STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R-C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/23/25.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled medication aides (MA) (Staff C) completed an examination test developed and administered by the North Carolina (NC) Division of Health Service Regulation (DHSR) within 60 days from the date of hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a MA on 07/24/25. -There was documentation Staff C completed the 15-hour medication training on 08/01/25. -There was documentation Staff C completed the MA Clinical Skills Competency Validation checklist on 08/01/25. -There was no documentation Staff C passed a medication aide examination developed and	D 125		

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D 125	Continued From page 1 administered by the NC DHSR. Review of a resident's October 2025 electronic medication administration record (eMAR) revealed there was documentation Staff C administered medications on 10/08/25 and 10/15/25. Interview with Staff C on 10/23/25 at 4:20pm revealed: -She was aware that an examination test developed and administered by the NC DHSR needed to be completed within 60 days from the date of hire. -She took the examination test on 10/15/25 and did not pass. -She was scheduled to retake the examination test on 10/28/25. Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 4:00pm revealed: -She was not aware that an examination test developed and administered by the NC DHSR needed to be completed within 60 days from the date of hire. -She thought MAs had 90 days to complete the examination test. Interview with the Administrator on 10/23/25 at 4:10pm revealed: -She was not aware that an examination test developed and administered by the NC DHSR needed to be completed within 60 days from the date of hire. -She thought MAs had 90 days to complete the examination test. -Staff C was being taken off the medication cart until she passed the examination test.	D 125		

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D 358	Continued From page 2	D 358		
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, record reviews and interviews, the facility failed to ensure medications were administered as ordered by a licensed practitioner for 1 of 3 sampled residents (#1) related to administration of medications packaged for evening administration administered at 1:20pm and medications for pain and gas relief not administered as scheduled at 1:00pm. The findings are: Review of Resident #1's current FL2 dated 06/11/25 revealed diagnoses included gastro-esophageal reflux disease, diabetes type II, angina, mixed lipidemia, peripheral neuropathy, hypertension, and long-term use of antiplatelets. Review of Resident #1's Resident Register revealed an admission date of 09/12/23. Review of Resident #1's Physician's After Visit summary of medications ordered dated 10/20/25 revealed: -There was an order for aspirin (used to help circulation) 81mg daily.	D 358		

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-There was an order for atorvastin (used to lower cholesterol) 40mg daily.
-There was an order for Beano (used to treat gastric gas buildup) 400mg 3 times daily.
-There was an order for vitamin D (used to supplement vitamin deficiency) 2000 units daily.
-There was an order for famotidine (used to treat increased gastric acid) 40mg nightly.
-There was an order for gabapentin (used to treat neuropathy pain) 300mg 3 times a day.
-There was an order for Zyrtec (used to treat allergies) 10mg daily.
-There was an order for loperamide (used to treat loose stools) 2 times a day.
-There was an order for lurasidone (used to treat mental disorders) 40mg nightly.
-There was an order for metoprolol tartrate (used to treat blood pressure) 50mg twice a day.
-There was an order for ropinirole (used to treat rest legs) 1mg at night.
-There was an order for sodium chloride (used to treat low sodium) 1 gram daily.
-There was an order for tamsulosin (used to increase urine stream) 0.4mg once daily.
-There was an order for Tradjenta (used to treat diabetes) 5mg daily.
-There was an order for trazadone (used to treat mental disorders) 200mg at bedtime.

Review of Resident #1's October 2025 electronic medication administration record (eMAR) from 10/01/25 to 10/23/25 revealed:
-There was an entry for aspirin 81mg daily, scheduled for administration at 8:00am.
-There was an entry for atorvastin 40mg daily, scheduled for administration at 8:00pm.
-There was an entry for Beano 400mg 3 times daily, scheduled for administration at 8:00am, 1:00pm, and 8:00pm.
-There was an entry for vitamin D 2000 units

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daily, scheduled for administration at 8:00am.
-There was an entry for famotidine 40mg nightly, scheduled for administration at 8:00pm.
-There was an entry for gabapentin 300mg 3 times a day, scheduled for administration at 8:00am, 1:00pm, and 8:00pm.
-There was an entry for Zyrtec 10mg daily, scheduled for administration at 8:00am.
-There was an entry for loperamide 2 times a day, scheduled for administration at 8:00am and 8:00pm.
-There was an entry for lurasidone 40mg nightly, scheduled for administration at 8:00pm.
-There was an entry for metoprolol tartrate 50mg twice a day, scheduled for administration at 8:00am and 8:00pm.
-There was an entry for ropinirole 1mg at night, scheduled for administration at 8:00pm.
-There was an entry for sodium chloride 1 gram daily, scheduled at 8:00am.
-There was an entry for tamsulosin 0.4mg once daily, scheduled for 8:00am.
-There was an entry for Tradjenta 5mg daily, scheduled for administration at 8:00am.
-There was an order for trazadone 200mg at bedtime, scheduled for administration at 8:00pm.

Observation of Resident #1's medication on hand for administration on 10/23/25 at 2:13pm revealed:
-Medications were dispensed for one week at a time in multi-dose bubble packs labeled for morning, noon, and bedtime with oral medications included in each multi-dose bubble corresponding to administration times scheduled on the eMAR.
-The weekly multi-dose bubble package was labeled for 10/17/25 to 10/23/25.
-The multi-dose bubbles were arranged by days, with each day's medication going left to right on the packaging and labeled for the date and time

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of administration daily.
-On 10/23/25 at 2:14pm, medications packed in the multi-dose bubble labeled for 10/23/25 at noon, containing Beano 400mg and gabapentin 300mg, were still on the multi-dose weekly package.
-On 10/23/25 at 2:14pm, medications packed in the multi-dose bubble labeled for 10/23/25 evening (8:00pm dose) were no longer available for administration. (The seal for the bubble had been opened and medications were not in the bubble).
-Medications scheduled for administration on 10/23/25 at 8:00pm included loperamide 2mg, atorvastatin 40mg, famotidine 40mg, gabapentin 300mg, Latuda 40mg, metoprolol 50mg, ropinirole 1mg and trazadone 200mg.

Interview with the Administrator on 10/23/25 at 2:00pm revealed:
-The medications aides (MAS) were supposed to administer medications from the multi-dose bubble packages following the date and time of day labeled on the multi-dose bubble.
-She had not had previous incidents with residents' medications being administered incorrectly as the time, medications included in the bubble, and date was on the individual multi-dose bubbles.
-She would ensure the primary care provider (PCP) was notified for the evening medications appearing to the administered at 2:00pm and the noon medications still available to be administered, and a medication error report filled out for the resident and MA.

Interview with Resident #1 on 10/23/25 at 2:40pm revealed:
-He was administered medication today, after lunch, around 1:45pm.

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-He was not sure how many medications he was administered.
-He thought it was only 2 or 3 medications because when he took his morning and evening medications, he had to take 2 big gulps of water for the large number of medications to be taken.
-He thought he only took one gulp of water at noon medications today.
-He was not feeling sleepy or tired and if he took his night time medications he was usually sleepy in a few minutes.

Interview with the MA on 10/23/25 at 3:00pm revealed:
-She administered medication today, 10/23/25, in the morning and at noon.
-Medications were routinely administered according to the date and time on the medication bubble.
-She did not know why Resident #1's noon medications for 10/23/25 were still on the weekly multi-dose bubble card and the evening medications for 10/23/25 had been administered.
-She thought she had administered Resident #1's medications scheduled for 10/23/25 at noon earlier today.
-It appeared Resident #1 had received his evening medications since the multi-dose bubble labeled for 10/23/25 in the evening was empty and the 10/23/25 noon multi-dose bubble 10/23/25 was still intact.
-All other multi-dose medication bubbles for the week of 10/17/25 to 10/23/25 were empty because today was the last day of the weekly package.

Attempted telephone interview with Resident #1's on 10/23/25 at 3:15pm was unsuccessful.

Interview with the Resident Care Coordinator

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D 358	Continued From page 7 (RCC) on 10/23/25 at 3:20pm revealed: -The facility staff had contacted Resident #1's PCP's office today around 2:00pm. -The facility staff was instructed to give the remaining medications due for the day at the next scheduled time of administration and watch the resident for any signs of unusual behaviors since the resident would receive all medications scheduled for the day.	D 358		