the eMAR. -There was no space to record Resident #3's blood pressure on the eMAR. -She usually checked Resident #3's blood pressure before administering her amlodipine each morning. -She forgot to check Resident #3's blood pressure this morning during the medication pass. -She never had to hold Resident #3's amlodipine due her systolic blood pressure being below 110. -She should have checked Resident #3's blood pressure prior to administering amlodipine. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 12:18pm revealed: -She did not realize there was no space on the eMAR to record Resident #3's blood pressure. -She would add a space to Resident #3's eMAR to record her blood pressure. -The MAs were to compare the residents' medication label to the eMAR order three times prior to administering their medications. -She expected the MAs to administer medications as ordered by the physician orders. -Resident #3's blood pressure should have been checked by the MA prior to administering the amlodipine. Interview with the Administrator on 10/01/25 at 12:28pm revealed: -The MAs were to always compare the residents' medication label to the eMAR. -If a medication had parameters, the MAs were expected to administer the medication as ordered by the physician.	D 358		

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D 358	Continued From page 17 Interview with Resident #3's primary care provider (PCP) on 10/03/25 at 10:47am revealed: -Amlodipine was prescribed for Resident #3 for high blood pressure. -It was important to check Resident #3's blood pressure prior to administering the amlodipine to see if the dose needed to be adjusted. -If amlodipine was administered to Resident #3 and her blood pressure was low, if could cause her blood pressure to be too low and could cause sweating, lethargy, increased heart rate, and dizziness. -She expected the MAs to check Resident #3's blood pressure prior to administering the amlodipine. b. Review of Resident #6's current FL2 dated 02/11/25 revealed: -Diagnoses included unspecified dementia, type 2 diabetes, and hypertension. -Her level of care was special care unit. -There was an order for famotidine (famotidine is used to treat heartburn, acid indigestion and gastroesophageal reflux disease) 20mg, take one every morning before breakfast. Review of Resident #6's signed physician's order sheet dated 02/11/25 revealed an order for famotidine 20mg, take one tablet every day before breakfast. Observation of the morning medication pass on 10/01/25 revealed: -The medication aide (MA) prepared Resident #6's morning medications that included famotidine 20mg. -The MA administered Resident #6's morning medications that included famotidine 20mg at 9:09am.	D 358		

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D 358	Continued From page 18 Interview with the MA on 10/01/25 at 9:10am revealed: -Breakfast was served in the special care unit between 8:00am and 8:30am. -Resident #6 had eaten breakfast prior to the morning medication pass. Observation of Resident #6's medications on hand revealed: -There was a bubble package of famotidine 20mg, take one tablet every day before breakfast with dispense date of 09/25/25 for 28 tablets. -There were 24 remaining tablets of famotidine 20mg for Resident #6 in the bubble package. Telephone interview with the pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:06pm revealed: -An order was received for Resident #6 for famotidine 20mg, take one tablet every day before breakfast on 02/20/25. -Famotidine 20mg, take one tablet every day before breakfast was dispensed for Resident #6 on 08/21/25 and 09/18/28 for 28 tablets each. -It was recommended the famotidine be administered on an empty stomach for better absorption of the medication. Second interview with the MA on 10/01/25 at 12:00pm revealed: -She knew Resident #6 was to receive her famotidine 20mg before breakfast. -Resident #6 usually received her medications before breakfast. -Another resident had to be sent to the emergency department this morning and she got behind on her medication pass. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 12:18pm revealed:	D 358		

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D 358	Continued From page 19 -The MAs were to follow the residents' medication orders as ordered by the provider. -Resident #6 usually received her morning medications before breakfast. Interview with the Administrator on 10/01/25 at 12:28pm revealed: -If a resident was to receive medications before a meal, the medication should be administered 30 minutes before the meal. -The MAs were to follow the prescriber's orders and administer the residents' medications as ordered. Interview with Resident #6's primary care provider (PCP) on 10/03/25 at 9:56pm revealed: -She prescribed famotidine 20mg to Resident #6 for gastroesophageal reflux. -Famotidine 20mg was absorbed better on an empty stomach and should be taken prior to a meal. 2. Review of Resident #5's current FL2 dated 06/02/25 revealed: -Diagnoses included type 2 diabetes, hypertension, generalized anxiety, irritable bowel syndrome, pancreatitis, and gastroesophageal reflux disease. -There was an order for lantus (lantus is a long-acting insulin used to treat elevated blood glucose levels) solostar inject 20u each morning. -There was an order for insulin lispro (lispro is a rapid acting insulin used to treat elevated blood glucose levels), check fingerstick blood sugars (FSBSs) before meals and at bedtime, and inject per sliding scale insulin (SSI), for FSBS of 150-199= 2 units, 200-249= 4 units, 250-299=6 units, 300-349= 8 units, 350-399=10 units, if greater than 400=12 units and notify primary care provider (PCP).	D 358		

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D 358	Continued From page 20 -The was an order for amlodipine (amlodipine is used to treat high blood pressure) 10mg, take one daily. -There was an order for Creon (Creon contains digestive enzymes to help break down and digest fats, starches, and proteins in food) DR 2400 units, take one three times a day with food. -There was an order for Vit D3 (Vitamin D3 is a supplement that promotes bone health) 2000 units , take one daily. -There was an order for dicyclomine (dicyclomine is used to treat symptoms of irritable bowel disease) 10mg, take four times per day, 30 minutes prior to meals and at bedtime. -There was an order for Farxiga (Farxiga is used to treat type 2 diabetes) 10mg, take one daily. -There was an order for lisinopril (lisinopril is used to treat high blood pressure) 20mg take one daily. -There was an order for metformin 1000mg, take one twice a day with meals. -There was an order polyethylene glycol (polyethylene glycol is a laxative used to treat constipation) 3350, mix 17 grams in 8 ounces of water daily. -There was an order for Restasis (Restasis is an eye drop used to treat dry eyes) 0.05%, instill one drop in each eye four times per day. -There was an order for sertraline (sertraline is used to treat depression and anxiety and mood disorders) 100mg, take one daily. -There was an order for trazodone (trazodone is used to treat depression and insomnia) 50mg, take a half tablet (25mg) daily at bedtime. -There was an order for ziprasidone (ziprasidone is an anti-psychotic medication used to treat schizophrenia and bi-polar disorder) 40mg, take twice daily with meals. a. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for	D 358		

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D 358	Continued From page 21 Lantus solostar 100U/ml, inject 20 units subcutaneously every morning, prime pen with 2 units prior to each use. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus solostar injection 100U/ml, inject 20 units subcutaneously every morning, prime pen with 2 units prior to each use, scheduled at 9:00am. -Lantus was documented as not administered at 9:00am on 08/03/25, with the exception documented as "resident asleep". -Lantus was not documented as administered at 9:00am on 08/22/25, with no exception documented and the space for initials on the eMAR was blank. -Lantus was not documented as administered at 9:00am on 08/25/25, with no exception documented and the space for initials on the eMAR was blank. -Lantus was not documented as administered at 9:00am on 08/31/25, with no exception documented and the space for initials on the eMAR was blank. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for Lantus solostar injection 100U/ml, inject 20 units subcutaneously every morning, prime pen with 2 units prior to each use, scheduled at 9:00am. -Lantus was documented as not administered at 9:00am on 09/02/25, with the exception documented as "resident asleep". -Lantus was not documented as administered at 9:00am on 09/03/25, with no exception documented and the space for initials on the eMAR was blank.	D 358		

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-Lantus was not documented as administered at 9:00am on 09/06/25, with no exception documented and the space for initials on the eMAR was blank.
-Lantus was not documented as administered at 9:00am on 09/07/25, with no exception documented and the space for initials on the eMAR was blank.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was received for Resident #5's Lantus solostar 100 units/ml on 04/13/25, to inject 20 units every morning.
-Two 3ml pens of Lantus solostar 100units/ml were dispensed for Resident #5 on 07/28/25 and 08/24/25, to inject 20 units every morning.

Interview with a medication aide (MA) on 10/03/25 at 4:35pm revealed:
-If a resident refused their medications or were asleep during the medication pass, she moved on to the next resident.
-She tried to catch the resident later if she saw them up and about.
-An exception was always required on the residents' eMAR if medications were not administered.
-There should never be blanks on the eMAR.
-There was no policy that she was aware of to notify the primary care provider (PCP) of missed medications.
-The Special Care Coordinator (SCC) or the Resident Care Coordinator (RCC) were responsible for ordering medication refills for the residents.
-She requested insulin pens for the residents when she opened the last pen.
-It was possible Resident #5's Lantus was not

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available, but she was not sure.
-If a resident did not have insulin in the facility, she always called the pharmacy.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Lantus was a long-acting insulin prescribed for Resident #5 to treat elevated blood glucose levels related to diabetes.
-Resident #5 needed the long-acting insulin to keep his blood sugar level regulated throughout the day.
-Short term effects of hyperglycemia or elevated blood sugar included sweating, lethargy, drooling, frequent urination, excessive thirst, and blurred vision.
-Long term effects of elevated blood sugars included damage to organs such as the kidneys, heart, and eyes and neuropathy.
-She expected Resident #5 to receive his Lantus as ordered.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

b. Review of Resident #5's signed physicians order sheet dated 07/14/25 revealed an order for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider.

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D 358	Continued From page 24 Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm. -Insulin lispro was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep" and there was no documentation of a FSBS. -Insulin lispro was not documented as administered and no FSBS was documented at 11:00am on 08/16/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank. -Resident #5's FSBS was documented as 333 at 4:00pm on 08/18/25 and 10 units of insulin lispro was documented as administered when 8 units of insulin lispro should have been administered per the resident's sliding scale. -Insulin lispro was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep", and there was no documentation of a FSBS. -Insulin lispro was documented as not administered at 7:00pm on 08/25/25, with the exception documented as "withheld per DR/RN orders", and there was no documentation of a FSBS. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10	D 358		

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D 358	Continued From page 25 units, if greater than 400=12 units and notify provider, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm. -Insulin lispro was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep" and there was documentation of a FSBS. -Resident #5's FSBS was documented as 405 at 11:00am on 09/02/25 and 12 units of insulin lispro was documented as administered. -Resident #5's FSBS was documented as 425 at 4:00pm on 09/02/25 and 12 units of insulin lispro was documented as administered. -Insulin lispro was not documented as administered and no FSBS was documented at 7:00pm on 09/02/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank. -Resident #5's FSBS was documented as 214 at 11:00am on 09/03/25 and 7 units of insulin lispro was documented as administered when 4 units of insulin lispro should have been administered per the resident's sliding scale. -Insulin lispro was not documented as administered and no FSBS was documented at 7:00am on 09/07/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank. -Resident #5's FSBS was documented as 202 at 7:00am and 2 units of insulin lispro was documented as administered when 4 units of insulin lispro should have been administered per the resident's sliding scale. -Insulin lispro was not documented as administered and no FSBS was documented at 11:00am on 09/10/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank. -Insulin lispro was not documented as administered and no FSBS was documented at	D 358		

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7:00am on 09/14/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank.
-Insulin lispro was documented as not administered at 7:00am on 09/17/25, with the exception documented as "withheld per DR/RN orders", and there was no documentation of a FSBS.
-Insulin lispro was not documented as administered and no FSBS was documented at 4:00pm on 09/19/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank.
-Insulin lispro was not documented as administered and no FSBS was documented at 11:00am on 09/30/25, with no exception documented, and the space for initials and the FSBS on the eMAR was blank.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was received for Resident #5's insulin lispro 100/ml, check FSBS before meals and at bedtime and inject SSI, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, if greater than 400=12 units and notify provider on 12/16/24.
-Five 3ml pens of insulin lispro were dispensed for Resident #5 on 05/31/25, 07/28/25 and 8/24/25.

Interview with a medication aide (MA) on 10/03/25 at 4:35pm revealed:
-If a resident refused their medications or were asleep during the medication pass, she moved on to the next resident.
-She tried to catch the resident later if she saw them up and about.
-An exception was always required on the

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residents' eMAR if medications were not administered.
-There should never be blanks on the eMAR.
-There was no policy that she was aware of to notify the PCP of missed medications.
-The Special Care Coordinator (SCC) or the Resident Care Coordinator (RCC) were responsible for ordering medication refills for the residents and requesting refill prescriptions from the PCP.
-She requested insulin pens for the residents when she opened the last pen.
-It was possible Resident #5's insulin lispro was not available, but she was not sure.
-If a resident did not have insulin in the facility, she always called the pharmacy.
-She always reviewed Resident #5's sliding scale insulin scale three times and thought she may have recorded his FSBS incorrectly and that was why the incorrect number of units of insulin lispro was documented as administered to Resident #5.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Insulin lispro was a rapid acting insulin that she prescribed for Resident #5 for elevated blood glucose levels.
-It was important that Resident #5 receive his FSBS and insulin lispro before meals and at bedtime as ordered per sliding scale to control his blood sugar.
-Resident #5 was a brittle diabetic and was non-compliant with his diet and she had stressed to staff the importance of checking his FSBSs and administering his insulin lispro as ordered.
-Resident #5's last HgbA1C (a blood test that measures the average blood glucose levels over the previous 90 days) was elevated at 6.3 in June 2025 and it was difficult to manage his insulin and

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blood glucose if she could not be sure he was receiving his insulin as ordered.
-On 09/02/25, when Resident #5 did not receive his 7:00am dose of insulin lispro and his 9:00am dose of lantus resulted in the FSBS being greater than 400 at 11:00am and 4:00pm that same day.
-Short term effects of hyperglycemia or elevated blood sugar included sweating, lethargy, drooling, frequent urination, excessive thirst, and blurred vision.
-Long term effects of elevated blood sugars included damage to organs such as the kidneys, heart, and eyes and neuropathy.
-She expected the MAs to review Resident #5's SSI scale and administer the proper number of units of insulin lispro.
-Too much insulin lispro could cause Resident #5's blood sugar to dip too low and he could have symptoms of hypoglycemia such as shakiness, tremors, and non-responsiveness.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

c. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for amlodipine 10mg, take one tablet every day for hypertension.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 10mg, take one tablet every day for hypertension, scheduled

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at 7:00am.
-Amlodipine 10mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for amlodipine 10mg, take one tablet every day for hypertension, scheduled at 7:00am.
-Amlodipine 10mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's amlodipine 10mg on 09/30/22, to take one tablet daily for hypertension.
-Amlodipine 10mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25 for a quantity of 28 tablets each time for a 28-day supply to take one daily for hypertension.

Interview with the facility's contracted primary care provider (PCP) on 10/03/256 at 10:55am revealed:
-She prescribed amlodipine for Resident #5 for high blood pressure.
-Missing doses of amlodipine could cause Resident #5's blood pressure to be elevated and not well controlled and could place him at risk for a stroke.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

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D 358	Continued From page 30 Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. d. Review of Resident #5's signed physician's order sheet revealed an order for Creon (a medication used to aid digestion due to a lack of pancreatic enzymes) DR 2400 units, take one capsule three times a day with meals for pancreatic supplement. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Creon DR 2400 units, take one capsule three times a day with meals for pancreatic supplement, scheduled at 7:30am, 12:00pm and 5:00pm.. -Creon DR was documented as not administered at 7:30am on 08/03/25, with the exception documented as "resident asleep". -Creon DR was not documented as administered at 12:00pm on 08/16/25 with no exception documented and the space for initials on the eMAR was blank. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for Creon DR 2400 units, take one capsule three times a day with meals for	D 358		

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pancreatic supplement, scheduled at 7:30am, 12:00pm and 5:00pm.
-Creon DR was documented as not administered at 7:30am on 09/02/25, with the exception documented as "resident asleep".
-Creon DR was not documented as administered at 5:00pm on 09/19/25 with no exception documented and the space for initials on the eMAR was blank.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's Creon DR 2400 units on 09/30/22, to take one capsule three times a day with meals for pancreatic supplement.
-Creon DR 2400 units was dispensed for Resident #5 on 06/16/25, 07/24/25, and 08/29/25, for a quantity of 100 capsules each time for a 33-day supply to take one three times a day with meals for pancreatic supplement.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Resident #5 had a history of pancreatitis.
-She prescribed Creon to Resident #5 to help keep his digestive enzymes regulated.
-Without the Creon, Resident #5 could experience abdominal pain and worsening of his pancreatitis.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care

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Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

e. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for Vitamin D3 2000 units, take one capsule every day for supplement.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 2000 units, take one every day with for supplement, scheduled at 7:00am.
-Vitamin D3 was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for Vitamin D3 2000 units, take one every day with for supplement, scheduled at 7:00am.
-Vitamin D3 was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident

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#5's Vitamin D3 2000 units on 09/30/22, to take one capsule every day for supplement.
-Vitamin D3 2000 units was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 28 capsules each time for a 28-day supply to take one daily for supplement.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Vitamin D3 was prescribed for Resident #5 for low Vitamin D 3 levels.
-Not receiving Vitamin D3 could cause Resident #5's Vitamin D3 level to continue to be low on his lab work.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facilty's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

f. Review of Resident #5's signed physician order sheet dated 07/14/25 revealed an order for dicyclomine 10mg, take one capsule 30 minutes prior to meals and bedtime (four times per day).

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D 358	Continued From page 34 Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for dicyclomine (a medication used to treat symptoms of irritable bowel syndrome) 10mg, take one capsule 30 minutes prior to meals and bedtime, four times a day, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm. -Dicyclomine 10mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep". -Dicyclomine 10mg was not documented as administered at 11:00am on 08/16/25 with no exception documented and the space for initials on the eMAR was blank. -Dicyclomine 10mg was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep". Review of Resident #5's September 2025 eMAR revealed: -There was an entry for dicyclomine 10mg, take one capsule 30 minutes prior to meals and bedtime, four times a day, scheduled at 7:00am, 11:00am, 4:00pm and 7:00pm. -Dicyclomine 10mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep". -Dicyclomine 10mg was not documented as administered at 4:00pm on 09/19/25 with no exception documented and the space for initials on the eMAR was blank. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed: -An order was originally received for Resident #5's dicyclomine 10mg on 09/30/22, to take one capsule 30 minutes prior to meals and at	D 358		

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bedtime.
-Dicyclomine 10mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 112 capsules each time for a 28-day supply, to take one capsule 30 minutes prior to meals and at bedtime.

Interview with the facilty's contracted primary care provider (PCP on 10/03/25 at 10:55am revealed:
-Dicyclomine was prescribed for Resident #5 for irritable bowel syndrome.
-Missing doses of dicyclomine could cause Resident #5's irritable bowel syndrome to flare up, resulting in abdominal pain, nausea, vomiting and diarrhea.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

g. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for Farxiga (a medication used to treat type 2 diabetes) 10mg, take one tablet every day.

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D 358	Continued From page 36 Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Farxiga 10mg, take one tablet every day, scheduled at 7:00am. -Farxiga 10mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep". Review of Resident #5's September 2025 eMAR revealed: -There was an entry for Farxiga 10mg, take one tablet every day, scheduled at 7:00am. -Farxiga 10mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep". Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed: -An order was originally received for Resident #5's Farxiga 10mg on 09/30/22, to take one tablet every day. -Farxiga 10mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 28 tablets each time for a 28-day supply to take one tablet every day. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed: -Farxiga 10mg was prescribed for Resident #5 for type 2 diabetes. -Not receiving Farxiga could cause Resident #5's blood glucose levels to be elevated and could increase his HgbA1C reading that could possibly indicate a change in medication dosage that was not warranted because he did not receive his diabetic medications as ordered.	D 358		

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h. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for lisinopril (a medication used to treat high blood pressure) 20mg, take one tablet twice a day for blood pressure.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for lisinopril 20mg take one tablet twice a day for blood pressure, scheduled at 7:00am and 7:00pm..
-Lisinopril 20mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep".
-Lisinopril 20mg was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for lisinopril 20mg take one tablet twice a day for blood pressure, scheduled at 7:00am and 7:00pm..
-Lisinopril 20mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".
-Lisinopril 20mg was documented as not administered at 7:00pm on 09/24/25, with the exception documented as "awaiting RX/MD prior auth".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's lisinopril 20mg on 09/30/22, to take tablet twice a day for blood pressure.
-Lisinopril 20mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a

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quantity of 56 tablets each time for a 28-day supply, to take one tablet twice a day for blood pressure.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Lisinopril 20mg was prescribed for Resident #5 for hypertension.
-Lisinopril also protected the kidneys.
-Missed doses of lisinopril could cause Resident #5's blood pressure to be elevated.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

i. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for metformin (a medication used to treat type 2 diabetes) 1000mg, take one tablet twice a day for diabetes with meals.

Review of Resident #5's August 2025 electronic medication administration record (eMAR)

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revealed:
-There was an entry for metformin 1000mg, take one tablet twice a day with meals for diabetes, scheduled at 7:00am and 5:00pm.
-Metformin 1000mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for metformin 1000mg, take one tablet twice a day with meals for diabetes, scheduled at 7:00am and 5:00pm.
-Metformin 1000mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".
-Metformin 1000mg was not documented as administered at 5:00pm on 09/19/25 with no exception documented and the space for initials on the eMAR was blank.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's metformin 1000mg on 09/30/22, to take tablet twice a day with meals for diabetes.
-Metformin 1000mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 56 tablets each time for a 28-day supply, to take one tablet twice a day with meals for diabetes.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Metformin was prescribed for Resident #5 for diabetes and elevated blood glucose levels.
-Not receiving metformin could cause Resident #5's blood glucose levels to be elevated and

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could increase his HgbA1C reading that could possibly indicate a change in medication dosage that was not warranted because he did not receive his diabetic medications as ordered.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

j. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for polyethylene glycol powder (a medication used to treat constipation) 3350, mix one capful (17 grams) in 8 ounces of liquid of choice and drink daily for constipation.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol powder 3350, mix one capful (17grams) in 8 ounces of liquid of choice and drink daily for constipation scheduled at 8:00am.
-Polyethylene glycol was documented as not administered at 8:00am on 08/03/25, with the

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exception documented as "resident asleep".
-Polyethylene glycol was not documented as administered at 8:00am on 08/18/25 with no exception documented and the space for initials on the eMAR was blank.
-Polyethylene glycol was documented as not administered at 8:00am on 08/21/25, with the exception documented as "resident refused".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for polyethylene glycol powder 3350, mix one capful (17grams) in 8 ounces of liquid of choice and drink daily for constipation scheduled at 8:00am.
-Polyethylene glycol was documented as not administered at 8:00am on 09/02/25, with the exception documented as "resident asleep".
-Polyethylene glycol was not documented as administered at 8:00am on 09/03/25 with no exception documented and the space for initials on the eMAR was blank.
-Polyethylene glycol was documented as not administered at 8:00am on 09/11/25, with the exception documented as "resident refused".
-Polyethylene glycol was documented as not administered at 8:00am on 09/25/25, with the exception documented as "resident refused".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's polyethylene glycol on 09/30/22, to mix one capful (17grams) in 8 ounces of liquid of choice and drink daily for constipation.
-Polyethylene glycol was dispensed for Resident #5 on 06/16/25, 07/20/25, and 08/18/25 for 510 grams each time for a 30 day supply, to mix one capful (17grams) in 8 ounces of liquid of choice

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and drink daily for constipation.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Polyethylene glycol was prescribed for Resident #5 to prevent constipation.
-Missed doses of polyethylene glycol could cause Resident #5 to experience abdominal pain which could be confusing to differentiate the cause with his history of pancreatitis.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

k. Review of Resident #5's signed physician's orders dated 07/14/25 revealed an order for Restasis (a medication used to treat dry eyes) 0.05%, instill one drop into each eye every 12 hours for dry eyes.

Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed:

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-There was an entry for Restasis 0.05%, instill one drop into each eye every 12 hours for dry eyes, scheduled at 7:00am and 7:00pm.
-Restasis 0.05% was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep".
-Restasis 0.05% was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep".

Review of Resident #5's September 2025 eMAR revealed:
-There was an entry for Restasis 0.05%, instill one drop into each eye every 12 hours for dry eyes, scheduled at 7:00am and 7:00pm.
-Restasis 0.05% was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's Restasis 0.05% on 09/30/22, to instill one drop into each eye every 12 hours for dry eyes.
-Restasis 0.05% was dispensed for Resident #5 on 06/26/25, 07/25/25, 08/29/25, and 09/30/25 for 60 dropperettes each time for a 30- day supply, to instill one drop in each eye every 12 hours for dry eyes.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Restasis drops were prescribed for Resident #5 for dry eyes.
-Missed doses of Restasis could cause Resident #5 to experience discomfort due to dry eyes.

Refer to interview with a medication aide (MA) on

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D 358	Continued From page 44 10/02/25 at 4:20pm. Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facilty's contracted primary care provider (PCP) on 10/03/25 at 11:18am. I. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for sertraline (a medication used to treat depression, anxiety, and mood disorders) 100mg, take one tablet every day for mood. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 100mg, take one tablet every day for mood, scheduled at 7:00am. -Sertraline 100mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep". Review of Resident #5's September 2025 eMAR revealed: -There was an entry for sertraline 100mg, take one tablet every day for mood, scheduled at 7:00am. -Sertraline 100mg was documented as not	D 358		

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administered at 7:00am on 09/02/25, with the exception documented as "resident asleep".

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #5's Sertraline 100mg on 09/30/22, to take one tablet every day for mood.
-Sertraline 100mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 28 tablets each time for a 28-day supply to take one tablet every day for mood.

Interview with the facilty's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Sertraline was prescribed for Resident #5 by his behavioral health provider for anxiety.
-Missed doses of sertraline could result in Resident #5 having increased anxiety.

Interview with Resident #5's behavioral health provider on 10/03/25 at 4:06pm revealed:
-Sertraline was prescribed for Resident #5 for anxiety.
-Resident #5's anxiety had been stable, and she was not concerned about an occasionally missed dose of sertraline.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm.

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D 358	Continued From page 46 Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. m. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for trazodone (a medication used to treat depression and insomnia) 50mg, take a half tablet (25mg) at bedtime for sleep/depression. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 50mg, take a half tablet (25mg) at bedtime for sleep/depression, scheduled at 7:00pm. -Trazodone 25mg was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep". Review of Resident #5's September 2025 eMAR revealed: -There was an entry for trazodone 50mg, take a half tablet (25mg) at bedtime for sleep/depression, scheduled at 7:00pm. -Trazodone 25mg was documented as not administered at 7:00pm on 09/23/25, with the exception documented as "awaiting RX/MD prior auth". -Trazodone 25mg was documented as not administered at 7:00pm on 09/24/25, with the exception documented as "awaiting RX/MD prior auth". Telephone interview with a pharmacist from the facility's contracted pharmacy provider on	D 358		

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D 358	Continued From page 47 10/03/25 at 3:14pm revealed: -An order was originally received for Resident #5's trazodone 50mg on 09/30/22, to take one half tablet (25mg) at bedtime for sleep/depression. -Trazodone 50mg was dispensed for Resident #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 14 tablets each time for a 28-day supply to take one half tablet at bedtime for sleep/depression. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed: -Trazodone was prescribed for Resident #5 by his behavioral health provider for insomnia. -Missed doses of trazadone could affect Resident #5's sleep pattern. Telephone interview with Resident #5's behavioral health provider on 10/03/25 at 4:06pm revealed: -Resident #5 was prescribed a very low dose of trazodone for insomnia. -Missed doses of trazodone could cause resident to have trouble sleeping. Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm. Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm.	D 358		

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D 358	Continued From page 48 Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. n. Review of Resident #5's signed physician's order sheet dated 07/14/25 revealed an order for ziprasidone (an anti-psychotic medication used to treat schizophrenia and bi-polar disorder) 40mg, take one capsule twice daily with meals. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ziprasidone 40mg take one tablet twice daily with meals, scheduled at 7:00am and 7:00pm. -Ziprasidone 40mg was documented as not administered at 7:00am on 08/03/25, with the exception documented as "resident asleep". -Ziprasidone 40mg was documented as not administered at 7:00pm on 08/22/25, with the exception documented as "resident asleep". Review of Resident #5's September 2025 eMAR revealed: -There was an entry for ziprasidone 40mg take one tablet twice daily with meals, scheduled at 7:00am and 7:00pm. -Ziprasidone 40mg was documented as not administered at 7:00am on 09/02/25, with the exception documented as "resident asleep". Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed: -An order was received for Resident #5's ziprasidone 40mg on 05/07/25, to take one tablet twice daily with meals. -Ziprasidone 40mg was dispensed for Resident	D 358		

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D 358	Continued From page 49 #5 on 07/24/25, 08/21/25, and 09/18/25, for a quantity of 56 tablets each time for a 28-day supply, to take one tablet twice daily with meals. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed ziprasidone 40mg was prescribed for Resident #5 by his behavioral health provider. Telephone interview with Resident #5's behavioral health provider on 10/03/25 at 4:06pm revealed: -Ziprasidone was prescribed for Resident #5 for schizophrenia. -Resident #5's schizophrenia was well controlled with the ziprasidone. -She knew occasionally Resident #5 like to "play possum" and pretend he was asleep. -She expected the MAs to circle back to administer medications to the residents if they were asleep, unavailable during the medication pass, or refused medications. Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm. Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.	D 358		

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D 358	Continued From page 50 Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm revealed: -If a resident was asleep or refused their medications, the MAs were to make three attempts to administer their medications before documenting on the eMAR that a medication was not administered and disposing of the medication. -An exception should always be documented on the eMAR if medications were not administered. -If a resident refused or missed two consecutive doses of medication, their PCP was to be notified. -If a medication was documented as not administered due to "error on order" it meant they were either waiting on the pharmacy to send the medication or waiting on the provider to approve or send a medication refill. -The facility occasionally had internet issues and that could have been why there were blanks on the residents' eMARs. -She, the SCC and the Administrator performed eMAR audits monthly to make sure medications were administered to the residents as ordered. -She was not sure when an eMAR audit had last been performed. -A medication cart audit consisted of making sure the residents' medications were available and removing expired or discontinued medications from the medication cart. Interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm revealed: -The MAs were to make three attempts to administer a resident's medications during each medication pass. -Monthly eMAR audits were done to look medications not administered or refused. -She looked for patterns such as refusal or residents being asleep at the medication pass	D 358		

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time so she could discuss with staff and the resident's PCP if needed.
-She was not sure when the last eMAR audit was.
-There should never be blanks or holes on the residents' eMARs.
-There should always be an exception as to why medications were not administered.
-The MAs could request refills or the MAs let her or the RCC know if medication refills were needed.
-When a medication order was received for a resident, it was sent to the pharmacy and if the medication did not arrive within 24 hours she contacted the pharmacy.

Interview with the Administrator on 10/03/25 at 7:40pm revealed:
-If a medication was not available on the medication cart for a resident, she expected staff to immediately notify the pharmacy.
-She expected medications to be re-ordered before a resident ran out of medication.
-If a resident refused medications or was asleep during the medication pass, the MAs were to make 3 attempts to administer the medications to the resident.
-She expected medications to be administered to the residents as ordered and there should never be blanks or gaps on the eMARs.
-The RCC and SCC performed monthly eMAR audits, looking for refusals or blanks on the eMARs.
-The RCC and SCC were responsible for monthly medication cart audits to make the residents medications were available for administration as ordered.

Second interview with the facility's contracted primary care provider on 10/03/25 at 11:18am revealed:

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D 358	Continued From page 52 -If a resident was asleep at the time of the medication pass, she expected the MA to cycle back to the resident to administer their medications. -Medications could be administered to the residents up to one hour before or after the scheduled dose. -Also, if there continued to be an issue with the resident's sleep schedule and the medication pass, the MAs should notify her so she could consider changing the scheduled dose time. 3. Review of Resident #1's current FL-2 dated 01/26/25 revealed diagnoses included vascular dementia and schizophrenia. a. Review of Resident #1's current FL-2 dated 01/26/25 revealed there was an order for Divalproex 250mg DR (used to treat mood instability) at bedtime. Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Divalproex 250mg DR at bedtime scheduled at 9:00pm. -Divalproex 250mg DR was documented as administered at 9:00pm 08/01/25 to 08/10/25, 08/12/25 to 08/15/25 and 08/17/25 to 08/31/25. -Divalproex 250mg DR was not documented as administered on 08/11/25 and 08/16/25, with the spaces for documentation on those dates left blank. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for Divalproex 250mg DR at bedtime scheduled at 9:00pm. -Divalproex 250mg DR was documented as administered at 9:00pm 09/01/25 to 09/12/25,	D 358		

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09/14/25 to 09/25/25, and 09/27/25 to 09/30/25.
-Divalproex 250mg DR was documented as not administered on 09/13/25 and 09/26/25 with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Divalproex 250mg DR dispensed on 09/25/25 with a quantity of 28.
-There were 21 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.
-The medication had multiple indications, but the indications were not listed on the orders.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Divalproex 250mg DR was dispensed on 07/24/25 for a 28-day supply and delivered to the facility on 07/29/25.
-Divalproex 250mg DR was dispensed on 08/21/25 for a 28-day supply and delivered to the facility on 08/26/25.
-Divalproex 250mg DR was dispensed on 09/18/25 for a 28-day supply and delivered to the facility on 09/23/25.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed she prescribed Divalproex for mood instability secondary to dementia and major depressive disorder.

b. Review of Resident #1's current FL-2 dated 01/26/25 revealed there was an order for Donepezil 10mg (used to treat dementia) at

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bedtime.

Review of Resident #1's August 2025 medication administration record (MAR) revealed:
-There was an entry for Donepezil 10mg at bedtime scheduled at 9:00pm.
-Donepezil 10mg was documented as administered at 9:00pm 08/01/25 to 08/10/25, 08/12/25 to 08/15/25 and 08/17/25 to 08/31/25.
-Donepezil 10mg was not documented as administered on 08/11/25 and 08/16/25, with the spaces for documentation on those dates left blank.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Donepezil 10mg at bedtime scheduled at 9:00pm.
-Donepezil 10mg was documented as administered at 9:00pm 09/01/25 to 09/12/25, 09/14/25 to 09/25/25, and 09/27/25 to 09/30/25.
-Donepezil 10mg was documented as not administered on 09/13/25 and 09/26/25 with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Donepezil dispensed on 09/25/25 with a quantity of 28.
-There were 21 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.
-The medication had multiple indications, but the indications were not listed on the orders.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the

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medication would have had on the resident.
-Donepezil 10mg at bedtime was dispensed on 07/24/25 for a 28-day supply and delivered to the facility on 07/29/25.
-Donepezil was dispensed on 08/21/25 for a 28-day supply and delivered to the facility on 08/26/25.
-Donepezil 10mg was dispensed on 09/18/25 for a 28-day supply and delivered to the facility on 09/23/25.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed:
-She prescribed Donepezil for dementia.
-She was not concerned about Resident #1 missing Donepezil because the medication built up in the system and did not just leave the system after missed doses.

c. Review of Resident #1's current FL-2 dated 01/26/25 revealed there was an order for Lexapro 5mg (used to treat depression and anxiety) daily.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Lexapro 10mg daily scheduled at 9:00am.
-Lexapro 5mg was documented as administered at 9:00am 08/01/25 to 08/12/25 and 08/14/25 to 08/31/25.
-Lexapro 5mg was documented as not administered on 08/13/25 and 08/16/25, with the exception documented as "resident asleep".

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Lexapro 10mg daily scheduled at 9:00am.
-Lexapro 5mg was documented as administered at 9:00pm 09/01/25 to 09/23/25, 09/25/25 to

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09/26/25, and 09/28/25 to 09/30/25.
-Lexapro 5mg was documented as not administered on 09/24/25 and 09/27/25 with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Donepezil dispensed on 09/25/25 with a quantity of 28.
-There were 21 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.
-The medication had multiple indications, but the indications were not listed on the orders.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Lexapro 5mg was dispensed on 07/24/25 for a 28-day supply and delivered to the facility on 07/29/25.
-Lexapro was dispensed on 08/21/25 for a 28-day supply and delivered to the facility on 08/26/25.
-Lexapro was dispensed on 09/18/25 for a 28-day supply and delivered to the facility on 09/23/25.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed she prescribed Lexapro for major depression and anxiety due to dementia.

d. Review of Resident #1's current FL-2 dated 01/26/25 revealed there was an order for Vitamin B12 1000mcg (used as a vitamin B12 supplement) daily.

Review of Resident #1's August 2025 eMAR

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revealed:
-There was an entry for Vitamin B12 1000mcg daily scheduled at 9:00am.
-Vitamin B12 1000mcg was documented as administered at 9:00am 08/01/25 to 08/12/25 and 08/14/25 to 08/31/25.
-Vitamin B12 1000mcg was not documented as administered on 08/13/25 with the exception documented as "resident asleep".

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Vitamin B12 1000mcg daily scheduled at 9:00pm.
-Vitamin B12 1000mcg was documented as administered at 9:00am 09/01/25 to 09/23/25, 09/25/25 to 09/26/25, and 09/28/25 to 09/30/25.
-Vitamin B12 1000mcg was documented as not administered on 09/24/25 and 09/27/25, with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Vitamin B12 1000mcg dispensed on 09/25/25 with a quantity of 28.
-There were 21 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.
-Vitamin B12 was an over the counter (OTC) supplemental vitamin.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Vitamin B12 1000mcg daily was dispensed on 07/24/25 for a 28-day supply and delivered to the

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facility on 07/29/25.
-Vitamin B12 1000mcg was dispensed on 08/21/25 for a 28-day supply and delivered to the facility on 08/26/25.
-Vitamin B12 1000mcg was dispensed on 09/18/25 for a 28-day supply and delivered to the facility on 09/23/25.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am and 11:38am revealed:
-She prescribed Vitamin B12 as a supplement for Vitamin deficiency.
-Missing doses of Vitamin B12 could have messed up the levels and interfered with her decision on whether to increase, decrease or stop the medication.

e. Review of Resident #1's current FL-2 dated 01/26/25 revealed there was an order for Vitamin D3 2000IU (50mcg) (used as a vitamin D3 supplement) take 2 daily.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Vitamin D3 2000IU (50mcg) take 2 tablets daily scheduled at 9:00am.
-Vitamin D3 2000IU (50mcg) was documented as administered at 9:00am 08/01/25 to 08/12/25 and 08/14/25 to 08/31/25.
-Vitamin D3 2000IU (50mcg) was not documented as administered on 08/13/25 with the exception documented as "resident asleep".

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Vitamin D3 2000IU (50mcg) take 2 tablets daily scheduled at 9:00am.
-Vitamin D3 2000IU (50mcg) was documented as administered at 9:00am 09/01/25 to 09/23/25,

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09/25/25 to 09/26/25, and 09/28/25 to 09/30/25.
-Vitamin D3 2000IU (50mcg) was documented as not administered on 09/24/25 and 09/27/25, with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Vitamin D3 2000IU (50mcg) dispensed on 09/25/25 with a quantity of 56.
-There were 42 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.
-Vitamin D3 was an over the counter (OTC) supplemental vitamin.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Vitamin D3 2000IU (50mcg) 2 tablets daily were dispensed on 07/24/25 for 56 tablets and delivered to the facility on 07/29/25.
-Vitamin D3 2000IU (50mcg) was dispensed on 08/21/25 for 56 tablets and delivered to the facility on 08/26/25.
-Vitamin D3 2000IU (50mcg) was dispensed on 09/18/25 for 56 tablets and delivered to the facility on 09/23/25.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am and 11:38am revealed:
-She prescribed Vitamin D3 as a supplement for Vitamin deficiency.
-Missing doses of Vitamin D3 could have messed up the levels and interfered with her decision on whether to increase, decrease or stop the

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medication.

f. Review of Resident #1's record revealed there was an order dated 02/26/25 for Mirtazapine 30mg (used to treat mood disorder and appetite) at bedtime.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Mirtazapine 30mg at bedtime scheduled at 9:00pm.
-Mirtazapine 30mg was documented as administered at 9:00pm 08/01/25 to 08/10/25, 08/12/25 to 08/15/25, and 08/17/25 to 08/31/25.
-Mirtazapine 30mg was not documented as administered on 08/11/25 and 08/16/25, with the spaces for documentation on those dates left blank.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Mirtazapine 30mg at bedtime scheduled at 9:00pm.
-Mirtazapine 30mg was documented as administered at 9:00pm 09/01/25 to 09/12/25, 09/14/25 to 09/25/25, and 09/27/25 to 09/30/25.
-Mirtazapine 30mg was not documented as administered on 09/13/25 and 09/26/25, with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Mirtazapine 30mg dispensed on 09/25/25 with a quantity of 28.
-There were 21 pills remaining.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill.

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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
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The medication had multiple indications, but the indications were not listed on the order.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Mirtazapine 30mg at bedtime was dispensed on 07/24/25 for a 28-day supply and delivered to the facility on 07/29/25.
-Mirtazapine 30mg was dispensed on 08/21/25 for a 28-day supply and delivered to the facility on 08/26/25.
-Mirtazapine 30mg was dispensed on 09/18/25 for a 28-day supply and delivered to the facility on 09/23/25.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed:
-She prescribed Mirtazapine for depression, insomnia and an appetite stimulant.
-She was not concerned about Resident #1 missing the Mirtazapine because she sundowned and waking her up to give her a medication that was prescribed to help her sleep did not make sense.

g. Review of Resident #1's record revealed there was an order dated 08/13/25 for Lorazepam 0.5mg (used to treat anxiety) 3 times daily.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 3 times a day scheduled at 8:00am, 2:00pm and 8:00pm.
-Lorazepam 0.5mg was documented as administered at 8:00am 08/14/25 to 08/31/25.
-Lorazepam 0.5mg was documented as administered at 2:00pm 08/14/25 to 08/21/25, 08/23/25 to 08/26/25 and 08/28/25, 08/29/25 and

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08/31/25.
-Lorazepam 0.5mg was documented as not administered at 2:00pm on 08/22/25, with the exception documented as "resident asleep".
-Lorazepam 0.5mg was not documented as administered at 2:00pm on 08/27/25, with the space for documentation on this date having 2 dash marks (--) in the box.
-Lorazepam 0.5mg was not documented as administered at 2:00pm on 08/30/25, with the space for documentation on this date left blank.
-Lorazepam 0.5mg was documented as administered at 8:00pm 08/14/25 to 08/15/25 and 08/17/25 to 08/31/25.
-Lorazepam 0.5mg was not documented as administered at 8:00pm on 08/16/25, with the space for documentation on this date left blank.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 3 times a day scheduled at 8:00am, 2:00pm and 8:00pm.
-Lorazepam 0.5mg was documented as administered at 8:00am 09/01/25 to 09/23/25, 09/25/25 to 09/26/25, and 09/29/25 to 09/30/25.
-Lorazepam 0.5mg was not documented as administered at 2:00pm on 09/24/25, 09/27/25 and 09/28/25, with the exception documented as "resident asleep".
-Lorazepam 0.5mg was documented as administered at 2:00pm 09/01/25 to 09/14/25, 09/16/25 to 09/24/25, 09/26/25 and 09/28/25 to 09/30/25.
-Lorazepam 0.5mg was documented as not administered at 2:00pm on 09/15/25 and 09/25/25, with the exception documented as "resident asleep".
-Lorazepam 0.5mg was not documented as administered at 2:00pm on 09/27/25, with the

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space for documentation on this date left blank.
-Lorazepam 0.5mg was documented as administered at 8:00pm 09/01/25 to 09/12/25, 09/14/25 to 09/25/25, and 09/27/25 to 09/30/25.
-Lorazepam 0.5mg was documented as not administered at 8:00pm on 09/13/25 and 09/26/25, with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Lorazepam 0.5mg dispensed on 09/10/25 with a quantity of 90 total (3 bubble packs of 30).
-There were 2 bubble packs remaining.
-There were 11 of 30 tablets remaining in the first bubble pack and 30 of 30 tablets remaining in the second bubble pack.

Review of the controlled substance log for Resident #1's Lorazepam 0.5mg tablets on 10/03/25 at 3:20pm revealed there was a quantity of 41 tablets remaining.

h. Review of a progress note dated 06/07/25 revealed there was an order for Memantine HCL 10mg (used to treat dementia) daily.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Memantine HCL 10mg every 12 hours scheduled at 9:00am and 9:00pm.
-Memantine HCL 10mg was documented as administered at 9:00am 08/01/25 to 08/12/25 and 08/14/25 to 08/31/25.
-Memantine HCL 10mg was documented as not administered on 08/13/25, with the exception documented as "resident asleep".
-Memantine HCL 10mg was documented as administered at 9:00pm 08/01/25 to 08/10/25,

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08/12/25 to 08/15/25, and 08/17/25 to 08/31/25.
-Memantine HCL 10mg was not documented as administered on 08/11/25 and 08/16/25, with the spaces for documentation on those dates left blank.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Memantine HCL 10mg every 12 hours scheduled at 9:00am and 9:00pm.
-Memantine HCL 10mg was documented as administered at 9:00am 09/01/25 to 09/09/25, 09/11/25 to 09/23/25, 09/25/25 to 09/26/25 and 09/28/25 to 09/30/25.
-Memantine HCL 10mg was not documented as administered on 09/10/25 at 9:00am, with the space for documentation on that date left blank.
-Memantine HCL 10mg was documented as not administered on 09/24/25 and 09/27/25 at 9:00am, with the exception documented as "resident asleep".
-Memantine HCL 10mg was documented as administered at 9:00pm 09/01/25 to 09/12/25, 09/14/25 to 09/25/25, and 09/27/25 to 09/30/25.
-Memantine HCL 10mg was not documented as administered on 09/13/25 and 09/26/25, with the exception documented as "resident asleep".

Observation of Resident #1's medications on hand on 10/03/25 at 3:20pm revealed:
-There was a bubble pack of Memantine HCL 10mg dispensed on 09/25/25 with a quantity of 56.
-There were 14 pills remaining on pack 1 of 2.

Interview with a pharmacist at the facility contracted pharmacy on 10/03/25 at 4:02pm revealed:
-Resident #1's medications were on cycle refill. The medication had multiple indications, but the

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indications were not listed on the order.
-Occasionally missing the medications would not have had an effect but without knowing Resident #1, she could not say what effect missing the medication would have had on the resident.
-Memantine 10mg every 12 hours was dispensed on 07/24/25 for 56 tablets and delivered to the facility on 07/29/25.
-Memantine 10mg was dispensed on 08/21/25 for 56 tablets and delivered to the facility on 08/26/25.
-Memantine 10mg was dispensed on 09/18/25 for 56 tablets and delivered to the facility on 09/23/25.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed:
-She prescribed Memantine for dementia.
-She was not concerned about Resident #1 missing Memantine because the medication built up in the system and did not just leave the system after missed doses.

Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:03pm revealed blank spaces on the eMAR meant the medication was not administered or the MA did not document that the medication was administered.

Interview with the Special Care Coordinator (SCC) on 10/03/25 at 5:03pm revealed:
-When administering medication, the medication aide (MA) was supposed to look at the medication and compare the label to the eMAR, scan the medication, administer the medication to the resident and document that the medication was administered.
-If a medication was not administered, the MA was supposed to choose a reason that the medication was not administered from the

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drop-down menu in the exceptions section of the eMAR.
-She was not aware of the blank spaces and missed medications due to Resident #1 being asleep.
-There should not have been any blank spaces on the eMAR.
-Circled initials on the eMAR meant the medication was not administered and there should have been an exception documented as to why the medication was not administered.
-She was unsure what the 2 dash marks (--) meant on the eMAR.
-By the time the MA documented a medication as not administered due to residents being asleep, the MA should have tried to administer the medication 3 times.
-The MAs did not document their 3 attempts to administer medication to residents anywhere.
-The PCP was supposed to be notified after medication was not administered 2 consecutive times.
-Prior to 09/30/25, shift reports were completed by the supervisor for each shift and kept in a binder at the Nurse's station.
-There was a section on the shift report titled "Additional information" where the supervisor documented any medication that was not administered due to the resident being asleep or any reason why the medication was not administered.
-As of 09/30/25, the shift report was given to the SCC each night.

Interview with the Administrator on 10/03/25 at 6:10pm revealed she was not aware of the missed medications for Resident #1.

Interview with the facility's contracted mental health provider on 10/03/25 at 4:26pm revealed:

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D 358	Continued From page 67 -She was aware Resident #1 missed medications. -Staff discussed Resident #1 missing medications due to her being asleep when the medication was due to be administered. -Resident #1 went from agitated to fighting to sleeping and then staff not being able to wake her up to administer medication. -It was best to let Resident #1 sleep if she was already sleeping when it was time to administer medication because if staff woke the resident, she would have been up trying to walk. -Resident #1 had behaviors of pinching and slapping others. -Resident #1's dementia progressed significantly in the past 2 months (August 2025 and September 2025). -Resident #1 would get so agitated that her gait would become very unsteady -Missing a couple of doses of the medications prescribed was not detrimental to Resident #1. -Missing the medications prescribed did not have an effect on Resident #1's behaviors because of the half-life of the medications. -Resident #1 had an as needed medication for administration if she missed scheduled medications and woke up agitated. -In general, she expected medications to be administered as ordered unless there was an acute circumstance. -She expected to be contacted if a resident consistently missed medications (2 to 3 doses). -She did not expect to be contacted when sporadic doses of medication were missed. -Missed medications had nothing to do with Resident #1's behavior. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am and 11:38am revealed:	D 358		

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D 358	Continued From page 68 -She was not aware medications had been documented as not administered due to the resident being asleep or had blank spaces on the MAR. -She was unsure why the medications had not been documented as not administered. -She expected medication orders to be followed by the facility. -Divalproex, Lexapro, Mirtazapine, Memantine, Lorazepam and Donepezil were prescribed by Resident #1's mental health provider. -The blank spaces on the MAR for Memantine and Donepezil meant Resident #1 was not kept on a regular level of the medication which did not help her dementia. -Not administering mental health medications could have created anxiety and behaviors in Resident #1. -Resident #1 had wandering behaviors. -She received a lot of reports of falls and behaviors for Resident #1. -Missing Mirtazapine, Lorazepam, Lexapro, Memantine, Divalproex and Donepezil could have contributed to Resident #1's falls, behaviors and wandering but she couldn't say for sure. Based on observations, interviews, and record reviews, Resident #1 was not interviewable. Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm.	D 358		

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D 358	Continued From page 69 Refer to second interview with the primary care provider (PCP) on 10/03/25 at 11:18am. 4. Review of Resident #4's current FL-2 dated 08/19/25 revealed: -Diagnoses included insulin dependant diabetes type II and right below the knee amputation (BKA). -She was semi-ambulatory with a wheelchair. -She was admitted to the facility on 08/19/25. Review of Resident #4's nursing note dated 08/19/25 revealed she was admitted that night as an emergency admission from local county Department of Social Services. Review of Resident #4's provider progress note dated 09/22/25 revealed: -Resident #4 was diagnosed with a urinary tract infection (UTI). -Levaquin 500mg was to the administered daily for 10 days. Review of Resident #4's electronic medication administration record (eMAR) for September 2025 revealed there was no entry for Levaquin 500mg to be administered. Review of Resident #4's eMAR for October 2025 revealed: -There was an electronic entry for Levaquin 500mg to be administered daily for 10 days and scheduled for 7:00am. -There was documentation the order was written on 09/22/25 and the stop date was 10/10/25. -There was documentation Levaquin 500mg was administered on 10/01/25 through 10/03/25. Observation of Resident #4's medications on	D 358		

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hand for administration on 10/02/25 at 3:43pm revealed:
-There was a dispensing card labeled Levaquin 500mg with instructions to take every day for 10 days.
-The label documented that 10 tablets were dispensed on 09/30/25.
-There were 8 doses remaining.

Interview with Resident #4 on 10/02/25 at 9:47pm revealed:
-She had a UTI a few weeks prior with pain in her groin area. (date unknown)
-She just received the first dose of antibiotic on 10/01/25 but should have almost finished the course of antibiotics by that point in time.
-She continued to experienced almost constant pain.
-She rated the pain in her groin a 7 on an scale from 1-10.
-She did not experience increased urinary frequency and her sleep was not disrupted due to the UTI.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 10/03/25 at 3:47pm revealed:
-Resident #4 was ordered Levaquin 500mg daily for 10 days on 09/22/25.
-The pharmacy dispensed 10 tablets for a 10 day supply on 09/30/25.
-She did not know why there was a delay in dispensing the Levaquin for Resident #4.

Telephone interview with a second pharmacist on 10/03/25 at 4:59pm revealed:
-Resident #4's Levaquin order was faxed to the pharmacy on 09/29/25 at 9:23pm.
-Pharmacy cut off time for same day dispensing was 5:00pm so the medication was not filled until

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D 358	Continued From page 71 the next day. Interview with Resident #4's primary care provider (PCP) on 10/03/25 at 3:05pm revealed: -Resident #4 was ordered Levaquin to treat a UTI during which she experienced increased confusion and painful urination. -The antibiotic should have started at least by the day after it was ordered. -She was not aware Levaquin was not started until 10/01/25 after the order was written on 09/22/25. -She would have expected the medication to be obtained from a back up pharmacy if it was not able to be dispensed. -Resident #4's UTI could have gotten worse during the delay in treatment and lead to sepsis. -Sepsis could lead to fever, lethargy, encephalopathy and cause Resident #4 to require IV antibiotics to treat the infection. Interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 6:00pm revealed: -She was responsible for processing orders and sending them to the pharmacy on 09/22/25. -She had already returned to work from vacation when the Resident #4's order for Levaquin came in but it was in a stack of papers and other orders she took to her home to process so it was sent to the pharmacy late. -Resident #4's UTI could have gotten worse due to the delay in processing the order. Interview with the Administrator on 10/03/25 at 5:43pm revealed: -The SCC was responsible for processing orders. -She was not aware there was a delay in starting the course of Levaquin 500mg for Resident #4. -Orders should be sent to the pharmacy as soon as they are received so the medication could be	D 358		

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dispensed and administered as ordered.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

5. Review of Resident #2's current FL-2 dated 03/26/25 revealed:
-Diagnoses included vascular dementia, generalized anxiety and insomnia.
-There was an order for trazodone 50mg, one-half tablet (25mg) to be administered each night.

Review of Resident #2's physician's order dated 08/27/25 revealed trazodone 25mg each night was to be discontinued.

Review of Resident #2's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for trazodone 50mg, one-half tablet (25mg) to be administered each night at bedtime and scheduled for 8:00pm with a start date of 11/11/24 and a stop date of

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08/27/25.
-There was documentation trazodone 50mg, one-half tablet (25mg) was not administered on 08/01/25 through 08/15/25 and on 08/17/25 through 08/27/25 because they were waiting on prior authorization.
-There was no documentation trazodone was administered on 08/16/25 with no documented reason for the omission of administration.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 10/03/25 at 3:47pm revealed:
-A 28 day supply of Trazodone (14 tablets) was last dispensed on 08/21/25 but was returned in full.
-A 28 day supply of Trazodone (14 tablets) was previously dispensed on 07/24/25 and was returned in full.
-She was not sure why the medications were returned to the pharmacy.

Telephone interview with a second pharmacist for the facility's contracted pharmacy on 10/03/25 at 4:59pm revealed the dispensing card sent on 07/24/25 was to start on 07/31/25 but was returned to the pharmacy in full but she did not know why.

Telephone interview with Resident #2's mental health provider on 10/03/25 at 4:04pm revealed:
-Resident #4 was prescribed trazodone to treat insomnia due to dementia.
-She could see in the system that Resident #4 was not administed trazodone on July 31st and in August because the pharmacy needed prior authorization but they did not always communicate well.
-Resident #2's sleep could have been disrupted by trazodone not being administered as

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prescribed but she was not in danger of withdrawal from the medication.

Interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 6:00pm revealed:
-She found that Resident #2's trazodone had not been administered during a quality review of the chart. (date unknown)
-She was told by a medication aide that Resident #2's medications had not come from pharmacy.
-She contacted the pharmacy for a refill and was told it was too soon to refill the order in August 2025.
-She did not know trazodone had been returned to the pharmacy or why it was sent back.
-There was no process in place for consistent review of eMARS but planned to implement one.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

6. Review of Resident #3's current FL2 dated 04/16/25 revealed:
-Diagnoses included unspecified dementia,

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diabetes type 2, and hyperlipidemia.
-Her level of care was special care unit.

a. Review of Resident #3's signed hospital discharge summary dated 07/31/25 revealed an order for benztropine (benztropine is used to treat movement disorders) 1mg, take one tablet twice per day.

Review of Resident #3's August 2025 electronic medication administration (eMAR) record revealed:
-There was an entry for benztropine 1mg, take one tablet twice per day scheduled at 8:00am and 8:00pm.
-Benztropine 1mg was documented as not administered at 8:00am on 08/11/25, with the exception documented as "resident asleep".
-Benztropine 1mg was not documented as administered at 8:00pm on 08/11/25, with no exception documented and the space for initials on the eMAR was blank.
-Benztropine 1mg was not documented as administered at 8:00pm on 08/16/25, with no exception documented and the space for initials on the eMAR was blank.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for benztropine 1mg, take one tablet twice a day scheduled at 8:00am and 8:00pm.
-Benztropine 1mg was documented as not administered at 8:00am on 09/15/25, with the exception documented as "resident asleep.

Observation of Resident #3's medications on hand on 10/02/25 at 4:20pm revealed:
-There were two bubble packs of benztropine 10mg dispensed on 09/25/25 each with 28 tablets

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for a quantity of 56 tablets.
-There were 13 benztropine 10mg tablets remaining on pack 1 of 2 and 28 benztropine 10mg tablets remaining in pack 2 of 2.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed:
-An order was received for Resident #3 for benztropine 1mg, take one tablet twice a day on 07/31/25.
-Benztropine 1mg, was dispensed for Resident #3 on 07/31/25, 08/21/25, and 09/18/25 for a quantity of 56 tablets each time for a 28-day supply, to take one tablet twice a day.

Interview with the facility's contracted primary care provider (PCP) on 10/03/26 at 10:55am revealed benztropine 1mg was prescribed for Resident #3 by behavioral health.

Telephone interview with Resident #3's behavioral health provider on 10/03/25 at 3:48pm revealed:
-Benztropine was prescribed for Resident #3 for tremors.
-Being without the benztropine could cause Resident #3 to have an increase in tremors and affect her swallowing.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

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D 358	Continued From page 77 Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. b. Review of Resident #3's signed physicians order sheet dated 04/14/25 revealed there was an order for carbamazepine (carbamazepine is used to treat seizures) 100mg, take 2 tablets (200mg) twice per day. Review of Resident #3 August 2025 electronic medication administration (eMAR) record revealed: -There was an entry for carbamazepine 100mg, take 2 tablets twice a day scheduled at 8:00am and 8:00pm. -Carbamazepine 100mg, was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep". -Carbamazepine 100mg was not documented as administered at 8:00pm on 08/11/25 with no exception documented and the space for initials on the eMAR was blank. -Carbamazepine 100mg was not documented as administered at 8:00pm on 08/16/25 with no exception documented and the space for initials on the eMAR was blank. Review of Resident #3's September 2025 eMAR revealed: -There was an entry for carbamazepine 100mg, take 2 tablets twice a day scheduled at 8:00am and 8:00pm. -Carbamazepine 100mg was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep".	D 358		

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D 358	Continued From page 78 Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/03/25 at 3:14pm revealed: -An order was received originally for Resident #3's carbamazepine 100mg on 09/30/22, to take 2 tablets twice a day. -Carbamazepine 100mg, was dispensed for Resident #3 on 07/24/25, 08/21/25, and 09/18/25 for a quantity of 112 tablets each time for a 28-day supply, to take 2 tablets twice per day. Interview with the facilty's contracted primary care provider (PCP) on 10/03/26 at 10:55am revealed carbamazepine 100mg was prescribed for Resident #3 by behavioral health. Telephone interview with Resident #3's behavioral health provider on 10/03/25 at 3:48pm revealed: -Carbamazepine 100mg was prescribed for Resident #3 for seizures. -She was not overly concerned about sporadic missed doses of the carbamazepine, but multiple missed doses could cause Resident #3's blood level of carbamazepine to be below the therapeutic range putting her at risk for seizure activity. Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm. Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.	D 358		

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D 358	Continued From page 79 Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. c. Review of Resident #3's signed physician's orders dated 04/14/25 revealed an order for clopidogrel (clopidogrel is an anti-platelet medication used to prevent blood clots, which can reduce the chance of heart attack and stroke)75mg, take one tablet every day. Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for clopidogrel 75mg, take one tablet every day scheduled at 8:00am. -There was documentation that clopidogrel 75mg was not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep". Review of Resident #3's September 2025 eMAR revealed: -There was an entry for clopidogrel 75mg, take one tablet every day scheduled at 8:00am. -Clopidogrel 75mg was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep". Observation of Resident #3's medications on hand on 10/02/25 at 4:20pm revealed: -There was a bubble pack of clopidogrel 75mg tablets dispensed on 09/25/25 for a quantity of 28 tablets. -There were 20 clopidogrel 75mg tablets remaining in the pack. Telephone interview with a pharmacist with the	D 358		

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facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's clopidogrel 75mg on 09/30/22 to take one tablet every day.
-Clopidogrel 75mg was dispensed for Resident #3 on 07/24/25, 08/21/25 and 09/18/25 for a quantity of 28 tablets each time for a 28-day supply to take one tablet every day.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Clopidogrel was a blood thinner.
-She prescribed clopidogrel for Resident #3 to help reduce the chance of a blood clot or stroke.
-Missed doses of clopidogrel could put Resident #3 at risk for stroke or blood clots.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

d. Review of Resident #3's signed physician's order sheet dated 04/14/25 revealed an order for

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Vitamin D3 (Vitamin D3 is a supplement used to support bone health) 2000 units, take one tablet every day.

Review of Resident #3's August 2025 electronic medication administration (eMAR) revealed:
-There was an entry for Vitamin D3 2000 units take one capsule every day scheduled at 8:00am.
-Vitamin D3 was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep".

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for Vitamin D3 2000 units take one capsule every day scheduled at 8:00am.
-Vitamin D3 was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep".

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's Vitamin D3 2000 units on 09/30/22, to take one capsule every day.
-Vitamin D3 2000 units was dispensed for Resident #3 on 07/24/25, 08/21/25, and 09/18/25 for a quantity of 28 tablets each time for a 28-day supply to take one capsule daily.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-She prescribed Vitamin D3 for Resident #3 for low Vitamin D levels.
-Missing doses of Vitamin D3 could cause her blood levels of Vitamin D3 to be low.
-Vitamin D3 supported bone health for Resident #3 and helped to treat osteoporosis (low bone

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density).
Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

e. Review of Resident #3's signed physician's order sheet dated 04/14/25 revealed an order for docusate (docusate is a stool softener used for constipation) sodium 100mg, take one capsule twice a day.

Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for docusate sodium 100mg, take one capsule twice a day scheduled at 8:00am and 8:00pm.
-Docusate sodium 100mg was documented as not administered at 8:00am on 08/11/25 with exception documented as "resident asleep".
-Docusate sodium 100mg was not documented as administered at 8:00pm on 08/11/25 with no exception documented and the space for initials on the eMAR was blank.
-Docusate sodium 100mg was not documented

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as administered at 8:00pm on 08/16/25 with no exception documented and the space for initials on the eMAR was blank.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for docusate sodium 100mg, take one capsule twice a day scheduled at 8:00am and 8:00pm.
-Docusate sodium 100mg was documented as not administered at 8:00am on 09/15/25 with exception documented as "resident asleep".

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's docusate sodium 100mg on 09/30/22 to take one capsule twice a day.
-Docusate Sodium 100mg was dispensed for Resident #3 on 07/24/25, 08/21/25, and 09/18/25 for a quantity of 56 capsules each time for a 28-day supply to take one capsule twice a day.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Docusate sodium was prescribed for Resident #3 to help prevent and treat constipation.
-Missed doses of docusate could cause Resident #3 to experience abdominal pain and discomfort associated with constipation.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care

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Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm.

Refer to interview with the Administrator on 10/03/25 at 7:40pm.

Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am.

f. Review of Resident #3's hospital discharge summary dated 07/31/25 revealed an order for lorazepam (lorazepam is used to treat anxiety disorders) 0.5mg, take one tablet three times per day.

Review of Resident #3's August electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg, take one tablet three times a day, scheduled at 8:00am, 1:00pm and 8:00pm.
-Lorazepam 0.5mg was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep".
-Lorazepam 0.5mg was not documented as administered at 8:00pm on 08/11/25 with no exception documented and the space for initials on the eMAR was blank.
-Lorazepam 0.5mg was not documented as administered at 8:00pm on 08/16/25 with no exception documented and the space for initials on the eMAR was blank.
-Lorazepam 0.5mg was documented as not administered at 1:00pm on 08/20/25 with the exception documented as "resident asleep".
-Lorazepam 0.5mg was not documented as administered at 1:00pm on 08/30/25 with no

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exception documented and the space for initials on the eMAR was blank.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet three times a day, scheduled at 8:00am,1:00pm, and 8:00pm.
-Lorazepam 0.5mg was documented as not administered at 8:00pm on 09/01/25, and at 8:00am, 1:00pm and 8:00pm on 09/02/25, with the exception documented as "error on order" for each occasion.
-Lorazepam 0.5mg was documented as not administered at 8:00am,1:00pm , and 8:00pm on 09/03/25 with the exception documented as "awaiting RX/MD prior auth on each occasion.
-Lorazepam 0.5mg was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep".
-Lorazepam 0.5mg was documented as not administered at 1:00pm on 09/15/25 with the exception documented as "resident refused".

Observation of Resident #3's medications on hand on 10/02/25 at 4:20pm revealed:
-There was a bubble pack of lorazepam 0.5mg tablets dispensed on 09/15/25 for a quantity of 45 tablets.
-There were 6 lorazepam 0.5mg tablets remaining in the pack.

Review of the controlled substance log for Resident #3's lorazepam 0.5mg tablets on 10/02/25 at 4:40pm revealed a quantity of 6 tablets of lorazepam 0.5mg tablets remaining.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 86 -An order was received for Resident #3's lorazepam 0.5mg on 07/31/25 to take one tablet three times a day. -Lorazepam 0.5mg was dispensed for Resident #3 on 07/31/25 for a quantity of 90 tablets, to take three times a day for a 30-day supply. -Lorazepam 0.5mg was dispensed for Resident #3 on 09/03/25 and on 09/15/25 for a quantity of 45 tablets each time for a 15-day supply to take one tablet three times a day. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed: -Lorazepam was prescribed for Resident #3 for anxiety, -Missing doses of lorazepam could increase Resident #3's anxiety level and heart rate. Telephone interview with Resident #3's behavioral health provider on 10/03/25 at 3:48pm revealed: -Resident #3 was prescribed lorazepam for anxiety. -Missing consecutive doses of lorazepam could cause Resident #3 to experience increased anxiety and agitation. Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm. Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm. Refer to interview with the Administrator on	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 87 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. g. Review of Resident #3's signed physician's order sheet dated 04/14/25 revealed an order for memantine (memantine is used to treat moderate to severe dementia associated with Alzheimer's Disease) HC 28 mg ER, take one capsule every day for dementia. Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for memantine HC 28 mg ER, take one capsule every day for dementia, scheduled at 8:00am. -Memantine HC 28 mg ER was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep". -Memantine HC 28 mg ER was not documented as administered at 8:00am on 08/12/25 with no exception documented and the space for initials on the eMAR was blank. Review of Resident #3's September 2025 eMAR revealed: -There was an entry for memantine HC 28 mg ER, take one capsule every day for dementia, scheduled at 8:00am. -Memantine HC 28 mg ER was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep". Observation of Resident #3's medications on hand on 10/02/25 at 4:20pm revealed: -There was a bubble pack of memantine HC 28mg ER capsules dispensed on 09/25/25 for a	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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quantity of 28 tablets.
-There were 20 memantine HC 28mg ER capsules remaining in the pack.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's memantine HC 28 mg ER on 09/30/22 to take one capsule every day for dementia.
-Memantine HC 28 mg ER was dispensed for Resident #3 on 07/24/25, 08/21/25 and 09/18/25 for a quantity of 28 tablets each time for a 28-day supply to take one capsule every day for dementia.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Memantine was prescribed for Resident #3 for dementia.
-It was important for Resident #3 to receive the memantine as ordered to maintain a constant level of the medication in her system.
-Missing doses of the memantine could cause the resident to experience anxiety or behavioral changes.

Telephone interview with Resident #3's behavioral health provider on 10/03/25 at 3:48pm revealed:
-Memantine was prescribed for Resident #3 for dementia.
-She was not overly concerned about the missed doses of memantine for Resident #3.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

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D 358	Continued From page 89 Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. h. Review of Resident #3's signed physician's order sheet dated 04/14/25 revealed an order for metformin (metformin is used to treat type 2 diabetes) 500mg, take a half of a tablet every day. Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for metformin 500mg, take a half of a tablet (250mg) every day scheduled at 8:00am. -Metformin 500mg, half tablet was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep". Review of Resident #3's September 2025 eMAR revealed: -There was an entry for metformin 500mg, take a half of a tablet (250mg) every day scheduled at 8:00am. -Metformin 500mg, half tablet was documented as not administered at 8:00am on 09/15/25 with the exception documented as "resident asleep". Observation of Resident #3's medications on	D 358		

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hand on 10/02/25 at 4:20pm revealed:
-There was a bubble pack of metformin 500mg tablets dispensed on 09/25/25 for a quantity of 14 tablets (28 half tablets).
-There were 20 half tablets of metformin 500mg remaining in the pack

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's metformin 500mg on 09/30/22 to take a half tablet (250mg) every day.
-Metformin 500mg was dispensed on 07/24/25, 08/21/25 and on 09/18/25 for 28 half tablets each time, to take a half tablet daily.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-She prescribed metformin for Resident #3 for type 2 diabetes.
-Missing doses of metformin could cause Resident #3 to experience hyperglycemia or elevated blood sugar which could lead to damage to the organs such as the kidneys, heart, eyes, and could cause neuropathy,
-Symptoms of hyperglycemia include lethargy, sweating, drooling, and dizziness.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm.

Refer to interview with the Special Care

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D 358	Continued From page 91 Coordinator (SCC) on 10/03/25 at 06:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. i. Review of Resident #3's signed physician's order sheet dated 04/14/25 revealed an order for sodium chloride (used to treat low sodium levels in the blood) 1 gram, take one tablet twice a day for supplement. Review of Resident #3's August electronic medication administration record (eMAR) revealed: -There was an entry for sodium chloride 1 gram, take one tablet twice a day for supplement, scheduled at 8:00am and 8:00pm. -Sodium chloride 1 gram was documented as not administered at 8:00am on 08/11/25 with the exception documented as "resident asleep". -Sodium chloride 1 gram was not documented as administered at 8:00pm on 08/11/25 with no exception documented and the space for initials on the eMAR was blank. -Sodium chloride 1 gram was not documented as administered at 8:00pm on 08/16/25 with no exception documented and the space for initials on the eMAR was blank. Review of Resident #3's September 2025 eMAR revealed: -There was an entry for sodium chloride 1 gram, take one tablet twice a day for supplement, scheduled at 8:00am and 8:00pm. -Sodium chloride 1 gram was documented as not administered at 8:00am on 09/15/25 with the	D 358		

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exception documented as "resident asleep".

Observation of Resident #3's medications on hand on 10/02/25 at 4:20pm revealed:
-There were two bubble packs of sodium chloride 1 gram tablets dispensed on 09/25/25 each with 28 tablets for a quantity of 56 tablets.
-There were 13 sodium chloride 1 gram tablets remaining in pack 1 of 2 and 28 sodium chloride 1 gram tablets remaining in pack 2 of 2.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/03/25 at 3:14pm revealed:
-An order was originally received for Resident #3's sodium chloride 1 gram on 09/30/22, to take one tablet twice a day.
-Sodium chloride 1 gram was dispensed for Resident #3 on 07/24/25, 08/21/25, and on 09/18/25 for a quantity of 56 tablets each for a 28-day supply to take one tablet twice a day.

Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:55am revealed:
-Sodium chloride was prescribed for Resident #3 for low sodium level.
-Missing dose of sodium chloride could cause Resident #3's sodium levels to drop which could result in lethargy.
-Also, the sodium-potassium balance could affect the heart.

Refer to interview with a medication aide (MA) on 10/02/25 at 4:20pm.

Refer to interview with a second medication aide (MA) on 10/03/25 at 4:20pm.

Refer to interview with the Resident Care

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D 358	Continued From page 93 Coordinator (RCC) on 10/03/25 at 5:36pm. Refer to interview with the Special Care Coordinator (SCC) on 10/03/25 at 06:33pm. Refer to interview with the Administrator on 10/03/25 at 7:40pm. Refer to second interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 11:18am. _____ Interview with a medication aide (MA) on 10/02/25 at 4:20pm revealed: -If a resident was asleep during the medication pass, she circled back to them to try to administer their medications. -The MAs were to make 3 attempts to administer the residents' medications before documenting that medications were not administered. -An exception was always to be documented if a resident did not receive their medications. -There was never to be blanks on the eMARs. Interview with a second MA on 10/03/25 at 4:20pm revealed: -If a resident refused their medications or were asleep during the medication pass, she moved on to the next resident. -She tried to catch the resident later if she saw them up and about. -An exception was always required on the residents' eMAR if medications were not administered. -There should never be blanks on the eMAR. -There was no policy that she was aware of to notify the PCP of missed medications. -The Special Care Coordinator (SCC) or the Resident Care Coordinator (RCC) were responsible for ordering medication refills for the	D 358		

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residents and requesting refill prescriptions from the PCP.
-She usually notified the SCC or the RCC when a resident was down to 10 doses remaining on a medication if it was not cycle filled.
-The residents' routine medications arrived quickly from the pharmacy.
-New medication orders for the residents sometime took longer to arrive from the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm revealed:
-If a resident was asleep or refused their medications, the MAs were to make three attempts to administer their medications before documenting on the eMAR that a medication was not administered and disposing of the medication.
-An exception should always be documented on the eMAR if medications were not administered.
-If a resident refused or missed two consecutive doses of medication, their PCP was to be notified.
-If a medication was documented as not administered due to "error on order" it meant they were either waiting on the pharmacy to send the medication or waiting on the provider to approve or send a medication refill.
-The facility occasionally had internet issues and that could have been why there were blanks on the residents' eMARs.
-She, the SCC and the Administrator performed eMAR audits monthly to make sure medications were administered to the residents as ordered.
-She was not sure when an eMAR audit had last been performed.
-She or the SCC did medication cart audits periodically.
-A medication cart audit consisted of making sure the residents' medications were available and removing expired or discontinued medications

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D 358	Continued From page 95 from the medication cart. Interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm revealed: -The MAs were to make three attempts to administer a resident's medications during each med pass. -Monthly eMAR audits were done to look for medications not administered or refused. -She looked for patterns such as refusal or residents being asleep at the medication pass time so she could discuss with staff and the resident's PCP if needed. -She was not sure when the last eMAR audit was. -There should never be blanks or holes on the residents' eMARs. -There should always be an exception as to why medications were not administered. -The MAs could request refills or the MAs let her or the RCC know if medication refills were needed. -When a medication order was received for a resident, it was sent to the pharmacy and if the medication did not arrive within 24 hours she contacted the pharmacy. -There should never be blanks or gaps on the residents' eMARs, the MAs needed to slow down and take their time and be thorough with their documentation. Interview with the Administrator on 10/03/25 at 7:40pm revealed: -If a medication was not available on the medication cart for a resident, she expected staff to immediately notify the pharmacy. -She expected medications to be re-ordered before a resident ran out of medication. -If a resident refused medications or was asleep during the medication pass, the MAs were to make 3 attempts to administer the medications to	D 358		

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D 358	Continued From page 96 the resident. -She expected medications to be administered to the residents as ordered and there should never be blanks or gaps on the eMARs. -The RCC and SCC performed monthly eMAR audits, looking for refusals or blanks on the eMARs. -The RCC and SCC were responsible for monthly medication cart audits to make the residents medications were available for administration as ordered. Second interview with the facility's contracted primary care provider on 10/03/25 at 11:18am revealed: -If a resident was asleep at the time of the medication pass, she expected the MA to cycle back to the resident to administer their medications. -Medications could be administered to the residents up to one hour before or after the scheduled dose. -Also, if there continued to be an issue with the resident's sleep schedule and the medication pass, the MAs should notify her so she could consider changing the scheduled dose time. _____ The facility's failure to administer medications as ordered to the residents pertaining to a 7:00am missed dose of short-acting and long-acting insulins that resulted in Resident #5's FSBSs being above 400 at 11:00am and 4:00pm the same day as the missed dose of insulins, Resident #4 had an order for antibiotics to treat a urinary tract infection that was not administered until 9 days after the antibiotic was ordered and the previous course of antibiotics was not completed, Resident #1 missed mood, anxiety and dementia medications that could have led to change in behaviors. This failure resulted in	D 358		

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D 358	Continued From page 97 substantial risk of serious injury to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/03/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 02, 2025	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the 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).	D 367		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 1 of 5 sampled residents (#4) related to documentation of medications used to infection.

The findings are:

Review of Resident #4's current FL-2 dated 08/19/25 revealed:
-Diagnoses included insulin dependant diabetes type II and right below the knee amputation (BKA).
-She was semi-ambulatory with a wheelchair.
-She was admitted to the facility on 08/19/25.

Review of Resident #4's nursing note dated 08/19/25 revealed she was admitted that night as an emergency admission from local county Department of Social Services.

Interview with Resident #4 on 10/02/25 at 9:47pm revealed:
-She had an amputation of her right lower leg in 2016.
-She fell prior to admission and sores on her stump that weren't healing well.
-She was prescribed antibiotics after admission to treat infection of the sores.

Observation of Resident #4 on 10/02/25 at 9:47 revealed:
-Resident #4 had a right BKA.
-There were 5 wounds at the end of her stump at various stages of healing.
-There was no drainage or odor observed.

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 99 Review of Resident #4's physician's order dated 08/25/25 revealed Bactrim DS, one tablet, every 12 hours for 10 days. (Bactrim is an antibiotic medication used to treat infection.) Review of Resident #4's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for SMZ/TMP DS, take one tablet every 12 hours for 10 days with a stop date of 09/06/25 and scheduled for 7:00am and 7:00pm. (SMZ/TMP DS is the equivalent of Bactrim DS) -There was documentation SMZ/TMP DS was not administered at 7:00am and 7:00pm because of waiting for prescription or prior authorization. -There was documentation SMZ/TMP DS was administered at 7:00am on 08/29/25 through 08/31/25. -There was documentation SMZ/TMP DS was administered at 7:00pm on 08/30/25 and 08/31/25. -There was no documentation SMZ/TMP DS was administered at 7:00pm on 08/29/25 and there was no documented reason for the omission of administration. -There was documentation 5 doses were administered to complete 2 and one half days of the 10 day course of antibiotics. Review of Resident #4's eMAR for September 2025 revealed: -There was an electronic entry for SMZ/TMP DS, take one tablet every 12 hours for 10 days with a stop date of 09/06/25 and scheduled for 7:00am and 7:00pm. -There was documentation SMZ/TMP DS was administered at 7:00am and 7:00pm on 09/01/25 through 09/06/25.	D 367		

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-There was documentation 12 doses were administered to complete 6 days of the 10 day course of antibiotics
-There was documentation 17 doses were administered from 08/29/25 to 09/06/25.

Review of Resident #4's controlled drug record revealed:
-There was documentation 20 tablets of SMZ/TMP DS were received but there was no date of receipt.
-There was documentation 1 tablet was administered at 8:00am on 08/29/25.
-There was documentation 1 tablet was administered at 8:00am and 8:00pm on 08/30/25 through 09/07/25.
-There was documentation 19 doses were administered from 08/29/25 to 09/07/25.

Interview with a medication aide (MA) on 10/02/25 at 3:50pm revealed:
-Antibiotic medications were accounted for and each was signed out as if it were a controlled drug.
-The administration of the antibiotic was to be documented on the eMAR.

Interview with a second MA on 10/03/25 at 4:20pm revealed:
-An exception was always required on the residents' eMAR if medications were not administered.
-There should never be blanks on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 5:36pm revealed:
-An exception should always be documented on the eMAR if medications were not administered.
-The facility occasionally had internet issues and that could have been why there were blanks on

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D 367	Continued From page 101 the residents' eMARs. -She, the Special Care Coordinator (SCC) and the Administrator performed eMAR audits monthly to make sure medications were administered to the residents as ordered. -She was not sure when an eMAR audit had last been performed. Interview with the Special Care Coordinator (SCC) on 10/03/25 at 6:33pm revealed: -Monthly eMAR audits were done to look medications not administered or refused. -She was not sure when the last eMAR audit was. -There should never be blanks or holes on the residents' eMARs. -There should always be an exception as to why medications were not administered. -There should never be blanks or gaps on the residents' eMARs, the MAs needed to slow down and take their time and be thorough with their documentation. Interview with the Administrator on 10/03/25 at 7:40pm revealed: -She expected medications to be administered to the residents as ordered and there should never be blanks or gaps on the eMARs. -The RCC and SCC performed monthly eMAR audits, looking for refusals or blanks on the eMARs.	D 367		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent	D 371		

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D 371	Continued From page 102 cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides observed during the 7:00am to 8:00am medication pass on 10/01/25, who did not sanitize her hands between the preparation and administration of medications to each resident to prevent the transmission of disease, infection, prevent cross-contamination, to provide a safe and sanitary environment for residents. The findings are: Review of the facility's Infection Prevention and Control policy dated 12/31/21 revealed: -The facility will provide access to alcohol-based sanitizer with at least 60% alcohol throughout the facility and keep sinks stocked with soap and paper towels. -Remind residents, visitors, and staff to frequently perform hand hygiene, -Hand hygiene, wash hands often with soap and water for 20 seconds. -Always wash immediately after removing gloves and after contact with a person who is sick. -If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. -If hands are visibly dirty, always wash hands with soap and water. Review of the facility's Blood Glucose Monitoring/Insulin Administration Policy dated	D 371		

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D 371	Continued From page 103 12/31/21 revealed: -Staff will wear gloves during blood glucose monitoring, insulin administration, and during any other procedures that involve potential exposure to blood or bodily fluids. -Staff will change gloves between resident contacts. -Staff will change gloves that have touched potentially blood-contaminated objects or finger-stick wounds before touching clean surfaces. -Staff will perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other persons. Review of the facility's Standard Precautions Policy dated 12/31/21 revealed: -Staff will wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood and body fluids. -Perform hand hygiene immediately after removing gloves. Observation of the medication aide (MA), Staff A, during the medication pass on 10/01/25 between 8:55am and 9:11am revealed: -There was no hand sanitizer on the medication cart located in the Special Care Unit. -The MA returned to the medication cart from the common resident seating area. -She did not sanitize her hands. -She reviewed a resident's electronic medication administration record (eMAR) using the computer keyboard on the medication cart. -She used keys to unlock the medication cart. -She removed medication cards from the medication cart and prepared 11 oral medications for a resident.	D 371		

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D 371	Continued From page 104 -She used a plastic sleeve and a pill crusher and crushed 8 oral medications and placed the crushed medications in a small amount of pudding. -She placed 3 gel capsule type oral medications in a separate medication cup. -She also removed a glucometer from the medication cart. -She retrieved a pair of clean gloves and took the medication cups and the glucometer to the common area where several residents were sitting. -She donned gloves and performed a finger stick blood sugar (FSBS) on a resident, she then administered the crushed medications mixed with pudding to the same resident and administered the 3 gel capsule type medications with water to the same resident. -She returned to the medication cart and removed the gloves and disposed of them and the medication cups. -She did not sanitize or wash her hands. -She used keys to unlock the medication cart and returned the glucometer to the medication cart. -She reviewed the eMAR for the next resident using the computer keyboard on the medication cart. -She retrieved medication cards and prepared seven oral medications for the next resident. -She retrieved a second glucometer from the medication cart. -She retrieved a fresh pair of gloves. -She took the medication cup and the glucometer to another resident in the common area. -She administered the oral medications with water to the resident and then performed a FSBS on the same resident. -She returned to the medication cart and removed and disposed of the gloves. -She did not wash or sanitize her hands and	D 371		

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started preparing medications for another resident.

Interview with Staff A on 10/01/25 at 12:00pm revealed:
-She washed her hands before starting the medication pass.
-She was supposed to use hand sanitizer between each resident, but she ran out of hand sanitizer and had not taken the time to find more because she was behind on her medication pass.
-She was supposed to wash her hands after performing FSBSs and removing gloves.
-She should have washed her hands after performing FSBSs and removing gloves before going to the next resident.

Interview with the Special Care Coordinator (SCC) on 10/01/25 at 12:18pm revealed:
-The MAs were to wash their hands at the start of the medication pass.
-The MAs were to use hand sanitizer between each resident.
-The MAs were to wash their hands after every third resident and after removing gloves for things like FSBSs and administering insulin.
-The MA should have made sure there was hand sanitizer on the medication cart before starting her medication pass.

Interview with the Administrator on 10/01/25 at 12:28pm revealed:
-The MAs were expected to wash their hands at the beginning of the medication pass and between every 3rd resident or if visibly soiled and before and after using gloves.
-The MAs were to use hand sanitizer between each resident.
-It was important for the MAs to follow hand hygiene guidelines to prevent the spread of

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D 371	Continued From page 106 germs. Interview with the facility's contracted primary care provider (PCP) on 10/03/25 at 10:30am: -The MAs should practice good hand hygiene during the medication pass between each resident. -She expected the MAs to at least hand sanitizer between each resident and should always wash their hand before and after procedures that required gloves such as FSBSs. -Good hand hygiene was important to prevent cross-contamination and the spread of illness.	D 371		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegations for 1 of 1 staff (Staff G). The findings are: Review of Resident #1's current FL-2 dated 01/26/25 revealed diagnoses included vascular dementia and schizophrenia. Review of the 24-Hour Initial Report revealed: -On 09/26/25, Staff G pulled Resident #1 by her	D 438		

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right arm on the floor causing bodily harm to the resident.
-Resident #1 had bruising on her arms.
-Date reported to law enforcement was 10/01/25.
-The fax cover sheet was addressed to Health Care Personnel Registry (HCPR) with a date of 10/01/25 from the Administrator.
-There was a typed note from the Administrator on the fax coversheet that stated the report was late because she was working on the floor yesterday (09/30/25) and was waiting on the PCP notes and pictures.

Review of Resident #1's care plan dated 12/02/24 revealed:
-She required limited assistance with eating, ambulation, and transfers.
-She required extensive assistance with toileting.
-She was totally dependent for bathing, dressing, and grooming.

Review of Staff G's Personnel Record revealed:
-She was hired as a personal care aide (PCA) on 11/24/24.
-The facility completed a criminal background check on Staff G on 11/14/24.
-The facility completed a HCPR check on Staff G on 11/24/24.
-There was documentation of 47 hours of Special Care Unit (SCU) training: 3 hours on 11/05/24, 5 hours on 11/07/24, 6 hours on 11/08/24, 6 hours on 11/24/24, 6 hours on 02/01/25, 8.5 hours on 02/02/25, 7 hours on 02/09/25, 3 hours on 02/10/25 and 2.5 hours on 02/11/25.

Interview with Resident #1's family member on 10/02/25 at 4:33pm revealed:
-He had no concerns about the care of Resident #1 at the facility.
-The facility was quick to let him know of any

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concerns or incidents with Resident #1.
-He received a call about Resident #1 being removed from another resident's room by a staff member.
-He was told that a staff member tried to remove Resident #1 from another resident's room but that was all he could remember and he was unsure which staff member called.
-He had no concerns about abuse at the facility.
-If there were questions as to how Resident #1 was removed by the staff member from the other resident's room, he was not given information as to how she was removed.
-He resided in another state and had not visited since Resident #1 was placed in the facility.

Interview with a PCA on 10/03/25 at 9:38am revealed:
-She heard about the incident between Resident #1 and another PCA, but she was not at work when the incident occurred.
-Staff G was no longer employed at the facility.
-When an incident between a resident and a staff member occurred, it was reported to the supervisor.
-The medication aide (MA) was the supervisor on 3rd shift (11:00pm to 7:00am) and the Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) were the supervisors on day shift.

Interview with a second PCA on 10/03/25 at 6:31pm revealed:
-On 09/26/25, Resident #1 was in another resident's room.
-She removed Resident #1 from the other resident's room because the resident did not want her in there.
-Resident #1 went back into the same resident's room.

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D 438	Continued From page 109 -Staff G went to remove Resident #1 from the other resident's room. -Resident #1 got down on the floor, pointed at Staff G and said, "You will not do that." -Staff G had not done anything to Resident #1 at that time. -Staff G said, "come on" and used Resident #1's name. -Resident #1 tried to kick Staff G. -Staff G moved Resident #1's foot, pulled her by her ankle, and said "Y'all do too [expletive] much. That's why nobody wants to come to work. That's why people call out." -Staff G drug Resident #1 almost to her room and made a lunging motion at Resident #1. -Another resident told another staff member that Staff G was dragging Resident #1. -The other staff member got Resident #1 up and took her to her room. -Staff G was sent home. -The MA called the supervisor. -It was unknown if Staff G had done this before. Interview with a third PCA on 10/03/25 at 6:48pm revealed: -She was coming down the hall on 09/26/25 when a resident said, "Look she is dragging her by her leg." -She saw Resident #1 on the floor. -She asked Resident #1 if she was okay, assisted her up and took her to her room. -She did not see how Resident #1 got on the floor. -Staff G and another PCA were present. -She reported the incident to the MA who was the supervisor. -Staff G was asked to leave. Interview with the SCC on 10/03/25 at 5:03pm revealed:	D 438		

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D 438	Continued From page 110 -She found out about the details of the incident between Resident #1 and Staff G on 09/29/25. -On 09/29/25, she was told that Staff G pulled Resident #1 down the hall by her arm. -The incident occurred on 09/26/25 and the Business Office Manager (BOM) was on call for that weekend. -The BOM called her on 09/26/25 and informed her that she was sending Staff G home for possible abuse. -She was unsure if the BOM notified the Administrator on the same day she called her. -The process after an incident of abuse occurred involved the Administrator being contacted immediately. -The Administrator handled the 24-hour report for HCPR. Interview with the Administrator on 10/02/25 at 5:00pm revealed: -She was not on call when the incident with a PCA and Resident #1 occurred. -The BOM was on call. -The incident involving Resident #1 occurred on 09/26/25. -The BOM informed her of the incident on 09/30/25. -She completed the 24-hour report to HCPR on 10/01/25. Second interview with the Administrator on 10/03/25 at 7:38pm revealed: -She was responsible for completing the 24-hour report to HCPR. -The 24-hour report was not sent within 24 hours because the incident occurred after hours and the BOM, who was the "Administrator in charge", secured the area and sent the staff member home. -Resident #1 was safe at that time.	D 438		

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D 438	Continued From page 111 -The BOM did not feel there was any threat since Staff G had been sent home so she did not inform her if the incident until that Monday (09/29/25). -She felt process had been followed. -Once informed, she immediately spoke with the SCC and went to assess Resident #1. -She looked for the incident report and reviewed witness statements. -She reviewed interviews with the local Department of Social Services, talked to the BOM, called the witnesses and viewed video footage. -The video footage of the incident was consistent with the statements provided. -She notified the PCP and Resident #1's family member of the incident and contacted law enforcement. -She agreed with the previous decision to suspend Staff G and faxed the 24-hour report to HCPR. Based on observations, interviews and record reviews, the resident that witnessed the incident was not interviewable. Based on observations, interviews and record reviews, Resident #1 was not interviewable.	D 438		