

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER THE INDIGO AT PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
(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 survey from May 20, 2025 to May 21, 2025.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the Special Care Unit (SCU) was free of hazards in 27 resident rooms including disposable shaving razors, antifungal cream, prescription toothpaste, hemorrhoid cream, and toiletries that were accessible to residents on the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed as a Special Care Unit	D 079	Facility staff immediately removed all hazardous items from residents' rooms. Facility administrator educated facility staff on the importance of removing items from residents' rooms that are considered hazardous. The Facility administrator will implement daily rounds by facility management at the beginning and end of day to include checks for hazardous items. Daily rounds will be implemented on 8/27/2025. Facility administrator or designee will educate all staff on facility policy for hazards on 8/26/2025 then monthly or as needed. Facility administrator or designee will educate new staff on company hazard policy within 30 days of hire. Facility administrator or designee will audit hazard checks weekly and educate staff as needed.	8/22/2025 8/22/2025 8/27/2025 8/26/2025 9/1/2025 9/1/2025

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

TITLE

(X6) DATE

Dorelle Smith
STATE FORM

Executive Director
6899 9STX11

9/29/25
If continuation sheet 1 of 41

Reviewand Acknowledged

SJS

10/14/25

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D 079	Continued From page 1 (SCU) effective 12/31/25 for a capacity of 40 residents. -The expiration date of the facility's license was 12/31/25. Review of the facility's census on 08/20/25 revealed the facility's census in the SCU was 27 residents. Review of the facility's dementia specific program dated 07/01/25 revealed hazardous items and or ingestible items, and chemicals should be stored and secured appropriately and per manufacturers direction. Review of the facility's undated SCU Disclosure Statement revealed: -Wandering was a common behavior exhibited by dementia residents and was often an expression of a need to find the boundaries in one's space. -The community may not allow sharps from home such as scissors, knitting needles, or knives. Observation of a resident on 08/21/25 at 8:23am and 8:25am revealed the resident wandered into an office where surveyors were working, he walked to the end of the room and returned to the hallway. Second observation of the resident on 08/21/25 at 10:18am revealed the resident, who resided in room 102, was asleep in a recliner in room 110. Interview with a personal care aide (PCA) on 08/21/25 at 10:20am revealed the resident sleeping in the recliner was in another resident's room (room 110) and the resident had wandering behaviors. Second interview with a PCA on 08/21/25 at	D 079		

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D 079	Continued From page 2 1:35pm revealed: -One or two times a week she observed the resident wander into another resident's room. -The resident usually walked into room 110. Observation of the resident who resided in room 102 on 08/21/25 at 1:36pm revealed he was leaving room 209. Observation of resident room 111 on 08/20/25 at 8:29am revealed: -There was a 6 ounce tube of toothpaste on the toilet tank. -There was a warning on the back of the toothpaste tube to keep out of reach of children under 6 years of age, if more than used for brushing was accidentally swallowed, get medical help or contact a poison control center right away. -There was one bar of soap unwrapped on the left side of the sink. Observation of a resident room 205 on 08/20/25 at 9:18am revealed: -There was a 6-ounce tube of toothpaste inside of an open container on top of the sink in the bathroom. -There was a warning on the back of the toothpaste tube to keep out of reach of children under 6 years of age, if accidentally swallowed, get medical help or contact a poison control center right away. -There was a 4-ounce tube of antifungal cream on top of a plastic cabinet drawer in the bathroom. -There was a warning on the back of the antifungal cream tube to avoid contact with eyes, irritation can occur, if swallowed, get medical help or contact a poison control center right away. Interview with the resident who resided in room	D 079		

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D 079	Continued From page 3 205 on 08/21/25 at 4:08pm revealed: -She used the toothpaste to brush her teeth daily. -She used antifungal cream on infected areas on herself, and she could place the cream in those areas herself. -She had used the cream for a couple of weeks. Observation of a resident room 208 on 08/20/25 at 8:33am revealed: -On a nightstand there was a bottle of prescription toothpaste and a second over-the-counter (OTC) toothpaste. -The prescription toothpaste had a warning; do not swallow. -The second toothpaste had a warning; if more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away. -In boxes next to the nightstand there were personal care items including hemorrhoidal cream with lidocaine, a container of medicated cooling hemorrhoidal pads, a box of lotion with sunscreen, at least five disposable shaving razors, and a bottle of mouthwash. -The hemorrhoidal cream, hemorrhoidal pads, and box of lotion with sunscreen all had warnings; if swallowed, get medical help or contact a Poison Control Center right away. -The mouthwash label had been partially removed, so there were no longer instructions for proper use or warnings on the bottle. -On the floor next to the boxes there was a can of spray deodorant that also had a warning; if swallowed, get medical help or contact a Poison Control Center right away. Based on observations, interviews, and record reviews it was determined that the resident who resided in room 111 was not interviewable. Based on observations, interviews, and record	D 079		

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D 079	Continued From page 4 reviews it was determined that the resident who resided in room 102 was not interviewable. Interview with a second PCA on 08/20/25 at 8:40am revealed: -She was aware of three residents that walked into other residents' rooms frequently and would pick up items. -She had not observed any residents' eating items that they were not supposed to eat. -PCAs and medication aide (MAs) looked in resident's rooms for hazardous items when they checked on residents which was usually every 30 minutes. -If she found a hazardous item in a resident's room, she removed it and placed it in the locked storage area. -She did not observe any hazards in resident's rooms when she toured the hall earlier this morning. Interview with a third PCA on 08/21/25 at 4:10pm revealed: -Some PCAs would forget and leave toiletries behind but they were not supposed to do that. -She never left toiletries behind and if she saw toiletries or creams, she would remove the items. -PCAs and MAs were supposed to assist with brushing teeth and then remove the toothpaste from the room. -MAs were supposed to apply the antifungal cream as needed then remove the antifungal cream from the room. Interview with the Administrator on 08/21/25 at 3:42pm revealed: -Residents should not have access to toiletries or any other items that could cause them harm. -Many residents on the SCU wandered and some picked up items from other residents' rooms.	D 079		

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D 079	Continued From page 5 -The MAs and PCAs were supposed to keep any hazardous items locked and secured away from residents to ensure their safety. Telephone interview with the facility's primary care provider (PCP) on 08/21/25 at 3:42pm revealed: -She did not want residents to have access to anything they could eat or swallow due to their cognitive limitations and inability to identify if an item could be hazardous to their health. -Residents on the SCU did wander into other residents' rooms which placed those residents at risk of ingesting items that were hazardous to their health. -She expected the facility to keep hazardous items such as toiletries in a safe and locked area to ensure resident's safety. The facility failed to secure hazardous items to protect 27 residents who resided on the Special Care Unit (SCU) who had known wandering behaviors including disposable shaving razors, antifungal cream, prescription toothpaste, hemorrhoid cream with lidocaine, and several toiletries with warnings that if accidentally ingested contact the poison control center or a physician right away. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 08/21/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 5, 2025.	D 079		

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D 113	Continued From page 6	D 113		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 8 of 9 fixtures sampled which were used by residents in the special care unit facility with hot water temperatures ranging from 123.0 °F to 136.4 °F. The findings are: Review of the facility's current license effective 12/31/24 revealed the facility was licensed as a Special Care Unit (SCU) facility with a capacity of 40 beds. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety issues memo revealed a hot water temperature of 131 degrees Fahrenheit (°F) can cause first degree burns within 17 seconds and	D 113	Facility Maintenance Director immediately adjusted water temperature on the hot water heater. Facility Administrator implemented daily water temperature checks for one week. Facility Maintenance Director or designee will perform daily water temperature checks for one week and then weekly for one month to ensure water temperatures remain between 100-116 F. Facility administrator educated facility maintenance director and facility staff on regulations or water temperatures and reporting if water temperatures feel above normal temperature on 8/26/25. Facility administrator or designee will audit temperature logs with maintenance director weekly for one month, then monthly and as needed.	8/22/2025 8/22/2025 8/22/2025 8/26/2025 9/1/2025

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D 113	Continued From page 7 second degree burns within 30 seconds. (A first degree burn is a superficial burn affecting the outer layer of skin. A second degree burn affects both the outer and second layer of skin and may cause blistering.) Review of the facility's census report for 08/20/25 revealed the current census was 27. Review of the facility's Water Supply Temperature policy dated 07/01/25 revealed the facility would ensure water temperatures were able to be regulated and the hot water would be provided at a range of 100 °F to 116 °F. Review of a service order for for the sprinkler service repair revealed there were 2 sprinkler heads replaced on 07/29/25. Observation of the hot water temperature in the sink of the shared bathroom for resident rooms 101 and 102 on 08/20/25 at 8:45am revealed the hot water temperature was 135.6 °F with visible steam. Observation of the spa shower room on the 100 hall on 08/20/25 at 8:49am revealed: -The hot water temperature in the sink was 136.4 °F with visible steam. -The hot water temperature in the shower was 133.8 °F with visible steam. Observation of the hot water temperature in the sink for resident room 106 on 08/20/25 at 8:24am revealed the hot water temperature in the sink was 132.8 °F. Observation of the hot water temperature in the sink of the shared bathroom for resident rooms 201 and 203 on 08/20/25 at 8:43am revealed the	D 113		

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D 113	Continued From page 8 hot water temperature was 136 °F with visible steam. Second observation of the hot water temperature in the sink of the shared bathroom for resident rooms 201 and 203 on 08/20/25 at 1:35pm revealed the hot water temperature was 136 °F with visible steam. Observation of the shared bathroom for residents in rooms 202 and 204 on 08/20/24 at 8:55am revealed the water temperature was 123 °F. Observation of the hot water temperature in the sink of the bathroom for resident room 205 on 08/20/25 at 8:35am revealed the hot water temperature was 129.4 °F with visible steam. Second observation of the hot water temperature in the sink of the bathroom for resident room 205 on 08/20/25 at 1:32pm revealed the hot water temperature was 131.4 °F with visible steam. Observation of the hot water temperature in the sink of the shared bathroom for resident rooms 207 and 209 on 08/20/25 at 8:30am revealed the hot water temperature was 130 °F with visible steam. Second observation of the hot water temperature in the sink of the shared bathroom for resident rooms 207 and 209 on 08/20/25 at 1:30pm revealed the hot water temperature was 136 °F with visible steam. Observation of the spa shower room on the 200 hall on 08/20/25 at 10:00am revealed the hot water temperature in the sink was 127.2 °F. Second observation of the spa shower room on	D 113		

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D 113	Continued From page 9 the 200 hall on 08/20/25 at 1:44pm revealed the hot water temperature in the sink was 135.1 °F. Interview with the resident who resided in room 201 on 08/21/25 at 8:45am revealed: -The water got hot so she would pull her hands out of the water and readjust the water. -She had told the medication aide (MA) that the water got hot, she could not recall her name or when she reported it. -The MA said, "she would look into it", but she was not aware if anything had been done. -She never saw maintenance check the water. Interview with the resident who resided in room 203 on 08/21/25 at 8:40am revealed: -The water got hot to the point that she would have to remove her hands. -She could not recall maintenance checking her water. -She had not told anyone that the water got too hot. Review of the facility's water temperature tracking sheet dated 06/26/25 revealed there were 16 water temperatures ranging from 100.0 °F to 120.0 °F in resident rooms, 2 spa shower rooms the kitchen and beauty shop. Review of the facility's water temperature tracking sheet dated 07/29/25 revealed there were 18 water temperatures ranging from 100.0 °F to 114.0 °F in resident rooms, 2 spa shower rooms the kitchen and beauty shop. Review of the facility's water temperature tracking sheet dated 08/20/25 revealed: -There was documentation the hot water temperature in resident rooms 101 and 103 was 135.6 °F.	D 113		

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D 113	Continued From page 10 -There was documentation the hot water temperature in resident rooms 102 and 104 was 131.3 °F. -There was documentation the hot water temperature in resident rooms 105 and 107 was 131.5 °F. -There was documentation the hot water temperature in resident rooms 106 was 131.3 °F. -There was documentation the hot water temperature in resident rooms 108 and 110 was 131.7 °F. -There was documentation the hot water temperature in resident room 109 was 133.2 °F. -There was documentation the hot water temperature in resident room 111 was 131.5 °F. -There was documentation the hot water temperature in the spa/shower room on the 100 hall was 137.6 °F. -There was documentation the hot water temperature in resident rooms 201 and 203 was 131.5 °F. -There was documentation that the hot water temperature in resident rooms 202 and 204 was 132.4 °F. -There was documentation the hot water temperature in resident room 205 was 131.7 °F. -There was documentation the hot water temperature in resident room 206 was 130.8 °F. -There was documentation the hot water temperature in resident rooms 207 and 209 was 131.7 °F. -There was documentation the hot water temperature in resident rooms 208 and 210 was 131.9 °F. -There was documentation the hot water temperature in spa/shower room on the 200 hall was 131.3 °F. Interview with a personal care aide (PCA) on 08/21/25 at 4:29pm and 4:38pm revealed:	D 113		

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D 113	Continued From page 11 -All residents were assisted with bathing. -She checked the temperature of the water by using the palm of her hand. -Residents complained about the water being too hot during their shower often. -She had not reported the resident complaints regarding the water being too hot because she could adjust the temperature. Interview with a MA on 08/20/25 at 8:53am revealed: -Staff always assisted residents with their showers and would adjust the hot water. -All residents complained the water was too hot, but no residents had been burned. -The residents' skin was fragile and they could not handle the hot water like they used to. Interview with the Maintenance Director (MD) on 08/20/25 at 10:33am and 10:45am revealed: -He thought the hot water should range between 80 °F to 90 °F. -The hot water temperature was 137.6 °F in the spa room when he checked it with his thermometer. -He did not know when his thermometer was last calibrated. -He was responsible for checking water temperatures monthly. -He did not know he was supposed to be checking only the hot water. -He always checked the water "midway" between the hot water and cold water. -He did not check water temperatures with only the hot water turned on. Second interview with the MD on 08/20/25 at 12:42am revealed he did not receive training on checking hot water temperatures but was told to check the water temperatures.	D 113		

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D 113	Continued From page 12 Interview with the Administrator on 08/20/25 at 10:50am revealed: -The Maintenance Director was responsible for checking the hot water temperatures monthly. -She was unsure what kind of training he received regarding hot water temperatures. -She was not aware the hot water temperatures were not in range of 100.0 °F- 116.0 °F. Second interview with the Administrator on 08/21/25 at 9:36am revealed: -The facility's contracted fire alarm and prevention company replaced sprinkler heads on the 200 hall recently and drained the hot water heater in the process. -She thought they turned the hot water heater all the way up and did not alert the facility. -The facility should have checked the hot water heater after the repairs were done. Telephone interview with the facility's contracted primary care provider (PCP) on 08/21/25 at 3:38pm revealed: -Staff should check the temperature of the hot water by feeling the water with their wrist or the underside of their arm. -The residents' skin was more fragile and some may not be able to articulate that the water was hot due to their cognition. -Some residents had decreased sensation and neuropathy and might not realize how hot the water was. -Water that was too hot can cause burning to the skin. The facility failed to ensure hot water temperatures for 8 of 9 fixtures in the facility used by residents with diagnoses of dementia or other cognitive disorders in the Special Care Unit	D 113		

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D 113	Continued From page 13 (SCU), were maintained between 100 - 116 degrees Fahrenheit (°F). The hot water temperatures out of the required range were from 123.0 degrees °F to 136.4 °F. When skin is in contact with a water temperature of 131 degrees F, this could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. This failure of the facility placed residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 08/20/25 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2025.	D 113		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#1) related to an order for checking blood sugars at meals and bedtime (#1). The findings are:	D 276	Administrator or designee will complete audit of all current residents with diabetes MAR by 10/3/2025 to ensure blood sugar orders and parameters are transcribed onto MAR correctly. RCC received re-education on order processing expectations by 9/23/2025. RCC received training on order processing expectations on 9/23/2025. The facility administrator or designee will complete a final review of medication /FI2's prior to resident admission to facility. Facility administrator or designee will complete routine audits to ensure compliance with order processing. Audits will be completed weekly until compliance is met and then monthly.	10/3/2025 9/23/2025 9/23/2025 9/22/2025 9/22/2025

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NAME OF PROVIDER OR SUPPLIER THE INDIGO AT PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
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D 276	Continued From page 14 Review of Resident #1's current FL-2 dated 07/23/25 revealed: -Diagnoses included Alzheimer's dementia, acute kidney injury, hypertension, type II diabetes, and peripheral arterial disease. -There was an order to monitor finger stick blood sugars (FSBS) at meals and at bedtime. Review of Resident #1's August electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times per day, before two meals and at bedtime with a start date of 07/23/25, scheduled daily at 6:30am, 11:30am, and 4:30pm. -There was a flow chart entry for FSBS results scheduled for 11:30am, 4:30pm, and 6:30am. -There was documentation of results and staff initials that FSBS checks were performed daily at 6:30am, 11:30am, 4:30pm from the date of 08/01/25 through 08/11/25 and from 08/13/25 through 08/19/25. -On 08/12/25 there was documentation of results and staff initials that the FSBS was checked two times on 08/12/25 at 6:30am and 11:30am. -There was no documentation that the blood sugar was checked at bedtime on the August eMAR. Telephone interview with a pharmacist for the facility's contracted pharmacy on 08/21/25 at 2:21pm revealed: -The pharmacy did not receive a copy of Resident #1's FL-2 dated 07/23/25. -The pharmacy received an order dated 07/23/25 to check FSBS at each meal. -The pharmacy did not have an order for Resident #1's FSBS check at bedtime.	D 276	New move in checklist binder created to ensure all documentation is received for residents prior to move in.	9/22/2025

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D 276	Continued From page 15 Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:44pm revealed: -She sent the orders to the pharmacy and approved entries on the eMAR. -The pharmacy entered orders into the eMAR. -She entered orders if the pharmacy did not get them back soon enough. -She always sent the FL-2 to the pharmacist. -She tried to look at all eMAR's once per week for all residents. -She last did an eMAR audit two weeks ago.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician orders were clarified for 2 of 3 sampled residents (#2, #3) who had an order for a medication used to treat high blood pressure and heart disease, and depression (#2) and who had an order for a medication used to treat arthritic pain (#3).	D 344	RCC received education on clarification of resident orders when orders are not written clear or incorrectly within 24 hours of admission or readmission or receipt of orders on 9/23/2025. Residents # 2 and #3 did not have an adverse reactions. Facility RCC was educated on 9/23/2025 regarding obtaining order clarifications for resident orders not written clear or incorrectly within 24 hours of admission, readmission or receipt of orders. Facility administrator to implement order tracking binder RCC to use for all resident orders on admission, readmission or after PCP visits. Facility administrator or designee will audit order tracking binder weekly as needed to ensure orders are being received, implemented and clarified within 24 hours of receipt. Administrator or Designee will audit MAR weekly for one month and then monthly, or as needed.	9/23/2025 9/23/2025 9/23/2025 10/1/2025 10/1/2025 10/1/2025

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D 344	Continued From page 16 The findings are: Review of the facility's medication administration record (MARS) policy revealed medication shall be administered and documented per order. 1. Review of Resident #2's current FL-2 dated 05/23/25 revealed: -Diagnoses included type II diabetes mellitus, dementia frontal temporal, severe early onset Alzheimer's, and hypertension. -The resident was ambulatory. -The resident was intermittently disoriented. -The resident had wandering behaviors. -The resident's current level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 05/20/25. Review of Resident #2's 05/21/25 emergency department (ED) after visit summary (AVS) revealed: -The reason for the visit was a fall. -His imaging consisted of computed tomography (CT) scan of the cervical spine and CT scan of the head. -The imaging did not show any concerning findings. -He was discharged back to the facility 05/23/25. -There were instructions to notify the primary care provider (PCP) about the medications for Metoprolol Succinate 25mg, 1 tablet daily (used to treat high blood pressure and heart disease). -The order was signed by Resident #2's PCP on 05/28/25. Review of Resident #2's 06/03/25 ED AVS revealed: -The reason for the visit was a fall with possible	D 344		

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D 344	Continued From page 17 head trauma. -His imaging consisted of CT scan of the cervical spine without contrast, CT scan of the head without contrast, and CT scan of the facial bones without contrast. -Independent interpretation of the CT scan of the head showed no bleed. -The imaging did not show any concerning findings. -He was mildly dehydrated and received fluids. -He was discharged back to the facility 06/03/25. -There was an order for Metoprolol Succinate 25mg, 1 tablet daily. -The order was signed by Resident #2's PCP on 06/28/25. Observation of Resident #2's medications on hand on 08/21/25 at 9:55am revealed there was no Metoprolol Succinate 25mg, 1 tablet daily on the medication cart. Review of Resident #2's June 2025 medication administration records (MARs) revealed there was no entry for Metoprolol Succinate 25mg, 1 tablet daily. Review of Resident #2's July 2025 MARs revealed there was no entry for Metoprolol Succinate 25mg, 1 tablet daily. Review of Resident #2's August 2025 MARs revealed there was no entry for Metoprolol Succinate 25mg, 1 tablet daily. Interview with a medication aide (MA) on 08/21/25 at 10:08am revealed: -There was no order in the system to administer Metoprolol Succinate to Resident #2. -If there was an order for Metoprolol Succinate she did not know why the medication was not on the MARs.	D 344		

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D 344	Continued From page 18 Interview with a Special Care Coordinator (SCC) on 08/21/25 at 10:25am revealed: -She was not aware of instructions requesting clarification about the medication on the AVS dated 05/23/25 and signed by the PCP on 05/28/25 for Resident #2 for the medication Metoprolol Succinate. -She did not notify Resident #2's PCP to clarify Metoprolol Succinate order on the AVS dated 05/23/25. -She was not aware Metoprolol Succinate ordered on the AVS dated 06/03/25 and signed by the PCP on 06/28/25 for Resident #2. -She reviewed the AVS when Resident #2 returned from the hospital but did not see the order for Metoprolol Succinate or instructions about medications. -She was responsible to ensure that medication orders were current and accurate on the MARs. Interview with the Administrator on 08/21/25 at 1:33pm revealed: -She was not aware Metoprolol Succinate was ordered on the AVS dated 06/03/25 and signed by the PCP on 06/28/25 for Resident #2. -She and the SCC were responsible for reviewing medication orders. -The last medication review was completed in April 2025 by her and the SCC. -The medication review consisted of reviewing medication orders to confirm medications matched between the PCP order and the MARs and discontinue any medications not currently ordered and clarify an order if needed. -She did not realize Metoprolol Succinate was ordered on the AVS dated 06/03/25 and signed by the PCP on 06/28/25 for Resident #2. -She was responsible to fax in all medication orders to the facility's pharmacy, but she did not	D 344		

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D 344	Continued From page 19 fax in the AVS orders. -She was responsible to ensure that medication orders were current and accurate on the MARs. Attempted telephone interview with Resident #2's PCP on 08/21/25 at 2:00pm and 4:00pm was unsuccessful. Based on observations, record reviews and interviews, it was determined that Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 01/17/25 revealed diagnoses included unspecified dementia, type 2 diabetes, urinary tract infections, and depression. Review of an orthopedist order for Resident #3 dated 06/17/25 revealed there was an order for Tramadol 50mg, take one tablet every 6 hours for right knee pain while awake (Tramadol is used to treat moderate to severe pain). Review of a physician order for Resident #3 dated 07/09/25 revealed there was an order for Tramadol 50mg, take one tablet twice a day, will send hard script when able. Review of a physician order for Resident #3 dated 07/21/25 revealed there was an order for Tramadol 50mg, take one tablet three times a day for arthritic pain. Review of Resident #3's August 2025 eMAR revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm	D 344		

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D 344	Continued From page 20 from 08/01/25 to 08/19/25. -Tramadol HCL 50mg was documented as administered at 8:00am on 08/20/25. -There was an entry for Tramadol HCL 50mg, take on tablet three times a day for arthritic pain. -Tramadol 50mg was documented as administered at 9:00am, 3:00pm, and 9:00pm from 08/08/25 to 08/19/25. -Tramadol 50mg was documented as administered at 9:00am on 08/20/25. Observation of medications on hand on 08/21/25 at 10:03am revealed: -There was one bubble card of Tramadol HCL 50mg, take one tablet three times a day at 8:00am, 2:00pm, and 8:00pm for arthritic pain. -There was a dispense date of 08/17/25. -There were 82 tablets of Tramadol available to administer to Resident #3. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/25 at 2:05pm revealed: -The pharmacy dispensed medications on a batch cycle and resident's medications started on the 17th of each month. -The pharmacy received an order for Tramadol 50mg, take one tablet every six hours when awake on 06/23/25. -The pharmacy never filled the prescription for Tramadol 50mg, take one tablet every six hours because the pharmacy did not receive a hard copy of the prescription. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 07/21/25 with a quantity of 78 tablets. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 08/11/25 with a quantity of 93 tablets to begin on 08/17/25.	D 344		

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D 344	Continued From page 21 Interview with a medication aide (MA) on 08/21/25 at 10:23am revealed: -She did not realize there were two different orders on Resident #3's eMAR. -She was not sure why she had not contacted the primary care provider (PCP) to obtain a clarification order. -She should not have documented that she administered both medications because she only had one bubble card with Tramadol to dispense. Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:45pm revealed: -She sent orders to the pharmacy, and the pharmacy entered the information of the eMAR. -She had not noticed that the pharmacy noted they needed a hard copy of the prescription for Tramadol HCL 50mg, take one tablet every six hours. -She did not realize there were two Tramadol HCL 50mg orders on Resident #3's eMAR. -She should have noticed the mistake and asked the PCP for a clarification order so she could send it to the pharmacy and have the Tramadol HCL 50mg, take one tablet every 6 hours discontinued. -She tried to review each resident's eMARS with physician orders once a week, but had missed the mistake of Tramadol HCL 50mg being listed two different ways on the eMAR. Telephone interview with Resident #3's PCP on 08/21/25 at 3:42pm revealed: -She was not aware that there were two different orders for Tramadol HCL 50mg on the resident's eMAR. -She remembered that Resident #3's orthopedist wrote a prescription for Tramadol HCL 50mg, take one tablet every 6 hours while awake. -When she wrote the order for Tramadol HCL	D 344		

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D 344	Continued From page 22 50mg, take one tablet three times a day, she should have discontinued the Tramadol order from the orthopedist but overlooked it. -The MA or SCC could have contacted her for a clarification order but no one contacted her about the order. Interview with the Administrator on 08/21/25 at 8:39am revealed: -There was confusion about the resident's Tramadol 50mg order because the resident's orthopedist first prescribed the Tramadol to take every 6 hours daily. -The resident's primary care provider (PCP) later prescribed Tramadol 50mg order for three times a day. -The orthopedist order for Tramadol 50mg, take one tablet every 6 hours should have been discontinued to avoid confusion. -The MA or the SCC should have notified the resident's PCP that a clarification order was needed for the Tramadol.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer	D 358		

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D 358	Continued From page 23 medications according to provider orders for 2 of 3 sampled residents (#1, #3) including medications used to treat diabetes with a fast acting insulin (#1), and medications used to treat high blood pressure and pain (#3). The findings are: Review of the facility's current medication administration policy from 12/20/24 revealed: -Medications were to be administered and documented per physician's orders. -Routine administration times for the communities were: 6:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm. -An example was written for medication frequency before meals: 8:00am, 12:00pm, and 5:00pm. -An example was written for bedtime medication frequency: 8:00pm. -An incident report was to be completed by any person who identified a medication error. -Any insulin or blood sugar orders were to be reviewed for provider-specific directions on parameters. 1. Review of Resident #3's current FL-2 dated 01/17/25 revealed: -Diagnoses included unspecified dementia, type 2 diabetes, urinary tract infections and depression. -There was an order to check Resident #3's blood pressure monthly. -There was an order for Carvedilol 25mg, take one tablet twice a day, hold if blood pressure is less than 110/60 (Carvedilol is used to treat high blood pressure and heart disease). a. Review of signed physician orders dated 04/23/25 revealed there was an order for Carvedilol 6.25mg, take one tablet twice a day.	D 358	Facility administrator or designee completed cart audits on 9/12/2025 to ensure all residents medications were in place for administration. Instant in-service was provided to all medication staff on proper medication administration, ensuring resident medications are in place for administration on 9/25/2025. Education was provided to the resident care coordinator, and medication aides regarding the FL2 process, care plans, resident medication orders, and ensuring appropriate signatures are in place on 9/25/2025. The facility administrator or designee will Inservice all new hire med passers on medication management within 30 days of hire. The facility administrator or designee will complete a final review of medication /FI2's prior to resident admission to facility. Facility administrator or designee will complete cart audits weekly, monthly or as needed as determined by the Facility Administrator or designee to ensure compliance. Audits will be completed weekly until compliance is met and then monthly.	9/12/2025 9/25/2025 9/25/2025 9/25/2025 10/1/2025 10/1/2025

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D 358	Continued From page 24 Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check the resident's blood pressure at 9:00am and 9:00pm daily. -There was an entry for Carvedilol 6.25mg, give one tablet twice a day at 9:00am and 9:00pm, hold if blood pressure is less than 110/60. -Carvedilol 6.25mg was documented as administered on 06/05/25 at 9:00am, when the resident's blood pressure was 121/57. -Carvedilol 6.25mg was documented as administered on 06/08/25 at 9:00pm when the resident's blood pressure was 152/48. -Carvedilol 6.25mg was documented as administered on 06/15/25 at 9:00am when the resident's blood pressure was 141/58. -Carvedilol 6.25mg was documented as administered on 06/19/25 at 9:00pm when the resident's blood pressure was 165/45. -Carvedilol 6.25mg was documented as administered on 06/21/25 at 9:00pm when the resident's blood pressure was 138/52. -Carvedilol 6.25mg was documented as administered on 06/22/25 at 9:00pm when the resident's blood pressure was 164/45. -Carvedilol 6.25mg was documented as administered on 06/25/25 at 9:00pm, when the resident's blood pressure was 92/56. -Carvedilol 6.25mg was documented as administered on 06/26/25 at 9:00am when the resident's blood pressure was 146/52. -Carvedilol 6.25mg was documented as administered on 06/29/25 at 9:00am when the resident's blood pressure was 124/56. -Carvedilol 6.25mg was documented as administered on 06/30/25 at 9:00pm when the resident's blood pressure was 136/55. -There were 10 times Carvedilol was	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 25 administered when the resident's blood pressure was less than 110/60. Review of Resident #3's July 2025 eMAR revealed: -There was an entry to check the resident's blood pressure at 9:00am and 9:00pm daily. -There was an entry for Carvedilol 6.25mg, give one tablet twice a day at 9:00am and 9:00pm, hold if blood pressure is less than 110/60. -Carvedilol 6.25mg was documented as administered on 07/06/25 at 9:00pm when the resident's blood pressure was 167/48. -Carvedilol 6.25mg was documented as administered on 07/08/25 at 9:00am when the resident's blood pressure was 125/54. -Carvedilol 6.25mg was documented as administered on 07/10/25 at 9:00am when the resident's blood pressure was 132/56. -Carvedilol 6.25mg was documented as administered on 07/13/25 at 9:00am when the resident's blood pressure was 117/56. -Carvedilol 6.25mg was documented as administered on 07/15/25 at 9:00pm when the resident's blood pressure was 156/43. -Carvedilol 6.25mg was documented as administered on 07/20/25 at 9:00pm when the resident's blood pressure was 173/56. -Carvedilol 6.25mg was documented as administered on 07/21/25 at 9:00pm when the resident's blood pressure was 128/59. -Carvedilol 6.25mg was documented as administered on 07/23/25 at 9:00am when the resident's blood pressure was 121/56. -Carvedilol 6.25mg was documented as administered on 07/24/25 at 9:00am when the resident's blood pressure was 135/56. -Carvedilol 6.25mg was documented as administered on 07/29/25 at 9:00pm when the resident's blood pressure was 142/59.	D 358		

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STATE FORM

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9STX11

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D 358	Continued From page 26 -Carvedilol 6.25mg was documented as administered on 07/30/25 at 9:00am when the resident's blood pressure was 137/59. -There were 11 times Carvedilol was administered when the resident's blood pressure was less than 110/60. Review of Resident #3's August 2025 eMAR revealed: -There was an entry to check the resident's blood pressure at 9:00am and 9:00pm daily. -There was an entry for Carvedilol 6.25mg, give one tablet twice a day at 9:00am and 9:00pm, hold if blood pressure is less than 110/60. -Carvedilol 6.25mg was documented as administered on 08/07/25 at 9:00pm when the resident's blood pressure was 162/43. -Carvedilol 6.25mg was documented as administered on 08/10/25 at 9:00am when the resident's blood pressure was 118/59. -Carvedilol 6.25mg was documented as administered on 08/16/25 at 9:00pm when the resident's blood pressure was 143/54. -Carvedilol 6.25mg was documented as administered on 08/17/25 at 9:00am when the resident's blood pressure was 161/59. -Carvedilol 6.25mg was documented as administered on 08/17/25 at 9:00pm when the resident's blood pressure was 143/46. -Carvedilol 6.25mg was documented as administered on 08/18/25 at 9:00am when the resident's blood pressure was 133/57. -There were 6 times Carvedilol was administered when the resident's blood pressure was less than 110/60. Interview with a medication aide (MA) on 08/21/25 at 10:23am revealed: -She was not aware that she had administered Resident #3 Carvedilol at times when Resident	D 358		

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D 358	Continued From page 27 #3's blood pressure was less than 110/60. -When she took Resident #3's blood pressure, if her blood pressure was less than 110/60, she held the medication and sent a message to the resident's PCP for direction on whether to administer the medications. -She thought she had documented that she notified the resident's PCP in her progress notes but evidently forgot to document her communication with the PCP. -She was not sure why she administered Resident #3 her Carvedilol when her blood pressure was below 110/60. -She should have followed the PCPs orders and held the medication when the resident's blood pressure was below 110/60. Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:45pm revealed: -She did not realize MAs had administered Resident #3 Carvedilol when her blood pressure was less than 110/60. -The MAs were expected to hold Resident #3's Carvedilol when her blood pressure was less than 110/60. -She usually reviewed medications on hand, physician orders, and the eMAR for all residents at least once a week. -She was not sure how she missed that Resident #3 was administered Carvedilol when the medications should have been held. -She completed an eMAR audit about two weeks ago. Telephone interview with Resident #3's PCP on 08/21/25 at 3:42pm revealed: -She was not aware that Resident #3's blood pressure was less than 110/60 and MAs had administered her Carvedilol. -She expected the MAs to follow her orders, and	D 358		

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D 358	Continued From page 28 they should have held her Carvedilol when her blood pressure was below the ordered parameters. -If the MAs had not administered the resident's Carvedilol when her blood pressure was less than 110/60, she may have considered decreasing one of the resident's medications to help with her blood pressure. -She expected the MAs to follow her orders. Interview with the Administrator on 08/21/25 at 3:00pm revealed: -She was not aware that MAs were administering Resident #3 Carvedilol when her blood pressure was less than 110/60. -MAs were supposed to hold Carvedilol when the resident's blood pressure was less than 110/60 because she expected MAs to follow PCP orders. -If MAs had notified the PCP that the resident's blood pressure was less than 110/60 and they had to hold the Carvedilol, there should have been a progress note in the resident's record. -She received a copy of emails that were sent to the PCP or Triage and had not received any notifications that Resident #3's PCP had been notified that her Carvedilol had not been held several times when her blood pressure was less than 110/60. -The MAs placed Resident #3 at risk of her blood pressure dropping too low which could lead to falls. b. Review of an orthopedist order for Resident #3 dated 06/17/25 revealed there was an order for Tramadol 50mg, take one tablet every 6 hours for right knee pain while awake (Tramadol is used to treat moderate to severe pain). Review of a physician order for Resident #3 dated 07/09/25 revealed there was an order for	D 358		

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D 358	Continued From page 29 Tramadol 50mg, take one tablet twice a day, will send hard script when able. Review of a physician order for Resident #3 dated 07/21/25 revealed there was an order for Tramadol 50mg, take one tablet three times a day for arthritic pain. Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as drug not available at 8:00am on 06/26/25. -Tramadol HCL 50mg was documented as administered at 2:00pm and 8:00pm on 06/26/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 06/27/25 to 06/30/25. Review of Resident #3's July 2025 eMAR revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 07/01/25 to 07/11/25. -Tramadol HCL 50mg was documented as drug not given on 07/12/25 and 07/13/25 at 8:00am and 2:00pm. -Tramadol HCL 50mg was documented as administered at 8:00pm from 07/12/25 to 07/13/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 07/14/25. -Tramadol HCL 50mg was documented as drug	D 358		

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D 358	Continued From page 30 not given from 07/15/25 to 07/18/25 at 8:00am and 2:00pm. -Tramadol HCL 50mg was documented as administered at 8:00pm from 07/15/25 to 07/18/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 07/19/25 to 07/20/25. -Tramadol HCL 50mg was documented as drug not given from 07/21/25 at 8:00am and 2:00pm. -Tramadol HCL 50mg was documented as administered at 8:00pm on 07/21/25 at 8:00pm. Observation of medications on hand on 08/21/25 at 10:03am revealed: -There was one bubble card of Tramadol HCL 50mg, take one tablet three times a day at 8:00am, 2:00pm, and 8:00pm for arthritic pain. -There was a dispense date of 08/17/25. -There were 82 tablets of Tramadol available to administer to Resident #3. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/25 at 2:05pm revealed: -The pharmacy dispensed medications on a batch cycle and resident's medications started on the 17th of each month. -The pharmacy received an order for Tramadol 50mg, take one tablet every six hours when awake on 06/23/25. -The pharmacy never filled the prescription for Tramadol 50mg, take one tablet every six hours because the pharmacy did not receive a hard copy of the prescription. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 07/21/25 with a quantity of 78 tablets. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 08/11/25 with a	D 358		

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D 358	Continued From page 31 quantity of 93 tablets to begin on 08/17/25. Based on observations, interviews, and record reviews there was no Tramadol dispensed and available for administration until 07/21/25. Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:45pm revealed: -She sent orders to the pharmacy, and the pharmacy entered the information of the eMAR. -She had not noticed the pharmacy noted they needed a hard copy of the prescription for Tramadol HCL 50mg, take one tablet every six hours. -She did not realize there were two Tramadol HCL 50mg orders on Resident #3's eMAR. Telephone interview with Resident #3's PCP on 08/21/25 at 3:42pm revealed: -She was not aware that there were two different orders for Tramadol HCL 50mg on the resident's eMAR. -She remembered that Resident #3's orthopedist wrote a prescription for Tramadol HCL 50mg, take one tablet every 6 hours while awake. -When she wrote the order for Tramadol HCL 50mg, take one tablet three times a day, she should have discontinued the Tramadol order from the orthopedist but overlooked it. -The MA or SCC could have contacted her for a clarification order but no one contacted her about the order. Interview with the Administrator on 08/21/25 at 8:39am revealed: -There was confusion about the resident's Tramadol 50mg order because the resident's orthopedist first prescribed the Tramadol to take every 6 hours daily. -The resident's PCP later prescribed Tramadol	D 358		

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D 358	Continued From page 32 50mg order for three times a day. 2. Review of Resident #1's current FL-2 dated 07/23/25 revealed: -Diagnoses included Alzheimer's dementia, acute kidney injury, hypertension, type II diabetes, and peripheral arterial disease. -There was an order to monitor finger stick blood sugars (FSBS) at meals and at bedtime. -There was an order for Humalog sliding scale insulin (SSI) administration; for blood sugar greater than 150 give no units, for 151-200 give two units subcutaneously, for 201-250 give four units subcutaneously, for 251-300 give six units subcutaneously, for 301-350 give eight units subcutaneously, for 351-400 give ten units subcutaneously, for FSBS greater than 400 give twelve units subcutaneously, for blood sugar (BS) 51-70 give juice/crackers. Review of Resident #1's July electronic medication administration record (eMAR) revealed: -There was an entry to monitor FSBS at meals and bedtime, three times per day before two meals and at bedtime, scheduled daily at 6:30am, 11:30am, and 4:30pm, with a start date of 07/23/25. -There was no entry to check the resident's blood sugars at bedtime. -There was documentation of staff initials under the eMAR entry for FSBS that staff performed FSBS checks three times per day at 6:30am, 11:30am, and 4:30pm from 07/23/25 through 07/31/25. -There was a flow chart entry for FSBS scheduled for 11:30am, 12:00pm, 4:30pm, 5:00pm, 6:30am, 7:00am, and 9:00pm. -There was documentation of results in the eMAR	D 358		

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D 358	Continued From page 33 flowsheet that the blood sugar was checked six times on 07/24/25 at 6:30am, 7:00am, 11:30am, 12:00pm, 4:30pm, and 5:00pm. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked six times on 07/25/25 at 6:30am, 7:00am, 11:30am, 12:00pm, 4:30pm, and 5:00pm. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked four times on 07/26/25 at 6:30am, 7:00am, 11:30am, and 12:00pm. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked six times on 07/27/25 at 6:30am, 7:00am, 11:30am, 12:00pm, 4:30pm, and 5:00pm. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked four times on 07/28/25 at 6:30am, 7:00am, 11:30am, and 12:00pm. -There was an entry for Humalog sliding scale insulin administration; for blood sugar 51-70 give juice/crackers, for 71-150 give no units, for 150-200 give two units, for 201-250 give four units, for 251-300 give six units, for 301-350 give eight units, scheduled daily at 7:00am, 12:00pm, and 5:00pm with a start date of 07/23/25. -There was documentation on 07/28/25 that four units of insulin were given at 7:00am when the blood sugar was 256, when 6 units should have been given. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked six times on 07/29/25 at 6:30am, 7:00am, 11:30am, 12:00pm, 4:30pm, and 5:00pm. -There was documentation on 07/29/25 that two units of insulin were given when the blood sugar was 150 at 5:00pm, when none should have been administered. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked five	D 358		

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D 358	Continued From page 34 times on 07/30/25 at 6:30am, 7:00am, 11:30am, 12:00pm, and 4:30pm. -There was documentation of results in the eMAR flowsheet that the blood sugar was checked three times on 07/31/25 at 6:30am, 11:30am, and 4:30pm. -There were no FSBS results or documentation of insulin administered at bedtime from 07/23/25 through 07/30/25. Telephone interview with a pharmacist for the facility's contracted pharmacy on 08/21/25 at 2:21pm revealed: -The pharmacy did not receive a copy of Resident #1's FL-2 dated 07/23/25. -The pharmacy received an order dated 07/23/25 to check FSBS at each meal. -The pharmacy did not have an order for Resident #1's FSBS check at bedtime. -The pharmacy received an order to discontinue the resident's sliding scale insulin on 07/30/25. -If the resident did not receive as much insulin as prescribed his blood sugars could have been higher, and if too much insulin was given his blood sugar could have gone too low. Telephone interview with Resident #1's primary care provider (PCP) on 08/21/25 at 3:38pm revealed: -She did not specify on her orders, but bedtime meant between 9:00pm and 11:00pm to her. -She did not feel that an extra FSBS at bedtime would have changed his care or progress. -She gave an order to stop sliding scale insulin (SSI) on 07/30/25. Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:44pm revealed: -She sent orders to the pharmacy. -She entered orders if the pharmacy did not get	D 358		

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D 358	Continued From page 35 them back soon enough. -She always sent the FL-2 to the pharmacy. -She tried to look at all eMAR's once per week for all residents. -She last did an eMAR audit two weeks ago. Interview with the Administrator on 08/21/25 at 2:50pm revealed: -She was not notified about a mismatch between orders and eMAR entries for Resident #1.	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	Instant in-service was provided to all medication staff on proper medication administration and documentation on resident MAR. 9/25/2025. The facility administrator or designee will Inservice all new hire med passers on proper documentation of resident MAR within 30 days of hire. Facility administrator or designee will complete cart audits weekly, monthly or as needed as determined by the Facility Administrator or designee to ensure compliance. Audits will be completed weekly until compliance is met and then monthly. Facility Administrator or designee will audit MAR weekly for one month then monthly or as needed to ensure compliance.	9/25/2025 10/1/2025 9/12/2025 9/12/2025

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D 367	Continued From page 36 This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) including inaccurate documentation of a pain medication. The findings are: Review of Resident #3's current FL-2 dated 01/17/25 revealed diagnoses included unspecified dementia, type 2 diabetes, urinary tract infections and depression. Review of an orthopedist order for Resident #3 dated 06/17/25 revealed there was an order for Tramadol 50mg, take one tablet every 6 hours for right knee pain while awake (Tramadol is used to treat moderate to severe pain). Review of a physician order for Resident #3 dated 07/09/25 revealed there was an order for Tramadol 50mg, take one tablet twice a day, will send hard script when able. Review of a physician order for Resident #3 dated 07/21/25 revealed there was an order for Tramadol 50mg, take one tablet three times a day for arthritic pain. Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 06/24/25 to 06/25/25.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER THE INDIGO AT PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
(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 37 -Tramadol HCL 50mg was documented as administered at 2:00pm and 8:00pm on 06/26/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 06/27/25 to 06/30/25. Review of Resident #3's July 2025 eMAR revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 07/01/25 to 07/11/25. -Tramadol HCL 50mg was documented as administered at 8:00pm from 07/12/25 to 07/13/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 07/14/25. -Tramadol HCL 50mg was documented as administered at 8:00pm from 07/15/25 to 07/18/25. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 07/19/25 to 07/20/25. -Tramadol HCL 50mg was documented as administered at 8:00pm on 07/21/25. Based on observations, interviews, and record reviews there was no Tramadol dispensed and available for administration until 07/21/25. Review of Resident #3's August 2025 eMAR revealed: -There was an entry for Tramadol HCL 50mg, take one tablet every 6 hours while awake for right knee pain, need script. -Tramadol HCL 50mg was documented as administered at 8:00am, 2:00pm, and 8:00pm	D 367		

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D 367	Continued From page 38 from 08/01/25 to 08/19/25. -Tramadol HCL 50mg was documented as administered at 8:00am on 08/20/25. -There was an entry for Tramadol HCL 50mg, take on tablet three times a day for arthritic pain. -Tramadol 50mg was documented as administered at 9:00am, 3:00pm, and 9:00pm from 08/08/25 to 08/19/25. -Tramadol 50mg was documented as administered at 9:00am on 08/20/25. Observation of medications on hand on 08/21/25 at 10:03am revealed: -There was one bubble card of Tramadol HCL 50mg, take one tablet three times a day at 8:00am, 2:00pm, and 8:00pm for arthritic pain. -There was a dispense date of 08/17/25. -There were 82 tablets of Tramadol available to administer to Resident #3. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/25 at 2:05pm revealed: -The pharmacy dispensed medications on a batch cycle and resident's medications started on the 17th of each month. -The pharmacy received an order for Tramadol 50mg, take one tablet every six hours when awake on 06/23/25. -The pharmacy never filled the prescription for Tramadol 50mg, take one tablet every six hours because the pharmacy did not receive a hard copy of the prescription. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 07/21/25 with a quantity of 78 tablets. -The pharmacy dispensed Tramadol 50mg, take one tablet three times a day on 08/11/25 with a quantity of 93 tablets to begin on 08/17/25.	D 367		

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NAME OF PROVIDER OR SUPPLIER THE INDIGO AT PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 NORTH PIKEVILLE, NC 27863		
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D 367	Continued From page 39 Interview with a medication aide (MA) on 08/21/25 at 10:23am revealed: -She had not realized that there were two different orders on Resident #3's eMAR. -She was not sure why she had not contacted the primary care provider (PCP) to obtain a clarification order. -She should not have documented that she administered both medications because she only had one bubble card with Tramadol to dispense. Interview with the Special Care Unit Coordinator (SCC) on 08/21/25 at 2:45pm revealed: -She sent orders to the pharmacy, and the pharmacy entered the information of the eMAR. -She had not noticed the pharmacy noted they needed a hard copy of the prescription for Tramadol HCL 50mg, take one tablet every six hours. -She did not realize there were two Tramadol HCL 50mg orders on Resident #3's eMAR. Telephone interview with Resident #3's PCP on 08/21/25 at 3:42pm revealed: -She was not aware that there were two different orders for Tramadol HCL 50mg on the resident's eMAR. -She remembered that Resident #3's orthopedist wrote a prescription for Tramadol HCL 50mg, take one tablet every 6 hours while awake. -When she wrote the order for Tramadol HCL 50mg, take one tablet three times a day, she should have discontinued the Tramadol order from the orthopedist but overlooked it. -The MA or SCC could have contacted her for a clarification order but no one contacted her about the order. Interview with the Administrator on 08/21/25 at 8:39am revealed:	D 367		

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D 367	Continued From page 40 -There was confusion about the resident's Tramadol 50mg order because the resident's orthopedist first prescribed the Tramadol to take every 6 hours daily. -The resident's primary care provider (PCP) later prescribed Tramadol 50mg order for three times a day. -The orthopedist order for Tramadol 50mg, take one tablet every 6 hours should have been discontinued to avoid confusion. -The MA or the SCC should have notified the resident's PCP that a clarification order was needed for the Tramadol.	D 367			