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	HAL024015	A. BUILDING: _____ B. WING _____	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABOR COMMONS	703 ELIZABETH STREET TABOR CITY, NC 28463

(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 on September 23-24, 2025.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to address personal care assistance in accordance with the resident's assessed needs and care plan for 1 of 5 residents sampled (#5) related to incontinence care and personal hygiene. The findings are: Review of Resident #5's current FL-2 dated 07/23/25 revealed: -Diagnoses included unspecified dementia, senile degeneration of brain, hypertension, diverticulitis, L1 fracture, atrial fibrillation, atrial flutter, anxiety, chronic back pain, neck injury. -The resident was constantly disoriented. -The resident was a wanderer. -The resident required personal care assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident was on hospice. -The recommended level of care was domiciliary.	D 269		

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Review of Resident #5's Resident Register dated 08/22/17 revealed the resident was admitted to the facility on 07/05/17.

Review of Resident #5's care plan dated 07/22/25 revealed:
-The resident had wandering behavior.
-The resident had daily incontinence of bowel.
-The resident had daily incontinence of bladder.
-The resident was always disoriented.
-The resident required extensive assistance with toileting, bathing, dressing, grooming and personal hygiene.
-The resident required limited assistance with eating, ambulation/locomotion, and transferring.

Review of Resident #5's hospice nurse notes from 07/14/25 revealed:
-The resident was found by the hospice nurse with feces on her left hand.
-The hospice nurse discussed her findings with facility staff and provided education on hygiene.

Review of Resident #5's hospice nurse notes dated 07/28/25 revealed:
-The resident had food all over herself while eating.
-The nurse educated staff that Resident #5 may need more assistance with eating.

Review of Resident #5's hospice nurse notes dated 07/28/25 revealed:
-Resident #5 was found on the side of the bed with soiled incontinence brief and feces on her hand.
-Staff was made aware of the situation and asked to clean the Resident #5's bed.

Review of Resident #5's hospice nurse notes dated 09/08/25 revealed the resident's clothes

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and wheelchair were covered in food.

Observation of Resident #5 on 09/24/25 at 8:15am revealed:
-The resident wandered around the hallway in her wheelchair with occasional redirection from staff to avoid wet floors.
-While self-propelling in the chair the resident used handrails in the facility and grabbed at least one door handle.
-The resident failed to self-propel up a ramp and rolled backward slowly with staff subsequently redirecting the resident away from the ramp.
-Closer observation of the resident revealed her hands were soiled with a dried brown substance, mostly located on the fingers and fingernails.

Interview with a personal care aide (PCA) on 09/24/25 at 10:03am revealed:
-When she was assigned to care for Resident #5, she tried to check that the resident's hands were clean each morning.
-She helped provide care for Resident #5 this morning.
-Resident #5 was resisting care from another PCA, so she was called to help.
-She did not check Resident #5's hands this morning.
-Staff was trained to provide personal care whenever a resident needed incontinence care.
-It was not allowed for PCA's to get residents up with feces on their hands and let them into the hall.
-She and the other PCA were responsible for this error.

Interview with a second PCA on 09/24/25 at 10:22am revealed:
-She checked to see that residents have a dry incontinence brief before getting them dressed.

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-Resident #5 was resisting care this morning, so she requested the help of another PCA.
-She did not see the fecal matter on the resident's hands until another staff member told her about it.
-When Resident #5 resisted care she usually used her legs to kick at staff.
-It was not allowed to let soiled residents get up and move around the facility.
-She made an error this morning, allowing Resident #5 to move about the facility with soiled hands.

Interview with a third PCA on 09/24/25 at 4:15pm revealed:
-Hospice gave the resident showers two or three times per week.
-She observed Resident #5 wandering the facility with soiled hands twice per week.
-When the resident was found with soiled hands, staff would clean her hands with warm water and soap.

Interview with the Resident Care Coordinator (RCC) on 09/24/25 at 12:15am revealed:
-PCA's knew to make sure residents were cleaned and groomed.
-She was aware that the resident had shown digging behaviors.
-Staff attempted interventions and tried to work with the provider regarding possible urinary tract infection.
-One or two times Resident #5 had gastrointestinal infections.

Interview with the Administrator on 09/24/25 at 11:07am revealed:
-Resident #5's personal care on the morning of 09/24/25 was not good and the resident should be clean and sanitized.

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-Staff should be providing incontinence care as soon as a situation was identified.
-Resident #5 was on a two-hour toileting program.
-PCA staff were responsible for checking to see if the resident's hands were clean.
-When PCA staff were hired they were trained by an experienced PCA who should provide that instruction.
-There was PCA training with a registered nurse to make sure that staff knew how to help with activities of daily living and nail care.

Interview with Resident #5's hospice nurse on 09/24/25 at 9:30am revealed:
-The resident had a previous history of resisting personal care.
-The resident's resistance of personal care improved with calming medications.
-She observed fecal matter on the resident's hands sometimes.
-She estimated that the resident's hands or incontinence brief were soiled on about one out of every three visits she made to the facility.
-On previous occasions, she observed the resident self-propelling in the facility with soiled hands, soiled incontinence brief, or both.
-The quality of personal care in the facility had recently improved after other staff expressed concern.
-She worked with Resident #5 about three times per week.

Telephone Interview with Resident #5's PCP on 09/24/25 at 1:40pm revealed
-Resident #5's soiled hands were a sanitation issue and staff did not check appropriately.
-Hospice mentioned to her that Resident #5 was frequently soiled.
-The resident's behavior of reaching into her

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D 269	Continued From page 5 incontinence brief was possibly agitation from being soiled, and possibly dementia-related. -Resident #5's soiled hands could result in E.coli infection, which would create risk to other residents and staff. -Hand to hand or object to hand contact transmission could occur with E.Coli bacteria. -E.Coli bacteria could cause infection, and infection could cause sepsis. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. Attempted telephone interview with Resident #5's Responsible Person (RP) on 09/24/25 at 1:57pm was not successful.	D 269		
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 notify the primary care provider (PCP) for 1 of 5 sampled residents (#1) who did not receive medications used to treat diabetes and elevated cholesterol. The findings are: Review of the facility's medication management plan dated 10/23 revealed: -Medications, prescription and non-prescription, and treatments will be administered in	D 273		

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accordance with the prescribing practitioner's orders.
-In the event of a medication error, omission, or adverse reaction to a medication, facility staff will; notify a physician or appropriate health professional, notify their immediate supervisor, notify the resident's responsible party or next of kin, document any orders received by the physician or health professional and actions taken by the facility to comply with the order, and document any events leading up to the error, as well as, any corrective actions taken to prevent future errors.

Review of Resident #1's current FL-2 dated 06/05/25 revealed diagnoses included diabetes, elevated cholesterol, hypertension, schizophrenia, atrial fibrillation, hypothyroidism, bipolar, stroke, and osteomyelitis of the left foot.

a. Review of Resident #1's signed physician orders dated 06/05/25 revealed there was an order for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm. (Atorvastatin is used to treat elevated cholesterol).

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm.
-Atorvastatin was documented as administered 08/01/25-08/14/25 and 08/16/25-08/26/25 at 8:00pm.
-There were circles around the staff initials on 08/15/25 and 08/27/25-08/31/25.
-There was documentation on the exceptions log on the eMAR that the Atorvastatin was out of stock on 08/15/25 and 08/27/25-08/31/25.

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Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm.
-Atorvastatin was documented and administered 09/02/25-09/04/25 and 09/23/25 at 8:00pm.
-There were circles around the staff initials on 09/01/25 and 09/05/25-09/22/25.
-There was documentation on the exceptions log on the eMAR that the Atorvastatin was out of stock on 09/01/25 and 09/05/25-09/22/25.

Interview with Resident #1 on 09/23/25 at 4:05pm revealed:
-He had not received his cholesterol medication in over a month.
-He identified that the cholesterol medication was the only half tablet that he received.
-He had asked the MA why he was not getting his cholesterol and was told that she did not know.

Interview with a medication aide (MA) on 09/23/25 at 3:30pm revealed:
-The pharmacist found Atorvastatin 10mg in the cycle fill box that came from the pharmacy.
-She was not sure why Atorvastatin had been marked as out of stock.
-When the facility was out of a medication, they were supposed to message the pharmacy and the primary care provider (PCP).
-She was able to locate in the facility's eMAR system that a MA had sent a refill request for the Atorvastatin 10mg.

Interview with the Resident Care Coordinator (RCC) on 09/23/25 at 3:55pm revealed:
-She did not know that Resident #1 had been out of his Atorvastatin 10mg.
-Medications that were in the facility or on the medication carts should be administered.

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D 273	Continued From page 8 Interview with the Administrator on 09/24/25 at 11:38pm revealed she did not know that Resident #1 was out of his Atorvastatin. Interview with a pharmacist at the facility's contracted pharmacy on 09/24/25 at 9:53pm revealed: -There was an order for Atorvastatin 10mg administer ½ tablet, 5mg daily. -Atorvastatin was used to treat high cholesterol. -Stopping the Atorvastatin could cause the cholesterol levels to increase. -Atorvastatin 10mg was dispensed on 06/24/25 for a quantity of 14 tablets, split in ½. -Atorvastatin 10mg was dispensed on 07/22/25 for a quantity of 14 tablets, split in ½. -Atorvastatin 10mg was dispensed on 08/20/25 for a quantity of 14 tablets, split in ½, delivered on 08/27/25. -Atorvastatin 10mg was dispensed on 06/24/25 for a quantity of 14 tablets, split in ½, delivered on 09/23/25. -This was a cycle fill medication that was filled 5 days prior to delivery. -The facility called and requested a refill on 08/30/25 and was informed it was delivered on 08/27/25 and if they were unable to locate to call back. -No one from the facility called and reported that they were unable to locate the Atorvastatin. Interview with the PCP on 09/24/25 at 10:10am revealed: -She did not know that Resident #1 was out of his Atorvastatin. -She was concerned because he was a brittle diabetic and an increase in his cholesterol levels could cause cardiac issues, stroke and complications with his diabetes.	D 273		

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D 273	Continued From page 9 b. Review of Resident #1's signed physician orders dated 06/05/25 revealed there was an order for Ozempic 2mg/0.75ml to be administered every week on the same day of the week, scheduled on Mondays at 8:00am. Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Ozempic 2mg subcutaneously every week on Monday at 8:00am. -There were circles around the staff initials on 07/07/25, 07/14/25, 07/21/25. -There was documentation on the exceptions log on the eMAR that the Ozempic was out of stock on 07/07/25, 07/14/25, 07/21/25. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Ozempic 2mg subcutaneously every week on Monday at 8:00am. -Ozempic 2mg was documented and administered on 08/04/25, 08/11/25, 08/18/25, and 08/25/25. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for subcutaneously every week on Monday at 8:00am. -Ozempic 2mg was documented and administered 09/01/25 and 09/08/25 at 8:00am. -There were 2 dashes on 09/15/25. -There was no documentation on the exceptions report for 09/15/25. -There was a circle around the staff initials on 09/22/25. -There was documentation on the exceptions log	D 273		

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on the eMAR that the Ozempic was out of stock.

Interview with Resident #1 on 09/23/25 at 4:05pm revealed:
-He had not received his weekly injection but had received his other two daily insulin injections.
-The last time he had received his weekly insulin injection was around the first of September 2025.

Interview with MA on 09/23/25 at 3:30pm revealed she was not sure why Resident #1 did not receive his Ozempic on 09/15/25 and 09/22/25.

Interview with the RCC on 09/23/25 at 3:55pm revealed:
-Ozempic was placed on the medication cart once it was opened.
-She thought the Business Office Manager (BOM)/MA had called the MA that did not administer the Ozempic dose to Resident #1 on 09/22/25 but was not sure.
-She thought that the MA administered the Ozempic yesterday (09/23/25) but not sure.
-MAs do not document in the staff notes when medications were not administered only in the eMARs.
-She was supposed to review the exceptions report to ensure the process was followed.

Interview with the Administrator on 09/24/25 at 11:38pm revealed:
-She did not know that Resident #1 missed 2 doses of his Ozempic this month (September 2025).
-This could negatively affect Resident #1 because he was a brittle diabetic.
-She expected the staff to notify her when medication doses were missed.
-The MA or RCC should have contacted the PCP

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through the computer and wait for the PCP to respond when resident's medications were not on the medication cart.
-The RCC was supposed to follow up on all exceptions by contacting the PCP and pharmacy.
-There was a process in place that should have caught this issue.
-The RCC was supposed to review the exceptions report daily.
-She had not been informed that there were any concerns with the exception report.
-She performed random partial medication cart audits twice monthly.
-The BOM/MA performed the medication cart audits on Fridays.
-She was not sure when the BOM/MA completed the last medication cart audit.
-The staff had not been educated on the medication administration policy.

Interview with a pharmacist at the facility's contracted pharmacy on 09/24/25 at 9:53pm revealed:
-Ozempic was used to treat diabetes.
-Ozempic was not a cycle refill medication.
-Ozempic 2mg was requested on 06/09/25 and dispensed on 06/19/25 for a 28-day supply.
-Ozempic 2mg was unavailable from their wholesaler in July 2025.
-The facility could have requested Ozempic from their backup pharmacy.
-The PCP and facility were notified that Ozempic 2mg was not available in July 2025.
-Ozempic was requested on 08/21/25 and dispensed on 08/22/25 for a 28-day supply.
-Ozempic 2mg was requested from their wholesaler on 09/16/25.

Interview with the PCP on 09/24/25 at 10:10am revealed:

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D 273	Continued From page 12 -She did not know that Resident #1 was out of his Ozempic. -She was concerned because his A1C would be uncontrolled. -His circulation could worsen since his circulation was already compromised.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#1) related to medications used to treat diabetes and elevated cholesterol. The findings are: Review of the facility's medication management plan dated 10/23 revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -In the event of a medication error, omission, or adverse reaction to a medication, facility staff will; notify a physician or appropriate health professional, notify their immediate supervisor, notify the resident's responsible party or next of	D 358		

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kin, document any orders received by the physician or health professional and actions taken by the facility to comply with the order, and document any events leading up to the error, as well as, any corrective actions taken to prevent future errors.
-The pharmacy will automatically deliver the next month's cycle refill up to a week before the cycle is completed and this will allow you to check in and verify the order.

Review of Resident #1's current FL-2 dated 06/05/25 revealed diagnoses included diabetes, elevated cholesterol, hypertension, schizophrenia, atrial fibrillation, hypothyroidism, bipolar, stroke, and osteomyelitis of the left foot.

a. Review of Resident #1's signed physician orders dated 06/05/25 revealed there was an order for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm. (Atorvastatin is used to treat elevated cholesterol).

Observation of Resident #1's medications on hand on 09/24/25 revealed:
-There was a medication card labeled as Atorvastatin 10mg administer ½ daily.
-The Atorvastatin 10mg was dispensed on 09/16/25 for 14 ½ tablets with 8 refills left.
-There was one ½ tablet of Atorvastatin that had been removed from the medication card.

Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm.
-Atorvastatin was documented as administered at 8:00pm 07/01/25-07/31/25.

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D 358	Continued From page 14 Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm. -Atorvastatin was documented as administered 08/01/25-08/14/25 and 08/16/25-08/26/25 at 8:00pm. -There were circles around the staff initials on 08/15/25 and 08/27/25-08/31/25. -There was documentation on the exceptions log on the eMAR that the Atorvastatin was out of stock on 08/15/25 and 08/27/25-08/31/25. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for Atorvastatin 10mg administer ½ tablet for 5mg daily at 8:00pm. -Atorvastatin was documented and administered 09/02/25-09/04/25 and 09/23/25 at 8:00pm. -There were circles around the staff initials on 09/01/25 and 09/05/25-09/22/25. -There was documentation on the exceptions log on the eMAR that the Atorvastatin was out of stock on 09/01/25 and 09/05/25-09/22/25. Interview with Resident #1 on 09/23/25 at 4:05pm revealed: -He had not received his cholesterol medication in over a month. -He identified that the cholesterol medication was the only half tablet that he received. -He had asked the MA why he was not getting his cholesterol and was told that she did not know. Interview with a medication aide (MA) on 09/23/25 at 3:30pm revealed: -The pharmacist found Atorvastatin 10mg in the cycle fill box that came from the pharmacy. -She was not sure why Atorvastatin had been marked as out of stock.	D 358		

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-When the facility was out of a medication, they were supposed to message the pharmacy and the primary care provider (PCP).
-She was able to locate in the facility's eMAR system that a MA had sent a refill request for the Atorvastatin 10mg.

Interview with the Resident Care Coordinator on 09/23/25 at 3:55pm revealed:
-She did not know that Resident #1 had been out of his Atorvastatin 10mg.
-Medications that were in the facility or on the medication carts should be administered.

Interview with the Administrator on 09/24/25 at 11:38pm revealed she did not know that Resident #1 was out of his Atorvastatin.

Interview with a pharmacist at the facility's contracted pharmacy on 09/24/25 at 9:53pm revealed:
-There was an order for Atorvastatin 10mg administer ½ tablet, 5mg daily.
-Atorvastatin was used to treat high cholesterol.
-Stopping the Atorvastatin could cause the cholesterol levels to increase.
-Atorvastatin 10mg was dispensed on 06/24/25 for a quantity of 14 tablets, split in ½.
-Atorvastatin 10mg was dispensed on 07/22/25 for a quantity of 14 tablets, split in ½.
-Atorvastatin 10mg was dispensed on 08/20/25 for a quantity of 14 tablets, split in ½, delivered on 08/27/25.
-Atorvastatin 10mg was dispensed on 06/24/25 for a quantity of 14 tablets, split in ½, delivered on 09/23/25.
-This was a cycle fill medication that was filled 5 days prior to delivery.
-The facility called and requested a refill on 08/30/25 and was informed it was delivered on

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08/27/25 and if they were unable to locate to call back.
-No one from the facility called that they were unable to locate the Atorvastatin.

Interview with the PCP on 09/24/25 at 10:10am revealed:
-She did not know that Resident #1 was out of his Atorvastatin.
-She was concerned because he was a brittle diabetic and an increase in his cholesterol levels could cause cardiac issues, stroke and complications with his diabetes.

Refer to interview with a second MA on 09/24/25 at 11:25am.

Refer to interview with the Resident Care Coordinator on 09/23/25 at 3:55pm.

Refer to interview with the Administrator on 09/24/25 at 11:38pm.

b. Review of Resident #1's signed physician orders dated 06/05/25 revealed there was an order for Ozempic 2mg/0.75 ml to be administered every week on the same day of the week, scheduled on Mondays at 8:00am.

Observation of the Resident #1's medications on hand on 09/24/25 revealed:
-There was one Ozempic pen labeled to administer 2mg (8mg/ml).
-Ozempic was dispensed on 08/21/25 with 11 refills.
-There was approximately ½ of the medication remaining in the pen.

Review of Resident #1's July 2025 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Ozempic 2mg subcutaneously every week on Monday at 8:00am.
-There were circles around the staff initials on 07/07/25, 07/14/25, 07/21/25.
-There was documentation on the exceptions log on the eMAR that the Ozempic was out of stock on 07/07/25, 07/14/25, 07/21/25.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Ozempic 2mg subcutaneously every week on Monday at 8:00am.
-Ozempic 2mg was documented and administered on 08/04/25, 08/11/25, 08/18/25, and 08/25/25.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for subcutaneously every week on Monday at 8:00am.
-Ozempic 2mg was documented and administered 09/01/25 and 09/08/25 at 8:00am.
-There were 2 dashes on 09/15/25.
-There was no documentation on the exceptions report for 09/15/25.
-There was a circle around the staff initials on 09/22/25.
-There was documentation on the exceptions log on the eMAR that the Ozempic was out of stock.

Interview with Resident #1 on 09/23/25 at 4:05pm revealed:
-He had not received his weekly insulin injection but had received his other two insulin injections.

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D 358	Continued From page 18 -The last time he had received his weekly insulin injection was around the first of September 2025. Interview with MA on 09/23/25 at 3:30pm revealed she was not sure why Resident #1 did not receive his Ozempic on 09/15/25 and 09/22/25. Interview with the Resident Care Coordinator on 09/23/25 at 3:55pm revealed Ozempic was placed on the medication cart once it was opened. Interview with the Administrator on 09/24/25 at 11:38pm revealed: -She did not know that Resident #1 missed 2 doses of his Ozempic this month (September 2025). -This could negatively affect Resident #1 because he was a brittle diabetic. -She expected the staff to notify her when medication doses were missed. Interview with a pharmacist at the facility's contracted pharmacy on 09/24/25 at 9:53pm revealed: -Ozempic was used to treat diabetes. -Ozempic was not a cycle refill medication. -Ozempic 2mg was requested on 06/09/25 and dispensed on 06/19/25 for a 28-day supply. -Ozempic 2mg was unavailable from their whole seller in July 2025. -The facility could have requested Ozempic from their backup pharmacy. -The PCP and facility were notified that Ozempic 2mg was not available in July 2025. -Ozempic was requested on 08/21/25 and dispensed on 08/22/25 for a 28-day supply. -Ozempic 2mg was requested from their wholesaler on 09/16/25.	D 358		

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D 358	Continued From page 19 Interview with the PCP on 09/24/25 at 10:10am revealed: -She did not know that Resident #1 was out of his Ozempic. -She was concerned because his A1C would be uncontrolled. -His circulation could worsen since his circulation was already compromised. Refer to interview with a second MA on 09/24/25 at 11:25am. Refer to interview with the Resident Care Coordinator (RCC) on 09/23/25 at 3:55pm. Refer to interview with the Administrator on 09/24/25 at 11:38pm. Interview with a second MA on 09/24/25 at 11:25am revealed: -She informed the residents when one of their medication was not available. -She documented in the eMAR the reason why the medication was not administered. -She sent a message to the PCP in the computer and called the pharmacy to make sure the medication had been requested. -Pharmacy delivered medications to the facility around 5:00-5:30pm Monday-Friday. -The facility also had a backup pharmacy that medications could be obtained. -She also completed an incident report for all medications that were not available and these were given to the RCC Interview with the Resident Care Coordinator on 09/23/25 at 3:55pm revealed:	D 358		

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D 358	Continued From page 20 -She thought the Business Office Manager (BOM)/MA had called the MA that did not give the Ozempic dose to Resident #1 on 09/22/25 but not sure. -She thought that the MA gave the Ozempic yesterday (09/23/25) but not sure. -MAs do not document in the staff notes when medications were not given only in the eMARs. -She was supposed to review the exceptions report to ensure the process was followed. Interview with the Administrator on 09/24/25 at 11:38pm revealed: -The MA or RCC should have contacted the PCP through the computer and wait for the PCP to respond when resident's medications were not on the medication cart. -The RCC was supposed to follow up on all exceptions by contacting the PCP and pharmacy. -There is a process in place that should have caught this issue. -The RCC was supposed to review the exceptions report daily. -She had not been informed that there were any concerns with the exception report. -She performed random partial medication cart audits twice monthly. -The BOM/MA performed the medication cart audits on Fridays. -She was not sure when the BOM/MA completed the last medication cart audit. -The staff had not been educated on the medication administration policy.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure accuracy of the medication administration record for 1 of 5 residents sampled (#2) related to trazodone.

The findings are:

Review of Resident #2's FL-2 dated 07/24/25 revealed:
-Diagnoses included arthritis, hypertension, insomnia, and peptic ulcer.
-The level of care was listed as domiciliary.
-The resident was constantly disoriented.

Review of Resident #2's Resident Register dated

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11/12/24 revealed the resident was admitted on 11/12/24.

Review of Resident #2's physician's orders dated 07/24/25 revealed there was an order for trazodone 150mg take ½ tablet by mouth at bedtime as needed (PRN) for sleep (trazodone is an antidepressant medication with sedative effects, that can be used to treat insomnia).

Review of Resident #2's physician's orders dated 08/21/25 revealed:
-There was an order for trazodone 150mg take ½ tablet, scheduled at bedtime for sleep.
-The order had originated on 08/07/25, and was written on 08/08/25.
-This order was signed on 08/21/25.

Review of a telephone order sheet for Resident #2 dated 08/28/25 revealed:
-There was an order to discontinue trazodone 75mg.
-There was an order to start trazodone 100mg scheduled at night time.

Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed:
-There was a discontinued entry with a stop date of 08/08/28 for trazodone 150mg take ½ tablet at bedtime PRN for sleep.
-The PRN trazodone was documented as administered once on 08/05/25.
-There was an entry that started 08/07/25 for trazodone 150mg take ½ tablet to be given at bedtime, at 7:00pm or 8:00pm.
-The trazodone 150mg ½ tablet was documented as administered nightly from 08/08/25 through 08/28/25.
-There was an entry that started 08/29/25 for

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trazodone 100mg to be given at bed time, scheduled for 7:00pm daily.
-The trazodone 100mg tablet was documented as administered nightly from 08/29/25 through 08/31/25.

Review of the Resident #2's September 2025 electronic medication eMAR revealed:
-There was an entry for trazodone 150mg take ½ tablet to be given at bedtime, scheduled for 7:00pm daily.
-There was documentation that a dose of trazodone 150mg ½ tablet was administered on 09/10/25, 09/11/25, 09/12/25, 09/13/25, 09/14/25, and 09/15/25.
-The eMAR entry for trazodone 150mg take ½ tablet at bedtime had a stop date of 09/16/25 and was listed as discontinued.
-There was an entry for trazodone 100mg to be given at bed time, scheduled for 7:00pm daily.
-There was documentation that the scheduled 100mg nighttime dose was administered nightly from 09/01/25 through 09/22/25.

Observation of Resident #2's medications on hand on 09/24/25 at 11:35am revealed:
-There was an empty package of Trazodone 100mg, 28 tablets dispensed on 8/28/25.
-There was a full package of Trazodone 100mg, 28 tablets dispensed on 09/25/25.
-There was no package of Trazodone 150mg on hand.

Interview with Resident #2 on 09/24/25 at 11:55am revealed:
-He did not recognize medications when he saw them.
-He received trazodone to help him sleep at night.
-He was given 100mg trazodone and sometimes received 75mg trazodone later.

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D 367	Continued From page 24 -He notified the medication aide (MA) that he was unable to sleep recently. -Trazodone did not feel like it was effective because he could only sleep for about 20 minutes. -Taking both doses of trazodone was not effective. Interview with a MA on 09/24/25 at 3:55pm revealed: -She could approve orders in the eMAR. -She did not create orders in the eMAR, but she could. -She has never had to create orders in the eMAR before. -Resident #2 only asked her for PRN trazodone when it was available in the eMAR. -She checked orders against the eMAR entries when performing eMAR entry approval. -The PCP would be notified if the resident complained of difficulty sleeping. Interview with the Resident Care Coordinator (RCC) on 09/24/25 at 12:15pm revealed: -She recognized Resident #2's trazodone 75mg as a medication error. -The trazodone 75mg should have been removed from the eMAR. -There was an error of documentation with Resident #2's trazodone. -At one time the resident was taking both scheduled and PRN trazodone, but that was discontinued. -Since Resident #2's PRN trazodone was discontinued, he was contacting the MA's to ask for a PRN dose in addition to the scheduled dose. Second interview with the RCC at 3:30pm revealed: -They could not see who put the eMAR entry in	D 367		

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the computer.
-The provider could send orders to the facility and to the pharmacy.
-The facility would fax the orders it received to the pharmacy.
-Once medication appeared on the MAR, the facility compared orders and eMAR entries before approving the entries.
-The RCC was responsible to ensure medications were discontinued as ordered in the eMAR system.

Interview with the Administrator on 09/24/25 at 3:20pm revealed:
-The facility could edit the eMAR, but the process was to have the pharmacy make the entry, and the facility approved the entry on the eMAR.
-The RCC could edit the MAR, but she was not sure if the MA's could create a new entry.
-The MA's could approve a new entry.
-The RCC never entered orders for medications.
-The MA's were responsible to check the eMAR against the copy of the order when approving entries.
-She performed random audits to make sure orders matched the MAR entries.
-She checked four or five orders to ensure accuracy each time the providers visited the facility.
-She checked all residents' charts but did not keep a record of this.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/24/25 at 2:15pm revealed:
-The most recent orders for trazodone were placed on 08/28/25 to discontinue the 75mg and start the scheduled 100mg tablet nightly.
-The Trazodone 75 mg showed as a discontinued medication in the eMAR on 09/16/25, but the

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TABOR COMMONS	703 ELIZABETH STREET TABOR CITY, NC 28463

(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 26 order was discontinued on 08/28/25. -The pharmacy attempted to stop the eMAR entry for 75mg trazodone at the end of the day on 08/28/25. -Somehow the medication was restarted in the eMAR on 09/10/25. -Trazodone 100mg was last dispensed on 09/23/25. -Trazodone 150mg was last dispensed on 08/25/25.	D 367		