STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065036	A. BUILDING: _____ B. WING _____	R 10/03/2025

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted an annual,follow up survey, and complaint investigation on September 30 through October 03, 2025. The County complaints were initiated by New Hanover County Department of Social Services on 08/19/25, 08/21/25, and 09/05/25.	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: Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care items in residents' rooms that were accessible to residents on the Special Care Unit (SCU). The findings are: Review of the facility policy for SCU safety measures for accidental ingestion dated	D 079		

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D 079	Continued From page 1 September 2021 revealed: -Assessment of the resident, on admission and periodically screening for; personal items that could be ingested are maintained by staff (all liquid personal items, aerosols, hearing aids, pins, buttons, clips, etc.). -Resident and responsible party are notified of policy on admission. -Resident rooms/care areas are inspected regularly for unsafe items that could be accidentally ingested or harmful (glass items, pictures with glass covers, vases, etc.). -Staff routinely monitor residents for possible hoarding of substances that could be ingested. -Staff training includes assessing residents for possible ingestion, initiating necessary emergency procedures calling the poison control center if necessary, monitoring the facility and resident rooms for substances that could be accidentally ingested, notifying the residents physician, responsible party and other required parties as necessary and per policy. Review of the facility's census report on 09/30/25 revealed there were 22 residents living in the Special Care Unit (SCU) of the facility. Observation of the SCU shower room door unlocked and open on 09/30/25 from 9:00am to 9:30am revealed: -The door to the shower room was unlocked and open. -There were numerous boxes labeled with resident's names that contained numerous resident's products that were accessible to all residents. -There was a bottle of lotion with a warning label to keep out of reach of children, for external use only, avoid contact with eyes, if swallowed get medical help or contact a poison control center	D 079		

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immediately.
-There was a bottle of aromatherapy body lotion with a warning label to keep out of reach of children, for external use only and avoid contact with eyes.

Observation of the SCU shower room door on 10/2/25 at 8:15am revealed that the shower room door was unlocked and opened.

Observation of the SCU hallway between the dining room and living room on 10/2/25 at 8:15am revealed:
-There was a spray can of disinfectant spray sitting on a half wall that separated the dining room from the hallway.
-There were 11 residents in the dining room and one staff member.
-The Clinical Nurse Consultant (CNC) removed the can of disinfectant spray.

Interview with the CNC on 10/2/25 at 8:15am revealed:
-The shower room door was supposed to be always closed.
-She was concerned that the residents could have ingested the personal care products.
-She did not know of any residents that had ever ingested a personal care product.
-She was concerned about the can of disinfectant spray because it could have been used as a weapon, sprayed on other residents or themselves.

Observation of room 104 on the SCU on 09/30/25 between 9:30am and 10:00am revealed there was a bottle of bodywash with a warning label to keep out of reach of children, for external use only, if eye contact occurs rinse with water, and use as directed.

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D 079	Continued From page 3 Observation of room 117 on the SCU on 09/30/25 between 9:30am and 10:00am revealed there was a bottle of body wash; with a warning label to keep out of reach of children, avoid eye contact if occurred flush thoroughly with water. Observation of room 120 on the SCU on 09/30/25 between 9:30am and 10:00am revealed: -There was wound cleaner in a spray bottle with a warning label to keep out of reach of children, and if ingested seek professional assistance or contain a poison control center immediately. -There was shaving gel with a warning label to keep out of reach of children, avoid contact with eyes, do not ingest if swallowed do not induce vomiting call a poison control center or physician immediately. -There was a can of spray deodorant can be fatal or harmful if inhaled and keep away from face and mouth, body wash for external use only, if swallowed could cause gastrointestinal irritation with nausea, vomiting, and diarrhea. Observation of room 124 on the SCU on 09/30/25 between 9:30am and 10:00am revealed: -There was a can of shaving cream with a warning label to keep out of reach of children, avoid contact with eyes, do not ingest if swallowed do not induce vomiting call a poison control center or physician immediately. -There were denture cleaner tablets on a shelf in the bathroom labeled keep out of reach of children, do not place in mouth, contains persulfates, which are known allergen and if ingested seek professional assistance or contain a poison control center immediately. Interview with a personal care aide (PCA) on 9:30am revealed:	D 079		

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-Personal care products were not supposed to be in the residents' rooms.
-Personal care products were stored in the shower room.
-She had never made rounds looking for personal care products.

Interview with a second PCA on 10/1/25 at 2:00pm revealed:
-She had never made rounds looking for personal care products.
-She did not know that the shower door was supposed to be always closed.

Interview with a third PCA on 10/2/25 at 9:30am revealed:
-There were not supposed to be personal care products in the residents' rooms.
-Personal care products were stored in the shower room.
-She had never made rounds to look for personal care products.

Interview with a medication aide (MA) on 09/30/25 at 10:50am revealed:
-Personal care products were not supposed to be in the residents' rooms.
-There is a box in the shower room with the resident's name on it to store their personal care products.
-All staff should make rounds to look for personal care products.

Interview with the Special Care Coordinator (SCC) on 09/30/25 at 11:20am revealed:
-She had worked at the facility for one month.
-She had not been oriented to her position of SCC.
-Residents had a personal care box in the shower room.

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-The staff made rounds every 2 hours and their rooms were checked after breakfast and throughout the day by staff.
-There was not a process for looking specifically for personal care products but they were not supposed to come out of the shower room.
-She made rounds on Sunday, 09/28/25 and there were not any personal care products in the residents' rooms.
-She did not look in any resident drawers when rounding.
-The shower room door was supposed to be shut at all times and she went and shut the shower door which is located across from her office.
-Her concern that the shower room door was left open was that the resident could get into the products and consume them.
-The consumption of products could make a resident sick.
-She was not sure why there were personal care products in the residents' rooms.

Interview with the Administrator on 10/2/25 at 9:37am revealed:
-She had worked at the facility since 03/23/25.
-She made rounds several times a day looking for personal care products, cleanliness of the residents, and to make sure activities were performed.
-She expected her staff to round every 2 hours to look for personal care products.
-Personal care products were supposed to be stored in the shower room.
-The shower room door should be closed and always locked.
-She had never had a resident ingest a personal care product.
-She did not know that there were personal care products in the resident's rooms.
-She was concerned that the can of disinfectant

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D 079	Continued From page 6 spray could have been used for a weapon, sprayed in their eyes or other residents' eyes. Attempted interview with the facility contracted primary care provider (PCP) on 10/02/25 at 2:54pm and 10/03/25 at 8:09am was unsuccessful.	D 079		
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: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the health care needs for 1 of 6 sampled residents including failing to notify a provider that a resident complained of right arm pain in her right arm after a fall (#6). The findings are: Review of Resident #6's current FL-2 dated 08/15/25 revealed: -Diagnoses included chronic pain syndrome, hypertension, chronic obstructive pulmonary disease, and chronic fatigue. -The resident was semi ambulatory; there was no information provided related to the resident's orientation. -The resident's level of care was assisted living (AL). Review of Resident #6's current care plan dated 06/06/25 revealed:	D 273		

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-Resident #6 was oriented.
-The resident was forgetful and needed reminders.
-The resident required supervision and set up with toileting, ambulation, bathing, dressing, grooming and transfers.

Review of an Incident and Accident (I/A) report dated 08/27/25 at 11:57pm revealed:
-Resident #6 was found in her room in her wheelchair by a personal care aide (PCA).
-The PCA reported to the medication aide (MA) on duty that the resident reported she fell out of her wheelchair and got herself back into the wheelchair independently.
-The MA observed a bump on the resident's forehead.
-The resident refused to go to the local emergency department (ED).
-The MA contacted the on call hospice nurse.
-The MA texted an update to the resident's primary care provider (PCP).

Review of Resident #6's electronic facility progress note on 08/28/25 at 6:22pm revealed:
-There was an entry that the MA checked on the resident for a follow up from a fall.
-The resident denied any complaint of pain.

Review of a PCP progress note dated 09/09/25 revealed:
-Resident #6 was seen for a regular visit.
-The PCP was notified by staff during her visit that the resident had a fall on 08/28/25.
-The resident had a large bruise to the left side of her face.

Interview with a personal care aide (PCA) on 10/03/25 at 8:38am revealed:
-When a resident had a bruise, new skin

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breakdown or complained of pain, she notified the MA on duty.
-She notified the MA because the resident may need to go to the local ED for treatment.

Telephone interview with a MA on 10/02/25 at 2:31pm revealed:
-He worked the evening of 08/29/25 on the AL unit.
-Resident #6 complained of right arm pain, which she always complained of.
-He asked the resident if she would go to the local ED and she refused.
-The resident reported that she had informed staff on the shift prior to his that her right arm was still hurting.
-He did not notify the resident's PCP or the hospice nurse because he assumed the MA on the previous shift had reported it to them.

Telephone interview with a second MA on 10/03/25 at 8:20am revealed:
-She did not work with Resident #6 for several weeks in August 2025 and September 2025.
-When a resident complained of pain that was different or unusual, she notified the PCP to seek guidance.
-If a resident complained of right arm pain and she was unable to reach the resident's PCP she would send the resident to the local ED.

Telephone interview with Resident #6's hospice nurse on 10/02/25 at 11:12am revealed:
-She received a telephone call from a MA notifying her that Resident #6 had a fall on 08/27/25.
-She attempted to visit Resident #6 on 08/27/25 but was informed by staff that the resident was at a doctor's appointment.
-She visited Resident #6 on 08/28/25.

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D 273	Continued From page 9 -The resident had a fall on 08/27/25, had a cast on her right arm, was bruised on the left side of her face, her left hip and her left knee. Interview with the Administrator on 10/03/25 at 12:54pm revealed: -Resident #6 had right arm pain most of the time. -The resident's right arm pain became worse after she fell on 08/27/25. -The resident refused to go to the local ED, but the hospice nurse was notified. -Staff should also notify the resident's PCP when the resident had pain to ensure appropriate evaluation and treatment.	D 273		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents. The findings are:	D 315		

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D 315	Continued From page 10 Observation of the facility on 10/01/25 at 8:15am revealed: -The was an October activities calendar posted on the assisted living (AL) side of the facility. -Snack time was scheduled from 10:00am to 10:30am. -There was an October activities calendar posted in the Special Care Unit (SCU). -At 10:15am revealed snacks were being passed to residents in their rooms on AL. Interview with a resident on 10/01/25 at 10:30am revealed: -She lived in AL. -The facility did not do the activities posted on the activity calendar. -There was not many activities being offered in the facility. -A resident did bingo on the weekends. -She would like to be offered more activities. Interview with a second resident on 10/01/25 at 10:35am revealed: -She lived on the AL. -The facility did not do the activities posted on the activity calendar. -The Activities Director (AD) was also the transportation person and was always out of the facility taking residents to appointments. -She would like to be offered more activities. Interview with a third resident on 10/01/25 at 10:40am revealed: -She lived on the AL. -The facility did not do any activities for residents. -It was boring in the facility and all she did was watch television. -She would like the facility to offer more outings and activities.	D 315		

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D 315	Continued From page 11 Interview with a fourth resident on 10/01/25 at 10:45am revealed: -She lived on the AL. -She did not see many activities being done in the facility. Interview with the AD on 10/01/25 at 10:50am revealed: -She was the AD and did the transportation for the facility. -Most week days residents had 1-3 appointments to which they needed to be transported. -Each time she transported residents to an appointment it took 30 minutes up to 4 hours. -She was aware there were supposed to be 14 hours of activities offered to residents each week. -She did not complete 14 hours of activities because she was too busy doing transportation. -The personal care aides (PCA) were supposed to do activities for residents when she was doing transportation. Interview with the Resident Care Coordinator (RCC) on 10/01/25 at 1:35pm revealed: -There were 14 hours of activities being done each week in the facility. -The AD was responsible for ensuring there were 14 hours of activities offered to residents weekly. -The AD also did transportation for the facility. -When the AD was doing transportation the PCAs were supposed to do the activities with the residents. Interview with the Administrator on 10/01/25 at 2:35pm revealed: -She did not believe snack time was an appropriate activity. -She expected a minimum of 14 hours of engaging and social activities to be offered to residents each week.	D 315		

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D 315	Continued From page 12 -She believed there were 14 hours of activities being done each week but they were not activities that were on the schedule.	D 315		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 6 sampled residents (#1) related to a medication for pain management and a resident that was prescribed an antibiotic for cellulitis (#6). The findings are: Review of the facility's Medication Services/Pharmaceutical Care Services Policy dated September 2021 revealed: -The community provided medication administration, ordering, and reordering of medication and medication administration services. -The Administrator, Resident Care Coordinator (RCC) or designee would ensure that medication administration services required for each resident	D 358		

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were provided.
-All medications that staff members administered, handled, and stored would be documented on the Medication Administration Record (MAR) and in accordance with state regulations and the Community's preferred pharmacy standard and procedure manual.

1. Review of Resident #6's current FL-2 dated 08/15/25 revealed diagnoses included chronic pain syndrome, hypertension, chronic obstructive pulmonary disease, and chronic fatigue.

Review of Resident #6's hospice physician certification of terminal illness dated 06/09/25 revealed the resident's hospice diagnosis was other frontotemporal neurocognitive disorder (Other frontotemporal neurocognitive disorder is a form of dementia).

Review of Resident #6's primary care provider (PCP) progress note dated 09/09/25 revealed:
-The resident was seen for complaint of increased pain to her left lower leg.
-Resident #6 was diagnosed with cellulitis to a large portion of her left lower leg, secondary to a small skin tear to the resident's anterior shin.
-She prescribed the resident Clindamycin 300mg, take one capsule every 8 hours for 10 days (Clindamycin is a medication used to treat bacterial infections).

Interview with Resident #6's PCP on 09/30/25 at 11:11am revealed:
-She visited Resident #6 on 09/09/25.
-The resident complained of pain to her lower left leg.
-The resident's lower left leg was very hot, bright red, painful and weeping.
-She wrote an order for Clindamycin 300mg, take

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one capsule every 8 hours for 10 days for cellulitis.
-She updated the resident's hospice nurse during her visit on 09/09/25 to inform her that she ordered Clindamycin for the cellulitis and discussed that if the Clindamycin did not start to improve the resident's cellulitis, the resident may need inpatient hospice care.
-The Resident Care Coordinator (RCC) was not at the facility on 09/09/25 so she hand delivered the Clindamycin order to the Administrator.
-She informed the Administrator that the resident had cellulitis and asked if she would fax the prescription to the pharmacy so the resident could start the antibiotic as soon as possible.
-She received an email from the RCC on 09/10/25 at 10:30am asking her if she was going to prescribe an antibiotic for Resident #6's left leg infection because the hospice nurse asked during her visit on 09/10/25 if the resident had started an antibiotic.
-She emailed the RCC and Administrator on 09/10/25 to inform the RCC that she had given the Administrator the prescription for Resident #6 on 09/09/25 and requested that she fax it to the facility's contracted pharmacy for the resident's cellulitis.
-She did not realize that Resident #6's antibiotic had not been sent to the pharmacy until she received the email from the RCC.
-She spoke with the resident's hospice nurse on 09/10/25, and they decided that if the resident's cellulitis was not better on Friday 09/12/25, the resident would probably need to be transferred to inpatient hospice for the cellulitis.
-If she had been notified by facility staff that the resident's lower left leg was hot, red and painful prior to her visit on 09/09/25 she would have ordered an antibiotic at that time.
-She had last seen Resident #6 during a visit on

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08/26/25, and there were no indications of cellulitis on the resident's lower left leg.
-The resident needed to start Clindamycin as soon as possible and she thought the facility would have been able to administer the first dose the evening of 09/09/25.

Telephone interview with Resident #6's hospice nurse on 10/02/25 at 11:12am revealed:
-She visited the resident on 09/09/25 after receiving a telephone call from the resident's PCP that she had cellulitis on her left lower leg.
-The PCP informed her that Resident #6 would be starting an antibiotic on 09/09/25.
-Resident #6's left lower leg was red and swollen on 09/09/25.
-When she visited Resident #6 on 09/10/25 and 09/11/25 her left lower leg was shiny, tight, weeping, hot to touch and red.
-She asked the RCC if the resident had Clindamycin on her 09/10/25 visit, and was informed by the RCC that the resident did not have Clindamycin available.
-She informed the RCC that the resident's PCP visited Resident #6 on 09/09/25 and wrote an order for Clindamycin.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/25 at 3:29pm revealed:
-The pharmacy received an order for Clindamycin 300mg, take one tablet every 8 hours for 10 days on 09/10/25 at 10:56am.
-A staff person called later in the day on 09/10/25 and requested that they send the prescription of Clindamycin to the facilities back up pharmacy so the medication would arrive the evening of 09/10/25.

Telephone interview with the facility's back up

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pharmacy on 10/02/25 at 2:16pm revealed:
-The pharmacy filled Clindamycin for Resident #6 on 09/10/25.
-A courier picked up the Clindamycin on 09/10/25 at 11:13pm.

Interview with a medication aide (MA) on 10/01/25 at 8:48am revealed:
-He observed the resident's leg on 09/09/25 and was told by another MA that the hospice nurse and PCP had been made aware of the lower left leg and an antibiotic had been ordered for the resident.
-When he observed Resident #6's lower left leg it was red, hot to touch, and weeping.

Second interview by telephone with a MA on 10/02/25 at 2:31pm revealed:
-He began his shift on 09/10/25 at 7:00pm.
-Resident #6's Clindamycin for the cellulitis on her left leg had not yet been delivered to the facility.
-He called the facility's contracted pharmacy on 09/10/25 in an effort to track down Resident #6's Clindamycin.
-A courier delivered the Clindamycin from the facility's back up pharmacy the evening of 09/10/25.
-The resident's hospice nurse had informed him to administer the resident her first dose of Clindamycin as soon as the medication arrived at the facility.
-He thought he gave Resident #6 her first dose of Clindamycin close to 12:15am on 09/11/25.

Review of an electronic progress note for Resident #6 dated 09/11/25 revealed:
-At 12:11am a MA contacted the facility's contracted pharmacy to inquire about the delivery of the resident's Clindamycin.
-The MA documented that the representative

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from the facilities contracted pharmacy informed him that the Clindamycin was in route to the facility from a courier service.
-The MA documented at 12:52am on 09/11/25 that the resident received her first dose of Clindamycin.

Review of Resident #6's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Clindamycin HCl 300mg, take one every 8 hours at 6:00am, 2:00pm, and 10:00pm for 10 days.
-Clindamycin HCl 300mg was documented as not administered on 09/10/25 at 6:00am, 2:00pm, and 10:00pm with an "X" at each entry time.
-Clindamycin HCl 300mg was documented as administered on 09/11/25 at 6:00am.
-There was an entry on the eMAR exceptions that Clindamycin HCl 300mg was not administered on 09/11/25 at 2:00pm, due to the resident being discharged to inpatient hospice care.

Interview with the Licensed Health Professional Support (LHPS) clinical nurse consultant on 10/02/25 at 2:42pm revealed:
-She completed Resident #6's quarterly LHPS on 09/10/25.
-She observed the resident's left lower leg that was fiery red and appeared as if it was beginning to ooze.
-She was informed by the RCC that the resident's PCP had been notified and had ordered an antibiotic for Resident #6.

Interview with the RCC on 10/03/25 at 12:20pm revealed:
-She did not work on 09/09/25 during the day but could not remember if she worked that night.
-The hospice nurse asked her about Resident

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#6's antibiotic on 09/10/25 during her visit.
-She was not aware that Resident #6 had been prescribed an antibiotic until the hospice nurse asked her about the antibiotic.
-The hospice nurse informed her that the PCP wrote an order for Clindamycin on 09/09/25 for cellulitis.
-She asked the Administrator if she received an order from the PCP on 09/09/25 for an antibiotic and the Administrator directed her to a pile of papers on her desk.
-She faxed an order to the facility's contracted pharmacy on 09/10/25.
-She did not want anything to happen to Resident #6 by not receiving her antibiotic when it was ordered such as the infection get worse.
-It was important to start an antibiotic as soon as possible to prevent the risk of further infection.

Interview with the Administrator on 10/03/25 at 12:54pm revealed:
-To her knowledge Resident #6's antibiotic arrived at the facility on 09/11/25.
-When she received orders from the PCP she faxed those orders to the facility's contracted pharmacy.
-She did not look at papers that the PCP gave her on 09/09/25.
-She should have looked at the papers the PCP gave her on 09/09/25 and faxed the order for Resident #6's antibiotic to the facility's contracted pharmacy.

2. Review of Resident #1's current FL2 dated 04/13/25 revealed
-Diagnoses including dementia, malignant neuroendocrine tumors, and mild cognitive impairment.
-The resident was constantly disoriented and semi-ambulatory.

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-The recommended level of care was special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 09/27/23.

Review of a primary care provider (PCP) encounter for Resident #1 dated 08/19/25 revealed:
-The resident's problem list included mild cognitive impairment and malignant neuroendocrine tumors.
-The resident's medications included fentanyl 12mcg/hr transdermal patch to be administered topically every 72 hours for management of chronic pain.

Review of PCP encounter note for Resident #1 dated 09/02/25 revealed the resident had chronic pain due to neuroendocrine cancer. The fentanyl patch was prescribed for pain control.

Review of Resident 1's physician's order dated 07/11/25 revealed:
-There was an order for Fentanyl transdermal patch 72 hours; 12 mcg/hour to be applied topically every 72 hours at 9:00am.
-The order was verified by the Administrator on 07/12/25 at 12:09pm.

Review of Resident #1's physician order dated 07/23/25 revealed:
-There was an order for Fentanyl transdermal patch 12 mcg/hour to be applied topically every 72 hours at 9:00am.
-The order was verified by the Resident Care Coordinator (RCC) on 07/23/25 at 1:15pm.

Review of Resident #1's physician orders dated 08/07/25 revealed:

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-There was an order for Fentanyl transdermal patch 25mcg/hour to be applied topically every 72 hours at 9:00am.
-Special instructions were to remove old patch before application of new one.
-The order was verified by the Administrator on 08/07/25 at 1:14pm.
-There was an order to discontinue Fentanyl transdermal patch 25mcg/hour to be applied topically every 72 hours at 9:00am.

Review of packing slips from Resident #1's pharmacy revealed on 07/11/25, 07/23/25, and 08/04/25 a quantity of five Fentanyl transdermal patches 12mcg/hour were shipped to the facility for Resident #1.

Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Fentanyl transdermal patch 72 hour 12 mcg/hr to be administered every 72 hours at 9:00am.
-Fentanyl transdermal patch 72 hour 12 mcg/hour was documented as administered on 017/13/25 at 9:00am.
-Site placement of the transdermal fentanyl 12mcg patch on Resident #1 was not documented on 07/13/25.
-Fentanyl transdermal patch 72 hour 12 mcg/hour was documented as administered on 017/19/25 at 9:00am
-Site placement of the Fentanyl transdermal patch 72 hours 12mcg/hr on Resident #1 was documented only as "arm" on the eMAR on 07/19/25.
-Fentanyl transdermal patch 72 hour 12 mcg/hour was documented as administered on 017/25/25 at 9:00am
-Site placement of the Fentanyl transdermal

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patch 72 hours 12mcg/hr on Resident #1 was documented with numeral 1 on the eMAR on 07/25/25.
-The eMAR information key had no indication of what numeral 1 meant.

Review of Resident #1's physician order dated 08/04/25 revealed:
-There was an order for Fentanyl transdermal patch 12 mcg/hour to be applied topically every 72 hours at 9:00am.
-The order for Fentanyl transdermal patch 72 hours; 12 mcg/hour to be applied topically every 72 hours was discontinued on 08/07/25 at 9:09am.

Review of Resident #1's physician order dated 08/04/25 revealed:
-There was an order for Fentanyl transdermal patch 12 mcg/hour to be applied topically every 72 hours at 9:00am.
-The order for Fentanyl transdermal patch 72 hours; 12 mcg/hour to be applied topically every 72 hours was discontinued on 08/07/25 at 9:09am.

Review of Resident #1's physician order dated 08/18/25 revealed there was an order for Fentanyl transdermal patch 72 hour; 25mcg/hour to be applied topically every 72 hours at 9:00am.

Review of Resident #1's Controlled Substance Report for Fentanyl transdermal patch 25mcg/hr patch 72 hour revealed:
-On 08/20/25 at 5:46pm 1 Fentanyl transdermal patch 25mcg/hr patch 72 hour was wasted by the SCC and a MA.
-The reason for the waste was documented as "other".
-The method of destruction was not documented.

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D 358	Continued From page 22 -On 08/24/25 at 5:50pm 8 Fentanyl transdermal patch 25mcg/hr patch 72 hour were wasted by the RCC and a MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -There was no signature of the administrator or the administrator's designee. -There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Fentanyl transdermal patch 72 hours 12mcg/hr to be administered every 72 hours at 9:00am. -Fentanyl transdermal patch 72 hours 12mcg/hr was documented as administered on 08/06/25 at 9:00am. -The order for Fentanyl transdermal patch 72 hours 12mcg/hr was documented as discontinued 08/07/25. -There was no documented administration of Fentanyl transdermal patch 72 hours 12mcg/hr to Resident #1 after 08/06/25. -There was an entry for Fentanyl transdermal patch 72 hours 25mcg/hr to be administered every 72 hours at 9:00am. -The documented start date for Fentanyl transdermal patch 72 hours 25mcg/hr was 08/21/25 on the eMAR. -There was no documented administration of Fentanyl transdermal patch 72 hours 25mcg/hr on 08/21/25. -Fentanyl transdermal patch 72 hours 25mcg/hr was documented as administered on 08/24/25 at 9:00am. -Site placement of the Fentanyl transdermal	D 358		

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patch 72 hours 25mcg/hr on Resident #1 was documented "on left/remove right" on the eMAR on 08/24/25.
-There was no documentation of Resident #1 administered a Fentanyl transdermal 72 hour between 08/06/25 and 08/24/25.

Review of packing slips from Resident #1's pharmacy revealed on 08/07/25, 08/18/25, 08/28/25, and 09/23/25 a quantity of five Fentanyl transdermal patches 25mcg/hour were shipped to the facility for Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Fentanyl transdermal patch 72 hours 25 mcg/hr to be administered at 9:00am.
-Fentanyl transdermal patch 72 hours 25mcg/hr was documented as administered on 09/20/25 at 9:00am.
-Site placement of the Fentanyl transdermal patch 72 hours 25mcg/hr on Resident #1 was documented as "rt" on 09/20/25.
-Fentanyl transdermal patch 72 hours 25mcg/hr was documented as administered on 09/23/25 at 9:00am.
-Site placement of the Fentanyl transdermal patch 72 hours 25mcg/hr on Resident #1 was documented as "rt" on 09/23/25.
-Fentanyl transdermal patch 72 hours 25mcg/hr was documented as administered on 09/29/25 at 9:00am.
-Site placement of the Fentanyl transdermal patch 72 hours 25mcg/hr on Resident #1 was documented as "rt" on 09/29/25.

Review of Resident #1's Controlled Substance Report for all controlled substances revealed:
-On 08/20/25 at 5:46pm, 1 Fentanyl transdermal

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patch 25mcg/hr patch 72 hour was wasted by the SCC and a MA.
-The reason for the waste was documented as "other".
- The entry under comments was 'the hospice nurse gave verbal order for med tech to put a fresh patch on'.
-The method of destruction was not documented.
-On 08/24/25 at 5:50pm 8 Fentanyl transdermal patches 25mcg/hr patch 72 hour was wasted by the RCC and a MA.
-The reason for the waste was documented as "other".
- The entry under Comments was 'medication patches moved to new order'.
-The method of destruction was not documented.

Review of Resident #1's Medication Disposition Form dated 09/17/25 revealed:
-A quantity of 6 Fentanyl transdermal patches 12mcg/hr 72 hour was disposed and no reason was documented.
-There was no documentation of dosage for the medications disposed.
-There was no documentation of method of destruction for the medications disposed.
-There was no signature of the Administrator or the Administrator's designee.
-There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

Telephone interview with pharmacist at Resident #1's pharmacy on 10/01/25 at 3:30pm revealed:
-On 08/07/25 the pharmacy received the order for change to the resident's transdermal fentanyl patch dosage; The fentanyl dosage increased from 12 mcg to 25 mcg.
-A quantity of five 25mcg fentanyl patches was

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delivered to the facility on 08/07/25; 08/18/25; 08/28/25; 09/09/25; and 09/23/25.
-The facility had 24 hour/7 day per week access to pharmacy technicians.
-She was unaware of any calls from the facility with concerns regarding the resident's eMAR or fentanyl order.

Telephone interview with hospice nurse on 10/02/25 at 11:12am revealed:
-Resident #1's order for transdermal 12mcg 72 hour fentanyl patches began on 07/11/25.
-The fentanyl order changed from 12mcg to 25 mcg on 08/06/25 after the resident's PCP reported an increase in Resident #1's pain.
-She sent the new order for transdermal fentanyl patch 25mcg to the resident's pharmacy and reviewed the med change with facility staff.
-The initial order for fentanyl patch 12mcg was discontinued on 08/06/25.
-On 08/08/25 the facility reported not receiving the fentanyl patches 25mcg from the pharmacy.
-On 08/12/25 staff reported Resident #1 with increased pain which the resident could not quantify.
-On 08/20/25 the hospice nurse found Resident #1 with two transdermal fentanyl patches administered. One was located on the resident's upper right arm and the second was located on the right upper back area.
-Neither fentanyl patch found on Resident #1 was either dated or initialed.
-She was unable to determine the dosage of either fentanyl patch found on Resident #1.
-She found both fentanyl patches 12mcg and fentanyl patches 25mcg for Resident #1 on the medication cart.
-Both the fentanyl patch 12mcg and the fentanyl patch 25mcg orders were active on Resident #1's eMAR.

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D 358	Continued From page 26 -She provided another written order to the RCC to discontinue the fentanyl patch 12 mcg. -The Administrator was not present on 08/20/25 when the two fentanyl patches were found on Resident #1. -She showed both the RCC and the SCC the two fentanyl patches on Resident #1 on 08/20/25. -She asked for the two small undated patches to be removed from Resident #1 and asked a MA to administer one 25 mcg patch. -She met with the Administrator on 08/21/25 about Resident #1 found with two fentanyl patches administered. -The fentanyl patches 25mcg were ordered for Resident #1 due to increased pain caused by malignant neuroendocrine cancer. -If Resident #1 had on two fentanyl patches 12 mcg , the resident would not have had effective pain management. -If Resident #1 had on two fentanyl patches 25 mcg, the resident would be at risk of overdose, which could be fatal. -If a MA simply forgot to remove the old fentanyl patch 12mcg before applying a new fentanyl patch 12mcg , the old fentanyl patch may not have administered significant medication to the resident, however, that was not the standard of care. -On 08/24/25 she had a care coordination meeting for Resident #1 with the Administrator present to discuss the medication error. -On 08/24/25 the Administrator was advised that both the fentanyl patch 12mcg and the fentanyl patch 25 mcg fentanyl patch was found on the medication cart. Interview with Resident #1's PCP on 09/30/25 at 11:00am revealed: -The hospice nurse called on 08/20/25 and reported Resident #1 found with two fentanyl	D 358		

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patches on.
-On 08/20/25 the nurse checked the medication cart and found both 12mcg fentanyl patches and 25mcg fentanyl patches.
-The 12mcg fentanyl patch had been discontinued by hospice.
-The nurse was unable to determine the dosage of either fentanyl patch found on Resident #1.
-The resident was at risk of opioid overdose or over sedation of the fentanyl patch was not administered properly.

Telephone interview with former MA on 08/28/25 at 2:10pm revealed:
-She could not recall the day the nurse found 2 patches on Resident #1.
-The nurse wanted the old patches removed and a new patch put on the resident.
-She had not previously administered a fentanyl patch to Resident #1.
-She could not recall the dosage of the patches but both patches were small.

Interview with a MA on 08/26/25 at 4:50pm revealed:
-She had not had to administer a fentanyl patch to Resident #1.
-The order was for the old patch removed and a new patch applied. The patch was to be initialed and dated.
-Resident #1 frequently reported having pain but would not always ask for a PRN (as needed) pain medication.

Interview with Special Care Coordinator (SCC) on 08/21/25 at 3:26pm revealed:
-She did not witness two fentanyl patches on Resident #1.
-The SCC was in the RCC's office when the nurse advised both that Resident #1 had on two

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fentanyl patches.
-The nurse did not show the SCC that Resident #1 with two fentanyl patches on.
-When she saw Resident #1, the resident had on one 25mcg fentanyl patch that was the proper dosage.

Interview with the RCC on 08/21/25 at 3:36pm revealed:
-She was in her office with the SCC when the nurse reported that Resident #1 had on two fentanyl patches.
-She did not leave her office to witness Resident #1 with two fentanyl patches on.
-The SCC also reported not seeing Resident #1 with two fentanyl patches on.

Interview with a second MA on 10/02/25 at 9:30am revealed:
-The eMAR system provided a prompt to properly document placement of topical patches.
-The location of the previous patch could be observed by checking the View History for the medication.
-A topical patch was to be dated and initiated by the MA upon application.

Second interview with Resident #1's hospice nurse on 10/03/25 at 10:20am revealed:
-Resident #1 had ongoing pain due to the spread of neuroendocrine cancer.
-The resident would have increased pain if the pain medication was not administered properly.
-The fentanyl patch dosage was increased due to the resident's ongoing pain reported by staff and the resident's PCP.
-The nurse met with the Administrator on 08/21/25 to discuss Resident #1 found with two fentanyl patches on.
-The Administrator reviewed Resident #1's eMAR

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on 08/21/25 and observed that there was no documented administration of a fentanyl patch between 08/06/25 and 08/24/25.
-The Administrator reported that she had administered a fentanyl patch to Resident #1 during that time.
-The Administrator observed that the fentanyl patch 12mcg was still active on the resident's eMAR.
-The Administrator called the resident's pharmacy and confirmed the resident's fentanyl patch 25mcg order began on 08/08/25.
-The nurse reviewed with the Administrator the administration process for the resident's fentanyl patch and provided instruction on site rotation.

Interview with the Administrator on 08/21/25 at 2:01pm revealed:
-She was advised on 08/21/25 by the hospice nurse that she found two fentanyl patches on Resident #1 on 08/20/25.
-She did not know which MA failed to remove the old fentanyl patch before administering a new fentanyl patch.
-The hospice nurse reported she showed the SCC (special care coordinator) and a MA that Resident #1 had on two fentanyl patches on 08/20/25.
-The nurse was unsure of the dosage of the two fentanyl patches found on Resident #1.
-The expectation was for the medication administration order to be followed.
-The MA should have looked for the old fentanyl patch before administering a new fentanyl patch.
-The fentanyl patches should have been dated and initialed by the MA.
-She reported that the two fentanyl patches found on Resident #1 on 08/20/25 were both 12 mcg because the 25mcg patches had not yet been administered.

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D 358	Continued From page 30 -She reported an audit of the resident's medication was needed because the resident had on two fentanyl patches and there was nothing was documented on the resident's eMAR. -She admitted the incident was a medication error and she had not yet interviewed MA staff. -Resident #1 was to have a new patch administered every 72 hours. The resident's eMAR shows the last two fentanyl patches were administered on 08/03/25 and 08/06/25. -The facility received from the resident's pharmacy five 25 mcg fentanyl patches on 08/05/25. Second interview with the Administrator on 10/02/25 at 3:38pm revealed: -Resident #1 had not had increased pain. -The hospice nurse reported Resident #1 had on two fentanyl patches however the Administrator never saw the resident with two patches. -She reports she was in the facility on 08/20/25 and the hospice nurse never came to her with concerns about Resident #1's fentanyl patches. -The nurse reported she showed the SCC the two fentanyl patches on Resident #1. -The SCC denied witnessing Resident #1 with two fentanyl patches on. -Resident #1 should not have had on two fentanyl patches. -The first fentanyl patch 25mcg administered to Resident #1 was the one that the hospice nurse asked a MA to administer to the resident on 08/20/25. -Narcotic orders from hospice were electronically sent to the resident's pharmacy and the facility did not receive a copy of those orders. -The only person who saw Resident #1 with two fentanyl patches was the hospice nurse. _____ The facility's failure to ensure medications were	D 358		

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D 358	Continued From page 31 administered as ordered to Resident #6 who was prescribed an antibiotic for cellulitis that was hot to touch, bright red, oozing, and weeping but did not receive her first dose of the antibiotic until two days later and Resident #1 who suffered from pain due to a diagnosis of malignant neuroendocrine cancer, who was found with two fentanyl pain patches on her body with no documentation of the date, time or signature of when they were placed on the resident and a delay in the facility ordering the resident's increased dose for the resident's fentanyl pain patch. 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. 131-34 on 10/02/25 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain proper documentation of disposition of controlled substances for 1 of 5 sampled residents.	D 392		

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The findings are:

Review of Resident #1's current FL2 dated 04/13/25 revealed
-Diagnoses including dementia, malignant neuroendocrine tumors, and mild cognitive impairment.
-The resident was constantly disoriented and semi-ambulatory.
-The recommended level of care was special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 09/27/23.

Review of Resident #1's Physician Order Report dated 04/13/25 revealed:
-There was an order for morphine concentrate 100mg/5mL to be administered 0.5ml by mouth every 3 hours as needed for pain or dyspnea. (Morphine is a narcotic used to treat severe pain.)
-There was an order for oxycodone 5mg to be administered by mouth every 6 hours as needed for pain. (Oxycodone is a narcotic used to treat severe pain.)
-There was an order for oxycodone 5mg three times daily.

Review of Resident #1's subsequent prescription orders revealed:
-On 07/11/25 there was an order for 12mcg/hr transdermal fentanyl patch to be applied topically every 72 hours. (Fentanyl is a narcotic used to treat severe pain.)
-On 08/07/25 there was an order for 25mcg/hr transdermal fentanyl patch to be applied topically every 72 hours.

Review of Resident #1's Controlled Substance

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D 392	Continued From page 33 Report for morphine concentrate, 100mg/5 mL solution revealed: -On 07/25/25 at 3:48pm 16 morphine concentrate were wasted by the Resident Care Coordinator (RCC) and witnessed by a medication aide (MA). -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 07/26/25 at 30 morphine concentrate were wasted by a MA and witnessed by a second MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 08/21/25 at 1:43pm 1 morphine concentrate was wasted by the Special Care Coordinator (SCC) and witnessed by a MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 09/11/25 at 2:45pm 50 morphine concentrate were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". -The method of destruction was not documented. -There was no signature of the Administrator or the Administrator's designee. Review of Resident #1's Controlled Substance Report for fentanyl 25mcg/hr patch 72 hour revealed: -On 08/20/25 at 5:46pm 1 fentanyl patch was wasted by the SCC and a MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -No dosage was documented. -On 08/24/25 at 5:50pm 8 fentanyl patches were wasted by the RCC and a MA. -The reason for the waste was documented as "other".	D 392		

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D 392	Continued From page 34 -The method of destruction was not documented. -No dosage was documented. -There was no signature of the Administrator or the Administrator's designee. -There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. Review of the Resident #1's Controlled Substance Report for all controlled substances revealed: -On 08/20/25 at 5:46pm 1 fentanyl patch every 72 hours was wasted by the SCC and a MA -There was no documented dosage. -The reason for the waste was documented as "other". -The entry under comments was 'the hospice nurse gave verbal order for med tech to put a fresh patch on. -The method of destruction was not documented. -There was no documented dosage. -On 08/24/25 at 5:50pm 8 fentanyl patch every 72 hours was wasted by the RCC and a MA. -There was no documented dosage. -The reason for the waste was documented as "other". - The entry under Comments was 'medication patches moved to new order'. -The method of destruction was not documented. -There was no documented dosage. -On 08/20/25 at 9:17am 5 oxycodone four times a day were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". - The entry under comments was stated medication in lock box awaiting nurse for disposal. -The method of destruction was not documented.	D 392		

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-There was no documented dosage.
-On 07/25/25 at 3:48pm 16 morphine concentrate every 3 hours were wasted by the RCC and a MA.
-The reason for the waste was documented as "other".
- The entry under comments stated discontinued.
-The method of destruction was not documented.
-There was no documented dosage.
-There was no documented dosage.
-On 07/26/25 at 6:08pm 30 morphine concentrate every 3 hours as needed were wasted by two MA.
-The reason for the waste was documented as "other".
- The entry under comments stated medication had expired.
-The method of destruction was not documented.
-On 08/20/25 at 11:16am 6 fentanyl every 72 hours were wasted by the RCC and the SCC.
-The reason for the waste was documented as "other".
-The entry under comments stated medication was discontinued.
-The method of destruction was not documented.
-There was no documented dosage.
-On 08/21/25 at 1:43pm 1 morphine concentrate every 3 hours as needed was wasted by the SCC and a MA.
-The reason for the waste was documented as "other".
- The entry under comments stated medication top had fallen off and the syringe was empty.
-The method of destruction was not documented.
-There was no documented dosage.
-There was no signature of the Administrator or the Administrator's designee.

Telephone interview with Resident #1's pharmacy on 09/30/25 at 3:30pm revealed:
-The pharmacy accepted medication for

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destruction.
-The facility had a process to destroy medication on site.
-The facility had not contacted the pharmacy for any medication disposals.

Interview with a MA on 08/19/25 at 5:15pm revealed:
-Some narcotics were kept in the safe instead of medication cart.
-There was conflicting information on where the medications should be located.

Interview with a second MA on 10/01/25 at 9:15am revealed:
-Expired and discontinued medication were pulled from the medication cart and placed in a safe.
-The safe was located in the office of either the Administrator or the RCC.
-The Administrator told the MA the pharmacy did not take back medications for destruction.

Interview with a third MA on 09/29/25 at 2:33pm revealed:
-The former SCC documented medication as wasted to remove it from the system.
-Those medications documented as wasted were placed in the safe instead of the medication cart.
-The former SCC did that to keep a smaller number of narcotics to count.
-The safe was always in the former SCC's office.

Interview with the Administrator on 08/21/25 at 2:01pm revealed:
-Narcotics pulled from the medication cart were put into the safe.
-The former SCC wasted medications and did not always document a reason.
-The former SCC sometimes documented medication as wasted to avoid a large count.

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D 392	Continued From page 37 -Medication received but not counted was placed into the safe.	D 392		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or	D 394		

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D 394	Continued From page 38 dispensing practitioner.	D 394		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure controlled substances including fentanyl and morphine for 1 of 5 sampled residents (Resident #1) were destroyed following facility policy and witnessed by the Administrator or designee and licensed Pharmacist or designee.

The findings are:

Review of the facility's Pharmaceutical Care Policy dated September 2021 revealed:
-An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly.
-Pharmaceutical care involves the identification, prevention and resolution of medication related to problems which includes the following: [d.] review the facility's procedures and records for the disposition of medications and provide assistance, if necessary.

Review of the facility's Medication Services/Pharmaceutical Care Services Policy

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D 394	Continued From page 39 dated September 2021 revealed: -The community provides medication administration, ordering, and reordering of medication and medication administration services. -The Executive Director, the Resident Care Coordinator (RCC) or designee will ensure that medication administration services required for each resident is provided. -All pharmacies are requested to meet the following Minimum Quality Standards which included provision of a pharmacist available for consultation services; conducting medication cart audits at a minimum quarterly; and having written standards and procedures that meet state regulations. Review of the facility's Medication Diversion Policy dated September 2021 revealed: -Staff must follow accurate documentation practices when charting the use of narcotics -If narcotic medication is prepared for administration but is contaminated or not given, staff shall dispose of the narcotic at the facility. -Only singe dose destruction/disposal can be done at the Community. -Another staff person must witness the disposition of the narcotic and initial the count sheet. -Any spill of a narcotic medication must be reported to supervisory staff immediately. -Any narcotic medication that is expired, discontinued, or no longer required, shall be removed from the cart and written up on the Medication Destruction Form. -If any ordered non-narcotic medication cannot be accounted for, staff shall immediately notify the administrator/executive director. -The administrator/executive director will be responsible for investigating the matter.	D 394		

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D 394	Continued From page 40 Review of Resident #1's current FL2 dated 04/13/25 revealed -Diagnoses including dementia, malignant neuroendocrine tumors, and mild cognitive impairment. -The resident was constantly disoriented and semi-ambulatory. -The recommended level of care was special care unit (SCU). Review of Resident #1's resident register revealed an admission date of 09/27/23. Review of Resident #1's Physician Order Report dated 04/13/25 revealed: -There was an order for morphine concentrate 100mg/5mL to be administered 0.5ml by mouth every 3 hours as needed for pain or dyspnea. (Morphine is a narcotic used to treat severe pain.) -There was an order for oxycodone 5mg to be administered by mouth every 6 hours as needed for pain. (Oxycodone is a narcotic used to treat severe pain.) -There was an order for oxycodone 5mg three times daily. -There was an order for lorazepam 1mg administer 1mg by mouth every four hours for anxiety. (Lorazepam is used to treat anxiety.) Review of Resident #1's subsequent prescription orders revealed: -On 07/11/25 there was an order for 12mcg/hr transdermal fentanyl patch to be applied topically every 72 hours. -Fentanyl is a narcotic used to treat severe pain. -On 08/07/25 there was an order for 25mcg/hr transdermal fentanyl patch to be applied topically every 72 hours.	D 394		

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Review of Resident #1's packing slips from the pharmacy revealed:
-On 07/09/25 a quantity of 60 oxycodone was shipped to the facility for Resident #1.
-On 07/11/25, 07/23/25, and 08/04/25 a quantity of five 12mcg/hr transdermal fentanyl patches were shipped to the facility for Resident #1.
-On 08/07/25, 08/18/25, 08/28/25, and 09/23/25, a quantity of five 25mcg/hr transdermal patches were shipped to the facility for Resident #1.

Review of Resident #1's prescription orders revealed Fentanyl 12mcg transdermal patch was discontinued on 08/08/25.

Review of Resident #1's Medication Disposition Form dated 09/17/25 revealed:
-A quantity of 28 Lorazepam 1mg was disposed and no reason was documented.
-A quantity of 5 Oxycodone 10mg was disposed and no reason was documented.
-A quantity of 50 Morphine 20mg was disposed and no reason was documented.
-A quantity of 6 Fentanyl 12mcg was disposed and no reason was documented.
-A quantity of 16 Morphine 100 mg was disposed and no reason documented.
-There was no documentation of method of destruction for the medications disposed.
-The disposals were witnessed by the Special Care Coordinator (SCC) and a nurse.
-There was no signature of the Administrator or the Administrator's designee
-There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

Review of Resident #1's Controlled Substance Report for morphine concentrate, 100mg/5 mL

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D 394	Continued From page 42 solution revealed: -On 07/25/25 at 3:48pm 16 morphine concentrate were wasted by the Resident Care Coordinator (RCC) and witnessed by a medication aide (MA). -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 07/26/25 at 30 morphine concentrate were wasted by a MA and witnessed by a second MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 08/21/25 at 1:43pm 1 morphine concentrate was wasted by the SCC and witnessed by a MA. -The reason for the waste was documented as "other". -The method of destruction was not documented. -On 09/11/25 at 2:45pm 50 morphine concentrate were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". -The method of destruction was not documented. -There was no signature of the Administrator or the Administrator's designee. -There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. Review of Resident #1's Controlled Substance Report for lorazepam 1mg tablet revealed: -On 09/11/25 at 2:36pm 28 lorazepam 1mg tablets were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". -The method of destruction was not documented. -There was no signature of the Administrator or the Administrator's designee. -There was no signature of the licensed	D 394		

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pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

Review of Resident #1's Controlled Substance Report for fentanyl 25mcg/hr patch 72 hour revealed:
-On 08/20/25 at 5:46pm 1 fentanyl patch was wasted by the SCC and a MA.
-The reason for the waste was documented as "other".
-The method of destruction was not documented.
-On 08/24/25 at 5:50pm 8 fentanyl patches were wasted by the RCC and a MA.
-The reason for the waste was documented as "other".
-The method of destruction was not documented.
-There was no signature of the Administrator or the Administrator's designee.
-There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

Review of the Resident #1's Controlled Substance Report for all controlled substances revealed:
-On 09/11/25 at 2:36pm 28 lorazepam 1mg tablets were wasted by the SCC with no other witness.
-The reason for the waste was documented as "other".
- The entry under comments was 'meds in narc safe meds are dc'.
-The method of destruction was not documented.
-There was no documented dosage.
-On 08/20/25 at 5:46pm 1 fentanyl patch every 72 hours was wasted by the SCC and a MA
-There was no documented dosage.
-The reason for the waste was documented as

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D 394	Continued From page 44 "other". -The entry under comments was 'the hospice nurse gave verbal order for med tech to put a fresh patch on'. -The method of destruction was not documented. -There was no documented dosage. -On 08/24/25 at 5:50pm 8 fentanyl patch every 72 hours were wasted by the RCC and a MA. -There was no documented dosage. -The reason for the waste was documented as "other". - The entry under comments was 'medication patches moved to new order'. -The method of destruction was not documented. -There was no documented dosage. -On 08/20/25 at 9:17am 5 oxycodone four times a day were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". - The entry under comments was stated medication in lock box awaiting nurse for disposal. -The method of destruction was not documented. -There was no documented dosage. -On 07/25/25 at 3:48pm 16 morphine concentrate every 3 hours were wasted by the RCC and a MA. -The reason for the waste was documented as "other". - The entry under comments stated discontinued. -The method of destruction was not documented. -There was no documented dosage. -On 07/26/25 at 6:08pm 30 morphine concentrate every 3 hours as needed were wasted by two MA. -The reason for the waste was documented as "other". - The entry under comments stated medication had expired. -The method of destruction was not documented.	D 394		

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D 394	Continued From page 45 -On 08/20/25 at 11:16am 6 fentanyl every 72 hours were wasted by the RCC and the SCC. -The reason for the waste was documented as "other". -The entry under comments stated medication was discontinued. -The method of destruction was not documented. -There was no documented dosage. -On 08/21/25 at 1:43pm 1 morphine concentrate every 3 hours as needed was wasted by the SCC and a MA. -The reason for the waste was documented as "other". - The entry under comments stated medication top had fallen off and the syringe was empty. -The method of destruction was not documented. -There was no documented dosage. -There was no signature of the Administrator or the Administrator's designee. -There was no signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. Telephone interview with Resident #1's pharmacy on 09/30/25 at 3:30pm revealed: -The pharmacy accepted medication for destruction. -The facility had a process to destroy medication on site. -The facility had not contacted the pharmacy for any medication disposals. Interview with a MA on 08/19/25 at 11:00am revealed: -A witness was required for destruction of narcotics. -She did not know the documentation process for destruction of narcotics. -She had never completed any documentation for	D 394		

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D 394	Continued From page 46 discontinued medication. Interview with the Resident Care Coordinator (RCC) on 08/19/25 at 11:10am revealed: -She was unsure of how the former SCC documented medication disposal. -Documentation for disposed medications should be placed in the resident's chart. -She maintained her own log for medication disposal. Interview with a second MA on 08/19/25 at 11:40am revealed: -Policy stated that a nurse had to be present for destruction of medication. -The facility did not always have a nurse present for destruction of medication. -The facility did not use the pharmacy reconciliation form for medication disposal. -The MA had witnessed disposal of medication but had not signed as a witness. -Both the person disposing of the medication and the witness must be on site for medication disposal. -The computer system required passwords from both parties for medication destruction. -The Administrator and the RCC could access the controlled substance tracking system remotely. Interview with a third MA on 08/19/25 at 5:15pm revealed: -Some narcotics were kept in the safe instead of medication cart. -There was conflicting information on where the medication should be located. Interview with the RCC on 09/19/25 at 12:15pm revealed the RCC and SCC were responsible for maintaining medication destruction logs.	D 394		

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D 394	Continued From page 47 Interview with a MA on 10/01/25 at 9:15am revealed: -Expired and discontinued medication were pulled from the medication cart and placed in a safe. -The safe was located in the office of either the Administrator or the RCC. -The Administrator told the MA the pharmacy did not take back medications for destruction. Interview with a second MA on 09/30/25 at 8:44am revealed: -Reason for wasting medication should be put into the electronic Medication Administration Record (eMAR) system. -Waste should be witnessed by another person. -Both the person and witness have to put enter a password. -Wasted medication should be put into the locked hazard box on the side of the medication cart. -The witness had to be another MA or a manager. -If a manager was not on site, the manager should be called. -The manager should come in to do a medication count. Interview with a third MA on 09/30/25 at 9:30am revealed: -If destroying a narcotic a witness was require the witness had to be a MA or manager. -Reason for the waste was documented in the computer system. -The pharmacy should be notified of the destruction. Second interview with the RCC on 09/30/25 at 12:20pm revealed: -The facility did not maintain the controlled substance log from the pharmacy. -All controlled substance logs were maintained on the computer system.	D 394		

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D 394	Continued From page 48 -The controlled substance report did not include the dosage of the medication destroyed. -All details of the controlled substance report were not visible on the computer printout. -She acknowledged the computer printout did not include the dosage or the prescription number destroyed. Interview with Administrator on 09/30/25 at 3:40pm revealed: -The former SCC was witnessing her own medication destruction. -The expectation was that MA would follow the medication destruction policy. -Medication should be documented on the destruction log if wasted. Second interview with the Administrator on 10/02/25 at 3:40pm revealed wasted medication should be documented on the disposition log.	D 394		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by:	D 399		

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Based on record reviews and interviews, the facility failed to report suspected drug diversion of controlled substances to the prescribing pharmacy for 1 of 5 sampled residents (Resident #1).

The findings are:

Review of the facility's Medication Diversion Policy dated September 2021 revealed:
-The Community will assure that all Federal and State regulations relevant to the control of narcotic medications are followed.
-All missing and unaccounted for narcotics medications must be reported.
-Staff must follow accurate documentation practices when charting the use of narcotics
-All missing and unaccounted for narcotics medications must be reported.
-Any narcotic medication that is expired, discontinued, or no longer required, shall be removed from the cart and written up on the Medication Destruction Form.
-If any ordered non-narcotic medication cannot be accounted for, staff shall immediately notify the administrator/executive director.
-The administrator/executive director will be responsible for investigating the matter.

Review of Resident #1's current FL2 dated 04/13/25 revealed
-Diagnoses including dementia, malignant neuroendocrine tumors, and mild cognitive impairment.
-The resident was constantly disoriented and semi-ambulatory.
-The recommended level of care was special care unit (SCU).

Review of Resident #1's Resident Register

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D 399	Continued From page 50 revealed an admission date of 09/27/23. Review of Resident #1's Physician Order Report dated 04/13/25 revealed: -There was an order for morphine concentrate 100mg/5mL to be administered 0.5ml by mouth every 3 hours as needed for pain or dyspnea. (Morphine is a narcotic used to treat severe pain.) -There was an order for oxycodone 5mg to be administered by mouth every 6 hours as needed for pain. (Oxycodone is a narcotic used to treat severe pain.) -There was an order for oxycodone 5mg three times daily. -There was an order for lorazepam 1mg administer 1mg by mouth every four hours for anxiety. (Lorazepam is used to treat anxiety.) Review of Resident #1's subsequent prescription orders revealed: -On 07/11/25 there was an order for 12mcg/hr transdermal fentanyl patch to be applied topically every 72 hours. (Fentanyl is a narcotic used to treat severe pain.) -On 08/07/25 there was an order for 25mcg/hr transdermal fentanyl patch to be applied topically every 72 hours. Review of Resident #1's Controlled Substance Report for lorazepam 1mg tablet revealed: -On 09/11/25 at 2:36pm 28 lorazepam 1mg tablets were wasted by the SCC with no other witness. -The reason for the waste was documented as "other". -The method of destruction was not documented. -There was no signature of the administrator or the administrator's designee. Telephone interview with a Health Care Personnel	D 399		

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Registry (HCPR) investigator on 09/29/25 at 4:51pm revealed:
-She was told by a MA that the binder kept by the former SCC was taken by the Administrator.
-Several staff reported the former SCC documented medication destruction properly.
-On 08/14/25 the Administrator provided computer printouts as proof the former SCC was diverting narcotics.
-The Administrator reported discovering discrepancies with narcotics after she submitted the 24/5 Report.
-The Administrator reported controlled narcotics were diverted on multiple dates from March 2025 to April 2025.
-The Administrator had completed an internal investigation and substantiated the former SCC for diversion.
-The internal investigation did not include an interview with the former SCC.

Interview with a hospice nurse on 10/03/25 at 10:20am revealed:
-The Administrator contacted Resident #1's pharmacy on 08/21/25 related to the resident's fentanyl patch order.
-The Administrator did not request a medication audit for Resident #1.

Interview with the Administrator on 09/19/25 at 12:45pm revealed:
-She had not contacted Resident #1's pharmacy with concerns of medication diversion.
-Facility policy stated that concerns for medication diversion must be reported to local law enforcement, the dispensing pharmacy and the resident's prescribing physician.
-She had to "deep dive into the records to see diversion going on".
-On 05/20/25 she reported concerns with the

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D 399	Continued From page 52 former SCC and medication diversion to local law enforcement and to the Health Care Personnel Registry. -She did not report any concerns with Resident #1's controlled substances to the resident's pharmacy. -The facility's policy specified that reporting to the dispensing pharmacy was required if the medication was not located or accounted for. -She could not state that any medication for Resident #1 was missing. Second interview with the Administrator on 10/02/25 at 3:40pm revealed: -She was made aware of the concern with medication diversion on 05/20/25. -She had received no details from staff regarding medication diversion. -No medication was missing from the medication cart for Resident #1. -She had no reason to contact Resident #1's pharmacy.	D 399		
D 400	10A NCAC 13F .1009 (a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following:	D 400		

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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 400	Continued From page 53 (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure to ensure quarterly pharmacy reviews were completed for 1 of 5 sampled residents (1). The findings are: Review of the facility's Pharmaceutical Care Policy dated September 2021 revealed: -An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly.	D 400		

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	HAL065036	A. BUILDING: _____ B. WING _____	R 10/03/2025

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D 400	Continued From page 54 -Pharmaceutical care involves the identification, prevention and resolution of medication related to problems which includes the following: [i] an on-site medication review for each resident which includes the following: the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, administration records, to determine that medications are administered as prescribed, and ensure any undesired side effects and potential and actual medication reactions or interactions are identified, evaluate for polypharmacy and GDR (gradual dose reduction) to assure minimum dosage for effectiveness, and medication errors are identified and reported to the appropriate prescribing practitioner; and [ii] making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed. [iii] documenting the results of the medication review in the resident's record [b.] review of all aspects of the medication of administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas. [c.] review of the medication system utilized by the facility, including packaging, labeling, and availability of medications. [d.] review the facility's procedures and records for the disposition of medications and provide assistance, if necessary. [e.] provision of a written report of findings and any recommendations for change are made to the community and the physician, or appropriate health professional, when necessary. [f.] conducting in-service programs as needed for the facility staff on medication usage that includes the following; potential or current medication related problems -The Community shall assure action is taken as	D 400		

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needed in response to the medication review and the response is documented, including the physician or appropriate health professional has been informed of the findings when necessary.
-The facility shall maintain the findings and reports resulting from the activities in [Paragraph 2 above] including action taken by the facility in the resident record (10A NCAC 13F .1009).

Review of the facility's Medication Services/Pharmaceutical Care Services Policy dated September 2021 revealed:
-The community provides medication administration, ordering, and reordering of medication and medication administration services.
-The Executive Director, the Resident Care Coordinator (RCC) or designee will ensure that medication administration services required for each resident is provided.
-All pharmacies are requested to meet the following Minimum Quality Standards which included providing a pharmacist available for consultation services; conducting medication cart audits at a minimum quarterly; and having written standards and procedures that meet state regulations.
-All medications that staff members administer, handle, store, and administer will be documented on the Medication Administration Record (MAR) and in accordance with the state regulations and the Community's preferred pharmacy standard and procedure manual.

Review of Resident #1's current FL2 dated 04/13/25 revealed
-Diagnoses including dementia, malignant neuroendocrine tumors, and mild cognitive impairment.
-The resident was constantly disoriented and

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semi-ambulatory.
-The recommended level of care was special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 09/27/23.

Review of Resident #1's pharmacy review revealed:
-There was a pharmacy review completed on 03/10/25.
-The 03/10/25 pharmacy review continued recommendations for the resident's prescribing provider.
-The resident had two active orders for Ondansetron 8mg with the same direction.
-The resident had two active orders for Docusate Sodium 100mg with the same direction.
-Recommendations to the provider were made for the purpose of avoiding overdose and correcting the resident's eMAR.
-There was no response documented for either recommendation.
-There was no pharmacy review completed in June 2025.
-There was no pharmacy review completed in September 2025.

Telephone interview with pharmacist at Resident #1's pharmacy on 10/01/25 at 3:30pm revealed:
-The facility had 24 hour/7 day per week access to pharmacy technicians.
-She was unaware of any calls from the facility with concerns regarding the resident's medications.

Interview with the Administrator on 08/21/25 at 2:01pm revealed:
-She contacted Resident #1's pharmacy on 08/21/25 but did not request a pharmacy review.

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D 400	Continued From page 57 -The expectation was that pharmacy reviews be completed quarterly.	D 400		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of two injuries requiring a medical evaluation for 1 of 6 sampled resident's (#6). The findings are: Review of the facility's Incident Reporting policy dated September 2021 revealed: -Incident reports should be completed for any incident involving a resident, or incident involving a resident and staff. -Incident reports must be sent to the local Department of Social Services (DSS) within 48 hours if the resident received medical intervention greater than first aide. Review of Resident #6's current FL-2 dated	D 451		

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08/15/25 revealed diagnoses included chronic pain syndrome, hypertension, chronic obstructive pulmonary disease, and chronic fatigue.

Review of an Incident and Accident report (I/A) dated 07/09/25 revealed:
-Resident #6 had an unwitnessed fall in her bedroom at approximately 8:30pm on 07/09/25.
-The resident hit her head and was bleeding from her head.
-Staff called 911 and applied pressure to the resident's head.
-The resident was transported to the local emergency department (ED) for evaluation.
-There was documentation that the residents' primary care provider (PCP) and responsible party were notified of the fall.
-There was no documentation that the facility notified or sent an IA Report to the local DSS.

Review of an After Visit Summary report from the local ED dated 07/09/25 revealed:
-The resident was seen for a fall.
-The resident was diagnosed with a scalp laceration, right wrist pain, and noninfected skin tear of the right leg.
-The resident received 2 staples to her scalp laceration, with order for them to be removed in 1 week.
-A Velcro splint was ordered for the resident's right wrist for 1 to 2 weeks as needed for pain.

Review of an IA report dated 07/20/25 revealed:
-Resident #6 fell on 07/20/25 at approximately 8:48am.
-The resident complained of right arm pain and the resident's right arm was red and swollen.
-Staff called 911 and the resident was transported to the local ED for evaluation.
-There was documentation that the residents'

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PCP and responsible party were notified of the fall.
-There was no documentation that the facility notified or sent an IA Report to the local DSS.
-There was documentation that the resident was admitted to the local hospital.

Interview with the Resident Care Coordinator (RCC) on 10/03/25 at 12:20pm revealed:
-Medication aides (MAs) completed any IA reports, and she did if she was working and an incident occurred.
-The MAs placed the IA reports in her box, she reviewed them and then placed them in the Administrator's box for review.
-When she completed an IA report, she placed it in the Administrator's box for her to review.
-She did not ask any questions when she received an IA report from an MA.
-She reported that she reviewed the IA report for Resident #6, "shook her head," and placed both of them in the Administrator's box.

Interview with the Administrator on 10/03/25 at 12:54pm revealed:
-When she received IA reports in her box she reviewed them, closed them and then shared with the facility's clinical nurse.
-She was responsible for faxing IA reports to the local DSS.
-She thought she had faxed the IA reports for Resident #6 to the local DSS from 07/09/25 and 07/20/25.
-She was unable to locate documentation that IA reports from 07/09/25 and 07/20/25 for Resident #6 were sent to DSS.
-She should have sent the IA reports to DSS.