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D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted an annual survey and complaint investigation on 10/07/25 - 10/10/25 and 10/13/25 - 10/14/25. The complaint investigations were initiated by the Duplin County Department of Social Services on 08/29/25, 09/17/25, 09/18/25, and 09/22/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 7 exit doors and one outdoor fire egress gate had a	D 067		

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sounding device engaged that was audible throughout the facility at all times when the doors were opened which were accessible to 2 of 3 sampled residents (#1, #3) who were documented as intermittently and sometimes disoriented.

The findings are:

Review of the facility's license effective 01/01/25 revealed the facility was licensed for 80 assisted living (AL) beds.

Review of the facility census on 10/07/25 revealed there were 24 residents residing in the facility.

Review of the facility's Environmental Safeguards Policy dated 03/29/23 revealed:
-The supervisor should check door alarms on each shift to assure they were working properly.
-The door alarms were turned on each evening at 8:00pm - 8:00am.
-At any time, there was a need to safeguard a resident, resident door alarms should be on.

Observation of the dining room exit door on 10/07/25 at 5:15pm revealed:
-There was no alarm sound when the surveyor opened the exit door between the dining room and smoking area.
-The exit gate was unlocked on the back fence with no alarm on the gate.
-There was no staff response noted when the surveyor opened and closed the gate.

Observation of the exit door from the dining room on 10/08/25 at 7:43am revealed:
-The alarm did not sound initially when the door was opened by the surveyor.

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-Two surveyors worked together to assess that the lock from the inside of the door was functioning properly.
-As one surveyor re-entered the building, the alarm sounded and staff responded.
-The door had been opened twice before the alarm sounded or staff responded.

Observation of the exit door near room 50 on 10/07/25 at 10:05am revealed:
-There was no alarm sound when the surveyor or Maintenance Director opened the door.
-The Maintenance Director then set the alarm at the door.

Interview with the Maintenance Director on 10/07/25 at 10:05am revealed:
-There was no sound when the door next to room 50 was checked.
-The resident that lived next to room 50 would turn the alarm off, and he told him not to touch it.
-The alarms were in place because the facility had a resident who wandered away, but the resident was now discharged.
-The resident who wandered away was not in the facility.
-Any resident who might wander out the facility was always discharged.
-He did not know if the facility policy was to have the alarms on, but he was told by the Department of Social Services (DSS) to have the alarms on.

Interview with a resident on 10/07/25 at 10:40am revealed:
-The exit door alarm near room 50 was always on.
-They kept an alarm on the exit door at room 50, and they kept a good eye on it.

Observation of exit doors on 10/08/25 at 7:53am

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revealed:
-Three exit doors in the men's hallway were properly functioning.
-The exit door next to room 50 had two different pieces of hardware that worked to provide an alarm.

Observation of the dining room exit door on 10/08/25 at 12:58pm revealed:
-Two residents came into the dining room from the outside smoking area.
-No alarm sounded when the dining room exit door was opened by the residents.

Second interview with the Maintenance Director on 10/08/25 at 1:12pm revealed:
-The dining room exit door alarm worked but someone must have turned the alarm off.
-He would turn it back on at the panel in the nurses' station.

Observation on 10/08/25 at 1:12pm revealed the Maintenance Director turned the dining room exit door alarm on at the panel in the nurses' station.

Interview with a medication aide (MA) on 10/08/25 at 1:18pm revealed:
-The exit door alarms were not supposed to be turned off.
-She did not know who turned off the door alarm to the dining room exit door on 10/08/25.

Interview with a personal care aide (PCA) on 10/10/25 at 11:00am revealed:
-The back door alarm was controlled by the system on the door.
-If it rang she would turn it off by the system on the door.
-If the small alarm on the door was turned off it would not turn off the alarm at the desk.

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-A resident turned the alarm off at the door, but it should still sound at the desk.
-She did not know why it did not sound at the desk when surveyors first arrived.
-Staff was not intentionally turning the alarm off.

Interview with a second MA on 10/10/25 at 12:22pm revealed:
-At the back door by room 50, she observed the alarm functioning properly.
-If a resident turned the alarm off at the door, staff would not know he went outside.
-She did not know how the alarm system worked.
-The back gate had an alarm system that sounded when the wind blew.

Observation of the gate in the rear courtyard on 10/13/25 at 4:45pm revealed:
-The gate was not easily opened.
-After the gate was opened it could not be closed.
-The gate was unstable and had loose nails.
-An alarm was secured with duct tape to the gate.

Telephone interview with the local police chief on 10/08/25 at 4:50pm revealed:
-There were 3-4 other instances where residents walked off from the facility, and two of them were trying to go home.
-In the past year there seemed to be more residents leaving the facility than in others.

Interview with the Director on 10/07/25 at 5:25pm revealed:
-The dining room door was monitored all day by maintenance and staff.
-Nobody was supposed to unlock the back locked gate.
-She did not know the back gate was open.
-The Maintenance Director kept a key to the back gate.

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D 067	Continued From page 5 -The exit door alarm was not on because it would go off all day with residents in and out of the building. Second interview with the Director on 10/09/25 at 4:45pm revealed: -A resident told the staff member he turned off his door alarm because he did not want to hear it. -She was not sure how many times he had turned off the alarm. -She did not believe any elopements occurred at that door by room 50. Third interview with the Director on 10/14/25 at 3:04pm revealed: -There was a resident that turned off the door alarm at room 50, and she educated him that he would have to move rooms if he would not stop turning off the alarm. -The resident turned it off because it was too loud. -The first alarm was not reliable and a second alarm had to be placed on the door. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed: -She made visits to the facility in December 2024 and either March or May 2025. -She checked the facility's fire drills and preparedness. -If the back gate was a fire egress, it could not be locked. 1. Review of Resident #1's current FL2 dated 08/03/25 revealed: -Diagnoses included anxiety, basal cell carcinoma of the nose status post rhinotomy (removal of the nose), chronic bilateral low back pain without sciatica, depression, dysphasia, hypertension and irregular heartbeat.	D 067		

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D 067	Continued From page 6 -Resident #1 was documented as semi-ambulatory and intermittently disoriented. Review of Resident #1's Resident Register revealed an admission date of 06/12/25. 2. Review of Resident #3's current FL-2 dated 02/12/25 revealed diagnoses included diabetes mellitus, history of hypertension, history of chronic obstructive pulmonary disease, history of diastolic congestive heart failure, osteoarthritis of both knees, anxiety, and depression. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 02/05/25. Review of Resident #3's current assessment and care plan completed 02/05/25 revealed: -The resident was documented as ambulatory with no aide or device documented as needed. -The resident was documented as sometimes disoriented, forgetful and needed reminders. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision.] The facility failed to ensure exit doors and a gate that was accessible to residents maintained an audible sounding device which was engaged and functioning at all times to sound when the doors or gate were opened to prevent residents from exiting the facility without staff's knowledge. There were at least 2 residents who resided at the facility which were assessed as sometimes disoriented and forgetful, at least one resident who was reported to have previously eloped and 3-4 reports to law enforcement of other residents who had walked away from the facility. This failure resulted in substantial risk for serious	D 067		

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D 067	Continued From page 7 physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/25 and updated on 10/08/25 for this violation. CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 067		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all plumbing fixtures were maintained in operating condition related to a leaking tub fixture in the bathroom between rooms 50 and 48. The findings are: Observation of the bathroom between rooms 48 and 50 on 10/07/25 at 10:40am revealed the tub fixture was continuously leaking in a steady stream. Observation of the bathroom between rooms 48 and 50 on 10/14/25 at 9:48am revealed the tub	D 105		

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fixture in the bathroom between rooms 48 and 50 was still continuously leaking in a steady stream.

Interview with the resident that resided in room 50 on 10/07/25 at 10:40am revealed:
-The O-ring was gone on the tub fixture between rooms 48 and 50, causing the leak.
-There was a problem with the plumbing.

Second interview with the resident that resided in room 50 on 10/10/25 at 9:56am revealed:
-The plumbing issue bothered him a little bit, but it did not affect him much, he hated to see it was wasteful.
-The plumbing had been like that for about a month.

Interview with the Maintenance Director on 10/07/25 at 10:51am revealed:
-The tub fixture in the bathroom between rooms 50 and 48 needed a ring.
-The resident that resided in room 50 reported the tub leak a week ago.

Interview with the Director on 10/14/25 at 3:04pm revealed
-The tub fixture in the bathroom between rooms 48 and 50 was still broken because the building was very old and was not easily fixed.
-The facility had called at least two plumbers who quoted very high prices, and they were still looking for help.

Telephone interview with the facility's Administrator on 10/14/25 at 4:52pm revealed:
-She made visits to the facility in December 2024 and either March or May 2025.
-The plumber would need to be called, and it was difficult to find help.

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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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 6 sampled medication aides (MA) (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) had completed the state approved 5-hour and 10-hour or 15-hour medication aide training courses and the medication administration clinical skills validation checklist prior to administering medications to residents. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/02/25. -Staff B passed the Adult Care Home MA examination on 06/12/12. -There was no documentation Staff B had completed the medication administration clinical skills validation checklist.	D 125		

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D 125	Continued From page 10 -There was no documentation of proof of employment as a MA in the past consecutive 24 months before hire. Review of September 2025 electronic medication administration records (eMARs) revealed there was documentation Staff B administered medications on 09/16/25 - 09/18/ 25, 09/22/25 - 09/26/25, and 09/28/25 - 09/30/25. Review of October 2025 eMARs revealed there was documentation Staff B administered medications on 10/01/25 and 10/02/25. Observation of the 8:00am medication pass on 10/08/25 revealed: -Staff B made a medication error during the medication pass. -Staff B did not measure the proper dosage of a laxative used to treat and prevent constipation for a resident. -The resident did not receive the full dosage due to Staff B measuring the wrong amount of medication to be administered. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 2. Review of Staff F's personnel record revealed: -Staff F was hired as a medication aide (MA) on 06/30/25. -Staff F passed the Adult Care Home MA examination on 01/23/08. -There was no documentation Staff F had completed the medication administration clinical skills validation checklist. -There was no documentation of proof of	D 125		

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employment as a MA in the past consecutive 24 months before hire.

Review of July 2025 electronic medication administration records (eMARs) revealed there was documentation Staff F administered medications on 07/19/25.

Review of August 2025 eMARs revealed there was documentation Staff F administered medications on 08/19/25, 08/21/25, 08/25/25, 08/26/25, and 08/28/25.

Review of September 2025 eMARs revealed there was documentation Staff F administered medications on 09/02/25, 09/03/25, 09/08/25, 09/09/25, 09/11/25, 09/15/25, 09/17/25 - 09/19/25, and 09/23/25.

Review of October 2025 eMARs from 10/01/25 to 10/08/25 revealed there was documentation Staff F administered medications on 10/01/25, 10/07/25, and 10/08/25.

Observation of the 8:00am medication pass on 10/08/25 revealed:
-Staff F made 4 medication errors during the medication pass.
-Staff F administered Loratadine (an antihistamine) instead of Losartan (for heart/high blood pressure) as ordered.
-Staff F did not use proper technique when administering an inhaler to a resident with chronic obstructive disease resulting in the medication vapors coming back out of the resident's mouth and not reaching the lungs to exert its effect.
-Staff F administered a diuretic for swelling that had been discontinued and should not have been administered.
-Staff F did not dispose of medications refused by

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two residents in accordance with the rules and the facility's policies and procedures, including a controlled substance.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

3. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 08/27/25.
-Staff A passed the Adult Care Home MA examination on 08/13/25.
-There was no documentation Staff A had completed the state approved 5-hour, 10-hour or 15-hour MA training course or the medication administration clinical skills validation checklist.

Review of September 2025 electronic medication administration records (eMARs) revealed there was documentation Staff A administered medications on 09/14/25.

Review of October 2025 eMARs revealed there was documentation Staff A administered medications on 10/02/25.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

4. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 07/08/25.
-Staff C passed the Adult Care Home MA examination on 11/05/21.

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D 125	Continued From page 13 -There was no documentation Staff C had completed the state approved 5-hour, 10-hour or 15-hour MA training course or the medication administration clinical skills validation checklist. Review of July 2025 electronic medication administration records (eMARs) revealed there was documentation Staff C administered medications on 07/10/25, 07/12/25, 07/1325, 07/16/25, 07/17/25, 07/19/25, 07/21/25, 07/23/25, 07/25/25, 07/2925, and 07/30/25. Review of August 2025 eMARs revealed there was documentation Staff C administered medications on 08/01/25, 08/07/25 - 08/09/25, 08/11/25, 08/14/25, 08/16/25 - 08/18/25, 08/25/25 - 08/27/25, 08/30/25, and 08/31/25. Review of September 2025 eMARs revealed there was documentation Staff C administered medications on 09/01/25, 09/04/25, 09/08/25, 09/11/25, 09/13/25, 09/14/25, and 09/16/25 Telephone interview with Staff C on 10/15/25 at 1:25pm revealed: -She had worked as a MA at the facility since the end of June or first part of July 2025. -She had been texting with the Director and was bringing her application to her around 12 noon that day she had been hired. -She received a call from the Director about 10:00am and the Director asked her if she could come in and work 2:00pm - 10:00pm on the day she was hired. -She worked with another MA for about 3 days and then she was on her own. -She worked at other facilities as a MA before she came to work at the current facility. -She had not completed the MA 5-hour, 10-hour or 15-hour medication aide training course or the	D 125		

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clinical skills validation checklist since she began working at the facility.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

5. Review of Staff D's personnel record revealed:
-Staff D was hired as a medication aide (MA) on 09/10/25.
-Staff D passed the Adult Care Home MA examination on 12/09/16.
-There was no documentation Staff D had completed the state approved 5-hour, 10-hour or 15-hour MA training course or the medication administration clinical skills validation checklist.

Review of September 2025 electronic medication administration records (eMARs) revealed there was documentation Staff D administered medications on 09/30/25.

Review of October 2025 eMARs revealed there was documentation Staff A administered medications on 10/02/25, 10/06/25, and 10/07/25.

Interview with Staff D on 10/07/25 at 9:59am revealed:
-She was the MA assigned to administering medications for the men's hall today, 10/07/25.
-She started administering medications at 6:00am and finished administering the morning medications between 8:30am and 9:00am.
-She started working at the facility about 7 to 10 days ago.
-She administered medications independently yesterday (10/06/25) and today (10/07/25).
-The facility's registered nurse (RN) had not

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completed the medication clinical skills validation checklist for her yet.
-She did not recall completing the state approved 5, 10, or 15-hour MA training course.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

6. Review of Staff E's personnel record revealed:
-Staff E was hired as a medication aide (MA) on 08/18/25.
-Staff E passed the Adult Care Home MA examination on 10/25/23.
-There was no documentation Staff E had completed the state approved 5-hour, 10-hour or 15-hour MA training course or the medication administration clinical skills validation checklist.

Review of August 2025 electronic medication administration records (eMARs) revealed there was documentation Staff E administered medications on 08/26/25.

Review of September 2025 eMARs revealed there was documentation Staff E administered medications on 09/01/25, 09/09/25, 09/10/25, 09/15/25, 09/24/25, 09/25/25, 09/28/25, and 09/29/25.

Interview with Staff E on 10/13/25 at 5:10pm revealed:
-She was currently the MA on duty for this shift today, 10/13/25.
-She worked at the facility for about a month.
-She administered medications since she started working at the facility.
-The facility's registered nurse (RN) observed her

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D 125	Continued From page 16 check blood sugar and administer insulin last week. -She had not completed the state approved 5, 10, or 15-hour MA training course. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration.] [Refer to Tag D367 10A NCAC 13F .1004 (j) Medication Administration] [Refer to Tag D391, 10A NCAC 13F .1007(f) Medication Disposition.] [Refer to Tag D398, 10A NCAC 13F .1008(g) Controlled Substances.] _____ Telephone interview with the facility's medication aide (MA) training nurse on 10/14/25 at 6:17pm revealed: -The Director would call her to come perform any training that the pharmacy had not done. -She was called one day last week but could not remember which day; but she was unable to come out until this week. -She came to the facility yesterday evening and did the 5-hour training for the MAs who came. -She was not aware that there was a state approved form that she had to use to complete the checklist; she had used one from her workplace to complete the skills checklists for the MAs. Interview with the Director on 10/14/25 at 3:04pm	D 125		

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D 125	Continued From page 17 revealed: -She could not find any MA training certificates for the sampled staff. -She did not know if the previous Director had completed MA training certificates for staff hired prior to her becoming the Director. -She was responsible for maintaining the staff records. -She had not done audits of the staff records since she became the Director about 5 months ago. -Her duties were being the Director, the acting Resident Care Coordinator (RCC) as well as the acting Business Office Manager (BOM). _____ The facility failed to ensure 6 of 6 sampled staff (Staff A, B, C, D, E, and F) who administered medications to residents, had completed the medication administration clinical skills validation checklist or the state approved 5-hour and 10-hour, or 15-hour MA training courses and/or employment verification form prior to administering medications. Staff F was observed during the medication pass on 10/08/25 and made four medication errors and Staff F failed to dispose of refused medications in accordance with the rules and the facility's policies and procedures, including disposal of a controlled substance. Staff B was observed during the medication pass on 10/08/25 and made one medication error. Failing to ensure required training for staff who administered medications resulted in medication errors and inaccuracy of the medication administration records. This failure resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/13/25 for	D 125		

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D 125	Continued From page 18 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 125		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to complete a criminal background check on 1 of 6 sampled staff (Staff B). The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/02/25. -There was no documentation Staff B had a criminal background check upon being hired on 09/02/25. Observation of Staff B on 10/08/25 during the 8:00am medication administration pass revealed Staff B was administering medications to residents. Review of September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff B administered	D 139		

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D 139	Continued From page 19 medications on 09/16/25 - 09/18/25, 09/22/25 - 09/26/25, and 09/28/25 - 09/30/25. Review of October 2025 eMAR revealed there was documentation Staff B administered medications on 10/01/25 and 10/02/25. Interview with the Director on 10/14/25 at 3:04pm revealed: -She could not find any criminal background check for Staff B. -She was responsible for maintaining the staff records. -Her duties were being the Director, the acting Resident Care Coordinator (RCC) as well as the acting Business Office Manager (BOM).	D 139		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.	D 161		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 6 of 6 medication aide/personal care aides (MA/PCA) (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration including applying, removing, and monitoring oxygen, transferring, ambulation with assistive devices, care of urinary catheter bag, inhalation of medication by machine, medication through injection, and collecting and testing of fingerstick blood sugars (FSBS).

The findings are:

Review of a resident's licensed health professional support (LHPS) review dated 08/13/25 revealed:
-Tasks required included transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that require physical assistance, and oxygen administration and monitoring.
-There were no staff competency validations documented at the bottom of the form.

Review of a second resident's LHPS review dated 08/22/25 revealed:
-The resident's LHPS tasks included positioning and emptying of urinary catheter bag and cleaning around the urinary catheter, transferring, ambulation using assistive devices, inhalation of medication by machine, medication through

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D 161	Continued From page 21	D 161		

injection, and collecting and testing of FSBS.
-There were no staff competency validations documented at the bottom of the form.

1. Review of Staff B's personnel record revealed:
-Staff B was hired as a medication aide (MA) on 09/02/25.
-Staff B passed the Adult Care Home MA examination on 06/12/12.
-There was no documentation Staff B had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration.

Review of Resident #2's October electronic Medication Administration Record (eMAR) revealed:
-Staff B documented she performed FSBS's on 10/01/25, 10/02/25, 10/06/25, and 10/08/25 at 7:30am and on 10/01/25, 10/02/25, and 10/08/25 at 11:30am.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

2. Review of Staff F's personnel record revealed:
-Staff F was hired as a medication aide (MA) on 06/30/25.
-Staff F passed the Adult Care Home MA examination on 01/23/08.
-There was no documentation Staff F had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration.

Review of Resident #2's August electronic Medication Administration Record (eMAR)

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revealed Staff F documented she administered insulin on 08/26/25 and 08/28/25 at 7:45am.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

3. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 08/27/25.
-Staff A passed the Adult Care Home MA examination on 08/13/25.
-There was no documentation Staff A had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

4. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 07/08/25.
-Staff C passed the Adult Care Home MA examination on 11/05/21.
-There was no documentation Staff C had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration.

Review of Resident #2's September electronic Medication Administration Record (eMAR) revealed Staff C documented she administered insulin on 09/25/25 and 09/27/25 at 7:45am.

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D 161	Continued From page 23 Telephone interview with a medication aide (MA) on 10/14/25 at 10:50am revealed: -She had worked as a MA at the facility since the end of June or first part of July. -She was the only staff working 10:00pm - 6:00am on 09/15/25 - 09/16/25. -When she checked on Resident #5 between 3:00am - 4:00am, she had to get her to put her oxygen back on and had to check her oxygen (O2) saturations (sats); it was 89-90%. -She had not been validated for competency for licensed health professional support (LHPS) tasks by return demonstration. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 5. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA) on 09/10/25. -Staff D passed the Adult Care Home MA examination on 12/09/16. -There was no documentation Staff D had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration. Review of Resident #2's October electronic Medication Administration Record (eMAR) revealed: -Staff D performed FSBS's 10/07/25 at 7:30am and on 10/06/25, 10/07/25, and 10/09/25 at 11:30am. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.	D 161		

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D 161	Continued From page 24 Refer to the interview with the Director on 10/14/25 at 3:04pm. 6. Review of Staff E's personnel record revealed: -Staff E was hired as a medication aide (MA) on 08/18/25. -Staff E passed the Adult Care Home MA examination on 10/25/23. -There was no documentation Staff E had been validated for competency for licensed health professional support (LHPS) tasks by return demonstration. Review of Resident #2's September electronic Medication Administration Record (eMAR) revealed Staff E documented she administered insulin on 09/28/25 at 4:45pm. Review of Resident #2's October electronic Medication Administration Record (eMAR) revealed Staff E documented she administered insulin on 10/08/25 and 10/09/25 at 4:45pm. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. _____ Telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. -The Director would call her to come perform any training that the pharmacy had not done. -She had been called one day last week but could not remember which day; but she was unable to come out until this week. -She was not aware that there was a state approved form that she had to use to complete the checklists; she had used one from her workplace to complete the medication skills	D 161		

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D 161	Continued From page 25 checklists for the MAs. Interview with the Director on 10/14/25 at 3:04pm revealed: -She could not find any LHPS training certificates for the sampled staff. -She did not know if the previous Director had completed LHPS training certificates for staff hired prior to her becoming the Director. -She was responsible for maintaining the staff records. -She had not done audits of the staff records since she became the Director about 5 months ago. -Her duties were being the Director, the acting Resident Care Coordinator (RCC) as well as the acting Business Office Manager (BOM).	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and	D 164		

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D 164	Continued From page 26 symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews and the facility failed to ensure 6 of 6 sampled medication aide (MA) staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) had completed training on the care of diabetic residents prior to administering insulin. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/02/25. -There was no documentation Staff B had completed training on the care of the diabetic resident prior to administering insulin. Observation of the medication pass on 10/08/25 at 8:00am revealed Staff B administered medications to residents. Review of September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff B administered insulin on 09/16, 17, 18, 22, 23, 24, 25, 26, 28, 29, and 30/25. Review of the October 1 - 10, 2025 eMAR revealed there was documentation Staff B	D 164		

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administered insulin on 10/01, 02, 06, and 08/25.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

2. Review of Staff F's personnel record revealed:
-Staff F was hired as a medication aide (MA) on 06/30/25.
-There was no documentation Staff F had completed training on the care of the diabetic resident prior to administering insulin.

Review of August 2025 eMAR revealed there was documentation Staff F administered insulin on 08/26/25 and 08/28/25.

Review of September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff F administered insulin on 09/03/25 09/08/25,

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

3. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 08/27/25.
-There was no documentation Staff A had completed training on the care of the diabetic resident prior to administering insulin.

Review of September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff A administered insulin

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D 164	Continued From page 28 on 09/22/25. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 4. Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) on 07/08/25. -There was no documentation Staff C had completed training on the care of the diabetic resident prior to administering insulin. Review of August 2025 electronic medication administration records (eMAR) revealed there was documentation Staff C administered insulin on 08/25/25. Review of September 2025 eMAR revealed there was documentation Staff C administered insulin on 09/01/25, 09/04/25, 09/08/25, 09/11/25, and 09/14/25. Interview with Staff C on 10/15/25 at 1:25pm revealed: -She had worked as a MA at the facility since the end of June or first part of July. -She had not completed a training on the care of the diabetic resident prior to administering insulin to residents at the facility. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 5. Review of Staff D's personnel record revealed:	D 164		

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-Staff D was hired as a medication aide (MA) on 09/10/25.
-There was no documentation Staff D had completed training on the care of the diabetic resident prior to administering insulin.

Review of October 2025 eMAR revealed there was documentation Staff D administered insulin on 10/06/25, 10/07/25, and 10/09/25.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

6. Review of Staff E's personnel record revealed:
-Staff E was hired as a medication aide (MA) on 08/18/25.
-There was no documentation Staff E had completed training on the care of the diabetic resident prior to administering insulin.

Review of August 2025 electronic medication administration records (eMAR) revealed there was documentation Staff E administered insulin on 08/26/25, 08/27/25, and 08/28/25.

Review of September 2025 eMAR revealed there was documentation Staff E administered insulin on 09/01/25, 09/09/25, 09/15/25, 09/16/25, and 09/29/25.

Review of the October 1 - 10, 2025 eMAR revealed there was documentation Staff E administered insulin on 10/08/25 and 10/09/25.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

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D 164	Continued From page 30 Refer to the interview with the Director on 10/14/25 at 3:04pm. _____ Telephone interview with the facility's medication aide (MA) training nurse on 10/14/25 at 6:17pm. -The Director would call her to come perform any training that the pharmacy did not do. -She had been called one day last week but could not remember which day; but she was unable to come out until this week. Interview with the Director on 10/14/25 at 3:04pm revealed: -She could not find any MA diabetic training certificates for the sampled staff. -She did not know if the previous Director had completed MA diabetic training certificates for staff hired prior to her becoming the Director. -She was responsible for maintaining the staff records. -She had not done audits of the staff records since she became the Director about 5 months ago. -Her duties were being the Director, the acting Resident Care Coordinator as well as the acting business office manager.	D 164		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council,	D 167		

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D 167	Continued From page 31 American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was at least one staff person on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 5 of 6 sampled staff (Staff A, Staff B, Staff C, Staff E, and Staff F). The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/02/25. -There was no documentation Staff B had completed an approved cardio-pulmonary resuscitation (CPR) training course. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 2. Review of Staff F's personnel record revealed: -Staff F was hired as a medication aide (MA) on 06/30/25. -There was no documentation Staff F had completed an approved cardio-pulmonary resuscitation (CPR) training course.	D 167		

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D 167	Continued From page 32 Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 3. Review of Staff A's personnel record revealed: -Staff A was hired as a medication aide (MA) on 08/27/25. -Staff A passed the state written MA examination on 08/13/25. -There was no documentation Staff A had completed an approved cardio-pulmonary resuscitation (CPR) training course. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 4. Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) on 07/08/25. -There was no documentation Staff C had completed an approved cardio-pulmonary resuscitation (CPR) training course. Interview with Staff C on 10/15/25 at 1:25pm revealed: -She had worked as a MA at the facility since the end of June or first part of July. -She had not completed an approved CPR training course. -She was the only staff working 10:00pm - 6:00am on 09/15/25 - 09/16/25. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.	D 167		

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D 167	Continued From page 33 Refer to the interview with the Director on 10/14/25 at 3:04pm. 5. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA) on 09/10/25. -The Director provided a cardio-pulmonary resuscitation (CPR) certificate for Staff D on 10/14/25. -The certificate was verified through the QR scan code as a valid certificate for adult first aid/CPR. -The training was completed on 08/26/25 and valid through 08/27/25. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 6. Review of Staff E's personnel record revealed: -Staff E was hired as a medication aide (MA) on 08/18/25. -There was no documentation Staff E had completed an approved cardio-pulmonary resuscitation (CPR) training course. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. Observation on 10/13/25 at 8:45am revealed: -The Director had arrived at the facility with yellow bags from a local store. -She had to "get some alcohol swabs as the facility had run out". -She placed two blue boxes of alcohol swabs on	D 167		

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D 167	Continued From page 34 the medication cart. Review of the local map revealed: -The closest local store with the brand on the yellow bags was 0.8 miles away from the facility. -There were no known cardio-pulmonary resuscitation (CPR) trained staff members working on the morning of 10/13/25 while the Director was not on the premises. Review of the document of American Heart Association Course Participants dated 05/09/25 provided by the Director on 10/14/25 revealed that none of the names of the sampled Staff A, Staff B, Staff C, Staff E, or Staff F appeared on the list. Review of the sample residents code status revealed Resident #2, #3 and #5 were full codes meaning that in the event their heart stops beating or they stop breathing all possible measures will be taken to revive them. _____ Telephone interview with the facility's medication aide (MA) training nurse on 10/14/25 at 6:17pm revealed: -The Director would call her to come hold cardio-pulmonary resuscitation (CPR) training courses as needed. -She was a certified American Heart Association (AHA) instructor. -The last time she had held a course was back in May or June 2025 for the employees who needed cardio-pulmonary resuscitation (CPR) training. -She had provided the Director with a sign-in sheet of the staff who received CPR training. Interview with the Director on 10/14/25 at 3:04pm revealed: -She could not find any cardio-pulmonary	D 167		

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D 167	Continued From page 35 resuscitation (CPR) training certificates for the sampled staff except for Staff D. -The last CPR class was sometime in May - June 2025 so the sampled staff (Staff A, Staff B, Staff C, Staff E and Staff F) were hired since then and were not part of that class. -She was responsible for maintaining the staff records. -She had not done audits of the staff records since she became the Director about 5 months ago. -Her duties were being the Director, the acting Resident Care Coordinator (RCC) as well as the acting Business Office Manager (BOM).	D 167		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers	D 176		

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D 176	Continued From page 36 to co administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation and management of the facility to ensure care and services were provided to maintain the health, safety, and welfare of the resident as related to physical environment; other requirements; qualifications of medication staff; other staff qualifications; competency evaluation and validation for licensed health professional support (LHPS) tasks; training on care of diabetic resident; training on cardio-pulmonary resuscitation; tuberculosis test, medical exam and immunizations; personal care and supervision; health care; LHPS; nutrition and food service; other resident care and services; medication orders; medication administration; medication disposition; controlled substances; infection prevention and control policies and procedures; and examination and screening of controlled substances. The findings are: Review of the facility's current 2025 license revealed the facility was licensed with a capacity of 80 residents.	D 176		

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Review of the facility's current census report dated October 2025 and received on 10/07/25 revealed there were 24 residents residing in the facility.

Interview with a personal care aide (PCA) on 09/18/25 at 9:41am revealed:
-The facility was not equipped for dementia residents.
-The PCA felt the facility was not adequately staffed to care for the needs of the residents.
-The morning a resident died, there was only one staff member in the facility.

Interview with a former dietary staff on 09/22/25 at 10:43am revealed the staff was certified in cardiopulmonary resuscitation (CPR) but was told not to touch residents when hired.

Interview with a second former staff on 10/14/25 at 11:00am revealed:
-They did not know who the facility's Administrator was and had never met the Administrator.
-The facility's Owner was the Director's boss.
-Residents had no one to go to with concerns other than the Director.
-The Director cut residents off when they went to her with concerns.
-They learned that one resident was exhibiting exit-seeking behaviors from a PCA, not from facility management.
-The facility lacked coordination of care from leadership to staff.

Interview with a third former staff on 10/14/25 at 2:03pm revealed:
-She never received any training for her position.
-She learned the job by trial and error.

Interview with the facility's contracted primary

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care provider (PCP) on 09/24/25 at 2:41pm revealed:
-There were issues with prior authorizations for insurance on medications.
-When the pharmacy was unable to get a response from the facility, they closed out the prior authorizations which delayed resident's medication delivery to the facility.

Interview with the facility's contracted PCP on 10/01/25 at 11:08am revealed:
-She was not well-informed when residents saw outside specialists.
-The facility should contact her care coordinator when residents saw outside providers because she needed to access the records.
-She had communicated this with the facility multiple times and that caused her to miss vital patient care information when she did not have records from outside appointments.
-She had a meeting with the facility in July 2025 about process and organization.
-When she returned the next week, nothing discussed in the meeting had been implemented.

Telephone interview with the facility's contracted PCP on 10/10/25 at 1:12pm revealed:
-She became the facility's provider in March 2025.
-She saw the Administrator maybe one time, a little bit after the current Director was promoted.
-She thought the Administrator's information was posted at the nurse's station for contact.
-She had provided the facility's contracted pharmacy with her personal contact information to reach her directly because, at times, the pharmacy reached out to the facility with no response.

Interview with the Director on 10/14/25 at 3:04pm

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revealed:
-The current Administrator had been the facility's Administrator since about March or April 2025.
-The Administrator had been on-site to the facility at least twice.
-On one visit about 5 months ago, the Administrator came to the facility and met her when she was the Resident Care Coordinator (RCC).
-The Administrator worked with the former Administrator during her first visit to the facility.
-She was not sure what the current Administrator did during her initial visit to the facility.
-On the second visit about 2 to 3 months after the first visit, the Administrator came to the facility to help her with a plan of correction (POC) for a corrective action report (CAR) issued by the local county Department of Social Services (DSS).
-During the second visit, the current Administrator helped her with the POC and trained her in the process of how things worked in the Director's role.
-The current Administrator went over some day-to-day operations of the facility, including ensuring they had meals for the residents, checking invoices for food orders, and discussing the facility's systems.
-The current Administrator's second visit lasted about a week.
-The current Administrator had been available to her via telephone.
-If the Administrator did not answer when she called, the Administrator usually returned her call.
-The current Administrator was going to come to the facility for another on-site visit, but she was the on-site Administrator at a sister facility that was about 5 hours away, so the current Administrator had not been back to this facility.
-The current Administrator was aware there was a state survey currently being conducted in the

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facility.
-She had spoken via telephone to the current Administrator about the survey.
-The current Administrator told her to get through the process and ensure the survey team had what they needed.
-She was the Director of the facility, and she had been the acting RCC since October 2025 when that position became vacant.
-She lived on the premises of the facility 24 hours a day, 7 days a week.
-She was aware there was only one staff person working on night shift on 09/16/25, when a resident passed.
-She could not get anyone to cover the shift that night and she was "burned out" so she instructed the one staff person on duty on 09/16/25 to call her if she needed anything.
-She was on the premises and available if needed.
-The RCC and Business Office Manager (BOM) positions were currently vacant.
-She initially tried to hire a new BOM, but the new hire was a "no show".
-She was currently trying to do the RCC and BOM duties along with her Director duties.
-She had never seen the residents' records so disorganized.
-She also helped with cooking, cleaning, and administering medications.
-She was not able to get everything done with the management part of her job because she was trying to be the Director, RCC, and BOM all at the same time.

Telephone interview with the facility's Owner on 10/14/25 at 2:50pm revealed:
-He usually came on-site to the facility about every other week; worst case, every other month.
-When he was at the facility, he just liked

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"chatting with everyone", liked to "mingle with staff", and he always asked if they needed anything.
-The current Administrator had been the facility's Administrator since March or April 2025.
-The current Administrator had been to the facility a "few" times.
-The current Administrator was always available via telephone.
-When the Administrator came to the facility, she made sure the full operation was working and made sure they were following the rules.
-He assumed the Administrator looked at resident records, asked the Director if there were systems in place, and asked the Director if she needed assistance.

Telephone interview with the facility's current Administrator on 10/14/25 at 4:52pm revealed:
-She made one visit to the facility in December 2024 prior to becoming the Administrator of the facility.
-She became the facility's Administrator in January 2025 because the previous Administrator retired.
-The facility's Owner originally asked her to be the Administrator until the end of February 2025 but he called her back in March 2025 and asked her to stay until the end of August 2025.
-She made another visit to the facility sometime between March 2025 and May 2025 and spent 3 days with the Director dealing with a complaint and the local county DSS.
-She mainly helped with the complaint while she was at the facility and she also checked other things such as staff and resident records, fire drills, safety; and offered her support.
-She spoke with the facility's Owner again in August 2025, when the Owner got his Administrator's license, so she did not visit the

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facility in August 2025.
-She continued to be the Administrator, but she had not visited the facility again; it was over 4 hours away.
-She stayed in touch with the Director; it could be weekly or whenever the Director needed anything.
-Being the Director was a challenging job; having staff call out; and dealing with staff and residents.
-The facility's census was currently low.
-Typically, the Director could handle a census of that size.
-The Director was currently functioning as the BOM.
-A lot of facilities did not have the luxury of having a BOM and a RCC.
-They hoped to fill the RCC position to free up the Director to perform her job role.
-They were working on getting help with management since the Director was also having to work on the floor.
-The Director let her know if there was anything she needed.
-The Director had called on her for things she needed but she could not think of an example off the top of her head.
-She was not aware until now that the police were involved with a resident on 10/09/25.
-The Director had told her there were some medication errors identified during the survey, but she did not go over specific errors.
-She was concerned about medication errors.
-It sounded like there needed to be extra safeguards in place.
-The Director was ultimately responsible for following up on the facility's systems.
-The Director was the supervisor/manager who lived on the property, so the Director was her "eyes and ears".
-She felt the Director was doing a fantastic job,

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D 176	Continued From page 43 but "we're humans". -She would be coming to the facility again but did not specify when. Non-compliance was identified at violation levels in the following areas: 1. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 7 exit doors and one outdoor fire egress gate had a sounding device engaged that was audible throughout the facility at all times when the doors were opened which were accessible to 2 of 3 sampled residents (#1, #3) who were documented as intermittently and sometimes disoriented. [Refer to Tag 067 10A NCAC 13F .0305 (h)(4) Physical Environment (A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 6 sampled medication aides (MA) (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) had completed the state approved 5-hour and 10-hour or 15-hour medication aide training courses and the medication administration clinical skills validation checklist prior to administering medications to residents. [Refer to Tag 125 10A NCAC 13F .0403(a) Qualifications of Medication Staff (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled residents (#7, #8) were supervised in accordance with the residents' assessed needs and current symptoms resulting in the residents, who were documented as being intermittently disoriented, leaving the facility without staff's knowledge. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D 176		

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D 176	Continued From page 44 4. Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 4 of 5 sampled residents (#2, #3, #5, #7) including failing to coordinate and follow up with the primary care provider (PCP) after discharge from the hospital (#5); failing to notify the PCP of a resident returning to the facility smelling of alcohol and mixing it with his medications (#2); failing to coordinate referrals and orders for dermatology, podiatry, and an arterial test to rule out clots (#2); failing to coordinate a neurocognitive referral for a resident exhibiting exit-seeking behaviors who left the facility without staff's knowledge (#7); and failing to obtain labwork to rule out anemia (#3). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 5. Based on observations, interviews, and record reviews the facility failed to ensure the immediate notification of the appropriate law enforcement agency and the county Department of Social Services when there was cause for concern about the safety of a resident whose whereabouts were unknown (#2). [Refer to Tag 328 10A NCAC 13F .0906(f)(4) Other Resident Care and Services (Type A2 Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#9, #10) observed during the medication pass including errors with medications for heart/blood pressure, swelling and excess fluid, chronic obstructive pulmonary disease, seasonal allergies (#10), and constipation (#9); and for 2 of 6 sampled residents (#2, #3) including errors with medications for chronic chest pain, chronic constipation, a blood thinner, insulin, a potassium	D 176		

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D 176	Continued From page 45 supplement, and controlled substances for anxiety and moderate to severe pain (#3); and a medication for chronic chest pain and diuretics for congestive heart failure (#2). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. _____ The facility failed to ensure the Administrator was responsible for the total operation and management of the facility to ensure care and services were provided to maintain the health, safety, and welfare of residents. The exit door alarms were not turned on at all times to prevent residents who were known to be or documented as disoriented from leaving the facility without the staff's knowledge, including two residents who were intermittently disoriented and left the facility without staff's knowledge. The facility failed to supervise the two residents resulting in one resident being located by local law enforcement at the local hospital and brought back to the facility and the other being located by a former staff member and brought back to the facility. Multiple medication errors were identified including medications for heart/blood pressure, swelling and excess fluid, chronic obstructive pulmonary disease, chronic chest pain, blood thinner, insulin, congestive heart failure, anxiety, and moderate to severe pain. There were 6 of 6 medications aides who administered medications that did not meet qualifications to administer medications. The facility failed to coordinate health care including notifying providers of clarifications needed upon discharge from the hospital, dermatology and podiatry referrals, and continuous oxygen and an arterial ultrasound to rule out occlusions, blood clots, plaque calcification, or any other acute processes, cardiology and oncology referrals and a neurocognitive referral. The facility failed to	D 176		

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D 176	Continued From page 46 ensure the immediate notification of Resident #2's responsible person, the appropriate law enforcement agency and the county Department of Social Services when there was cause for concern about the safety of a resident whose whereabouts were unknown. These failures of the facility resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 176		
D 238	10A NCAC 13F .0703 (f) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to clarify FL-2 orders for medication	D 238		

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and to determine if the facility could meet the individual's needs for 1 of 3 sampled residents (#2), who had a recommended level of care listed for a higher level of care.

The findings are:

Review of Resident #2's most recent FL-2 dated 07/30/25 revealed diagnoses included head injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction, non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction.

Review of the Resident Register for Resident #2 revealed:
-The resident was his own responsible party
-The resident was admitted on 01/16/25.

a. Review of Resident #2's most recent FL-2 dated 07/30/25 revealed:
-The recommended level of care was skilled nursing facility (SNF).
-The FL-2 was signed by a hospital provider.

Interview with the Director on 10/07/25 at 4:08pm revealed:
-She monitored to make sure the level of care matched the resident's FL-2, and she wanted to make sure the resident could be admitted.
-Residents needed to receive the proper level of care.
-She would check to make sure they could take care of the resident's needs.
-Resident #2 was initially admitted with a domiciliary FL-2.
-She did not want to assume, but thought the hospital just put SNF.
-The facility met Resident #2's needs for oxygen

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D 238	Continued From page 48 support and activities of daily living. Interview with the facility Director on 10/14/25 at 3:04pm revealed: -She was acting as the Resident Care Coordinator (RCC) right now, since October 2025. -She was working on the FL-2 for domiciliary level of care and notified the primary care provider (PCP) that the previous FL-2 was written for SNF. -Resident #2's PCP was reviewing medication before signing the FL-2. -The RCC was responsible for clarifying orders. Telephone interview with the facility's Administrator on 10/14/25 at 4:52pm revealed she was concerned that Resident #2 may need skilled nursing care. Telephone interview with the PCP for Resident #2 on 10/10/25 at 1:12pm revealed: -SNF was a completely different level of care than assisted living. -Resident #2's FL-2 may have been written for SNF because of his extensive cardiac procedures. -She was concerned about his safety because assisted living may not be able to provide care that he needed if it was written for SNF. -In SNF there were nurses on hand instead of medication aides. -SNF had more resources available, and SNF did not need to outsource care to home health. -She did not know about the FL-2 written for SNF. Refer to interview with the PCP for Resident #2 on 10/10/25 at 1:12pm. b. Review of Resident #2's most recent FL-2 dated 07/30/25 revealed:	D 238		

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D 238	Continued From page 49 -There was an order for insulin lispro 25 units 15 minutes prior to meals (insulin lispro is a fast acting medication to lower the blood sugar). -There was an order for as needed (PRN) alprazolam with no specified dosage, frequency, or indication listed (alprazolam is a controlled substance medication used to treat anxiety disorder, panic disorder, and anxiety caused by depression). -There was an order for PRN hydrocodone with no specified dosage, frequency, or indication listed (hydrocodone is controlled substance medication used to treat pain). -There was an order for PRN aluminum and magnesium hydroxide-simethicone, with no specified dosage, frequency, or indication listed (aluminum and magnesium hydroxide-simethicone is medication used to treat dyspepsia and flatulence). -There was an order for PRN guaifenesin with no specified dosage, frequency, or indication listed (guaifenesin is a mucus-thinning medication for chest congestion). -There was an order for PRN melatonin with no specified dosage, frequency, or indication listed (melatonin is a medication given to aide sleep). -There was an order for PRN morphine injection with no specified dosage, frequency, or indication listed (morphine injection is medication used to treat pain). -There was an order for PRN ondansetron with no specified dosage, frequency, or indication listed (ondansetron is medication used to treat nausea and vomiting). -There was an order for PRN polyethylene glycol with no specified dosage, frequency, or indication listed (polyethylene glycol is medication used to treat constipation). -There was an order for PRN tramadol with no specified dosage, frequency, or indication listed	D 238		

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D 238	Continued From page 50 (tramadol is a controlled substance medication used to treat pain). Review of Resident #2's Hospital Discharge Paperwork dated 07/30/25 at 12:47pm revealed: -The resident was to take insulin aspart 25 units 15 minutes prior to meals (insulin aspart is a fast acting medication to lower the blood sugar). -The paperwork included warning that the list had 2 medications that were the same as other medications prescribed. -There was instruction to talk to the PCP or prescribing provider if there were any questions about the medication. Review of electronic medication administration record eMAR for the months of July, August, September, and October 2025 revealed: -There were no entries for insulin lispro, alprazolam, hydrocodone, aluminum and magnesium hydroxide simethicone, guaifenesin, melatonin, morphine, ondansetron, polyethylene glycol, or tramadol. -Insulin aspart 25 units 15 minutes prior to meals was documented as administered. Telephone interview with a former staff member on 10/14/25 at 10:53am revealed: -Resident #2's paperwork should have been sent to the pharmacy. -When Resident #2 returned from the hospital, that paperwork should have been faxed. -The Resident Care Coordinator (RCC) was responsible for clarifying orders. Interview with the Director on 10/07/25 at 3:45pm revealed the PRN medications should have clarification from the 07/30/25 FL-2. Second interview with the facility Director on	D 238		

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D 238	Continued From page 51 10/14/25 at 3:04pm revealed -The medication aide (MA) or RCC were responsible for sending orders to the pharmacy. -MA's approved orders after the pharmacy entered them. -Orders should be sent as soon as they were received with no delay. -The pharmacist sent or gave recommendations to the RCC and the RCC was responsible for following up. -She was acting as the RCC right now, since October. -When orders came back from the hospital the MA was to fax all orders to the pharmacy, and if there were old orders they should be clarified. -An order should have the seven rights in order to administer the medication. -Verbal orders needed to be signed in 2 days. -The RCC was responsible for clarifying orders. Telephone interview with the facility's Administrator on 10/14/25 at 4:52pm revealed an FL-2 would typically be clarified with a subsequent medication list. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/13/25 at 2:51pm revealed: -The pharmacy entered orders based on what they received and facility staff approved these eMAR entries. -He did not see any history of the resident having orders or receiving alprazolam, tramadol, or hydrocodone. Refer to interview with the PCP for Resident #2 on 10/10/25 at 1:12pm. _____ Telephone interview with the PCP for Resident #2 on 10/10/25 at 1:12pm revealed:	D 238		

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D 238	Continued From page 52 -She could not say that she knew about the FL-2 from his hospitalization at the end of July 2025. -She had concerns that the orders on that FL-2 might not be followed.	D 238		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled residents (#7, #8) were supervised in accordance with the residents' assessed needs and current symptoms resulting in the residents, who were documented as being intermittently disoriented, leaving the facility without staff's knowledge. The findings are: 1. Review of Resident #7's current FL-2 dated 07/16/25 revealed: -Resident #7's level of care was documented as domiciliary/rest home (assisted living). -Diagnoses included metabolic encephalopathy,	D 270		

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D 270	Continued From page 53 Vitamin D deficiency, dysarthria, history of alcohol use disorder, history of cocaine abuse, history of cerebrovascular accident (CVA), left arm weakness, and cognitive decline. -The resident was documented as being intermittently disoriented. Review of Resident #7's Resident Register revealed: -The resident's date of admission was 09/30/24. -The resident's responsible person was documented as "self". -The resident was forgetful and needed reminders. -The resident used a walker. Review of Resident #7's current assessment and care plan dated 09/30/24 revealed: -The resident used a walker for ambulation/locomotion. -The resident required limited assistance with ambulation/locomotion and bathing. -The resident required supervision with eating, dressing, and transferring. -The resident was documented as sometimes disoriented. -The resident was forgetful and needed reminders. -The resident required daily mental stimulation. Review of Resident #7's licensed health professional support (LHPS) review dated 08/13/25 revealed the resident required assistance with transferring and ambulation using assistive devices that required physical assistance. Review of Resident #7's hospital emergency room (ER) after visit summary (AVS) dated 07/27/25 revealed:	D 270		

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D 270	Continued From page 54 -Resident #7 presented to the ER for altered mental status. -The resident was diagnosed with altered mental status, unspecified type and transient confusion. Review of Resident #7's primary care provider (PCP) progress note dated 07/30/25 revealed: -The resident was seen by the PCP for ER follow-up. -The resident was exhibiting a new development of exit-seeking behaviors and required monitoring. Review of Resident #7's Accident/Incident Report dated 09/03/25 revealed: -The report was completed by a medication aide (MA). -Resident #7 walked away from the facility at 2:30am and was found by police at the magistrate's office. -He was taken to the hospital by emergency medical services (EMS). -The resident's family was contacted at 3:03am by the MA. -The PCP was contacted at 9:21am. -The Department of Social Services (DSS) was contacted at 11:01am. Review of Resident #7's hospital ER records dated 09/03/25 revealed: -The resident was missing from the facility and found by police walking on the side of the road. -The resident presented to the ER at 3:21am confused, unable to tell police where he belonged. -The resident had severe dementia at baseline, unable to provide history. -The resident reported to ER staff he did not know how he ended up here. -The resident was unable to participate in review	D 270		

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of systems due to dementia.

Review of Resident #7's EMS record dated 09/03/25 revealed:
-The responding EMS unit was dispatched to the magistrate's office at 2:18am to check the resident out for law enforcement.
-The resident did not know where he was or how he got there.
-The resident was not oriented to place, time, or event.
-The resident was transported to the hospital where hospital staff informed EMS staff that the resident was a resident at the facility.

Interview with Resident #7 on 09/03/25 at 3:15pm revealed:
-He did not know where he was going, he just went somewhere.
-He did not know what time it was when he left but stated "it looked pretty late."
-It seemed like he was walking in the woods.
-He thought he was going to the club with other people.
-He did not know which facility door he exited.
-Staff did not check on him at night.
-He got lost and ended up by the hospital.
-Someone brought the resident back, but he did not know who.
-The resident "didn't know where the [expletive] I was".

Interview with a MA on 09/03/25 at 3:55pm revealed:
-Facility rounds were normally done every 3 hours.
-When the personal care aides (PCAs) did rounds at 12:00am, Resident #7 was in his room.
-The facility received a call from the hospital around 2:50am reporting that the resident was at

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the hospital.
-The MA checked to see if Resident #7 was in his room and he was not.
-The MA called the facility's Director and informed her of the situation, completed an Accident/Incident report, and called Resident #7's family member.
-The door alarms were not on and staff did not hear any door alarms sound.

Interview with a personal care aide (PCA) on 10/08/25 at 1:35pm revealed:
-She was on duty the morning Resident #7 wandered away from the facility.
-Rounds were usually done on night shift at 12:00am, 3:00am, and 5:00am.
-During 12:00am rounds on 09/03/25, all residents were accounted for.
-Staff was located near the nurse's station at around 2:50am when a call was received from hospital police reporting that Resident #7 was at the hospital.
-Staff went to check Resident #7's room and he was not there and the facility's Director was called.
-She did not see Resident #7 leave the facility.
-She had never known Resident #7 to wander off in the past.
-Resident #7 seemed confused because he always talked about getting out.
-Resident #7 was not receiving any increased supervision checks but staff was told to keep an eye on him.

Interview with a second PCA on 10/08/25 at 2:06pm revealed:
-Resident #7 was in bed and accounted for on 09/02/25 at 10:00pm when her shift started.
-Resident #7 was not there during the 12:00am round because he had already left.

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-Staff was trying to look for him outside and all staff knew he was gone.
-The facility's Director was called after the hospital called.
-She didn't know the resident was confused because no increased checks were in place for the resident.
-A week before Resident #7 wandered off, the resident said he was ready to go home.

Interview with the Director on 09/03/25 at 4:09pm revealed:
-The resident ran out of the building two months ago but did not go anywhere and was sent to the hospital and diagnosed with encephalopathy (a disease that alters brain function).
-Supervision was not increased at that time because he did not go anywhere.
-She received a call from a PCA on 09/03/25 at 2:45am informing her that Resident #7 was found at the magistrate's office by police.
-According to staff, no door alarms were heard by staff.
-She was unsure how the resident left the facility because doors were locked about 10:30pm to 11:00pm.
-She had known the door alarms to malfunction in the past before she became the Director.
-She did not know what was done to repair the previous malfunction of the door alarms because she was not the Director at that time.
-Prior to 09/03/25, Resident #7 did not seem lost within the facility.
-The resident came back from the hospital with a diagnosis of dementia on 09/03/25.
-Resident #7 seemed lost inside the facility on 09/03/25 and she spoke with the resident's PCP about it.
-She was working on placement for the resident.
-Supervision was increased for Resident #7 on

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09/03/25 with a PCA watching him all the time.
-She was unaware the PCP's progress note dated 07/30/25 indicated Resident #7 was exhibiting exit-seeking behaviors and required monitoring because the former Resident Care Coordinator (RCC) nor the resident's PCP did not bring it to her attention.

Interview with a third PCA on 09/24/25 at 12:21pm revealed Resident #7 was severely confused but the PCA had never known him to try to leave the facility before 09/03/25.

Interview with Resident #7's PCP on 09/24/25 at 2:41pm revealed:
-The resident recently went to the hospital for altered mental status and he was different after he returned to the facility.
-The PCP mentioned a higher level of care may be needed but did not document it.

Telephone interview with a family member on 10/08/25 at 9:23am revealed:
-The facility called another family member to inform them that Resident #7 walked away from the facility.
-Resident #7 had never walked away from the facility before but the resident had been telling her that he had to get out of there.
-The family had been trying to find him a place closer to home.

Telephone interview with Resident #7's second family member/guardian on 10/08/25 at 9:31am revealed:
-The resident had dementia with confusion.
-The guardian visited the resident often and knew the resident wanted to relocate.
-The guardian was informed that the resident had wandered away from the facility on 09/03/25

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through another family member.
-The facility did not call the guardian to inform him the resident wandered away from the facility on 09/03/25.

Telephone interview with a third family member on 10/08/25 at 10:09am revealed:
-She was contacted around 3:00am on 09/03/25 about Resident #7 leaving the facility.
-This was not the first time the resident had left the facility, but maybe the second or third time.
-He walked away from the facility about one month prior to 09/03/25 and staff were able to find him.
-During the prior incident, Resident #7 was trying to remain within the facility but opened a facility door and got lost.
-According to the resident, he was headed to a community in his hometown.
-After she was contacted about the resident's wandering on 09/03/25, they asked for permission to place a bracelet (for wanderers).
-She was not the resident's guardian and informed them who the correct guardian was, but they continued to call her.
-The actual guardian provided the facility guardianship paperwork; however, they continued to call her.

Interview with the facility's housekeeper on 10/08/25 at 10:49am revealed:
-Resident #7 walked away from the facility twice.
-The first time he left the facility was about two months ago, he was taken to the hospital, and he did not know where he was.

Interview with the Maintenance Director on 10/08/25 at 11:13am revealed:
-Resident #7 would get lost inside of the facility by walking past his own room.

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-He thought the first time he ever wandered away from the facility was 09/03/25.

Interview with a second MA on 10/08/25 at 11:25am revealed:
-Resident #7 had been acting confused for about a month.
-He would say he was going home and say that he was in another state.
-No checks or supervision were in place for Resident #7.

Second interview with the facility's Director on 10/10/25 at 9:21am revealed:
-Prior to 09/03/25, there were no concerns or reports of Resident #7 exit-seeking.
-She was not aware Resident #7 had been talking about leaving or going home.
-She was shocked to learn the PCP noted on 07/30/25 that Resident #7 was exhibiting exit-seeking behaviors.
-The former RCC should have alerted her that the PCP noted exit-seeking behaviors so that a safety plan could have been developed.
-Door alarms were operable prior to 09/03/25.
-She thought there was some kind of outage on 09/03/25 that affected the door alarms.
-When door alarms sounded, staff were to check to see what was triggering the alarm.

Telephone interview with a former MA on 10/14/25 at 11:00am revealed:
-No increased supervision was put into place for Resident #7.
-She heard from a PCA that Resident #7 was exit-seeking and trying to leave the facility.
-She was never given any direction about the resident's exit-seeking behaviors by the RCC or the facility's Director.
-There was no coordination of care provided to

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D 270	Continued From page 61 staff from leadership. Refer to telephone interview with the facility's contracted PCP on 10/14/25 at 2:03pm. 2. Review of Resident #8's current FL-2 dated 09/24/25 revealed: -Resident #8's level of care was documented as domiciliary/rest home (assisted living). -Diagnoses included dementia - unspecified, headache, syncope, and history of stroke. -The resident was documented as intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #8's Resident Register revealed: -The resident's date of admission was 03/01/24. -The resident's responsible person was documented as "self". -The resident required assistance with bathing, ambulation, and scheduling appointments. -The resident required assistance with shaving as needed (prn) and orientation to time and place prn. -The resident was forgetful, needed reminders, and used a walker for ambulation. Review of Resident #8's current assessment and care plan dated 03/25/25 revealed: -The resident used a walker for ambulation/locomotion. -The resident had right sided weakness. -The resident required supervision with ambulation/locomotion, dressing, and transferring. -The resident required limited assistance with eating, toileting, and dressing. -The resident required extensive assistance with bathing.	D 270		

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-The resident was documented as sometimes disoriented.
-The resident was forgetful and needed reminders.

Review of Resident #8's primary care provider (PCP) progress note dated 02/19/25 revealed diagnosis of dementia with a plan to monitor the resident for safety.

Review of Resident #8's PCP progress note dated 06/13/25 revealed:
-The resident was given a new diagnosis of confusion.
-Staff reported the resident tried to leave the facility, was exit-seeking, and the plan was to monitor his cognition function and behavior.

Review of Resident #8's facility progress note dated 08/02/25 revealed the resident was confused.

Review of Resident #8's facility progress note dated 08/10/25 revealed:
-The resident got up around 11:00pm confused.
-The resident was saying someone woke him up, but no one did.
-The resident laid back down around 12:00am.
-The resident was back up at 3:00am, gave the medication aide (MA) his pants and suspenders to give to someone else.
-The MA returned the resident's pants and suspenders to the resident's room when the resident went back to sleep.

Observation of Resident #8 on 09/16/25 at 10:00am revealed he was being dropped off at the facility by someone in a white pickup truck.

Interview with the facility's Director on 09/16/25 at

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4:30pm revealed Resident #8 walked away from the facility while the Adult Home Specialist (AHS) was in the facility on 09/16/25.

Review of Resident #8's Accident/Incident Report dated 09/16/25 revealed:
-The report was completed by the RCC.
-The resident was brought back to the facility at 9:54am after going for a walk.
-Staff encouraged the resident to stay inside because it started raining.
-The PCP was contacted at 5:39pm.
-The Department of Social Services (DSS) was contacted at 4:55pm.
-The resident's family was contacted at 4:45pm.
-The resident's responsible party asked staff to place an air tag on the resident.
-Staff were to start 30-minute checks on the resident.
-Staff would request the PCP to reassess the resident to see if a higher level of care was needed.

Review of Resident #8's PCP triage note dated 09/16/25 revealed:
-The RCC reported that Resident #8 walked off from the facility and was brought back by a former employee.
-Staff did not know the resident left the facility.
-The resident stated he wanted to go home but eventually calmed down.
-Staff was ordered to "Please look internally if any changes need to be made that could have prevented this patient from walking out of the facility."

Second interview with the facility's Director on 10/10/25 at 8:35am revealed:
-Resident #8 would sit outside alone but there were no concerns that he would try to leave.

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D 270	Continued From page 64 -The incident on 09/16/25 was the only time she was aware that Resident #8 tried to leave the facility. -The resident was placed on 30-minute checks after 09/16/25. -Prior to 09/16/25, there was no need for any special checks or increased supervision for Resident #8. -She was not aware of a PCP progress note dated 06/13/25 indicating Resident #8 tried to leave the facility. -She was not aware that staff reported Resident #8 as "exit-seeking". -The former Resident Care Coordinator (RCC) was responsible for reviewing provider progress notes. -The former RCC should have notified her of Resident #8's 06/13/25 progress note so that a plan could have been developed in June 2025. -Had a safety plan been developed in June 2025 for Resident #8, the 09/16/25 elopement could have been prevented. Interview with Resident #8 on 09/16/25 at 4:55pm revealed the resident went to another town to "the medicine place". Interview with the RCC on 09/16/25 at 5:01pm revealed: -A former employee picked Resident #8 up and brought him back to the facility. -Staff did not know Resident #8 had left the facility. -The RCC informed the facility's Director that the resident was gone at 9:59am. -The RCC was helping the MA pass medications when the resident returned to the facility. -An air tag was placed on the resident when he returned to the facility.	D 270		

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D 270	Continued From page 65 Interview with a MA on 09/16/25 at 5:17pm revealed: -The MA saw that resident #8 was in a white truck with a former employee when she arrived at work. -When Resident #8 returned to the facility, he said that he just wanted to go to the store. -A dietary aide asked the MA to take the resident on a ride in the facility's vehicle to a neighboring town (Resident #8's hometown) to calm him down. Interview with a second MA on 09/18/25 at 12:03pm revealed: -The MA worked the night shift and her shift ended at 6:00am on 09/16/25. -Resident #8 was in bed when he was checked around 5:30am. -Resident #8 had to leave the facility after the MA got off at 6:00am. -Resident #8 had wandered away from the facility before. Interview with a third MA on 09/18/25 at 8:46am revealed: -The MA arrived at work at 6:00am on 09/16/25. -The MA did not know that Resident #8 was gone. -The MA thought she saw Resident #8 walking the halls around 8:00am. -Rounds were being done every 2 hours. -Resident #8 had it in his mind that he wanted to go somewhere. Second interview with the third MA on 10/08/25 at 9:45am revealed: -Prior to 09/16/25, staff were told to keep an eye on Resident #8 because he liked to go outside. -After the resident eloped on 09/16/25, he was placed on 30-minute checks. Interview with a fourth MA on 10/09/25 at 4:50pm	D 270		

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revealed:
-Resident #8 had always been persistent about going to another town or going home.
-Staff would take him for a ride to try to calm him down.
-After the resident tried to leave, facility staff were making sure door alarms were working.
-The two front doors always chimed but the other facility doors did not.
-When door alarms sounded staff were to check to see if anyone was outside or going in and out.
-Some staff would just let the door alarms sound without checking.

Interview with a fifth MA on 10/10/25 at 12:10pm revealed:
-Resident #8 would get in moods and want to go walking.
-Resident #8 was confused and had been on supervision checks before.
-Staff knew that the resident would walk off and he was monitored when he went outside.

Interview with a former employee on 09/18/25 at 11:45am revealed:
-On the morning of 09/16/25, the former employee arrived home and found Resident #8 in his yard.
-The former employee lived within walking distance of the facility.
-The former employee drove Resident #8 back to the facility within 10-15 minutes of finding him.
-Resident #8 had wandered away from the facility before and the facility's Director knew about it.
-The facility's Director knew who the wandering residents were; there were a couple more who wandered.

Interview with a dietary aide on 09/22/25 at 10:43am revealed:

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-Resident #8 had wandered away from the facility at least 3 or 4 times.
-Resident #8 had walked to the road and staff had to try to block him.
-Staff sometimes had to bribe Resident #8 by riding him around or taking him to get food.

Interview with a PCA on 09/19/25 at 1:27pm revealed Resident #8 was confused, memory care level, and likely to get lost.

Interview with a second PCA on 10/08/25 at 1:35pm revealed:
-Staff had to keep an eye out for Resident #8 because he was up all times of the night.
-The resident was not on any specific checks prior to 09/16/25, staff were just keeping an eye out for him.
-The resident was on 30-minute checks, every shift after 09/16/25.

Interview with a third PCA on 10/08/25 at 2:06pm revealed:
-Resident #8 was confused but she had never known him to walk off.
-Resident #8 was not on any special checks or increased supervision.

Interview with a fourth PCA revealed:
-Resident #8 would always try to leave on night shift.
-She was told the resident tried to walk off a couple of times when she started working at the facility.

Telephone interview with a former MA on 10/14/25 at 10:09am revealed:
-Resident #8 tried to walk away from the facility at least 5 times.
-Staff would not always call the Department of

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Social Services (DSS) or law enforcement; they would go find the resident.
-The resident was placed on 30-minute checks after he walked away from the facility in September 2025 but was not on any checks then.

Interview with a resident on 09/18/25 revealed:
-Resident #8 walked away from the facility all the time.
-Staff did not do anything about it because the resident had family down the road.

Interview with a second resident on 09/18/25 revealed Resident #8 walked away from the facility once, but she did not know if Resident #8 got lost.

Interview with a third resident on 10/08/25 revealed:
-Resident #8 would often sit outside on the swing.
-No one would be monitoring the resident when he was sitting on the swing; he sat alone.
-The resident had left the facility more than twice and staff would go get him.

Interview with the facility's housekeeper on 09/18/25 revealed:
-He saw Resident #8 when he came back to the facility on the morning of 09/16/25.
-Resident #8 would sometimes do whatever he wanted to do.

Second interview with the facility's housekeeper on 10/08/25 at 10:49am revealed:
-Resident #8 would sit outside sometimes alone, but someone always knew he was outside.
-Staff was checking on the resident every 15 minutes.

Interview with the facility's PCP on 09/24/25 at

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D 270	Continued From page 69 2:41pm revealed: -Resident #8 would sometimes sit outside. -There had been concerns about his exit-seeking behaviors. -A higher level of care was recommended on 09/17/25. Review of Resident #8's PCP progress note dated 09/17/25 revealed: -Resident #8 eloped from the facility on 09/16/25, but this was not the first incident of elopement indicating a significant risk. -The resident had expressed a desire to go home. -Orders include placement in a secured special care unit (SCU) or a facility with an electronic wandering guard system to prevent further incidents of elopement. Attempted telephone interview with Resident #8's guardian on 10/08/25 at 9:42am was unsuccessful. Refer to telephone interview with the facility's contracted PCP on 10/14/25 at 2:03pm. _____ Telephone interview with the facility's primary care provider (PCP) on 10/14/25 at 2:03pm revealed: -There were safety risks related to Residents #7 and #8 walking away from the facility without staff knowing they were gone because of their dementia diagnoses. -Residents #7 and #8 could get lost, fall without being able to get themselves up due to their ambulatory need for assistive devices, which placed them at risk for serious injury or death. -Residents #7 and #8 were further placed at risk of serious injury if the facility did not know they were gone because the residents were at risk of not receiving ordered medications which could	D 270		

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D 270	Continued From page 70 have caused delirium and stress if they were unable to find their way back. -The location of the facility was a concern because of the hills and curves that Residents #7 and #8 would have to navigate which could have further increased risks of falling without being able to get up and being struck by vehicles, which put them at risk for serious injury or death. _____ The facility failed to ensure two residents were supervised in accordance with their current symptoms of exit-seeking behavior to prevent the residents from leaving the facility without staff's knowledge. Resident #7 who had a diagnosis of dementia with confusion, and was documented as intermittently disoriented and forgetful, and documented as exhibiting exit-seeking left the facility on 09/03/25 without staff's knowledge and was found by local police and taken to the emergency room due to the resident being confused and not knowing where he was in the middle of the night. Resident #8 who had a diagnosis of cognitive decline and was documented as intermittently disoriented, confused, forgetful, and documented as exhibiting exit-seeking behavior prior to leaving the facility on 09/16/25 left the facility without staff's knowledge and was brought back to the facility by a former staff on 09/16/25. The facility's failure put the residents at substantial risk of serious physical harm and death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/25, 09/18/25, and 10/09/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 270		

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 4 of 5 sampled residents (#2, #3, #5, #7) including failing to coordinate and follow up with the primary care provider (PCP) after discharge from the hospital (#5); failing to notify the PCP of a resident returning to the facility smelling of alcohol and mixing it with his medications (#2); failing to coordinate referrals and orders for dermatology, podiatry, and an arterial test to rule out clots (#2); failing to coordinate a neurocognitive referral for a resident exhibiting exit-seeking behaviors who left the facility without staff's knowledge (#7); and failing to obtain labwork to rule out anemia (#3). The findings are: 1. Review of Resident #5's current FL2 dated 06/10/25 revealed: -Diagnoses included hyperlipidemia, hypothyroid and schizoaffective disorder. -Resident #5's recommended level of care was assisted living facility. -Resident #5 was ambulatory and intermittently disoriented. -There was an order for oxygen at 2 liters/minute via nasal cannula.	D 273		

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D 273	Continued From page 72 Review of Resident #5's Resident Register revealed an admission date of 03/13/25. Review of Resident #5's hospital discharge summary dated 09/05/25 revealed: -Her active hospital diagnoses included thrombocytopenia, controlled type 2 diabetes mellitus without complications, no long term current use of insulin, chronic obstructive pulmonary disease (COPD), hypothyroidism, hyperlipidemia, and pe. -Her resolved hospital problems included hyponatremia, septic shock, and acute respiratory failure with hypoxia and hypercapnia. -Resident #5 was started on metformin used to treat high blood sugar levels that were caused by diabetes mellitus) for a hemoglobin A1C of 7.5%. -Supplies were sent to spot check finger stick blood sugars (FSBS) at least once or twice a week. -There was an order for a follow-up with the primary care provider (PCP) in one - two weeks of discharge. -The discharge medication list included the following: -Insulin pen needles to use as directed with insulin up to four times a day as needed. -Lancets used as directed to check blood sugar as directed with insulin 3 times a day and for symptoms of high or low blood sugar. -Glucose monitor as directed used to check blood sugar as directed with insulin 3 times a day for symptoms of high or low blood sugar. -Glucose test strips to use as directed to check blood sugar as directed with insulin 3 times a day and for symptoms of higher low blood sugar. -Prednisone 10 mg take 20 mg 2 tablets with breakfast for two days, then 10 mg 1 tablet with breakfast for two days to start taking on September 6, 2025.	D 273		

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D 273	Continued From page 73 -The following medications were discontinued Divalproex 250 mg (used to treat seizures, and manic episodes associated with bipolar disorder) and Promethazine 25 mg (used to treat nausea and vomiting and to help patients sleep). -There was no physical nor electronic signature of the primary care provider from the hospital on the discharge orders. Review of Resident #5's September 2025 electronic medication administration record (eMAR) revealed: -There were additional diagnoses of COPD and pulmonary disease. -There was an entry for Divalproex 250 mg take 3 tablets (750mg) at bedtime which was documented as administered at 8:00pm on 09/05 - 09/10, 09/12 and 09/15/25 and documented as resident refused at 8:00pm on 09/11, 09/13, and 09/14/25. -There was an entry for Promethazine 25 mg take 1 tablet three times a day which was documented as administered on 09/06 - 09/15/25 at 8:00am, 09/05 - 09/15/25 at 2:00pm, and 09/05-09/10 - 09/12 - 09/15/25 at 8:00pm and documented as resident refused on 09/11/25. -There was an entry for Prednisone 10 mg take 20 mg 2 tablets with breakfast for two days which was documented as administered at 8:00am on 09/06-09/08/25. -There was an entry for Prednisone 10 mg take 1 tablet with breakfast for two days which was documented as administered at 8:00am on 09/06-09/08/25. -There were no entries for insulin or finger stick blood sugars. Review of Resident #5's physicians orders dated 03/26/25 revealed: -There was an order for oxygen at 2 to 3 liters per	D 273		

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minute at bedtime and remove in the AM.
-There was an order for pulse oximetry as needed (PRN) for shortness of breath.
-There was an order for oxygen 2 to 3 liters per minute PRN (no reason was documented).

Interview with the former Resident Care Coordinator (RCC) on 10/14/25 at 1:59pm revealed:
-She had started at the facility about 6-7 months ago as a medication aide (MA) and then as the transporter and then moved to the RCC position.
-Her last day at the facility was 10/02/25 due to low census.
-Resident #5 had been in and out of the hospital, was on oxygen and used a walker to ambulate.
-Residents' discharge orders were reviewed by the medication aide (MA) or the RCC depending on what time the orders came into the facility.
-The orders would be faxed to the pharmacy,
-If there were any questions about any of the orders, they would contact the primary care provider (PCP) to get the orders clarified.
-She did not remember what orders Resident #5 had returned back to the facility with on 09/05/25.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The MAs were supposed to fax the hospital discharge orders to the pharmacy.
-They should clarify any new orders, any changes in previous orders as well as discontinued orders with the primary care provider.
-The orders should contain all the information for the medication like the "rights" of giving the medication such as the right patient, medication, route, time, reason, etc.
-If there was no signature of the hospital provider, the orders were not considered complete orders and would need to be followed up with the PCP to

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verify what she would order for the resident.

Telephone interview with Resident #5's PCP on 10/10/25 at 3:15pm revealed:
-Resident #5 had a history of COPD and she was non-compliant with her inhalers and oxygen.
-She had been admitted to the local hospital in August and was discharged on 09/05/25.
-She was scheduled to be seen by me on my next visit to the facility which was 09/17/25 but she passed before I saw her.
-She did not remember receiving any discharge orders for Resident #5 upon her discharge on 09/05/25.
-Due to the length of time Resident #5 had been out of the facility and in the hospital, she had been discharged from the PCP's system and had not been reentered (readmitted).
-She always liked to see the resident after returning from the hospital so she could review their paperwork from the hospital stay and talk with the resident about in changes in orders.
-She was not aware of Resident #5 was having any problems with her blood sugar but receiving prednisone could have made her blood sugar high.

2. Review of Resident #2's most recent FL-2 dated 07/30/25 revealed diagnoses included head injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction, non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction.

Review of the Resident Register for Resident #2 revealed:
-The resident was his own responsible party.
-The resident was admitted on 01/16/25.

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a. Review of a progress note from Resident #2's primary care provider (PCP) dated 10/01/25 revealed:
-The resident had no history of illicit drug use.
-The resident never used alcohol.
-The resident did not have a power of attorney (POA) or legal guardian.

Review of Resident #2's mental health provider (MHP) progress note dated 07/10/25 revealed the resident had a history of drug and alcohol use in his younger years but stopped around age 25-28.

Interview with a former staff member on 10/14/25 at 11:38am revealed:
-She was concerned that Resident #2 would sign out because he would not come back until 2:00am or 3:00am.
-There were no incidents, but it was a concern.
-Another staff member quit because she was concerned about Resident #2 signing out.
-There was no guideline for staff to know what to do.
-There was no guideline to notify police or responsible party.
-There was one night Resident #2 came in and he was under the influence of alcohol.
-Resident #2 asked for Norco and she did not give it (Norco is a controlled substance medication used to treat pain).
-She could tell Resident #2 was drinking by looking at his eyes, she could smell it, and he asked if she wanted a drink.
-She reported that incident to the Director, but did not enter a progress note.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-She heard staff report Resident #2 was talking about drinking.

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D 273	Continued From page 77 -Staff never reported he returned to the facility under the influence. Telephone interview with Resident #2's PCP on 10/14/25 at 2:14pm revealed: -She would be concerned if Resident #2 was drinking alcohol. -She was concerned that he was on a medication that was advised not to mix with alcohol, she was also concerned that he may be driving a moped under the influence of alcohol. -She was also concerned that the setting of assisted living facility may not be appropriate if he continued to put himself at harm. -She did not recall being made aware that he was drinking, but she had heard speculation that he left to purchase beer. -It was advised not to take Norco with alcohol. -If Resident #2 drank alcohol, the expectation was that she should be notified immediately and she would have sent him to the hospital. -The medical concern with mixing medication and alcohol was that there could be abuse, and it could cause altered mental status, overdose, respiratory complications, cardiovascular complications, and it could cause decreased oxygen to the brain. -There could be stroke, anoxic brain injury with vegetative state, his heart rate could stop and breathing could stop, and it could cause death. b. Review of Resident #2's primary care provider (PCP) office visit records dated 09/03/25 revealed: -There was a concern for possible occlusions in the lower extremities, and an order for arterial ultrasound with ankle-brachial indices (ABIs) of the bilateral lower extremities to rule out occlusions, blood clots, plaque calcification, or any other acute processes.	D 273		

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-The record, which included orders and assessment, was electronically signed by Resident #2's PCP on 09/08/25.

Telephone interview with a radiology provider's office staff on 10/13/25 at 11:45am revealed:
-The provider received a referral from Resident #2's PCP on 10/09/25.
-Resident #2 had an appointment for an ABI test scheduled for 10/15/25 at 11:00am.
-The facility called on 10/09/25 to schedule the appointment.

Telephone interview with the PCP for Resident #2 on 10/10/25 at 1:12pm revealed:
-She thought the ABI test was performed.
-She was concerned that he may have had occlusions that needed stents.
-Occlusions could cause clots, pain, wounds, and amputation.
-Plaques could build up and cause clots.

Second telephone interview with Resident #2's PCP on 10/14/25 at 2:14pm revealed:
-She thought the ABI was done already, but she would have to check.
-The facility should book an appointment within one to two days of notification from the provider.
-If the facility had a delay they should document it and notify the PCP.

Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed the facility should attempt to book appointments about one week after a referral was made.

c. Review of an order sheet for Resident #2 dated 08/06/25 revealed his primary care provider (PCP) made a referral for dermatology for recurrent skin infections and abscesses.

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D 273	Continued From page 79 Interview with Resident #2 on 10/10/25 at 9:56am revealed: -The facility had problems setting up appointments for his skin doctor and cancer doctor. -They were getting around to it now, but it took a while to get referrals. -His dermatology appointment had to be changed from one location to another. Second interview with Resident #2 on 10/13/25 at 5:20pm revealed: -He did not have a skin problem until he was in the hospital. -He tried to get a dermatology appointment once, but it was missed due to his hospitalization. -He had to switch to the current dermatology provider because of a delay in the appointment. -He wanted to see if his skin cancer had come back. Observation of Resident #2 on 10/13/25 at 5:23pm revealed the resident had numerous small round scabs and scars on his upper and lower extremities. Telephone interview with the PCP for Resident #2 on 10/10/25 at 1:12pm revealed she was not sure about the status of the dermatology referral. Interview with the Director on 10/13/25 at 12:05pm revealed: -She thought there was a dermatology appointment for Resident #2 on 11/07/25 at 10:00am. -She called the dermatology clinic to confirm a time, and she learned that the appointment was made for 11/04/25 at 10:30am. -She would take out the dermatology appointment	D 273		

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D 273	Continued From page 80 book entry for 11/07/25. Telephone interview with a representative from Resident #2's dermatology clinic on 10/13/25 at 12:17pm revealed: -An appointment was scheduled for 11/04/25 at 10:30am. -The appointment was made on 09/24/25. -The appointment was made for concerns of patches on the arm and legs. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed the facility should attempt to book referral appointments about one week after a referral was made. Telephone interview with Resident #2's PCP on 10/14/25 at 2:14pm revealed: -The facility should book an appointment within one to two days of notification from the provider. -If the facility had a delay they should document it and notify the PCP. d. Review of a verbal order sheet dated 09/15/25 revealed an order was received from Resident #2's primary care provider (PCP) to schedule him for a podiatry evaluation appointment. Review of documentation from an office visit on 09/17/25 with Resident #2's PCP revealed: -There was a referral to podiatry. -Podiatry was recommended for further evaluation of right heel pain and possible bone spurs. Interview with Resident #2 on 10/13/25 at 5:20pm revealed: -His feet became a concern due to discoloration. -His feet had turned dark but might be a little better now.	D 273		

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D 273	Continued From page 81 Observation of Resident #2's feet on 10/13/25 at 5:22pm revealed: -Both feet had discoloration of possible dirt. -There was a skin crack on the resident's right inner heel. Telephone interview with Resident #2's podiatry provider office staff on 10/13/25 at 11:55am revealed: -An appointment was scheduled for Resident #2 for 11/07/25 at 10:00am -The appointment was made on 10/09/25 at 10:22am by the facility. -The appointment was made for concerns of sore and tender feet. Telephone interview with Resident #2's PCP on 10/14/25 at 2:14pm revealed: -Resident #2's podiatry referral needed to be done in a timely manner and the facility did not have a podiatrist. -A diabetic patient should follow with podiatry for toenails and foot health. -The facility should book an appointment within one to two days of notification from the provider. -If the facility had a delay they should make documentation and report that to the provider. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed the facility should attempt to book referral appointments about one week after a referral was made. 3. Review of Resident #7's current FL-2 dated 07/16/25 revealed: -Diagnoses included metabolic encephalopathy, Vitamin D deficiency, dysarthria, history of cerebrovascular accident (CVA), left arm weakness, and cognitive decline.	D 273		

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D 273	Continued From page 82 -The resident was documented as intermittently disoriented. Review of Resident #7's Resident Register revealed: -The resident's date of admission was 09/30/24. -The resident's responsible person was documented as "self". -The resident was forgetful and needed reminders. -The resident used a walker. Review of Resident #7's current assessment and care plan dated 09/30/24 revealed: -The resident used a walker for ambulation/locomotion. -The resident required limited assistance with ambulation/locomotion and bathing. -The resident required supervision with eating, dressing, and transferring. -The resident was documented as sometimes disoriented. -The resident was forgetful and needed reminders. -The resident required daily mental stimulation. Review of Resident #7's primary care provider (PCP) visit note dated 07/23/25 revealed: -The resident was suspected of having vascular dementia. -Orders included a referral to a neurocognitive specialist for further evaluation. Review of Resident #7's record revealed no documentation of Resident #7 being seen by a neurocognitive specialist. Review of Resident #7's hospital emergency room (ER) after visit summary (AVS) dated 07/27/25 revealed:	D 273		

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-Resident #7 presented to the ER for altered mental status.
-The resident was diagnosed with altered mental status, unspecified type and transient confusion.

Review of Resident #7's PCP progress note dated 07/30/25 revealed:
-The resident was seen by the PCP for ER follow-up.
-The resident was exhibiting a new development of exit-seeking behaviors and required monitoring.

Review of Resident #7's Accident/Incident Report dated 09/03/25 revealed:
-Resident #7 walked away from the facility at 2:30am and was found by police at the magistrate's office.
-He was taken to the hospital by emergency medical services (EMS).

Review of Resident #7's EMS record dated 09/03/25 revealed:
-The responding EMS unit was dispatched to the magistrate's office at 2:18am to check the resident out for law enforcement.
-The resident did not know where he was or how he got there.
-The resident was not oriented to place, time, or event.
-The resident was transported to the hospital where hospital staff informed EMS staff that the resident was a resident at the facility.
-EMS staff transferred the resident's care to ER staff.

Review of Resident #7's hospital ER records dated 09/03/25 revealed:
-The resident was missing from the facility and found by police walking on the side of the road.

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D 273	Continued From page 84 -The resident presented to the ER at 3:21am confused, unable to tell police where he belonged. -The resident had severe dementia as his baseline, unable to provide history. -The resident reported to ER staff he did not know how he ended up there. -The resident was unable to participate in review of systems due to dementia. Interview with Resident #7 on 09/03/25 at 3:15pm revealed: -He did not know where he was going when he left the facility on 09/03/25, he just went somewhere. -He did not know what time it was when he left but stated "it looked pretty late." -It seemed like he was walking in the woods. -He thought he was going to the club with other people. -He did not know which facility door he exited. -He got lost and ended up by the hospital. -Someone brought him back but he did not know who. -He "didn't know where the [expletive] he was". Telephone interview with Resident #7's family member/guardian on 10/08/25 at 9:31am revealed: -The resident had dementia with confusion. -The guardian visited the resident often and knew he wanted to relocate. -The guardian was informed that the resident had wandered away from the facility 09/03/25 through another family member. Interview with the Director on 10/08/25 at 10:59am revealed: -Referral to a neurocognitive specialist was not made by the facility for Resident #7.	D 273		

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-The former Resident Care Coordinator (RCC) was responsible for following up on the order to refer Resident #7 to the specialist.
-Normally, she would check behind the RCC, but she did not know why it was not checked up on.

Second interview with the Director on 10/10/25 at 9:21am revealed:
-She noticed issues with the former RCC not following up on physician's orders.
-She consulted with the Administrator and the facility's owner and the former RCC was demoted and subsequently terminated in August 2025.

Telephone interview with the Administrator on 10/14/25 at 5:43pm revealed:
-The Administrator last visited the facility in March or April of 2025.
-The facility should be attempting to schedule referrals and follow-up on referrals after a week to see if anything further was needed from facility staff.

Telephone interview with Resident #7's PCP on 09/24/25 at 2:41pm revealed:
-Resident #7 was supposed to follow-up with a specialist.
-The PCP did not think the specialist follow-up had been scheduled.

4. Review of Resident #3's current FL-2 dated 02/12/25 revealed:
-Diagnoses included diabetes mellitus, history of hypertension, history of chronic obstructive pulmonary disease (COPD), history of diastolic congestive heart failure, osteoarthritis of both knees, anxiety, and depression.

Review of Resident #3's primary care provider (PCP) visit note dated 07/02/25 revealed an order

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for a complete blood count (CBC) lab test to be done. (A CBC is a common blood test used to diagnose and monitor conditions like anemia and infection.)

Review of Resident #3's provider visit notes, facility progress notes, and lab results revealed:
-There was a CBC completed on 02/18/25 with all test levels in the normal range.
-There was a CBC completed on 05/09/25 with all test levels in the normal range.
-There was no documentation of a CBC being completed as ordered on 07/02/25.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He was not feeling well and had some back pain.
-He thought he had some labwork drawn about 1 to 2 months ago but he was not sure when or what kind of labwork was checked.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The Resident Care Coordinator (RCC) was responsible for ensuring labs were completed as ordered.
-In the absence of an RCC, she was responsible for making sure lab orders were followed.
-The PCP's office usually sent orders for labwork to a contracted lab company and someone from the lab company would come to the facility to obtain the labwork.
-The lab staff usually documented in a log at the facility when they drew labwork.
-She checked the logbook and there was no documentation of a CBC being drawn for Resident #3.
-Resident #3's order to draw a CBC on 07/02/25 was overlooked.

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D 273	Continued From page 87 Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed: -She ordered a CBC for Resident #3 on 07/02/25 because the resident was complaining of feeling cold. -She wanted to check to see if the resident had anemia. -Resident #3's CBC should have been checked as ordered on 07/02/25. -If Resident #3's labwork had been checked and the hemoglobin was low (low hemoglobin may be a sign of blood loss), it could have indicated the resident had a slow bleed. -Resident #3 received blood thinning medication; a slow bleed could have caused increased weakness and blood loss which over time could lead to hospitalization. _____ The facility failed to ensure health care referral and follow-up for 4 of 5 sampled residents. Resident #5's primary care provider (PCP) was not contacted after a hospitalization with discharge paperwork with unclear orders related to the use of oxygen, insulin, and blood sugar checks. Resident #2's PCP was not notified when the resident returned to the facility smelling of alcohol leading to the PCP's concerns that mixing alcohol with the resident's medications could lead to abuse, altered mental status, overdose, respiratory and heart complications, decreased oxygen to the brain, and death. Resident #2 did not have an arterial test to rule out blood clots putting the resident at risk of clots, pain, wounds, and amputation. Resident #7 was not referred to a neurocognitive specialist, had exit-seeking behaviors, left the facility without staff's knowledge, was confused, did not know where he was, and was found and taken by police to the local hospital with symptoms of confusion and dementia. This failure of the facility resulted	D 273		

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D 273	Continued From page 88 in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/10/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 2 of 4 sampled residents (#1, #5) who orders for oxygen therapy (#1, #5) and monitoring oxygen saturations (O2 sats) (#5) and monthly and as needed blood pressures (#1). The findings are: 1. Review of Resident #5's current FL-2 dated 06/10/25 revealed: -Diagnoses included hyperlipidemia, hypothyroid and schizoaffective disorder. -Resident #5's recommended level of care was	D 276		

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assisted living facility.
-Resident #5 was ambulatory and intermittently disoriented.
-There was an order for oxygen at 2 liters/minute via nasal cannula.

Review of Resident #5's September 2025 electronic medication administration record (eMAR) revealed additional diagnoses of chronic obstructive pulmonary disease and pulmonary disease.

Review of Resident #5's Resident Register revealed an admission date of 03/13/25.

Review of Resident #5's physicians orders dated 03/26/25 revealed:
-There was an order for oxygen (O2) at 2 to 3 liters per minute (L/min) /at bedtime and remove in the AM.
-There was an order for pulse oximetry as needed (PRN) for shortness of breath.
-There was an order for oxygen 2 to 3 liters per minute PRN (no reason was documented).

Review of Resident #5's record revealed there was no current care plan available for review.

Interview with a personal care aide (PCA) on 10/10/25 at 10:00am revealed:
-Resident #5 was ambulatory and independent with her activities of daily living (ADLs).
-If she needed any help, she would let you know.
-Resident #5 required supervision with toileting, ambulation, dressing, grooming, transfers, eating and bathing.
-She used her walker and went outside to smoke quite a bit.
-She wore O2 at night but would have it on sometimes during the day.

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-The PCAs would help with vital signs and weights and report them to the MA.
-She was not sure where those were documented.

Telephone interview with a medication aide (MA) on 10/14/25 at 10:10am revealed:
-Resident #5 wore her O2 at night when she went to bed and when she got up in the morning she would take it off.
-Resident #5 would get short of breath at times and need her O2.
-I would help her put on her O2 if she needed help.
-When I checked on her between 3:00am - 4:00am on 09/16/25, I had to get her to put her oxygen back on and had to check her oxygen saturations; it was 89-90%.
-She had not documented the O2 or the O2 sats anywhere.

Interview with the former Resident Care Coordinator (RCC) on 10/14/25 at 1:19pm revealed:
-Things like treatments like O2, O2 sats, Thrombo-Embolic Deterrent (TED) hose or vital signs would be documented in the medication administration record (MAR).
-There were spaces for those on the MAR.

Interview with Resident #5's family member on 10/08/25 at 11:04am revealed:
-Resident #5 had COPD and the facility needed to check her O2 saturations because her O2 sats were going down to the 60's and 70s.
-He told each nurse that he saw that Resident #5's got COPD and they needed to keep checking her O2 levels.
-He even ordered her a "PAP" machine.
-He got it off the delivery truck and brought it out

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there cause he knew it was urgent and that Resident #5 needed it.

Refer to telephone interview with the PCP on 10/10/25 at 3:15pm.

2. Review of Resident #1's current FL-2 dated 08/03/25 revealed:
-Diagnoses included anxiety, basal cell carcinoma of the nose status post rhinotomy (removal of the nose), chronic bilateral low back pain without sciatica, depression, dysphasia, hypertension and irregular heartbeat.
-Resident #1's recommended level of care was assisted living facility.
-Resident #1 was semi-ambulatory and intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 06/12/25.

a. Review of Resident #1's physicians orders dated 08/13/25 revealed there was an order for oxygen (O2) at 2 liters per minute (L/min) via nasal cannula PRN for shortness of breath.

Observation of Resident #1 on 10/08/24 1:19pm revealed:
-The resident was in her bed lying on her back with her head elevated.
-The resident was not wearing a nasal cannula for her oxygen.
-There was an oxygen concentrator present with tubing connected and led to a green plastic bag which enclosed a non-rebreather face mask used to deliver O2.
-There was not a supplemental oxygen cylinder present.

Review of Resident #1's August 2025 electronic

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medication administration records (eMAR) revealed:
-There was an entry for oxygen 2 L/M via nasal cannula as needed for shortness of breath.
-There was no documentation that the O2 had been administered during the month of August.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for oxygen 2 L/M via nasal cannula as needed for shortness of breath.
-There was no documentation that the O2 had been administered during the month of September.

Review of Resident #1's October 2025 eMAR revealed:
-There was an entry for oxygen 2 L/M via nasal cannula as needed for shortness of breath.
-There was no documentation that the O2 had been administered during the month of October.

Telephone interview with a medication aide (MA) on 10/14/25 at 10:10am revealed:
-Resident #1 would get short of breath at times and need her O2 usually if she was upset.
-She believed Resident #1 had medication for her anxiety too.
-She would help Resident #1 put on her O2 if she needed help.
-Resident #1 had a face mask with a bag on the end of the mask.
-She had not documented Resident #1's O2 or the O2 sats anywhere.

b. Review of Resident #1's current FL-2 dated 08/03/25 revealed there was an order for monthly blood pressures and as needed (PRN).

Review of Resident #1's August 2025 electronic

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D 276	Continued From page 93 medication administration records (eMAR) revealed there was no documentation of blood pressure readings during the month of August. Review of Resident #1's September 2025 eMAR revealed there was no documentation of blood pressure readings during the month of September. Review of Resident #1's October 2025 eMAR revealed there was no documentation of blood pressure readings during the month of October. Telephone interview with Resident #1's PCP on 10/10/25 at 3:15pm revealed: -Resident #1 had a diagnosis of hypertension and received blood pressure medication. -It was important to keep a check on her blood pressure to make sure her medication was working or if changes needed to be made. Refer to telephone interview with the PCP on 10/10/25 at 3:15pm. _____ Telephone interview with Resident #1 and Resident #5's PCP on 10/10/25 at 3:15pm revealed: -She had trouble getting things like oxygen (O2) saturations (sats) and vital signs for review on her residents with orders for O2 and vital signs. -She and her company supervisor and medical assistant had a telephone meeting with the facility Director and the Resident Care Coordinator back in June or July in regard to communicating and relaying important information to the providers like vital signs, weights etc. -She continued to have trouble getting that information on residents.	D 276		

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D 280	Continued From page 94	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 3 of 3 sampled residents (#1, #2, #3) with LHPS tasks were completed and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for assistance with positioning and emptying of the urinary catheter bag and cleaning	D 280		

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around the urinary catheter (#3), medication administration through injection (#2, #3), collecting and testing of fingerstick blood sugars (#2, #3), ambulation (#1), transferring (#1), oxygen administration and monitoring (#1, #2) and inhalation medication by machine (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 02/12/25 revealed:
-Diagnoses included diabetes mellitus, history of hypertension, history of chronic obstructive pulmonary disease, history of diastolic congestive heart failure, osteoarthritis of both knees, anxiety, and depression.
-There was an order for Ozempic 2mg/dose inject 2mg subcutaneously once a week. (Ozempic is a once weekly injection used to lower blood sugar and lower the risk of heart and kidney disease.)

Review of Resident #3's primary care provider (PCP) order dated 03/05/25 revealed an order for Lantus insulin inject 4 units subcutaneously, hold if blood sugar is 100 or less. (Lantus is long-acting insulin used to lower blood sugar.)

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 02/05/25.

Review of Resident #3's August 2025 - October 2025 electronic medication administration records (eMARs) revealed:
-There was documentation the resident was administered Ozempic once a week at 8:00am.
-There was documentation the resident was administered Lantus insulin daily at 8:00am.
-There was documentation the resident's blood sugar was checked once daily at 8:00am.

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D 280	Continued From page 96 Review of Resident #3's current assessment and care plan completed 02/05/25 revealed: -The resident was documented as ambulatory with no aide or device documented as needed. -The resident was documented as having limited range of motion in his upper extremities. -The resident was documented as sometimes disoriented, forgetful and needed reminders. -The resident was documented as having an indwelling urinary catheter. -The resident was independent with transfers. -The resident required supervision by staff with eating, toileting, and ambulation. -The resident required limited assistance by staff with bathing, dressing, and grooming. -The resident was documented as insulin dependent and requiring fingerstick blood sugars daily. Observation of Resident #3 on 10/10/25 at 3:23pm revealed: -The resident was in his room walking around independently with a rolling walker. -There resident had a urinary catheter bag with clear, yellow urine. Interview with Resident #3 on 10/10/25 at 3:23pm revealed: -A home health nurse came once a month to change his urinary catheter and it was last changed about 2 weeks ago. -He received an Ozempic injection once a week. -His blood sugar was checked once a day before he received Lantus insulin. Review of Resident #3's licensed health professional support (LHPS) review dated 06/25/25 revealed: -LHPS tasks checked off for Resident #3 included	D 280		

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positioning and emptying the urinary catheter bag and cleaning around the urinary catheter, medication administration through injection, and collecting and testing of fingerstick blood sugars.
-The section for vital signs and weight was blank.
-The section to document the physical assessment was blank.
-There was no physical assessment related to any of the resident's LHPS tasks.
-The section for changes and recommendations to meet the resident's needs was blank.
-The section to indicate if staff was competency validated for the resident's LHPS tasks was blank.
-The LHPS review was signed by the facility's contracted LHPS nurse.

Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 08/13/25 revealed:
-LHPS tasks checked off for Resident #3 included positioning and emptying the urinary catheter bag and cleaning around the urinary catheter, medication administration through injection, and collecting and testing of fingerstick blood sugars.
-The resident's vitals signs and weight were documented as blood pressure 126/60, heart rate 81, respirations 16, temperature 97.9, and weight 281.1 pounds.
-The section to document the physical assessment was blank.
-There was no physical assessment related to any of the resident's LHPS tasks.
-The section for changes and recommendations to meet the resident's needs was blank.
-The section to indicate if staff was competency validated for the resident's LHPS tasks was blank.
-The LHPS review was signed by the facility's contracted PCP, a Family Nurse Practitioner

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D 280	Continued From page 98 (FNP). Refer to telephone interview with the facility's contracted PCP on 10/10/25 at 1:15pm. Refer to interview with the Director on 10/14/25 at 3:04pm. 2. Review of Resident #1's current FL2 dated 08/03/25 revealed: -Diagnoses included anxiety, Basal cell carcinoma of the nose status post rhinotomy (removal of the nose), chronic bilateral low back pain without sciatica, depression, dysphasia, hypertension and irregular heartbeat. -Resident #1's recommended level of care was assisted living facility. -Resident #1 was semi-ambulatory and intermittently disoriented. Review of Resident #1's Resident Register revealed an admission date of 06/12/25. Observation of Resident #1 on 10/08/24 1:19pm revealed: -The resident was in her bed lying on her back with her head elevated. -There was an oxygen concentrator present with tubing connected which led to a green plastic bag which enclosed a non-rebreather face mask used to deliver O2. -There was not a supplemental oxygen cylinder present. -There was a high back recliner chair with wheels present at the foot of her bed. Review of Resident #1's physicians orders dated 08/13/25 revealed there was an order for oxygen (O2) at 2 liters per minute (L/min) via nasal cannula PRN for shortness of breath.	D 280		

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D 280	Continued From page 99 Review of Resident #1's current Licensed Health Professional Support (LHPS) review dated 08/13/25 revealed: -The boxes were checked for transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that requires physical assistance and oxygen administration and monitoring as personal care tasks currently present. -There was no physical assessment documentation related to the LHPS tasks. -There were no physical assessment documentation related to the LHPS tasks, reviews of her health status, progress to care provided, or recommended changes in care. -There was no staff competency validation documented on the form. Telephone interview with the facility's primary care provider (PCP) on 10/10/25 at 3:11pm revealed: -She was asked to sign the LHPS forms on 08/13/25. -She had not performed an assessment on the residents at that time, she only signed and dated the forms. Refer to telephone interview with the facility's contracted PCP on 10/10/25 at 1:15pm. Refer to interview with the Director on 10/14/25 at 3:04pm. 3. Review of Resident #2's most recent FL-2 dated 07/30/25 revealed: -The resident was ambulatory and no assistive device was listed. -Diagnoses included head injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction,	D 280		

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non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction.
-The resident needed continuous oxygen 4L/min
-There was an order for insulin lispro 25 units subcutaneous to be given 15 minutes prior to meals (insulin lispro is injectable short-acting medication used to treat high blood sugar)
-There was an order for insulin glargine 35 units subcutaneous to be given at bedtime (insulin glargine is injectable long-acting medication used to treat high blood sugar).
-There was an order for as needed (PRN) ipratropium-albuterol without specified amount or indication (ipratropium-albuterol is an inhaled medication that can be used to treat certain breathing problems).
-There was an order for PRN budesonide formoterol without specified amount or indication (budesonide formoterol is an inhaled medication that can be used to treat certain breathing problems).

Review of the Resident Register for Resident #2 completed 01/16/25 revealed:
-The resident was his own responsible party
-The resident was admitted on 01/16/25.

Review of Resident #2's Hospital Discharge Paperwork dated 07/30/25 revealed:
-There was an order for a Dexcom G7 sensor (Dexcom G7 sensor can be used to monitor blood sugar).
-There was an order for insulin aspart inject 25 units into the skin 15 minutes before meals (insulin aspart is injectable short-acting medication used to treat high blood sugar).
-There was an order for budesonide formoterol 160-4.5 inhale two puffs into the lungs two times daily.
-There was an order for insulin glargine inject 35

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D 280	Continued From page 101 units into the skin at bedtime. Review of Resident #2's physician orders dated 08/06/25 revealed the resident required 2L of continuous oxygen. Review of a physician's order sheet dated 08/06/25 revealed there was an order for ipratropium-albuterol 0.083% give 3ml via nebulizer every six hours as needed. Observation of the Resident #2's room on 10/10/25 at 3:45pm revealed: -There was an oxygen concentrator which required wall plug in. -There was tubing, nasal cannula, and a mask. Review of Resident #2's most recent Licensed Health Professional Support (LHPS) evaluation dated and signed 08/13/25 revealed: -Personal care tasks included: transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that requires physical assistance, inhalation medication by machine, medication administration through injection, collecting and testing of fingerstick blood samples, and oxygen administration and monitoring. -There was no review of health status and care provided. -There was no physical assessment as related to diagnoses/current condition. -There was no progress to care provided or recommended changes in care. -There were no changes or follow up recommendations to meet the resident's needs. -There was no documentation that staff competency was validated for any of the resident's personal care tasks.	D 280		

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Review of Resident #2's electronic medical administration record (eMAR) for the months of August, September, and October 2025 revealed:
-There was documentation that the resident received medication by inhalation.
-There was documentation that the resident received medication by injection.
-There was documentation that the resident's blood glucose was being monitored.
-There was documentation that the resident had a Dexcom blood glucose monitor.

Interview with Resident #2 on 10/07/25 at 10:40am revealed:
-He received assistance with medications and meals.
-He used an oxygen concentrator, took an inhaler, and used a nebulizer one to two times per week.
-Staff checked his oxygen saturation with a finger probe.

Refer to telephone interview with the facility's contracted PCP on 10/10/25 at 1:15pm.

Refer to interview with the Director on 10/14/25 at 3:04pm.

_____

Telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-This facility was her first assisted living facility.
-The facility's Director requested she sign the resident's licensed health professional support (LHPS) reviews in August 2025.
-She was not given any instructions to complete any information on the LHPS forms other than to sign them.
-The top of the form with the residents' names and the LHPS tasks were already filled out by the

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D 280	Continued From page 103 facility staff when she signed the forms. Interview with the Director on 10/14/25 at 3:04pm revealed: -The previous Resident Care Coordinator (RCC) was responsible for making sure LHPS review were complete and included a physical assessment for each resident's LHPS tasks. -There was no system to check behind the RCC to make sure the LHPS reviews were complete. -She was not aware the LHPS reviews for June 2025 and August 2025 were incomplete. -Since the RCC position was currently vacant, she would be responsible for the LHPS reviews.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 3 sampled residents (#6) who had a physician's order for a mechanical soft diet. The findings are: Review of Resident #6's current FL-2 dated 11/20/24 revealed diagnoses Included hemorrhagic shock, gastrointestinal (GI) bleed, severe protein-calorie malnutrition, history of	D 310		

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D 310	Continued From page 104	D 310		

hypertension, stomach cancer, colon cancer, cerebrovascular disease and cerebrovascular accident (CVA).

Observation of the list of residents on special diets in the kitchen on 10/07/25 at 10:10am revealed Resident #6's diet order was mechanical soft.

Review of Resident #6's Resident Register revealed an admission date of 11/20/24.

Review of Resident #6's physician order dated 12/02/24 revealed a diet order for mechanical soft diet.

Observation of breakfast on 10/08/25 from 7:55am - 8:45am revealed Resident #6 was served grits, scrambled eggs, link sausage and gravy and biscuit.

Review of the menu for mechanical soft diets revealed:
-Meat and meat substitutes recommended moistened ground or cooked meat, poultry, or fish; moist ground or tender meat may be served with gravy or sauce.
-Dry meats, tough meats (such as bacon, sausage, hot dogs, bratwurst) should be avoided.

Interview with a medication aide (MA) on 10/08/25 at 8:01am revealed she did not know what diet Resident #6 had ordered without looking in his record.

Observation of the MA on 10/08/25 at 8:01am revealed she put on gloves and removed the link sausage from Resident #6's tray after being informed by the survey staff that it was not appropriate.

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D 310	Continued From page 105 Interview with the cook on 10/08/25 at 8:03am revealed: -He did not realize the link sausage could not be served whole on a mechanical-soft diet. -He should have reviewed the therapeutic diet menu. -He was responsible for ensuring each resident received their proper diet. -He was concerned if a resident did not receive the proper diet they could possibly choke. Observation of the cook and housekeeping staff on 10/08/25 at 8:04am revealed: -The cook prepared Resident #6 a link sausage diced into ¼" - ½" pieces and placed it in a covered dish. -Staff put on gloves and carried the covered dish of diced link sausage into Resident #6's room and placed it on his tray. Interview with Resident #6's primary care provider (PCP) on 10/10/25 at 3:15pm revealed: -She had concerns of choking and aspirations for residents that did not get served their therapeutic diets as ordered. -She expected the facility to follow therapeutic diets as ordered. Interview with the Director on 10/08/25 at 10:05am revealed: -The breakfast served to Resident #6 on 10/08/25 was not prepared correctly. -She expected the kitchen staff to serve therapeutic diets as ordered. -She had concerns for residents choking if they did not get their therapeutic diets served as ordered.	D 310		

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D 327	Continued From page 106	D 327		
D 327	10A NCAC 13F .0906 (f-3) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services Visting (3) A signout register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure a resident (#2) who left the facility completed the sign out register to include time of return. The findings are: Review of Resident #2's most recent FL-2 dated 07/30/25 revealed diagnoses included head injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction, non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction. Review of the Resident Register for Resident #2 revealed: -The resident was his own responsible party. -The resident was admitted on 01/16/25. -There was a contact person listed with a telephone number and no address. Observation of the men's hallway and rooms on	D 327		

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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 327	Continued From page 107 10/09/25 at 8:10am revealed Resident #2 was not in the facility. Review of the facility's sign out log book on 10/08/25 at 4:16pm revealed there were no sign outs for Resident #2 dated 10/08/25. Review of the facility's sign out log book on 10/09/25 at 8:07am revealed: -Resident #2 was signed out of the facility. -Resident #2 signed the most recent page of the log book and the date written by the signature was 09/08/25. -There was no estimated return time listed for Resident #2 on the sign out dated 09/08/25. -There was a signature in the column for responsible party on the sign out dated 09/08/25. -There was no destination or contact phone number listed on the sign out dated 09/08/25. Observation of hallways and Resident #2's room on 10/14/25 at 9:48am revealed Resident #2 was not in the facility. Review of the facility's sign out log on 10/14/25 at 9:43am revealed Resident #2 was signed out of the facility on 10/14/25 at 9:00am and no expected return time was listed. Review of the facility's sign out log on 10/14/25 at 1:38pm revealed "1140" was written in the expected return time on the log entry dated 10/14/25. Interview with a former staff member on 10/14/25 at 11:38am revealed: -She was concerned that Resident #2 would sign out. -She was worried because he would not come back until 2:00am or 3:00am.	D 327		

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D 327	Continued From page 108 -There were no incidents, but it was a concern. -Another staff member quit because she was concerned about the same thing. -There was no guideline for staff to know what to do. Telephone interview with a second former staff on 10/14/25 at 2:40pm revealed it was Resident #2's right to sign out and leave the facility, but he did not let them know when he would come back. Interview with the Director on 10/09/25 at 4:45pm revealed: -Resident #2 signed himself out as usual 10/08/25. -Resident #2 did not come back, based on the lack of return time. -Resident #2 normally came back in at midnight or a little after if he was out with friends. -She called his contact person at 4:30am. -She knew that Resident #2 had the right to be signed out because he was alert, oriented, and could make decisions. Second interview with the Director on 10/14/25 at 9:45am revealed: -She did not see Resident #2 this morning and did not know when he would be back. -She had just talked with him about completing the log. Third interview with the Director on 10/14/25 at 3:04pm revealed: -She notified the Administrator about the resident leaving the facility recently. -She was responsible for maintaining the sign out logs. -She reminded Resident #2 this morning that he forgot to put a return time on the log.	D 327		

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D 327	Continued From page 109 Telephone interview with the facility's Administrator on 10/14/25 at 4:52pm revealed she was concerned that Resident #2 did not sign out.	D 327		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the immediate notification of the appropriate law enforcement agency and the county Department of Social Services when there was cause for concern about the safety of a resident whose whereabouts were unknown (#2). The findings are: Review of Community Rules and Policies signed by Resident #2 on 01/16/25 revealed: -Residents were required to sign out and sign back in upon return to the facility. -Residents who signed out were to return to the facility no later than 8:30pm.	D 328		

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-Residents were not to sign out or leave the grounds after 8:30pm.
-When arranging for any overnight pass, the resident was to notify the facility in time to arrange for the medication to be packaged and ready.
-If a resident signed out and did not return to the facility as indicated and had not called to notify the facility of their whereabouts and safety, the facility was to notify the police department, local Department of Social Services (DSS), and the responsible party.
-Any resident failing to follow the policy would be asked to find other placement with the assistance of DSS.

Review of Resident #2's most recent FL-2 dated 07/30/25 revealed:
-The recommended level of care was skilled nursing facility (SNF).
-Diagnoses included head injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction, non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction.

Review of the Resident Register for Resident #2 revealed:
-The resident was his own responsible party
-The resident was admitted on 01/16/25.
-There was a resident contact person listed with a telephone number and no address.

Review of a handwritten facility progress note dated 10/08/25 at 4:45am revealed:
-The Director spoke with a resident contact and asked if the resident was out with him.
-The resident contact stated Resident #2 was not with him.
-The contact person stated that resident was with

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another buddy.
-The progress note was signed by the Director.

Interview with the Director on 10/09/25 at 10:15am revealed she contacted Resident #2's resident contact person around 11:00pm last night when the resident did not return.

Second interview with the Director on 10/09/25 at 4:45pm revealed:
-Resident #2 signed himself out as usual yesterday (10/08/25).
-Resident #2 did not come back, based on the lack of return time.
-Resident #2 normally came back in at midnight or a little after if he was out with friends.
-She called his resident contact person at 4:30am.
-The resident contact person told her he was with a friend.
-The resident contact person was not able to give her a phone number to call for Resident #2
-She was not concerned about the absence, but she was concerned Resident #2 got mad last time law enforcement was called.
-When Resident #2 returned, he told her that a friend parked his moped in a fire zone and was ticketed and the moped was impounded.
-She made a note on 10/09/25 at 4:38am (note is dated 10/08/25 at 4:45am).

Review of the facility's sign out log book on 10/09/25 at 8:07am revealed:
-Resident #2 was signed out of the facility.
-Resident #2 signed the log book and the date written by the signature was 09/08/25.
-There was no return time listed for Resident #2.

Observation of the men's hallway and rooms on 10/09/25 at 8:10am revealed Resident #2 was not

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D 328	Continued From page 112 in his room. Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed: -There was 1 oral medication scheduled for administration at 6:00pm that was docuemented as not administered on 10/08/25 with the exception of "out of facilty". -There were 5 oral medications, 1 inhaler and scheduled insulin documented as not administered on 10/08/25 for the 8:00pm dose with the exception of "out of facility". -There was 1 medication scheduled at 12:00am that was documented as not administered on 10/09/25 with the exception of "out of facility". -There was 1 medication scheduled at 6:00am that was documented as not administered on 10/09/25 with the exception of "out of facility". -There were 13 oral medication, 2 inhalers, and insulin documented as not administered on 10/09/25 for the 7:30am/8:00am dose with the exception of "out of facility". Interview with the housekeeping supervisor on 10/09/25 at 8:16am revealed -Resident #2 stayed out with his friends last night. -Resident #2 signed out with his friend. -Resident #2 signed what appeared to be a "9" (September) was supposed to be a "10" (October). -Staff was aware that Resident #2 left with a friend. Observation on 10/09/25 at 8:16am revealed, the housekeeping supervisor changed the "9" (September) to a "10" (October), on Resident #2's entry dated 09/08/25 in the sign out log book. Interview with a personal care aide (PCA) on	D 328		

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D 328	Continued From page 113 10/09/25 at 8:40am -In the morning she made rounds at 8:00am. -She was unaware Resident #2 was gone. -She figured he was in his room because he always was, and nobody said he was out. -Resident #2 always remembered meals and daily tasks. -The resident only required assistance with laundry and room cleaning, and did not require assistance with grooming, bathing, toileting, eating, or dressing. Interview with a medication aide (MA) on 10/09/25 at 8:42am revealed: -Resident #2 was not disoriented and did not have trouble with his memory. -She did not think Resident #2 took his medications with him when he left the facility. -She was aware Resident #2 was not in the building. -The Director told her at shift change that Resident #2 was not in the building. -She did not know where Resident #2 was. -If residents took medications with them when they left the facility, a medication sign out sheet was used, especially if they took narcotics. -If a resident signed out with medications, the resident would take his medication packages in a bag. -When a resident re-entered the facility with medications, she had to check the list to make sure all the medications came back. -The list was kept in the nurses' station. -There was not a sign out list for Resident #2 for 10/08/25. -The resident was not able to self-administer medications to her knowledge. Interview with the Maintenance Director on 10/09/25 at 9:23am revealed:	D 328		

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-He did not know Resident #2 was not in the building.
-He got off around 6:30pm last night (10/08/25).
-Resident #2 was in the facility at dinnertime last night.
-He did not see him after that.
-Resident #2 would sign himself out and told the Director.
-He had not known Resident #2 to leave overnight and not come back.
-The last time he saw Resident #2 was at dinner, but usually the resident left and came back in the same day.
-The Director would call the police every time if Resident #2 was gone overnight.
-Resident #2 did not seem confused.

Interview with Resident #2 on 10/09/25 at 10:03am revealed:
-He was signed out last night and was now signed in.
-He did not want to provide any further information.

Interview with the county Department of Social Services (DSS) adult home specialist (AHS) on 10/13/25 at 12:13pm revealed:
-She was not notified of Resident #2's absence from the facility from 10/08/25 until 10/09/25.
-She learned of his absence when she arrived at the facility on the morning of 10/09/25.
-Staff at the facility did not seem to know he was gone.
-No accident or incident report had been received by the county DSS.

Telephone interview with the local police chief on 10/09/25 at 8:35am revealed:
-A local person was operating Resident #2's moped and was arrested on 10/08/25.

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D 328	Continued From page 115 -Resident #2's moped was impounded at a local tow yard. -The person operating Resident #2's moped reported to police that he was at the local store to buy beer to take back to his home for them to consume, which was where Resident #2 was currently located. -The local person lived in a dwelling with suspected criminal activity with an ongoing police investigation. Second telephone interview with the local police chief on 10/09/25 at 9:46am revealed: -Resident #2 was found by police. -The moped was impounded. -Resident #2 appeared to be in normal condition. Third telephone interview with the local police chief on 10/13/25 at 12:29pm: -The police were notified by the facility that Resident #2 was not in the facility on 10/09/25, after the state surveyors talked with the chief that morning. -They were notified by the facility on 10/09/25 around 9:00am. -The police were aware that the resident was out of the facility when his moped was towed. -He went with the Director of the facility to pick up Resident #2. -When the Director pulled into the police parking lot, she thought Resident #2 was already at the police station. -As soon as they arrived at the house, Resident #2 was leaving out of the front door. Telephone interview with a former staff member on 10/14/25 at 10:53am revealed Resident #2 would tell her where he would go and never went far off when she was working.	D 328		

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Third interview with the Director on 10/09/25 at 9:37am revealed:
-Resident #2 was now in the building.
-Resident #2's moped was impounded because he let a friend use it.
-She notified Resident #2's contact person.
-Resident #2 tried to call last night but the phones were down.

Review of charting notes for Resident #2 revealed:
-There was an entry on 10/09/25 at 9:45am that Resident #2 arrived back inside the facility at 9:30am.
-The entry on 10/09/25 at 9:45am was written by the Director.

Fourth interview with the Director on 10/09/25 at 4:45pm revealed:
-She called authorities on 10/09/25 at 8:30am.
-She spoke to the local police chief on the morning of 10/09/25.
-The contact person for Resident #2 called her to ask if she could go pick him up and gave her the address.
-Resident #2 did not seem to be in any distress and seemed to be fine.
-She was concerned because state surveyors were asking staff where the resident was.
-She knew that Resident #2 had the right to be signed out because he was alert, oriented, and could make decisions.
-She called the police because that was the protocol; he had not come back yet, and that was what the policy said to do.
-The policy she was referring to was the procedure for handling accidents and incidents, when the whereabouts of a resident were unknown.
-There was concern that he was diabetic, on

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oxygen, and used medications.
-The facility was responsible to ensure proper medication and treatment.
-The facility was not responsible for care needs such as oxygen and medications because the liability was not on the facility.
-Resident #2 thought he was going to come back to the facility that evening.
-Resident #2 told her not to send the authorities after him.
-She educated Resident #2 on concerns about local difficulties with phone services and gas services.
-Resident #2 took his medication this morning at his regular scheduled dose time.
-She contacted the PCP this morning through telemed, contacted police this morning, and contacted the responsible party this morning (10/09/25).

Observation of Resident #2 on 10/10/25 at 10:52am revealed:
-He was not wearing his oxygen.
-He walked to a friend's room.
-He complained to his friend that the walk was getting longer and longer.
-He was breathing heavily.
-He reached an arm to the wall to rest.

Fifth interview with the Director on 10/14/25 at 3:04pm revealed:
-Staff would notify her if a resident was missing.
-She was responsible to notify DSS, the resident's responsible party, and local authorities if a resident was missing.
-She notified the Administrator about Resident #2 leaving the facility recently.
-She was responsible for maintaining the sign out logs.

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D 328	Continued From page 118 Telephone interview with the Administrator on 10/14/25 at 4:52pm: -She was concerned that Resident #2 did not sign out. -She was not aware until this interview that the police were involved with Resident #2 on 10/09/25. Telephone interview with the PCP for Resident #2 at 1:12pm on 10/10/25 revealed: -If a resident left with no medications or oxygen then the facility should call at the next medication pass. -Resident #2 was advised to wear oxygen at night, so if was not available to him, the facility should call around 8:00pm to ensure access to medication and oxygen. -If Resident #2 did not have medication and oxygen, the potential impacts could be chest pain, increased risk for heart attack, diabetic ketoacidosis with hospitalization (diabetic ketoacidosis is a serious condition caused when the body does not have enough insulin). -If medications were not administered as ordered related to diabetes care, coronary artery disease, congestive heart failure he could have infection, problems with rapid rate atrial fibrillation (irregular heartbeat), and hospitalization. -She had not observed forgetfulness or disorientation with Resident #2, so she did not have concerns that he would not be able to sign himself out. Attempted telephone interview with the mental health provider (MHP) for Resident #2 on 10/13/25 at 12:50pm was unsuccessful. [Refer to Tag 327 10A NCAC 13F .0906(f)(3) Other Resident Care and Services.]	D 328		

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D 328	Continued From page 119 The facility failed to notify law enforcement and the Department of Social Services when there was reason to be concerned about the safety of a resident (Resident #2) and his whereabouts were unknown. The resident left the facility after dinner on 10/08/25 and did not return until the morning of 10/09/25 when the police chief and facility Director went to pick him up. The resident did not have access to ordered medications and oxygen while he was away from the facility which could have caused cardiovascular, respiratory, or diabetic complications. This failure resulted in substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/13/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 328		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 4 sampled residents (#1, #5) including a nebulizer treatment used for shortness of breath in chronic obstructive pulmonary disease (COPD), a medication used as a sleep aide, a medication to treat nausea and vomiting, and oxygen for shortness of breath and pulse oximetry used to monitor oxygen saturations in the blood and to determine the effectiveness of oxygen treatment (#5), a controlled substance used for pain and eye drops used for dry eyes (#1).

The findings are:

1. Review of Resident #5's current FL2 dated 06/10/25 revealed:
-Diagnoses included hyperlipidemia, hypothyroid and schizoaffective disorder.
-Resident #5's recommended level of care was assisted living facility.
-Resident #5 was ambulatory and intermittently disoriented.

Review of Resident #5's September 2025 electronic medication administration record (eMAR) revealed there were additional diagnoses of chronic obstructive pulmonary disease (COPD) and pulmonary disease.

Review of Resident #5's Resident Register revealed an admission date of 03/13/25.

Resident #5's current care plan was requested but not received prior to exit.

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D 344	Continued From page 121 a. Review of Resident #5's physicians orders dated 03/11/25 revealed there was an order for ipratropium-albuterol (used to treat shortness of breath) to inhale 1 vial every 8 hours as needed (no reason was documented). Review of Resident #5's August eMAR revealed: -There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25. -There was an entry for ipratropium-albuterol to inhale 1 vial every 8 hours as needed (no reason was documented). -There was no documentation that ipratropium-albuterol was administered during the month of August. Review of Resident #5's September eMAR revealed: -There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25. -There was an entry for ipratropium-albuterol to inhale 1 vial every 8 hours as needed (no reason was documented). -There was no documentation that ipratropium-albuterol was administered during the month of September. b. Review of Resident #5's physicians orders dated 03/11/25 revealed there was an order for melatonin 3mg (used as a sleep aid) take 1 tablet by mouth nightly as needed (no reason was documented). Review of Resident #5's August eMAR revealed: -There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25. -There was an entry for melatonin 3mg take 1 tablet by mouth nightly as needed (no reason was documented). -There was no documentation that melatonin was	D 344		

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administered during the month of August.

Review of Resident #5's September eMAR revealed:
-There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25.
-There was an entry for melatonin 3mg take 1 tablet by mouth nightly as needed (no reason was documented).
-There was no documentation that melatonin was administered during the month of September.

c. Review of Resident #5's physicians orders dated 03/21/25 revealed there was an order for promethazine 25mg (used to treat nausea and vomiting and to help patients sleep) take 1 tablet by mouth three times a day as needed (no reason was documented).

Review of Resident #5's August eMAR revealed:
-There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25.
-There was an entry for promethazine 25mg take 1 tablet by mouth three times a day as needed (no reason was documented).
-There was no documentation that promethazine was administered during the month of August.

Review of Resident #5's September eMAR revealed:
-There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25.
-There was an entry for promethazine 25mg take 1 tablet by mouth three times a day as needed (no reason was documented).
-There was no documentation that promethazine was administered during the month of September.

d. Review of Resident #5's physicians orders

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dated 03/26/25 revealed there was an order for pulse oximetry as needed (prn) (no reason was documented).
Review of Resident #5's August eMAR revealed:
-There was documentation that Resident #5 was out of the facility 08/04/25 - 08/31/25.
-There was an entry for pulse oximetry as needed (prn) (no reason was documented).
-There was no documentation that pulse oximetry was done during the month of August.

Review of Resident #5's September eMAR revealed:
-There was documentation that Resident #5 was out of the facility 08/04/25 - 09/05/25.
-There was an entry for pulse oximetry as needed (prn) (no reason was documented).
-There was no documentation that pulse oximetry was done during the month of September.

e. Review of Resident #5's physicians orders dated 03/26/25 revealed here was an order for oxygen 2 to 3 liters per minute prn (no reason was documented).

Review of Resident #5's June eMAR revealed:
-There was an entry resident may use oxygen at 2-3 liters per minute as needed (no reason was documented).
-There was no documentation that oxygen was administered during the month of June.

Review of eCare Triage Note dated 06/07/25 revealed:
-The medication aide (MA) contacted the contracted primary care providers (PCP) after hours team on 06/07/25 at 8:30pm.
-Resident #5's oxygen (O2) saturation (sats) was reading 50.
-Resident #5 was instructed to put on her oxygen

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while the doctor was contacted.
-This entry was on 06/07/25 at 9:06pm.
-Asked what her 02 reading was with oxygen applied, stated she hasn't been on it for long.
-After O2 was administered, the oxygen saturation increased to hey 62.
-No other complaints were voiced by the resident, O2 was on at 2.5 liters.
-The MA was asked to recheck the O2 again since Resident #5 had been at rest and the sats increased to 72% - 75%.
-The MA was instructed to increase the O2 to 4 liters.
-The MA informed triage that Resident #5's O2 machine (O2 concentrator) stopped at 3 liters.
-The triage provider instructed the MA to increase the O2 to 3 liters.
-The triage provider asked "Does she have any treatments on hand to administer?"
-The MA replied, it was given at 8:00pm with her night medications.
-Resident #5's O2 sats were "jumping from 50s to 60s" (fluctuating from 50%-60%).
-The triage provider instructed the MA to send Resident #5 out to local emergency department.

Review of Resident #5's September eMAR revealed:
-There was documentation that Resident #5 was out of the facility 09/01/25 - 09/05/25.
-There was an entry resident may use oxygen at 2-3 liters per minute as needed (no reason was documented).
-There was no documentation that oxygen was administered during the month of September.

Telephone interview with a medication aide (MA) on 10/14/25 at 10:50am revealed:
-She was the only staff working 10:00pm - 6:00am on 09/15/25 - 09/16/25.

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-When she checked on Resident #5 between 3:00am - 4:00am, she had to get her to put her oxygen back on and had to check her oxygen (O2) saturations (sats); it was 89-90%.

Interview with Resident #5's family member on 10/08/25 at 11:04am revealed:
-Resident #5 had COPD and the facility needed to check her O2 saturations because her O2 sats were going down to the 60's and 70s.
-He told each nurse that he saw that Resident #5's got COPD and they needed to keep checking her O2 levels.

2. Review of Resident #1's current FL2 dated 08/03/25 revealed:
-Diagnoses included anxiety, basal cell carcinoma of the nose status post rhinotomy (removal of the nose), chronic bilateral low back pain without sciatica, depression, dysphasia, hypertension and irregular heartbeat.
-Resident #1's recommended level of care was assisted living facility.
-Resident #1 was semi-ambulatory and intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 06/12/25.

a. Review of Resident #1's current FL2 dated 08/03/25 revealed there was an order for morphine sulfate (used to treat severe pain) 100/5mL take (5mg) every 4 hours as needed hospice patient (with no reason given for the need).

Review of Resident #1's September 2025 eMAR revealed there was an entry for morphine sulfate solution take 0.25mL (5mg) every 4 hours as needed hospice patient (with no reason given for

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the need).
-There was documentation that morphine sulfate was administered on 09/02/25.

Review of Resident #1's October 2025 eMAR revealed:
-There was an entry for morphine sulfate solution take 0.25mL (5mg) every 4 hours as needed hospice patient (with no reason given for the need).
-There was no documentation that morphine sulfate was administered during the month of October.

Telephone interview with a medication aide (MA) on 10/14/25 at 10:10am revealed:
-Medications that were ordered to be given as needed should have the reason for them so the MAs would know the reason for administering them.
-Resident #1 would complain of pain at times.
-She did not remember giving Resident #1 her morphine sulfate medication; she gave her the hydrocodone tablets she had ordered for pain.

Interview with the hospice registered nurse (RN) on 10/09/25 at 9:00am revealed she was not sure about the why the morphine order had hospice patient and did not have a reason for administration.

b. Review of Resident #1's current FL2 dated 08/03/25 revealed there was an order for Refresh classic ophthalmic solution (used to treat dry eyes) instill 2 drops in both eyes as needed (with no reason given for the need or the frequency to instill the drops).

Review of Resident #1's September 2025 eMAR revealed:

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D 344	Continued From page 127 -There was an entry for Refresh classic ophthalmic solution (used to treat dry eyes) instill 2 drops in both eyes as needed (with no reason given for the need or the frequency to instill the drops). -There was no documentation that Refresh classic ophthalmic solution was administered during the month of September. Review of Resident #1's October 2025 eMAR revealed: -There was an entry for Refresh classic ophthalmic solution (used to treat dry eyes) instill 2 drops in both eyes as needed (with no reason given for the need or the frequency to instill the drops). -There was no documentation that Refresh classic ophthalmic solution was administered during the month of October. Telephone interview with a medication aide (MA) on 10/14/25 at 10:10am revealed: -Medications that were ordered to be given as needed should have the reason for them so the MAs would know the reason for administering them. -She did not remember Resident #1 complaining of anything regarding her eyes nor ever administering any eye drops.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#9, #10) observed during the medication pass including errors with medications for heart/blood pressure, swelling and excess fluid, chronic obstructive pulmonary disease, seasonal allergies (#10), and constipation (#9); and for 2 of 6 sampled residents (#2, #3) including errors with medications for chronic chest pain, chronic constipation, a blood thinner, insulin, a potassium supplement, and controlled substances for anxiety and moderate to severe pain (#3); and a medication for chronic chest pain and diuretics for congestive heart failure (#2).

The findings are:

1. The medication error rate was 17% as evidenced by 5 errors out of 29 opportunities during the 8:00am medication pass on 10/08/25.

a. Review of Resident #10's current FL-2 dated 09/04/24 revealed diagnoses included acute encephalopathy and schizoaffective disorder.

Review of Resident #10's primary care provider (PCP) order dated 05/14/25 revealed an order for Furosemide 20mg ½ tablet twice a day. (Furosemide is a diuretic used for swelling and excess fluid.)

Review of Resident #10's PCP visit note dated

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D 358	Continued From page 129 07/30/25 revealed: -The resident had chronic kidney disease and retention of urine. -The PCP wanted to transition scheduled Furosemide to an as needed basis due to sufficient urine output. -There was an order to stop scheduled Furosemide 10mg. -There was an order to start Furosemide 10mg every 24 hours as needed (prn). -There was to be monitoring for signs of fluid overload or renal side effects. Observation of the 8:00am medication pass on 10/08/25 revealed: -The medication aide (MA) prepared and administered Furosemide 20mg ½ tablet (10mg) to Resident #10 when she received her other morning medications at 8:51am. -Resident #10 was administered Furosemide 10mg after it was discontinued on 07/30/25. Review of Resident #10's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 20mg take ½ tablet (10mg) twice daily scheduled at 8:00am and 2:00pm. -Lasix 20mg ½ tablet (10mg) was documented as administered twice a day from 10/01/25 - 10/08/25 (8:00am). Observation of Resident #10's medications on hand on 10/08/25 from 1:36pm - 1:46pm revealed: -There was a supply of Furosemide 20mg tablets dispensed on 09/03/25 with instructions to take ½ tablet (10mg) twice daily. -There were 48 of 62 half tablets of Lasix 20mg remaining.	D 358		

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D 358	Continued From page 130 Interview with Resident #10 on 10/08/25 at 12:58pm revealed: -She took Furosemide because of her kidneys. -She had a partial kidney because one of her kidneys collapsed in 2016. -She received Furosemide every day to her knowledge. -She did not know if her PCP had discontinued the Furosemide. -She was urinating "fair" today and she did not have any swelling. Observation of Resident #10 on 10/08/25 at 12:58pm revealed there was no swelling in the resident's lower extremities. Interview with the MA on 10/08/25 at 1:19pm revealed: -She administered Furosemide to Resident #10 that morning because it was on the eMAR and in the medication cart. -She was not aware Resident #10's scheduled Furosemide had been discontinued. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed: -The pharmacy received an order on 07/30/25 to stop Resident #10's scheduled Furosemide and start prn Furosemide. -The pharmacy usually entered orders into the eMAR system but they had to be approved by facility staff for the orders to become active on the eMAR. -He was not sure why Resident #10's scheduled Furosemide order was not discontinued on the eMAR. -The facility had not contacted the pharmacy about Resident #10's Furosemide order.	D 358		

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D 358	Continued From page 131 Interview with the Director on 10/08/25 at 1:51pm revealed: -The Resident Care Coordinator (RCC) or the MAs could send orders to the pharmacy. -The pharmacy usually entered orders into the eMAR system. -Either she, the RCC, or a supervisor had to approve orders in the eMAR system for the orders to become active, including discontinue orders. -She was not sure why Resident #10's Furosemide was still on the eMAR after it was ordered to be discontinued. Telephone interview with Resident #10's PCP on 10/10/25 at 1:15pm revealed: -Resident #10 had stage 3 kidney disease. -Resident #10's scheduled Furosemide should have been discontinued. -Continuing to receive Furosemide could worsen the resident's chronic kidney disease, cause dehydration, decreased appetite, low blood pressure, and increased risk of falls. b. Review of Resident #10's physician's order sheet dated 05/29/25 revealed an order for Ventolin HFA 90mcg inhale 2 puffs 4 times daily as needed (prn) for wheezing or shortness of breath. (Ventolin HFA is a rescue inhaler used to treat symptoms of chronic obstructive pulmonary disease. An oral inhaler should be shaken then exhale to empty lungs; take a deep breath while pressing down on the inhaler; hold breath for 10 seconds to allow the medication to go deep into the lungs; and wait at least 1 minutes between puffs to allow the first puff time to open the airways.) Observation of the 8:00am medication pass on	D 358		

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D 358	Continued From page 132 10/08/25 revealed: -Resident #10 requested her prn Ventolin inhaler be administered. -The medication aide (MA) shook up the Ventolin HFA 90mcg inhaler and handed it to Resident #10. -The MA did not instruct the resident to take a deep breath in and hold her breath after pressing down on the inhaler. -The MA did not instruct the resident to wait one minute between puffs. -The resident pressed the inhaler 2 quick times in a row without breathing in, holding her breath, or waiting between the puffs. -The medication vapors came back out of the resident's mouth. -The medication did not reach the resident's lungs to exert its effect. Review of Resident #10's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Ventolin HFA inhale 2 puffs four times a day as needed for wheezing or shortness of breath. -Ventolin HFA inhaler was documented as administered as needed on 10/06/25 at 7:10pm and 10/08/25 at 8:57am. Observation of Resident #10's medications on hand on 10/08/25 from 1:36pm - 1:46pm revealed: -There was one Ventolin HFA 90mcg inhaler dispensed on 08/29/25. -The instructions were to inhale 2 puffs four times daily as needed for wheezing and shortness of breath. Interview with Resident #10 on 10/08/25 at 12:58pm revealed:	D 358		

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-She used the Ventolin inhaler twice a day if she needed it in the morning and at night.
-She usually took 2 puffs of the inhaler.
-She usually got short of breath when she overexerted herself.

Interview with the MA on 10/08/25 at 1:19pm revealed:
-She did not recall being trained on the proper technique for using inhalers.
-Resident #10 usually did 2 quick puffs in a row of the Ventolin inhaler.
-She was not aware she needed to instruct the resident to take a deep breath in, hold her breath, or wait a minute between puffs.

Interview with the Director on 10/08/25 at 1:51pm revealed the MAs should use proper technique when administering inhalers, including having the resident breathe in and hold breath for a few seconds and waiting a few minutes between puffs.

Telephone interview with Resident #10's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-Resident #10 had chronic obstructive pulmonary disease and was a heavy smoker.
-Not using the correct technique to receive the full dosage of Ventolin inhaler increased the resident's risk of having an exacerbation of chronic obstructive pulmonary disease (COPD) symptoms such as shortness of breath.
-The resident complained about being short of breath at times.

c. Review of Resident #10's nephrology visit note dated 07/09/25 revealed:
-The resident had chronic kidney disease - stage 3b (moderate to severe loss of kidney function).

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D 358	Continued From page 134 -There was an order to start Losartan 25mg daily. (Losartan is primarily used to lower blood pressure and may also be used to protect the kidneys in kidney disease.) Observation of the 8:00am medication pass on 10/08/25 revealed: -The medication aide (MA) prepared and administered medications scheduled for 8:00am to Resident #10 at 8:51am. -The MA did not prepare and administer Losartan 25mg when she administered 8:00am medications to the resident at 8:51am. -The resident did not receive Losartan 25mg as ordered. -The MA clicked on the Losartan on the eMAR as if the medication were administered. Review of Resident #10's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Losartan 25mg 1 tablet daily scheduled at 8:00am. -Losartan 25mg was documented as administered daily from 10/01/25 - 10/08/25. Observation of Resident #10's medications on hand on 10/08/25 from 1:36pm - 1:46pm revealed: -There was a supply of Losartan 25mg tablets dispensed on 09/10/25 with instructions to take 1 tablet daily. -There were 3 of 31 tablets remaining. Interview with Resident #10 on 10/08/25 at 12:58pm revealed: -She had kidney problems, but her kidney provider had retired. -She was not sure if she took Losartan.	D 358		

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Interview with the MA on 10/08/25 at 1:19pm revealed:
-She thought she administered Losartan 25mg to Resident #10 that morning.
-She did not realize she forgot to include Losartan in Resident #10's morning medications today.

Interview with the Director on 10/08/25 at 1:51pm revealed:
-The MAs should read the eMARs and compare them to the medication labels when administering medications.
-The MA should have administered Resident #10's Losartan during the 8:00am medication pass.

Telephone interview with Resident #10's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-Resident #10 had stage 3 kidney disease.
-She was concerned about the resident not receiving the Losartan 25mg as ordered.
-Not receiving Losartan could cause the resident to have elevated blood pressure which could put more strain on the resident's kidneys.

d. Review of Resident #10's triage provider note dated 09/28/25 revealed:
-The resident was complaining of some pain and burning in her left eye with some redness and some puffiness.
-The resident complained of watery drainage in eye, nasal drainage, and cough.
-There was an order for Loratadine 10mg 1 tablet once a day for 7 days. (Loratadine is an antihistamine used to treat allergy symptoms.)

Observation of the 8:00am medication pass on 10/08/25 revealed:
-The medication aide (MA) prepared and

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administered medications scheduled for 8:00am to Resident #10 at 8:51am, including one Loratadine 10mg tablet.
-Loratadine 10mg was not due to be administered beyond the 7 days ordered on 09/28/25.

Review of Resident #10's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Loratadine 10mg 1 tablet once daily for 7 days scheduled at 8:00am.
-Loratadine 10mg was documented as administered on 09/30/25 at 8:00am.

Review of Resident #10's October 2025 eMAR revealed:
-There was an entry for Loratadine 10mg 1 tablet once daily for 7 days scheduled at 8:00am.
-Loratadine 10mg was documented as administered daily from 10/01/25 - 10/06/25 and noted to be discontinued on 10/06/25.
-No Loratadine 10mg was due to be administered after 10/06/25.

Observation of Resident #10's medications on hand on 10/08/25 from 1:36pm - 1:46pm revealed there were no Loratadine 10mg tablets available for administration.

Interview with Resident #10 on 10/08/25 at 12:58pm revealed:
-She usually only received Loratadine as needed for allergy symptoms.
-Her allergy symptoms were "doing pretty good today".

Interview with the MA on 10/08/25 at 1:19pm revealed:
-She administered the last Loratadine 10mg tablet in the bubble card that morning, 10/08/25.

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-She discarded the bubble card and had already taken the trash out.
-She had not noticed Loratadine 10mg was not on Resident #10's eMAR to be administered today.
-She was not sure why there was one tablet of Loratadine 10mg still on hand when the 7 days to administer had already passed.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-The pharmacy received Resident #10's order dated 09/28/25 for Loratadine 10mg 1 tablet daily for 7 days on 09/28/25.
-The pharmacy dispensed 7 Loratadine 10mg tablets on 09/28/25.

Interview with the Director on 10/08/25 at 1:51pm revealed:
-The MAs should read the eMARs and compare them to the medication labels when administering medications.
-The MAs should not administer a medication if it was not on the eMAR or if something did not match.

Telephone interview with Resident #10's primary care provider (PCP) on 10/10/25 at 1:15pm revealed she was not concerned about Resident #10 receiving Loratadine 10mg on 10/08/25.

e. Review of Resident #9's current FL-2 dated 10/08/24 revealed:
-Diagnoses included unspecified cognitive disorder and acute encephalopathy.
-There was an order for Miralax 17 grams (g) once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for

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17g that should be used to measure the dosage at the top of the white section of the inner cap.)

Review of Resident #9's physician's order sheet dated 05/29/25 revealed an order for Miralax mix 17g in suitable liquid and drink once daily.

Observation of the 8:00am medication pass on 10/08/25 revealed:
-The medication aide (MA) retrieved Resident #9's Miralax bottle from the medication cart.
-There was a white inner lining inside of the blue cap on the Miralax bottle.
-There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white inner lining inside the cap.
-The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g dose.
-The MA mixed the Miralax powder in water and gave it to Resident #9 to take with his oral medications at 8:26am.
-The resident drank all the water with Miralax.
-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.
-The resident did not receive the full dosage of Miralax.

Review of Resident #9's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax, mix 17g in suitable liquid and drink once daily scheduled at 8:00am.
-Miralax was documented as administered daily from 10/01/25 - 10/08/25.

Observation of Resident #9's medications on

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D 358	Continued From page 139 hand on 10/08/25 at 12:50pm revealed there was a bottle of Miralax dispensed on 04/08/25 with a directions to mix 17g in suitable liquid and drink once daily. Interview with the MA on 10/08/25 at 12:50pm revealed: -She measured the Miralax dosage using the white inner cap. -She usually measured the Miralax powder below the "17g" marking. -She had not noticed the marking for 17g pointing to the top of the inner white lining of the cap. -She thought the marking for 17g was the groove below the "17g". -Resident #9 had not complained of any issues with constipation. Interview with Resident #9 on 10/08/25 at 12:41pm revealed: -He usually drank all of the water with his morning medications. -He denied any current issues with constipation. Interview with the Director on 10/08/25 at 1:51pm revealed: -The MAs were supposed to use the white inner lining of the Miralax cap to measure the correct dosage. -There was a marking to measure 17 grams imprinted on the white inner lining of the cap. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed the MAs should be aware of how to measure medications to make sure the correct dosages were administered. Telephone interview with Resident #9's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:	D 358		

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D 358	Continued From page 140 -Resident #9 had no recent complaints or issues with constipation. -Not receiving the full dosage of Miralax could cause constipation which could lead to bowel obstruction. 2. Review of Resident #3's current FL-2 dated 02/12/25 revealed diagnoses included diabetes mellitus, history of hypertension, history of chronic obstructive pulmonary disease, history of diastolic congestive heart failure, osteoarthritis of both knees, anxiety, and depression. a. Review of Resident #3's current FL-2 dated 02/12/25 revealed an order for Eliquis 5mg 1 tablet daily. (Eliquis is a blood thinning medication used to prevent blood clots.) Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Eliquis 5mg 1 tablet twice daily. Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg 1 tablet twice daily. -Eliquis was only scheduled once daily at 8:00am. -Eliquis was documented as administered once daily at 8:00am from 07/01/25 - 07/31/25 instead of twice daily as ordered. Review of Resident #3's August 2025 eMAR revealed: -There was an entry for Eliquis 5mg 1 tablet twice daily. -Eliquis was only scheduled once daily at 8:00am. -Eliquis was documented as administered once daily at 8:00am from 08/01/25 - 08/31/25 instead of twice daily as ordered.	D 358		

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D 358	Continued From page 141 Review of Resident #3's September 2025 eMAR revealed: -There was an entry for Eliquis 5mg 1 tablet twice daily scheduled once daily at 8:00am. -Eliquis was documented as administered once daily at 8:00am from 09/01/25 - 09/24/25 instead of twice daily as ordered. -There was a second entry for Eliquis 5mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -Eliquis was documented as administered twice daily from 08/25/25 - 08/30/25, except on 08/30/25 at 8:00am when the resident refused it. Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed: -There was a supply of Eliquis 5mg tablets dispensed on 09/10/25 with instructions to take 1 tablet twice a day. -There were 24 of 60 tablets remaining. Interview with Resident #3 on 10/10/25 at 3:23pm revealed: -He thought he only received Eliquis once a day. -He denied any current symptoms of bruising, bleeding, or blood clots. Interviews with a medication aide (MA) on 10/10/25 at 12:11pm and 2:50pm revealed: -When the MAs administered medications, they were supposed to check the eMAR and medication label 3 times to make sure it matched. -She did not recall noticing any discrepancies with Resident #3's Eliquis. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed: -They had an order for Eliquis 5mg twice a day	D 358		

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dated 07/02/25 for Resident #3.
-They dispensed 62 Eliquis 5mg tablets on 08/04/25.
-They dispensed 60 Eliquis 5mg tablets on 09/03/25.
-They dispensed 62 Eliquis 5mg tablets on 10/02/25.
-The pharmacy entered orders into the eMAR system but the facility had to check the orders and approve the orders for them to become active on the eMAR.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The MAs or the Resident Care Coordinator (RCC) were responsible for sending orders to the pharmacy.
-The pharmacy usually entered orders into the eMAR system.
-Either she, the RCC, or the MAs had to approve orders for the orders to become active on the eMAR system.
-Resident #3's Eliquis should have been administered twice daily.

Telephone interview with Resident #3's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-Resident #3 was supposed to receive Eliquis twice a day because he had cardiac stents.
-Not receiving the correct dosage of Eliquis could increase the resident's risk of blood clots.
-Blood clots could go anywhere in the body, including the heart, brain, lungs and legs.
-Blood clots could cause heart attacks or strokes which could lead to death.

b. Review of Resident #3's cardiology visit note dated 06/25/25 revealed:
-There was an order to increase Isosorbide

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Mononitrate from 30mg ER to 60mg ER every morning. (Isosorbide Mononitrate ER is used to treat chest pain and heart failure.)
-There was an order to start taking Ranexa 500mg 1 tablet twice a day. (Ranexa is used to treat chronic chest pain caused by reduced blood flow to the heart.)
-The resident's primary care provider (PCP) initialed and dated these orders on 07/02/25.

Review of Resident #3's PCP orders dated 07/02/25 revealed:
-There was an order to increase Isosorbide Mononitrate ER from 30mg to 60mg daily.
-There was an order to start Ranexa 500mg twice daily.

Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Isosorbide Mononitrate 30mg ER take 1 tablet once daily scheduled at 8:00am.
-Isosorbide Mononitrate 30mg ER was documented as administered daily at 8:00am from 07/01/25 - 07/31/25.
-There was no entry to increase Isosorbide Mononitrate ER to 60mg daily.
-There was no entry for Ranexa 500mg twice daily and none was documented as administered.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Isosorbide Mononitrate 30mg ER take 1 tablet once daily scheduled at 8:00am.
-Isosorbide Mononitrate 30mg ER was documented as administered daily at 8:00am from 08/01/25 - 08/31/25.
-There was no entry to increase Isosorbide

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D 358	Continued From page 144 Mononitrate ER to 60mg daily. -There was no entry for Ranexa 500mg twice daily and none was documented as administered. Review of Resident #3's September 2025 eMAR revealed: -There was an entry for Isosorbide Mononitrate 30mg ER take 1 tablet once daily scheduled at 8:00am. -Isosorbide Mononitrate 30mg ER was documented as administered daily at 8:00am from 09/01/25 - 09/26/25 except on 09/10/25 and 09/15/25 - 09/17/25 when it was documented as being unavailable. -There was a second entry for Isosorbide Mononitrate ER 60mg once daily scheduled at 8:00am. -Documentation for the administration of Isosorbide Mononitrate ER 60mg started on 09/27/25. -There was an entry for Ranexa 500mg twice daily scheduled at 8:00am and 8:00pm. -The first dosage of Ranexa 500mg was not administered until 09/27/25. Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed: -There was a supply of Isosorbide Mononitrate 60mg tablets dispensed on 09/26/25 with instructions to take 1 tablet daily. -There were 3 of 14 tablets remaining. -There was a second supply of Isosorbide Mononitrate 60mg tablets dispensed on 10/06/25 with instructions to take 1 tablet daily. -There were 14 of 14 tablets remaining. -There was a supply of Ranexa 500mg tablets dispensed on 09/26/25 with instructions to take 1 tablet twice daily. -There were 6 of 28 tablets remaining.	D 358		

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D 358	Continued From page 145 Interview with Resident #3 on 10/10/25 at 3:23pm revealed: -He was not sure which medications he took for his heart. -He had chest pains "once in a while". -He had some Nitroglycerin tablets (used to treat acute chest pains) that he could take when he had chest pains. Interviews with a medication aide (MA) on 10/10/25 at 12:11pm and 2:50pm revealed: -The pharmacy usually entered orders into the eMAR system. -She was not aware there had been a delay in starting Resident #3's Ranexa or increased dosage of Isosorbide Mononitrate. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed: -The pharmacy received Resident #3's order dated 07/02/25 to increase Isosorbide Mononitrate to 60mg once a day on 09/26/25. -They dispensed 14 Isosorbide Mononitrate 60mg tablets on 09/26/25. -They dispensed 60 Isosorbide Mononitrate 60mg tablets on 10/06/25. -The pharmacy received Resident #3's order dated 07/02/25 to start Ranexa 500mg twice daily on 09/26/25. -They dispensed 28 Ranexa 500mg tablets on 09/26/25. -They dispensed 60 Ranexa 500mg tablets on 10/06/25. Interview with the Director on 10/14/25 at 3:04pm revealed: -The MAs or the Resident Care Coordinator (RCC) were responsible for sending orders to the pharmacy.	D 358		

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-Either she, the RCC, or the MAs had to approve orders for the orders to become active on the eMAR system.
-If they were unable to approve an order, they were supposed to contact the pharmacy.
-She was unsure why there was a delay in starting the orders for Ranexa and Isosorbide Mononitrate 60mg for Resident #3.
-The night shift MA was responsible for auditing carts to make sure all medications were available.
-If MAs had a problem getting medications, the MAs were supposed to notify her.

Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed:
-Resident #3's Isosorbide Mononitrate should have been increased as ordered to 60mg daily.
-Resident #3's Ranexa should have been started when ordered.
-Isosorbide Mononitrate and Ranexa cause dilation which helped the blood flow better and decreased chest pain.
-Not receiving Isosorbide Mononitrate and Ranexa as ordered increased further strain on the heart and increased the resident's risk of having a heart attack.

Attempted telephone interview with Resident #3's cardiology provider on 10/14/25 at 9:49am was unsuccessful.

c. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Lorazepam 0.5mg 1 tablet twice a day. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #3's mental health provider (MHP) visit notes dated 07/24/25 revealed:

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-The resident was being seen for generalized anxiety disorder and insomnia.
-The resident reported anxiety and feeling anxious about the "permanence of his current situation".
-The resident reported difficulty sleeping, waking up multiple times during the night and sitting on the edge of the bed.
-The resident attributed this to his "mind not stopping", which the resident believed was related to his anxiety.
-There was an order to increase Lorazepam to 1mg twice a day for anxiety.

Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 07/01/25 - 07/31/25 except documentation was blank with no reason at 8:00pm on 07/08/25.
-There was no entry for Lorazepam 1mg twice daily and none was documented as administered.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 08/01/25 - 08/31/25 except on 08/21/25 at 9:00pm due to the medication being in transit.
-There was no entry for Lorazepam 1mg twice daily and none was documented as administered.

Review of Resident #3's September 2025 eMAR

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D 358	Continued From page 148 revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Lorazepam 0.5mg was documented as administered twice daily from 09/01/25 - 09/30/25 except on 09/29/25 at 9:00pm duet to awaiting pharmacy and on 09/30/25 at 9:00am due to the resident refusing. -There was an entry for Lorazepam 1mg twice daily with documentation from on 09/29/25 - 09/30/25 but none was documented as administered due to awaiting pharmacy. Review of Resident #3's October 2025 eMAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Lorazepam 0.5mg was documented as administered at 9:00am on 10/01/25 and 10/06/25 - 10/09/25. -Lorazepam 0.5mg was documented as administered at 9:00pm on 10/02/25 and 106/25 - 10/09/25. -Lorazepam 0.5mg was documented as not administered at 9:00am on 10/02/25 - 10/05/25 and 10/10/25 due to either resident refused or duplicate order. -Lorazepam 0.5mg was documented as not administered at 9:00pm on 10/01/25 and 10/03/25 - 10/05/25 due to either resident refused or duplicate order. -There was an entry for Lorazepam 1mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Lorazepam 1mg was documented as administered at 9:00am on 10/04/25, 10/05/25, and 10/10/25 and at 9:00pm on 10/02/25 - 10/05/25 and 10/09/25. -Lorazepam 1mg was documented as not being	D 358		

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administered at 9:00am on 10/01/25 - 10/03/25 and 10/06/25 - 10/09/25 due to medication unavailable, awaiting pharmacy.
-Lorazepam 1mg was documented and not being administered at 9:00pm on 10/01/25 and 10/06/25 - 10/08/25.

Review of Resident #3's controlled substance (CS) records for Lorazepam revealed:
-There was a CS record for the supply of Lorazepam 0.5mg dispensed on 09/03/25 with 54 tablets.
-All 54 tablets were documented as administered from 09/06/25 at 8:00pm through 10/06/25 at 8:00pm.
-There was a second CS record for the supply of Lorazepam 0.5mg dispensed on 10/03/25 with 54 tablets.
-There were 7 times that one Lorazepam 0.5mg tablet was documented as administered from 9:00am on 10/07/25 through 9:00am on 10/10/25, leaving a balance of 47 Lorazepam 0.5mg tablets.
-There was no CS record for Lorazepam 1mg tablets and none documented as administered.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 10/03/25 with instructions to take 1 tablet twice daily.
-There were 47 of 54 tablets remaining.
-There were no Lorazepam 1mg tablets available for administration.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He usually received Lorazepam about once a day for anxiety.
-He was not sure what strength of Lorazepam he

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received.
-Lorazepam helped with his anxiety.

Interviews with a medication aide (MA) on 10/10/25 at 12:11pm and 2:50pm revealed:
-She administered Lorazepam 0.5mg to Resident #3 because that was listed on the eMAR and that was the medication available for administration.
-She was not aware the resident was supposed to be receiving Lorazepam 1mg instead of Lorazepam 0.5mg tablets.
-She did not know why Lorazepam 1mg was documented as administered on the eMAR because there were no Lorazepam 1mg tablets for Resident #3.
-She thought it was a documentation error.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-The pharmacy had Resident #3's order dated 06/13/25 for Lorazepam 0.5mg 1 tablet twice a day that they received on 06/13/25.
-They dispensed 54 Lorazepam 0.5mg tablets each on 08/08/25, 09/05/25, and 10/03/25.
-The pharmacy did not receive Resident #3's order dated 07/24/25 to increase Lorazepam to 1mg twice a day until 09/26/25.
-The pharmacy either called or faxed the facility on 09/26/25 because they needed a hard copy of the prescription.
-They never heard back from the facility and never dispensed Lorazepam 1mg tablets for Resident #3.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The MAs or the Resident Care Coordinator (RCC) were responsible for sending orders to the pharmacy.

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-Either she, the RCC, or the MAs had to approve orders for the orders to become active on the eMAR system.
-If they were unable to approve an order, they were supposed to contact the pharmacy.
-Resident #3's Lorazepam should have been increased to 1mg twice a day.
-The night shift MA was responsible for auditing carts to make sure all medications were available.
-If MAs had a problem getting medications, the MAs were supposed to notify her.

Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed:
-Resident #3's Lorazepam should have been increased to 1mg twice a day because the resident was experiencing more anxiety.
-Not increasing the Lorazepam could cause the resident to have increased anxiety and shortness of breath.
-It may have caused the resident to be more irritable or to have more pain from muscle tension caused by anxiety,

Attempted telephone interview with Resident #3's MHP on 10/13/25 at 12:50pm was unsuccessful.

d. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Oxycodone 15mg 1 tablet every 6 hours scheduled, not to exceed 4 times a day. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 15mg 1 tablet every 6 hours scheduled at 12:00am, 6:00am,

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12:00pm, and 6:00pm.
-Oxycodone 15mg was documented as not administered for 3 doses on 08/10/25 at 12:00am, 6:00am, and 12:00pm due to the medication being unavailable and waiting on pharmacy.

Review of Resident #3's controlled substance (CS) record for Oxycodone 15mg revealed:
-There was a CS record for a supply of Oxycodone 15mg dispensed on 07/09/25 for a bubble card with 60 tablets.
-All 60 tablets were documented as administered from 07/25/25 at 6:00pm through 08/09/25 at 6:00pm.
-There was no documentation of any Oxycodone being administered and declined from a CS record on 08/10/25 at 12:00am, 6:00am, and 12:00pm.
-There was a second CS record with 8 Oxycodone 15mg tablets received on 08/10/25 from a backup pharmacy.
-The first dose documented as administered on this supply was 08/10/25 at 6:00pm.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Oxycodone 15mg tablets dispensed on 09/08/25 with instructions to take 1 tablet every 6 hours at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There were 8 of 120 tablets remaining.
-There was a second supply of Oxycodone 15mg tablets dispensed on 10/08/25 with instructions to take 1 tablet every 6 hours
-There were 120 of 120 tablets remaining.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-The facility had run out of his Oxycodone 3 or 4

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times.
-The last time they ran out of the Oxycodone was 3 to 4 weeks ago.
-He had back pain every day.
-When he took the Oxycodone, his pain level would be around 7 or 8 on a 0 to 10 scale.
-When they were out of his Oxycodone and he missed doses, his pain level was 9.5 on a 0 to 10 scale with 10 being the most severe pain.

Interview with a medication aide (MA) on 10/10/25 at 12:11pm revealed:
-If a controlled substance was unavailable, it was probably because they needed a new prescription for it.
-She tried to order controlled substances when there was a 4-to-5-day supply remaining because they needed time to get a new prescription.
-If they ran out of a controlled substance, they could contact the triage provider, but they would only give a short term 3-day supply.
-She did not know why Resident #3 ran out of Oxycodone in August 2025.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-They dispensed 120 tablets of Oxycodone 15mg on 07/09/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 08/12/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 09/08/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 10/08/25 for Resident #3.
-They usually dispensed medication the same day the order was received and delivered it either the same night or the next day.

Interview with the Director on 10/14/25 at 3:04pm

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revealed:
-When a medication got down to 7 to 14 tablets, the MAs were supposed to go into the eMAR system and click to reorder.
-If there were no refills, the pharmacy would notify the facility via phone or fax.
-The MAs were responsible for contacting triage via telemed to get a few days supply of a medication if a resident was out of a medication until the primary care provider (PCP) could send a new order.
-Resident #3 used a pain clinic and the MAs should use the same procedure to reorder his pain medications.
-No resident should run out of any medication.
-The night shift MA was responsible for auditing carts to make sure all medications were available.
-If MAs had a problem getting medications, the MAs were supposed to notify her.

Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed:
-Not receiving scheduled Oxycodone as ordered could cause the resident to have increased pain.
-The facility had 24-hour access to contact her office if refills or a new prescription were needed for any medication.

e. Review of Resident #3's physician's order dated 04/02/25 revealed an order for Oxycodone 15mg 1 tablet every 6 hours as needed (prn) pain, not to exceed 4 times a day. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 15mg 1 tablet

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every 6 hours as needed.
-There were 24 doses of Oxycodone 15mg prn documented as administered from 08/12/25 - 08/19/25.
-There were 8 of 24 doses documented as being administered sooner than every 6 hours prn.
-The dosages ranged from 10 minutes prior to the 6-hour time frame up to 1 hour and 15 minutes prior to the 6-hour time frame.
-For example, Oxycodone 15mg was documented as administered prn on 08/18/25 at 7:21pm and again on 08/19/25 at 12:06am, but it would not have been due to be administered again until 1:21am on 08/19/25.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Oxycodone 15mg tablets dispensed on 09/08/25 with instructions to take 1 tablet every 6 hours at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There were 8 of 120 tablets remaining.
-There was a second supply of Oxycodone 15mg tablets dispensed on 10/08/25 with instructions to take 1 tablet every 6 hours.
-There were 120 of 120 tablets remaining.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He took Oxycodone for back pain.
-He could not recall how often he received prn Oxycodone.
-Oxycodone did not usually cause him to feel oversedated.

Interview with a medication aide (MA) on 10/10/25 at 12:11pm revealed:
-The prn medications should only be administered at the time frame ordered.
-The prn medication should not be administered

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too soon.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The MAs should administer prn medications based on the order on the eMAR.
-The MAs should not administer a prn medication more often than ordered.

Telephone interview with Resident #3's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-Resident #3's prn Oxycodone should not be administered more frequently than every 6 hours as indicated in the order.
-Resident #3 had heart and lung disease and receiving prn Oxycodone too soon could cause respiratory depression, decreasing his ability to breathe on his own.

f. Review of Resident #3's primary care provider (PCP) order dated 03/05/25 revealed an order for Lantus insulin 4 units once a day, hold if blood sugar is 100 or less (<). (Lantus is long-acting insulin used to lower blood sugar in diabetes.)

Review of Resident #3's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus inject 4 units once a day, hold if blood sugar is 100 or less.
-Lantus was scheduled for administration at 8:00am.
-Lantus was documented as administered on 2 of 5 occasions when the resident's blood sugar was 100 or less.
-On 09/14/25, the resident's blood sugar was 98 but staff documented Lantus was administered with an injection site of "L" (left side of body).
-On 09/15/25, the resident's blood sugar was 89

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but staff documented Lantus was administered with an injection site of "L".
-Resident #3's blood sugars ranged from 89 - 276.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He usually received Lantus insulin every day.
-His blood sugar was usually around 100.
-They did not hold his insulin.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-The MAs should administer medications as ordered, including insulin.
-Resident #3's Lantus insulin should be held when the blood sugar was 100 or less.

Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed:
-Resident #3's Lantus should be held if his blood sugar was 100 or less.
-Not holding Lantus as ordered could cause the resident to have low blood sugar, which could lead to a hospitalization.

g. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Lubiprostone 24mcg 1 capsule twice a day with food and water. (Lubiprostone is used to treat chronic constipation and irritable bowel syndrome.)

Review of Resident #3's quarterly medication review dated 08/29/25 revealed:
-The pharmacist noted the resident was receiving duplicate therapy with Linzess and Lubiprostone. (Linzess is used to treat irritable bowel syndrome with chronic constipation. Linzess and Lubiprostone are two different medications with

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the same indication.)
-The pharmacist recommended one of the medications be discontinued.
-The primary care provider (PCP) agreed to the recommendation and ordered to discontinue Lubiprostone on 09/03/25.

Review of Resident #3's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lubiprostone 24mcg 1 capsule twice a day with food and water scheduled at 8:00am and 8:00pm.
-Lubiprostone was documented as administered twice daily from 09/01/25 - 09/30/25 except on 09/30/25 at 8:00am when the resident refused.
-There was no documentation on the eMAR that Lubiprostone had been discontinued on 09/03/25 and the resident continued to receive the medication.

Review of Resident #3's October 2025 eMAR revealed:
-There was an entry for Lubiprostone 24mcg 1 capsule twice a day with food and water scheduled at 8:00am and 8:00pm.
-Lubiprostone was documented as administered twice daily from 10/01/25 - 10/10/25 except on 10/01/25 and 10/09/25 at 8:00pm when the resident refused.
-There was no documentation on the eMAR that Lubiprostone had been discontinued on 09/03/25 and the resident continued to receive the medication.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Lubiprostone 24mcg capsule dispensed on 09/03/25 with instructions to take 1 capsule twice daily with food and water.

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D 358	Continued From page 159 -There were 31 of 60 capsules remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed they never received an order dated 09/03/25 to discontinue Lubiprostone for Resident #3. Interview with Resident #3 on 10/10/25 at 3:23pm revealed: -He was not sure which medication he took for constipation. -He had diarrhea once in a while but he could not remember when he last had diarrhea. -He was currently having issues with constipation. Review of Resident #3's 72-hour acute charting flow sheet dated 09/10/25 on third shift revealed: -Resident #3 was up all night with diarrhea, falling asleep on the toilet. -Staff tried to arouse the resident but he slept almost one hour on the toilet. -Staff continued to offer support and would alert the PCP and responsible party to any changes in care. Interviews with a medication aide (MA) on 10/10/25 at 12:11pm and 2:50pm revealed: -She was not aware Resident #3's Lubiprostone had been discontinued. -They administered Lubiprostone to Resident #3 because it was on the eMAR and available in the medication cart. Interview with the Director on 10/14/25 at 3:04pm revealed: -The MAs or the Resident Care Coordinator (RCC) were responsible for sending orders to the pharmacy. -Either she, the RCC, or the MAs had to approve	D 358		

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orders for the orders to become active on the eMAR system.
-If they were unable to approve an order, they were supposed to contact the pharmacy.
-Orders for discontinued medications would follow the same process.
-The MAs were responsible for removing any discontinued medications from the medication cart.

Telephone interview with Resident #3's PCP on 10/10/25 at 1:15pm revealed:
-Lubiprostone was supposed to be discontinued when she first ordered Linzess (a different medication for constipation).
-Taking the Lubiprostone and Linzess together could have contributed to the resident having episodes of diarrhea.
-She was concerned that taking both medications at the same time could lead to diarrhea, dehydration, abdominal pain, decreased appetite, weight loss, and malnutrition.

h. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Linzess 145mcg 1 capsule once daily. (Linzess is used to treat irritable bowel syndrome with constipation.)

Review of Resident #3's physician's order dated 09/25/25 revealed an order to increase Linzess to 290mcg 1 capsule at least 30 minutes before fist meal of the day on an empty stomach once a day.

Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Linzess 145mcg 1 capsule once daily scheduled at 8:00am.

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-Linzess was documented as not being administered on 08/14/25 due to the medication being unavailable and awaiting pharmacy.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for Linzess 145mcg 1 capsule once daily scheduled at 8:00am.
-Linzess was documented as not being administered on 09/02/25, 09/10/25, 09/13/25, 09/14/25, and 09/18/25 due to the medication being unavailable and awaiting pharmacy.
-Linzess 145mcg was documented as being discontinued on 09/26/25.
-There was a second entry for Linzess 290mcg 1 capsule at least 30 minutes before the first meal of the day on an empty stomach once a day scheduled at 8:00am.
-Documentation for the administration of Linzess 290mcg started on 09/26/25.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Linzess 290mcg capsules with a start date of 09/25/25.
-The instructions were to take 1 capsule at least 30 minutes before the first meal of the day on an empty stomach once a day.
-There was no Linzess 145mcg capsules available for administration.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He was not sure which medication he took for constipation.
-He had diarrhea once in a while but he could not remember when he last had diarrhea.
-He was currently having issues with constipation.

Interview with a medication aide (MA) on

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D 358	Continued From page 162 10/10/25 at 12:11pm revealed: -If a medication was unavailable, it was probably because they needed a new prescription for it. -She tried to order medications when there was a 4-to-5-day supply remaining because they needed time to get a new prescription. -If they ran out of a medication, they could contact the triage provider, but they would only give a short term 3-day supply. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed: -They dispensed 30 Linzess 145mcg tablets on 06/27/25 for Resident #3. -There was no documentation the facility requested a refill for Resident #3's Linzess in July 2025. -They dispensed 30 Linzess 145mcg tablets on 08/16/25 for Resident #3. -They dispensed 30 Linzess 145mcg tablets on 09/10/25 for Resident #3. Interview with the Director on 10/14/25 at 3:04pm revealed: -When a medication got down to 7 to 14 tablets, the MAs were supposed to go into the eMAR system and click to reorder. -If there were no refills, the pharmacy would notify the facility via phone or fax. -No resident should run out of any medication. -The night shift MA was responsible for auditing carts to make sure all medications were available. Telephone interview with Resident #3's primary care provider (PCP) on 10/10/25 at 1:15pm revealed: -Resident #3 was taking a lot of pain medication that could cause constipation.	D 358		

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-Missing doses of Linzess put the resident at increased risk of a bowel obstruction, which could lead to the need for a hospitalization and/or surgery.

i. Review of Resident #3's current FL-2 dated 02/12/25 revealed an order for Potassium Chloride 10mEq 1 tablet twice a day. (Potassium Chloride is used to treat and prevent low potassium levels.)

Review of Resident #3's September 2025 electronic medication administration record (eMARs) revealed:
-There was an entry for Potassium Chloride 10mEq 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-Potassium Chloride 10mEq was documented as not administered at 8:00am on 09/14/25 and 09/15/25 due to the medication being unavailable and awaiting pharmacy.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Potassium Chloride 10mEq tablets dispensed on 09/03/25 with instructions to take 1 tablet twice daily.
-There were 49 of 60 tablets remaining.

Interview with Resident #3 on 10/10/25 at 3:23pm revealed:
-He was not sure how often he received Potassium Chloride.
-He did not know if he had missed any doses of Potassium Chloride.

Interview with a medication aide (MA) on 10/10/25 at 12:11pm revealed:
-If a medication was unavailable, it was probably because they needed a new prescription for it.

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-She tried to order medications when there was a 4-to-5-day supply remaining because they needed time to get a new prescription.
-If they ran out of a medication, they could contact the triage provider, but they would only give a short term 3-day supply.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-They dispensed 62 Potassium Chloride 10mEq tablets on 08/04/25 for Resident #3.
-They dispensed 60 Potassium Chloride 10mEq tablets on 09/03/25 for Resident #3.
-They dispensed 62 Potassium Chloride 10mEq tablets on 10/02/25 for Resident #3.

Interview with the Director on 10/14/25 at 3:04pm revealed:
-When a medication got down to 7 to 14 tablets, the MAs were supposed to go into the eMAR system and click to reorder.
-If there were no refills, the pharmacy would notify the facility via phone or fax.
-No resident should run out of any medication.
-The night shift MA was responsible for auditing carts to make sure all medications were available.

Telephone interview with Resident #3's primary care provider (PCP) on 10/10/25 at 1:15pm revealed:
-Resident #3 needed to receive Potassium Chloride as ordered.
-Missing doses of Potassium Chloride could cause muscle cramping, acute kidney injury, heart arrythmias, or chest discomfort.

3. Review of Resident #2's most recent FL-2 dated 07/30/25 revealed diagnoses included head

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injury, head injury motor vehicle accident, gout, diabetes, asthma, hypertension, myocardial infarction, non-psychotic mental disorder, seizures, chest pain, non-ST elevated myocardial infarction.

Review of the Resident Register for Resident #2 revealed the resident was admitted on 01/16/25.

a. Review of Resident #2's most recent FL-2 dated 07/30/25 at 10:45am revealed an order for Ranolazine 1000mg to be taken twice daily (Ranolazine is a medication for people with chronic chest pain due to heart disease, given to alleviate symptoms, minimize their occurrence, and reduce the risk of heart attack and mortality).

Review of Resident #2's Hospital Discharge Paperwork dated 07/30/25 revealed:
-The resident was to take Ranolazine 500mg twice daily.
-The paperwork included warning that the list had 2 medications that were the same as other medications prescribed.
-There was a warning that Resident #2 might also be taking other medications not listed above.
-There was instruction to talk to the primary care provider (PCP) or prescribing provider if there were any questions about the medication.

Review of an after-visit summary from Resident #2's cardiology provider on 08/27/25 revealed Resident #2 was to stop taking Ranolazine (Ranexa).

Review of Resident #2's cardiology provider's signed letter to the facility regarding medication orders written 09/10/25 revealed:
-The letter was written regarding recent medication changes made to Resident #2's

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regimen during his office visit on 08/27/25.
-Discontinue Ranolazine 500 mg tablet.

Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Ranolazine 1000mg take one tablet twice daily, scheduled at 12:00am and 12:00pm.
-Ranolazine 1000mg was documented as administered twice daily from 08/02/25 to 08/31/25 except on 08/08/25 at 12:00pm (Reason: physically unable to take), 08/24/25 at 12:00am, and 08/27/25 at 12:00pm.
-There were entries for Ranolazine 500mg take one tablet twice daily scheduled for 12:00am and 12:00pm.
-Ranolazine 500mg was documented as administered on 08/06/25 at 12:00pm, 08/08/25 at 12:00am and 12:00pm, 08/08/25 at 12:00am and 08/10/25 at 12:00am.
-Ranolazine 500mg was documented as not administered on 08/01/25 at 12:00pm, 08/08/25 at 12:00pm, 08/09/25 at 12:00pm, and 08/10/25 at 12:00pm with the reason being physically unable to take.
-Ranolazine 500mg was documented as not administered on 08/09/25 at 12:00am with a reason of withheld per DR/RN orders, and 08/11/25 at 12:00am with a reason of withheld per DR/RN orders.

Review of Resident #2's September eMAR revealed:
-There was an entry for Ranolazine 1000mg take one tablet twice daily, scheduled at 12:00am and 12:00pm.
-Ranolazine 1000mg was documented as administered at 12:00am and 12:00pm on 09/01/25-9/04/25, 09/08/25 and 09/10/25, and at

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D 358	Continued From page 167 12:00am on 09/05/25-09/07/25 and 09/09/25. -Ranolazine 1000mg was documented as not administered at 12:00pm on 09/05/25-09/07/25 with reason of withheld per DR/RN orders. Interview with Resident #2 on 10/07/25 at 10:40am revealed he received assistance with medications and meals. Second interview with Resident #2 on 10/10/25 at 9:56am revealed: -He could not be scheduled for open heart surgery until his heart could be built back up with medicines. -He had to wait until medications arrived from the pharmacy in the morning a couple of times, he did not know which medications. Interview with the Director on 10/09/25 at 12:40pm revealed: -The facility did not know about Resident #2's 08/27/25 orders from cardiology. -The normal process for receiving orders was that transport brought in orders, those were given to the Resident Care Coordinator (RCC), the RCC scanned orders to the pharmacy, the pharmacy ensured orders were entered into the eMAR, and the RCC or medication aide (MA) approved new orders on the eMAR. -She did not know where the failure occurred in this process. -There were two situations where the RCC changed hands, and the RCC was removed from this position because orders were missing. Second interview with the Director on 10/14/25 at 3:04pm revealed -Night shift usually made sure orders were received from the pharmacy and put new medications on the cart.	D 358		

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-The MA or RCC were responsible for sending orders to the pharmacy.
-MAs approved orders after the pharmacy entered them.
-Orders should be sent on receipt with no delay.
-Orders to discontinue medication should also be followed by night shift MAs removing the medications from the cart.
-The pharmacist sent recommendations to the RCC, usually sent or given to the RCC and RCC was responsible for following up.
-She was acting as the RCC right now, since October.
-When orders came back from the hospital the MA was to fax all orders to the pharmacy, and if there were old orders they should be clarified.
-Order should have the seven rights in order to administer the medication (the seven rights of medication administration are right patient, right medication, right dose, right time, right route, right reason, right documentation).
-Verbal orders needed to be signed in two days.
-The RCC was responsible to clarify orders.

Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed:
-An FL-2 would typically be clarified with a subsequent medication list.
-She was concerned about medication errors.

Telephone interview with a nurse from Resident #2's cardiology provider's office on 10/14/25 at 9:08 AM revealed:
-Ranolazine 500 milligrams was stopped 08/27/25.
-Ranolazine 1000 milligrams was stopped 07/30/25.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/13/25 at

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2:51pm revealed:
-The pharmacy entered orders based on what they received and facility staff approved these eMAR entries.
-Sixty-two tablets of Resident #2's 500mg Ranolazine were dispensed on 07/01/25, and again on 08/06/25.
-Sixty tablets of Ranolazine 1000mg were dispensed for Resident #2 on 09/03/25.
-There was an order for Ranolazine 500mg twice daily for Resident #2 dated 05/22/25.
-There was an after visit summary for Resident #2 dated 06/24/25, with instructions for Ranolazine 1000mg, but this was not a clear prescription, it was just an after visit summary.
-He did not see orders to discontinue the 500mg Ranolazine or the 1000mg Ranolazine.
-On 7/10/25 there were orders to change the time of day that Ranolazine was given only.
-There was no record of orders to change Resident #2's Ranolazine dosage made on 08/27/25.

Telephone interview with the PCP for Resident #2 at 1:12pm on 10/10/25 revealed:
-Cardiology changed Resident #2's Ranolazine in July and she called to clarify the order.
-She learned he was receiving too much, which could cause bradycardia, falls, hypotension.
-The medication aide notified her of the Ranolazine and she clarified the orders.

b. Review of Resident #2's most recent FL-2 dated 07/30/25 at 10:45am revealed there was an order for Furosemide 40mg to be taken twice daily at 6:00am and 2:00pm (Furosemide is used to treat fluid retention).

Review of Resident #2's Hospital Discharge Paperwork dated 07/30/25 at 12:47pm revealed:

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-The resident was to take Furosemide 40mg once daily.
-The paperwork included warning that the list had 2 medications that were the same as other medications prescribed.
-There was a warning that Resident #2 might also be taking other medications not listed above.
-There was instruction to talk to the primary care provider (PCP) or prescribing provider if there were any questions about the medication.

Review of an after-visit summary from Resident #2's cardiology provider on 08/27/25 revealed:
-Resident #2 was to stop taking Furosemide.
-Instead of Furosemide, he was to start taking Torsemide 20mg once daily. (Torsemide is a diuretic used to treat swelling and remove excess fluid.)
-Resident #2 was to take an extra Torsemide 20mg as needed for any of the following: increased weight by 3 lbs in a day or 5 lbs in a week, worsening shortness of breath, decreased appetite, trouble laying flat or sleeping, worsening fatigue.

Review of Resident #2's cardiology provider's signed letter to the facility regarding medication orders written 09/10/25 revealed:
-The letter was written regarding recent medication changes made to Resident #2's regimen during his office visit on 08/27/25.
-Discontinue Furosemide 20 mg tablet and 40 mg tablet.
-Add Torsemide 20 mg daily (and an additional 20 mg as needed (PRN).

Review of a verbal physician order sheet written for Resident #2 on 09/24/25 revealed Torsemide was ordered to be increased to 40 mg daily for four days and then resumed 20 mg daily.

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D 358	Continued From page 171 Review of an after visit summary dated 09/24/25 from Resident #2's cardiology provider's office revealed Torsemide was ordered to be increased to 40 mg daily for four days and then resumed 20 mg daily. Review of physician documentation dated 10/01/25 revealed: -The previous Torsemide 20mg once daily was discontinued. -There was a new order for Torsemide 20mg take two tablets once a day. Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 40mg take one tablet once daily. -Furosemide 40mg was documented as administered from 08/01/25 to 08/31/25. -There was an entry for Torsemide 20mg take one tablet daily. -Torsemide 20mg was documented as administered daily from 08/28/25 through 08/31/25. Review of Resident #2's September 2025 eMAR revealed: -There was an entry for Furosemide 40mg take one tablet once daily. -Furosemide 40mg was documented as administered 09/01/25, 09/02/25, 09/03/25, 09/04/25, and 09/08/25. -Exceptions for Furosemide 40 mg were written on 09/05/25, 09/06/25, and 09/07/25 with a reason of withheld per DR/RN orders. -Exceptions for Furosemide were written on 09/09/25 and 09/10/25 with a reason that the medication was unavailable.	D 358		

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D 358	Continued From page 172 -There was an entry for Torsemide 20mg take one tablet daily. -Torsemide was documented as administered daily from 09/01/25 through 09/25/25. -There was a second entry for Torsemide 20mg take one tablet daily. -Torsemide 20mg was documented on the second entry as administered one time on 09/30/25. -There was a third entry for Torsemide 20mg take two tablets once daily for four days with a written date of 09/24/25. -Torsemide 20mg two tablets were documented as administered once daily from 09/26/25 through 09/29/25. Review of Resident #2's October 2025 eMAR revealed: -There was an entry for Torsemide 20mg take one tablet once daily. -Torsemide 20 mg one tablet once daily was documented as administered on 10/01/25 and 10/02/25. -There was a second entry for Torsemide 20mg take two tablets once daily. -Torsemide 20mg two tablets once daily was documented as administered from 10/03/25 through 10/08/25 and again on 10/10/25. -There was an exception written for 10/09/25 with a reason that the resident was out of the facility. Observation of Resident #2's medications on hand on 10/09/25 at 8:54pm revealed -There were 34 20mg Torsemide tablets on hand for Resident #2. -The two packages of Torsemide 20mg on hand had instructions for Resident #2 to take one tablet by mouth daily. Interview with Resident #2 on 10/10/25 at 9:56am	D 358		

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revealed:
-He could not be scheduled for open heart surgery until his heart could be built back up with medicines.
-Sometimes he had to wait until medications arrived from the pharmacy in the morning a couple of times, he did not know which medications.

Interview with the Director on 10/09/25 at 12:40pm revealed:
-The facility did not know about Resident #2's 08/27/25 orders from cardiology.
-The normal process for receiving orders was that transport brought in orders, those were given to the Resident Care Coordinator (RCC), the RCC scanned orders to the pharmacy, the pharmacy ensured orders were entered into the eMAR, and the RCC or medication aide (MA) approved new orders on the eMAR.
-She did not know where the failure occurred in this process.
-There were two situations where the RCC changed hands, and the RCC was removed from this position because orders were missing.

Second interview with the Director on 10/14/25 at 3:04pm revealed:
-Night shift usually made sure orders were received from the pharmacy and put new medications on the cart.
-The MA or RCC were responsible for sending orders to the pharmacy.
-MAs approved orders after the pharmacy entered them.
-Orders should be sent on receipt with no delay.
-Orders to discontinue medication should also be followed by night shift MAs removing the medications from the cart.
-The pharmacist sent recommendations to the

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D 358	Continued From page 174 RCC, usually sent or given to the RCC and the RCC was responsible for following up. -She was acting as the RCC right now, since October 2025. -When orders came back from the hospital the MA was to fax all orders to the pharmacy, and if there were old orders they should be clarified. -Verbal orders needed to be signed in two days. -The RCC was responsible for clarifying orders. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed: -An FL-2 would typically be clarified with a subsequent medication list. -She was concerned about medication errors. Telephone interview with a nurse from Resident #2's cardiology provider's office on 10/14/25 at 9:08 AM revealed: -08/27/25 orders were made at the appointment. -Discontinuation of Furosemide and change to Torsemide was made on 08/27/25, ordered at the visit. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/13/25 at 2:51pm revealed: -The pharmacy had dispensed Furosemide 30 tablets, 40mg on 09/03/25 for Resident #2. -The orders for Furosemide were written on 07/02/25 for one 40mg tablet at bedtime and the 20mg tablet was a PRN medication. _____ The facility failed to administer medications as ordered to 2 of 4 residents observed during the medication pass on 10/08/25. Resident #10 received a diuretic that should have been discontinued putting her at risk of worsening kidney disease, dehydration, low blood pressure and increased risk of falls. Resident #10's inhaler	D 358		

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D 358	Continued From page 175 was not administered with the proper technique putting her at risk of exacerbation of chronic obstructive pulmonary disease, including shortness of breath. Resident #9's medication for constipation was not measured correctly, putting him at risk of constipation that could lead to a bowel obstruction. Resident #3, who had heart stents, did not receive the correct dosage of a blood thinner putting him at risk of blood clots which could cause heart attack or stroke and result in death. Resident #3 also had a delay in starting a new medication and a dosage increase of a second medication for chronic chest pain, putting him at risk of heart attack. Resident #3 also missed doses of a controlled substance used for moderate to severe pain, causing an increased pain level and the prn dosage of was administered too close together putting him at risk of respiratory depression. Resident #3's insulin was also not held as ordered putting him at risk of low blood sugar and hospitalization. Resident #3 also received duplicate therapy of two medications for chronic constipation and had diarrhea all night on 09/10/25 and was at put at risk of further diarrhea and dehydration. Resident #2 did not receive medications for chronic chest pain and congestive heart failure as ordered which put him at risk of having atrial fibrillation that could lead to hospitalization. The failure of the facility to administer medications as ordered put the residents at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/24/25 and updated on 10/10/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER	D 358		

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D 358	Continued From page 176 13, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 4 of 5 sampled residents (#1, #3, #4, #6) for documentation of controlled substances for moderate to severe pain (#1, #3, #4, #6) and for anxiety and agitation (#3).	D 367		

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D 367	Continued From page 177 The findings are: 1. Review of Resident #3's current FL-2 dated 02/12/25 revealed diagnoses included diabetes mellitus, history of hypertension, history of chronic obstructive pulmonary disease, history of diastolic congestive heart failure, osteoarthritis of both knees, anxiety, and depression. a. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Lorazepam 0.5mg 1 tablet twice a day. (Lorazepam is a controlled substance used to treat anxiety.) Review of Resident #3's mental health provider (MHP) visit notes dated 07/24/25 revealed: -The resident was being seen for generalized anxiety disorder and insomnia. -The resident reported anxiety and feeling anxious about the "permanence of his current situation". -The resident reported difficulty sleeping, waking up multiple times during the night and sitting on the edge of the bed. -The resident attributed this to his "mind not stopping", which the resident believed was related to his anxiety. -There was an order to increase Lorazepam to 1mg twice a day for anxiety. Review of Resident #3's August 2025 controlled substance records (CSR) for Lorazepam 0.5mg revealed Lorazepam 0.5mg was documented as administered on 60 occasions from 08/01/25 - 08/31/25. Review of Resident #3's August 2025 electronic medication administration record (eMAR)	D 367		

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revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 08/01/25 - 08/31/25 except on 08/21/25 at 9:00pm due to the medication being in transit.
-Lorazepam 0.5mg was documented as administered on the eMAR on 61 occasions from 08/01/25 - 08/31/25.
-Lorazepam 0.5mg was documented as administered on the eMAR on 08/12/25 at 8:00am but it was not documented as administered on the CSR at that time.
-The eMAR did not accurately reflect the administration of Lorazepam 0.5mg.
-There was no entry for Lorazepam 1mg twice daily and none was documented as administered.

Review of Resident #3's September 2025 CSR for Lorazepam 0.5mg revealed Lorazepam 0.5mg was documented as administered on 54 occasions from 09/01/25 - 09/30/25.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 09/01/25 - 09/30/25 except on 09/29/25 at 9:00pm due to awaiting pharmacy and on 09/30/25 at 9:00am due to the resident refusing.
-Lorazepam 0.5mg was documented as administered on the eMAR on 58 occasions from 09/01/25 - 09/30/25.
-Lorazepam 0.5mg was documented as administered on the eMAR on 6 occasions that it

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was not documented as administered on the CSR: 09/03/25, 09/17/25, and 09/24/25 at 8:00am and 09/16/25 and 09/18/25 at 8:00pm.
-The eMAR did not accurately reflect the administration of Lorazepam 0.5mg.
-There was an entry for Lorazepam 1mg twice daily with documentation on 09/29/25 - 09/30/25 but none was documented as administered due to awaiting pharmacy.

Review of Resident #3's October 2025 CSR dated 10/01/25 - 10/10/25 for Lorazepam 0.5mg revealed
-Lorazepam 0.5mg was documented as administered on 17 occasions from 10/01/25 - 10/10/25, leaving a balance of 47 tablets.
-There was no CSR for Lorazepam 1mg tablets, and none was documented as administered.

Review of Resident #3's October 2025 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered at 9:00am on 10/01/25 and 10/06/25 - 10/09/25.
-Lorazepam 0.5mg was documented as administered at 9:00pm on 10/02/25 and 10/06/25 - 10/09/25.
-Lorazepam 0.5mg was documented as not administered at 9:00am on 10/02/25 - 10/05/25 and 10/10/25 due to either resident refused or duplicate order.
-Lorazepam 0.5mg was documented as not administered at 9:00pm on 10/01/25 and 10/03/25 - 10/05/25 due to either resident refused or duplicate order.
-Lorazepam 0.5mg was documented as administered on 10 occasions from 10/01/25 -

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10/10/25 (9:00am).
-Lorazepam 0.5mg was documented as administered on the eMAR on 2 occasions that it was not documented as administered on the CSR: 10/01/25 at 8:00pm and 10/02/25 at 8:00am.
-Lorazepam 0.5mg was documented as administered on the eMAR on 6 occasions that it was not documented as administered on the CSR: 09/03/25, 09/17/25, and 09/24/25 at 8:00am and 09/16/25 and 09/18/25 at 8:00pm
-There was an entry for Lorazepam 1mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 1mg was documented as administered at 9:00am on 10/04/25, 10/05/25, and 10/10/25 and at 9:00pm on 10/02/25 - 10/05/25 and 10/09/25.
-Lorazepam 1mg was documented as not being administered at 9:00am on 10/01/25 - 10/03/25 and 10/06/25 - 10/09/25 due to medication unavailable, awaiting pharmacy.
-Lorazepam 1mg was documented as not being administered at 9:00pm on 10/01/25 and 10/06/25 - 10/08/25.
-The eMAR did not accurately reflect the administration of Lorazepam 0.5mg or Lorazepam 1mg.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 10/03/25 with instructions to take 1 tablet twice daily.
-There were 47 of 54 tablets remaining.
-There were no Lorazepam 1mg tablets available for administration.

Interviews with a medication aide (MA) on 10/10/25 at 12:11pm and 2:50pm revealed:
-She administered Lorazepam 0.5mg to Resident

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#3 because that was listed on the eMAR and that was the medication available for administration.
-She was not aware the resident was supposed to be receiving Lorazepam 1mg instead of Lorazepam 0.5mg tablets.
-She did not know why Lorazepam 1mg was documented as administered on the eMAR because there were no Lorazepam 1mg tablets for Resident #3.
-She thought it was a documentation error.
-She did not know why Resident #3's eMARs did not match documentation on the CSRs for Lorazepam 0.5mg.
-The MAs were supposed to document on the administration of controlled substances on the eMAR and the CSR when the medication was administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-They dispensed 54 Lorazepam 0.5mg tablets each on 08/08/25, 09/05/25, and 10/03/25 for Resident #3.
-The pharmacy did not receive an order dated 07/24/25 to increase Lorazepam to 1mg twice a day for Resident #3 until 09/26/25.
-The pharmacy either called or faxed the facility on 09/26/25 because they needed a hard copy of the prescription.
-They never heard back from the facility and never dispensed Lorazepam 1mg tablets for Resident #3.

Refer to interview with the Director on 10/14/25 at 3:04pm.

b. Review of Resident #3's physician's order sheet dated 07/02/25 revealed an order for Oxycodone 15mg 1 tablet every 6 hours

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scheduled, not to exceed 4 times a day. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's October 2025 controlled substance records (CSR) for Oxycodone 15mg revealed Oxycodone 15mg was documented as administered on 39 occasions from 10/01/25 - 10/10/25 (12:00pm), leaving a balance of 8 tablets.

Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 15mg 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-Oxycodone 15mg was documented as administered 36 times from 10/01/25 - 10/10/25 (12:00pm).
-Oxycodone 15mg was not documented as administered on the eMAR on 10/07/25 at 6:00pm, 10/08/25 at 6:00am, and 10/10/25 at 12:00am but it was documented as administered on those 3 occasions on the CSR.
-The eMAR did not accurately reflect the administration of Oxycodone 15mg.

Observation of Resident #3's medications on hand on 10/10/25 at 2:50pm revealed:
-There was a supply of Oxycodone 15mg tablets dispensed on 09/08/25 with instructions to take 1 tablet every 6 hours at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There were 8 of 120 tablets remaining.
-There was a second supply of Oxycodone 15mg tablets dispensed on 10/08/25 with instructions to take 1 tablet every 6 hours
-There were 120 of 120 tablets remaining.

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Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/13/25 at 2:31pm revealed:
-They dispensed 120 tablets of Oxycodone 15mg on 07/09/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 08/12/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 09/08/25 for Resident #3.
-They dispensed 120 tablets of Oxycodone 15mg on 10/08/25 for Resident #3.
-They usually dispensed medication the same day the order was received and delivered it either the same night or the next day.

Interview with a medication aide (MA) on 10/10/25 at 12:11pm revealed:
-She did not know why Resident #3's eMARs did not match documentation on the CSRs for Oxycodone.
-The MAs were supposed to document on the administration of controlled substances on the eMAR and the CSR when the medication was administered.

Refer to interview with the Director on 10/14/25 at 3:04pm.

2. Review of Resident #1's current FL2 dated 08/03/25 revealed diagnoses included anxiety, basal cell carcinoma of the nose status post rhinotomy (removal of the nose), chronic bilateral low back pain without sciatica, depression, dysphasia, hypertension and irregular heartbeat.

Review of Resident #1's Resident Register revealed an admission date of 06/12/25.

a. Review of Resident #1's current FL2 dated 08/03/25 revealed there was an order for

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morphine sulfate 100/5mL take 0.25mL (5mg) every four hours as needed (prn), with no reason given for administration.

Review of Resident #1's August 2025 electronic medication administration records (eMAR) revealed:
-There was an entry for morphine sulfate 100/5mL take 0.25mL (5mg) every four hours prn, with no reason given for administration.
-The prn morphine sulfate was documented as administered on 4 occasions in August on 08/06/25 at 1:00am, 08/13/25 at 10:00am, 08/27/25 at 8:00pm, and 08/29/25 at 10:00am.
-Documentation for the administration of morphine sulfate on the eMAR did not accurately reflect the administration of morphine sulfate as administered on 08/07/25 at 8:00am, 08/11/25 at 8:00am as documented on the controlled substance records (CSR).

Review of Resident #1's August 2025 CSR there were 6 doses of morphine sulfate documented as administered on the CSR which were 08/06/25 at 1:00am, 08/07/25 at 8:00am, 08/11/25 at 8:00am, 08/13/25 at 10:00am, 08/27/25 at 8:00pm, and 08/29/25 at 10:00am.
-Documentation for the administration of morphine sulfate on the eMAR was not documented as administered on 08/07/25 at 8:00am and 08/11/25 at 8:00am as documented on the CSR.
-This did not accurately reflect the administration of morphine sulfate on the CSR.

Refer to interview with the Director on 10/14/25 at 3:04pm.

b. Review of Resident #1's current FL2 dated 08/03/25 revealed there was an order for

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hydrocodone/APAP 5-325mg take one tablet every four hours as needed (prn) for pain.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for hydrocodone/APAP 5-325mg take one tablet every four hours prn for pain.
-The prn hydrocodone/APAP was documented as administered on 13 occasions from 09/01/25 - 09/30/25.
-There were two times hydrocodone/APAP 5-325mg was documented as administered on 09/04/25 at 4:03am and 3:32pm.
-There was one time that hydrocodone/APAP 5-325mg was documented as administered on 09/08/25 at 6:22pm.
-There were 3 times that hydrocodone/APAP 5-325mg was documented as administered on 09/11/25 at 5:44am, 2:59pm and 7:53pm.
-There were 3 times that hydrocodone/APAP 5-325mg was documented as administered on 09/14/25 at 1:10pm 7:00pm and no time noted for the 3rd dose that had been administered.

Review of Resident #1's September 2025 controlled substance records (CSR) there were 11 doses of morphine sulfate documented as administered on the CSR from 09/01/25 - 09/30/25.
-There was one time hydrocodone/APAP 5-325mg was documented as administered on 09/04/25 at 2:00am.
-There were two times hydrocodone/APAP 5-325mg was documented as administered on 09/11/25 at 2:00pm and 8:00pm.
-There were three times hydrocodone/APAP 5-325mg was documented as administered on 09/14/25 at 3:30am, 1:00pm and 7:00pm.
-There was one time hydrocodone/APAP

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5-325mg was documented as administered on 09/18/25 at 8:00pm.
-There were only 11 doses of hydrocodone/APAP documented as administered on the CS record with 13 doses documented on the eMAR.
-Documentation for the administration of hydrocodone/APAP on the eMAR did not accurately reflect the administration of hydrocodone/APAP on the CS records.

Refer to interview with the Director on 10/14/25 at 3:04pm.

3. Review of Resident #6's current FL-2 dated 11/20/24 revealed:
-Diagnoses included hemorrhagic shock, gastrointestinal (GI) bleed, severe protein-calorie malnutrition, history of hypertension, stomach cancer, colon cancer, cerebrovascular disease and cerebrovascular accident (CVA).
-There was an order for oxycodone 10mg (used to treat moderate to severe pain) 1 tablet every 4 hours as needed (prn) for severe pain.

Review of Resident #6's Resident Register revealed an admission date of 11/20/24.

Review of Resident #6's-controlled substance records (CSR) for oxycodone for August 2025 revealed the prn oxycodone was documented as administered on 72 occasions from 08/01/25 - 08/31/25.
-There were 5 entries for oxycodone 10mg on 08/02/25 at 1:00am, 5:00am, 9:28am 2:35pm, and 8:38pm
-There were 2 entries for oxycodone 10mg on 08/03/25 at 1:00am and 8:38pm.
-There were 2 entries for oxycodone 10mg on 08/04/25 at 12:00am and 8:00am.
-There was 1 entry for oxycodone 10mg on

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D 367	Continued From page 187 08/05/25 at 8:00am. -There were 2 entries for oxycodone 10mg on 08/06/25 at 7:00am and 5:00pm. -There were 4 entries for oxycodone 10mg on 08/07/25 at 12:00am, 8:00am, 8:00 pm, and 12:00am. -There were 2 entries for oxycodone 10mg on 08/08/25 at 5:00am and 8:00pm. -There were 3 entries for oxycodone 10mg on 08/09/25 at 12:00am, 5:00am and 8:00pm. -There was 1 entry for oxycodone 10mg on 08/10/25 at 8:00pm. -There were 2 entries for oxycodone 10mg on 08/11/25 at 8:00am and 11:00pm. -There were 2 entries for oxycodone 10mg on 08/12/25 at 4:00am and 8:00pm. -There were 3 entries for oxycodone 10mg on 08/13/25 at 8:00am, 4:28pm, and 8:00pm. -There were 2 entries for oxycodone 10mg on 08/14/25 at 2:00am and 8:00am. -There was 1 entry for oxycodone 10mg on 08/15/25 at 8:00pm. -There were 5 entries for oxycodone 10mg on 08/16/25 at 12:00am, 5:00am, 8:55am, 1:40pm and 8:38pm. -There were 3 entries for oxycodone 10mg on 08/17/25 at 12:00am, 6:00am and 8:08pm. -There were 4 entries for oxycodone 10mg on 08/18/25 at 12:00am, 5:00am, 9:00am, and 8:00pm. -There were 3 entries for oxycodone 10mg on 08/19/25 at 12:00am, 5:00am, and 8:00pm. -There were 2 entries for oxycodone 10mg on 08/20/25 at 1:55pm and 8:00pm. -There were 3 entries for oxycodone 10mg on 08/21/25 at 12:00am, 8:00am and 3:15pm. -There was 1 entry for oxycodone 10mg on 08/22/25 at 8:00 pm. -There was 1 entry for oxycodone 10mg on 08/23/25 at 8:00 pm.	D 367		

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D 367	Continued From page 188 -There was 1 entry for oxycodone 10mg on 08/24/25 at 8:00 pm. -There were 4 entries for oxycodone 10mg on 08/25/25 at 2:00am, 8:00am, 2:00pm and 8:00pm. -There were 2 entries for oxycodone 10mg on 08/26/25 at 8:00pm and 8:00am. -There was 1 entry for oxycodone 10mg on 08/26/25 at 3:00am. -There were 3 entries for oxycodone 10mg on 08/27/25 at 3:00am and two other times with no times indicated. -There was 1 entry for oxycodone 10mg on 08/27/25 at 8:00pm. -There was 1 entry for oxycodone 10mg on 08/28/25 at 1:00am. -There was 1 entry for oxycodone 10mg on 08/29/25 at 8:00 pm. -There were 2 entries for oxycodone 10mg on 08/30/25 at 2:00am and 2:00pm. -There were 2 entries for oxycodone 10mg on 08/31/25 at 12:00am and 8:00am. Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours as needed (prn) for severe pain. -The prn oxycodone was documented as administered on 48 occasions from 08/01/25 - 08/31/25. -Multiple doses of prn medications given in a day were documented as how many times (2X, 3X, 4X, 5X) doses were given on that date; there were not separate entries for each prn dose documented. -There was an entry for oxycodone 10mg documented as administered three times on 08/02/25.	D 367		

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D 367	Continued From page 189 -There was an entry for oxycodone 10mg documented as administered once on 08/03/25. -There was an entry for oxycodone 10mg documented as administered once on 08/04/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/07/25. -There was an entry for oxycodone 10mg documented as administered once on 08/08/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/09/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/13/25. -There was an entry for oxycodone 10mg documented as administered once on 08/14/25. -There was no entry for oxycodone 10mg documented as administered on 08/15/25. -There was an entry for oxycodone 10mg documented as administered four times on 08/16/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/17/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/18/25. -There was an entry for oxycodone 10mg documented as administered once on 08/19/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/21/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/25/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/27/25. -There was no entry for oxycodone 10mg documented as administered on 08/28/25. -There was an entry for oxycodone 10mg documented as administered twice on 08/31/25. -There were 24 doses of oxycodone documented as administered on the CSR that were not	D 367		

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documented on the August 2025 eMAR.
-Documentation for the administration of oxycodone on the eMAR did not accurately reflect the administration of oxycodone on the CSR.

Refer to interview with the Director on 10/14/25 at 3:04pm.

4. Review of Resident #4's current FL-2 dated 12/03/24 revealed diagnoses included hypertension, congestive heart failure, atrial fibrillation, peripheral vascular disease, depression, right sided hemiplegia, arterial disease, and left diastolic heart failure.

Review of Resident #4's physician order dated 06/11/25 revealed an order for Norco 5-325mg every 6 hours as needed for pain management. (Norco is a controlled substance used to treat moderate to severe pain.)

Review of (Resident #4's October 2025 controlled substance record (CSR) for Norco 5-325mg revealed Norco 5-325mg was documented as administered on 10/08/25 at 8:00pm.

Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Norco 5-325mg take 1 tablet every 6 hours as needed.
-There was no documentation of any Norco 5-325mg being administered to the resident in October 2025.
-The eMAR did not accurately reflect the administration of Norco 5-325mg.

Observations of Resident #4's medications on hand on 10/13/25 at 11:47am revealed
-There was a supply of Norco 5-325mg tablets

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D 367	Continued From page 191 dispensed on 06/11/25 with 3 of 20 tablets remaining. -There was a supply of Norco 5-325mg tablets dispensed on 10/10/25 with 20 of 20 tablets remaining. Refer to interview with the Director on 10/14/25 at 3:04pm. _____ Interview with the Director on 10/14/25 at 3:04pm revealed: -The medication aides (MAs) were supposed to document the administration of controlled substances on the electronic medication administration record (eMAR) and the controlled substance record (CSR) at the same time. -The MAs should document the same information on the CSR as they documented on the eMAR. -Sometimes a MA may have forgotten to sign the CSR and had to return to sign the CSR. -There was no system to check to compare the eMARs and the CSRs to make sure the documentation on the eMARs accurately reflected the administration of controlled substances documented on the CSRs.	D 367		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by:	D 371		

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D 371	Continued From page 192 Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented during medication passes on 10/08/25 by 2 of 2 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering multiple oral medications to residents and an oral inhaler to one resident. The findings are: Review of the facility's Medication Administration Policies and Procedures dated 03/29/23 revealed: -General preparation for medication administration included gathering appropriate materials, cleansing hands, and begin the six rights of medication administration. -After assisting a resident take their medications, the medication aides (MAs) hands were to be cleansed. Review of the facility's undated Bloodborne Pathogens Policies and Procedures revealed: -Universal precautions were to be observed at each facility in order to prevent contact with blood or other potentially infectious materials. -Gloves and an alcohol-based hand rub must be used for all possible contact with bloodborne pathogens and bodily fluids containing blood or where blood may be suspected. -If hands or the skin were visibly dirty, became soiled or contaminated, proper hand washing hygiene should be followed. -Hands were to be sanitized or washed appropriately when each procedure was completed before moving on to the next resident. Observation of a MA administering medications during the 8:00am medication pass on 10/08/25	D 371		

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D 371	Continued From page 193 from 7:45am - 8:14am and 8:45am - 8:56am revealed: -There was a bottle of hand sanitizer on the medication cart. -At 7:45am, the MA opened a drawer of the medication cart, retrieved, and prepared medications for a resident. -The MA did not sanitize or wash her hands prior to preparing medications for the resident. -The MA crushed the medications, put them in applesauce and attempted to feed the medications crushed in applesauce with a plastic spoon to the resident. -The resident refused after multiple attempts. -At 7:50am, the MA walked down the hall to a common bathroom and put the applesauce with crushed medications in the toilet using a plastic spoon. -The MA then flushed the toilet by touching the lever with her bare hands. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared a liquid medication and administered it to a second resident at 8:02am. -The MA prepared multiple oral medications by crushing and putting them in applesauce for the second resident, except one capsule was opened and sprinkled in the applesauce. -At 8:11am, the MA attempted to feed the crushed medications to the second resident multiple times but the resident refused. -At 8:14am, the MA walked down the hall to a common bathroom and put the applesauce with crushed medications in the toilet using a plastic spoon. -The MA then flushed the toilet by touching the lever with her bare hands. -The MA rinsed her hands with water at the	D 371		

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bathroom sink.
-The MA did not wash with soap or sanitize her hands.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-At 8:45am, the MA prepared 14 oral medications for a third resident.
-The MA did not wash or sanitize her hands prior to preparing the medications.
-The MA administered the 14 medications to the third resident at 8:51am and an oral liquid medication at 8:56am.
-The MA administered an oral inhaler to the third resident at 8:55am.
-The MA did not wash or sanitize her hands after administering the oral medications and the inhaler to the third resident.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA continued with the morning medication pass.

Interview with the MA on 10/08/25 at 1:19pm revealed:
-There was hand sanitizer available on the medication carts.
-She did not recall being trained on when to wash and/or sanitize her hands during the medication pass.
-She usually washed or sanitized her hands at the end of the medication pass.

Observation of a second MA administering medications during the 8:00am medication pass on 10/08/25 from 8:20am - 8:32am revealed:
-There was a bottle of hand sanitizer on the medication cart.
-At 8:20am, the MA had just finished

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administering medications to a resident.
-The MA did not wash or sanitize her hands after administering the medications.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA then began preparing medications for a second resident including mixing a powdered medication in water.
-The MA did not sanitize or wash her hands prior to preparing medications for the resident.
-At 8:26am, the MA administered 5 medications to the second resident.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared 7 oral medications for a third resident and administered them to the third resident at 8:32am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not wash or sanitize her hands.
-The MA continued with the morning medication pass.

Interview with the second MA on 10/08/25 at 12:50pm revealed:
-She did not recall having any training on when to wash or sanitize her hands during the medication pass.
-She usually sanitized her hands between each resident and washed her hands after every third resident.
-She forgot to sanitize or wash her hands today, 10/08/25, during the morning medication pass because she was nervous.

Interview with the Director on 10/08/25 at 1:51pm

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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 371	Continued From page 196 revealed: -The MAs should wash or sanitize their hands between each resident during the medication pass. -The MAs could also wear gloves. -She was concerned not washing or sanitizing hands, could cause contamination and passing of germs. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed: -She had a lot of concerns about the MAs not sanitizing or washing their hands. -The MAs should wash their hands between each resident. -It was important for the MAs to wash or sanitize their hands because of cross-contamination. -She knew the MAs needed more training. Telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm revealed: -Not washing or sanitizing hands during the medication pass could put residents at risk of infections. -Residents could get bacterial or fungal infections from contamination. -Residents could also get virus such as COVID-19 or the flu.	D 371		
D 391	10A NCAC 13F .1007 (f) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (f) A dose of any medication prepared for administration and accidentally contaminated or not administered shall be destroyed at the facility according to the facility's policies and procedures.	D 391		

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D 391	Continued From page 197	D 391		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications refused by 2 of 2 residents (#1, #11) observed during the medication pass on 10/08/25 were destroyed and documented in accordance with the facility's policies and procedures.

The findings are:

Review of the facility's Medication Disposition Policies and Procedures dated 03/29/23 revealed:
-Any medication contaminated or not administered may be destroyed in the facility by flushing the medication in the toilet.
-Documentation should reflect actions taken.
-A record of medications destroyed will be maintained.

1. Review of Resident #1's current FL-2 dated 08/03/25 revealed diagnoses included dysphagia, anxiety, depression, irregular heartbeat, hypertension, and chronic bilateral low back pain.

Observation of the 8:00am medication pass on 10/08/25 revealed:
-At 7:45am, the medication aide (MA) prepared two Dulcolax 5mg tablets (for constipation); two Buspar 10mg tablets (antidepressant); one Zyrtec 5mg tablet (antihistamine); one Lisinopril 10mg tablet (lowers blood pressure); one Zyprexa 10mg tablet (antipsychotic), and one Lorazepam 1mg tablet (for anxiety) for administration Resident #1.
-The MA crushed all the medications and mixed them in applesauce.
-Resident #1 refused to take the crushed medications in applesauce after multiple attempts

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D 391	Continued From page 198	D 391		

to administer the medications by the MA.
-At 7:50am, the MA went into an unlocked public common bathroom (used by residents, staff, and visitors) near the dining room and used a plastic spoon to scoop the applesauce with crushed medications and flushed it down the toilet.
-There was a residue of applesauce with crushed medication particles left on the inside of the plastic medication cup and on the spoon.
-The MA put the plastic spoon and plastic medication with remnants of applesauce and crushed medication particles in the trash can in the common bathroom.
-The MA walked out of the common bathroom, leaving the door unlocked and open for anyone to enter the bathroom.
-The MA did not document the destruction of the medications on the electronic medication administration record (eMAR).

Refer to interview with the MA on 10/08/25 at 1:19pm.

Refer to interview with the Director on 10/08/25 at 1:51pm.

Refer to telephone interview with the Administrator on 10/14/25 at 4:52pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm.

2. Review of Resident #11's current FL-2 dated 02/14/25 revealed diagnosis included forehead laceration.

Observation of the 8:00am medication pass on 10/08/25 revealed:
-At 8:00am, the medication aide (MA) prepared

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D 391	Continued From page 199 two Tylenol 650mg tablets (for pain/fever); one Aspirin 81mg tablet (to prevent heart disease); one Calcium 500mg tablet (calcium supplement); 1 and ½ Sinemet 25/100mg tablets (for Parkinson's disease); one Allegra 180mg tablet (antihistamine); one Midodrine 10mg (used to treat low blood pressure); one Namzaric 28-10mg capsule (for Alzheimer's disease); Potassium Chloride 10mEq (potassium supplement); and one Therems Multivitamin tablet (vitamin supplement) for administration to Resident #11. -The MA crushed the tablets and mixed them in applesauce and opened the contents of one capsule and sprinkled in the applesauce. -Resident #11 refused to take the crushed medications in applesauce after multiple attempts to administer the medications by the MA. -At 7:50am, the MA went into an unlocked public common bathroom (used by residents, staff, and visitors) near the dining room and used a plastic spoon to scoop the applesauce with crushed medications and flushed it down the toilet. -There was a residue of applesauce with crushed medication particles left on the inside of the plastic medication cup and on the spoon. -The MA put the plastic spoon and plastic medication with remnants of applesauce and crushed medication particles in the trash can in the common bathroom. -The MA walked out of the common bathroom, leaving the door unlocked and open for anyone to enter the bathroom. -The MA did not document the destruction of the medications on the electronic medication administration record (eMAR). Refer to interview with the MA on 10/08/25 at 1:19pm. Refer to interview with the Director on 10/08/25 at	D 391		

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D 391	Continued From page 200 1:51pm. Refer to telephone interview with the Administrator on 10/14/25 at 4:52pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm. _____ Interview with the MA on 10/08/25 at 1:19pm revealed: -If a medication was refused, she usually put the whole pills in the "drug buster" container. (Drug Buster is a drug disposal system with a solution designed to neutralize and dissolve medications, making the safe for disposal.) -If medications were crushed in applesauce, she usually put them in the toilet and flushed them so no one else could use or get to the medication. -She did not think she could put applesauce in the drug buster container. -She did not know the facility's policy for disposing of medications. -She did not know if she was supposed to document the disposal of medications. Interview with the Director on 10/08/25 at 1:51pm revealed: -The facility's policy was for the MAs to dispose of medications in the Drug Buster container, including any crushed medications. -The MAs could put crushed medications in the toilet and flush them if there was no Drug Buster container available. -The MA should document the disposal of medications on the eMAR when they documented the medication as refused. -The MA should not put the plastic spoon or plastic medication cup with remnants of crushed medications in the trash can because it would be	D 391		

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D 391	Continued From page 201 accessible to others. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed: -Typically, the MAs could dispose of medications in the sharp's container. -She was concerned that someone could get the left-over medications from the trash can and lick it or touch it. -She knew the MAs needed more training. Telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm revealed: -It was concerning and problematic to leave a spoon and plastic medication cup with particles of medication, including a controlled substance, in a trash can accessible to others. -A resident could decide to eat the left-over applesauce with medication particles which could cause side effects. -A staff person or family/visitors would also have access to the left-over medication if left in a trash can in a common bathroom. -It was important for the MAs to document when a medication was refused and destroyed because she made medical decisions based on documentation of administration of medications.	D 391		
D 398	10A NCAC 13F .1008 (g) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. The destruction shall be documented on the medication administration record (MAR) or the	D 398		

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D 398	Continued From page 202 controlled substance record showing the time, date, quantity, manner of destruction, and the initials or signature of the person destroying the substance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a dose of a controlled substance refused and not administered to a resident (#1) during the medication pass on 10/08/25 was destroyed and disposed of in a safe manner and documented as required. The findings are: Review of the facility's Controlled Substances Policies and Procedures dated 03/29/23 revealed: -A controlled substance contaminated or not administered would be destroyed and documented on the controlled substance record. -Documentation would include time; date; quantity; manner of destruction; initials or signature of person destroying the medication and initials of a witness. Review of Resident #1's current FL-2 dated 08/03/25 revealed: -Diagnoses included dysphagia, anxiety, depression, irregular heartbeat, hypertension, and chronic bilateral low back pain. -There was an order for Lorazepam 1mg 1 tablet 3 times a day for anxiety or agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.)	D 398		

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D 398	Continued From page 203 Observation of the 8:00am medication pass on 10/08/25 revealed: -At 7:45am, the medication aide (MA) prepared 6 oral medications, including one Lorazepam 1mg tablet, for administration to a resident. -The MA crushed all the medications, including the Lorazepam 1mg tablet and mixed them in applesauce. -The MA had documented Lorazepam as administered on the controlled substance record and declined the count by one. -The resident refused to take the crushed medications in applesauce after multiple attempts to administer the medications by the MA. -At 7:50am, the MA went into an unlocked public common bathroom (used by residents, staff, and visitors) near the dining room and used a plastic spoon to scoop the applesauce with crushed medications, including the Lorazepam 1mg tablet, and flushed it down the toilet. -There was a residue of applesauce with crushed medication particles left on the inside of the plastic medication cup and on the spoon. -The MA put the plastic spoon and plastic medication with remnants of applesauce and crushed medication particles in the trash can in the common bathroom. -The MA walked out of the common bathroom, leaving the door unlocked and open for anyone to enter the bathroom. -The MA did not get another facility staff person to witness the destruction of the medications that included Lorazepam, a controlled substance. -The MA did not document the destruction of the Lorazepam on the eMAR or the controlled substance record. Interview with the MA on 10/08/25 at 1:19pm revealed: -If a medication was refused, she usually put the	D 398		

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D 398	Continued From page 204 whole pills in the "drug buster" container. (Drug Buster is a drug disposal system with a solution designed to neutralize and dissolve medications, making the safe for disposal.) -If medications were crushed in applesauce, she usually put them in the toilet and flushed them so no one else could use or get to the medication. -She did not think she could put applesauce in the drug buster container. -She did not know the facility's policy for disposing of medications. -She did not know if she was supposed to document the disposal of medications. -She did not know if she was supposed to get a witness when she destroyed controlled substances. Interview with the Director on 10/08/25 at 1:51pm revealed: -The MAs should dispose of medications in the Drug Buster container, including any crushed medications and/or controlled substances. -The MAs could put crushed medications in the toilet and flush them if there was no Drug Buster container available. -If a controlled substance was destroyed, the MAs needed a witness which could be any staff person. -The MA should document the disposal of medications on the eMAR when they documented the medication as refused. -The disposal of controlled substances should be documented on the controlled substance record. -The MA should not put the plastic spoon or plastic medication cup with remnants of crushed medications in the trash can because it would be accessible to others. Telephone interview with the Administrator on 10/14/25 at 4:52pm revealed:	D 398		

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D 398	Continued From page 205 -Typically the MAs could dispose of medications in the sharp's container. -She was concerned that someone could get the left-over medications from the trash can and lick it or touch it. -She knew the MAs needed more training. Telephone interview with the facility's contracted primary care provider (PCP) on 10/10/25 at 1:15pm revealed: -It was concerning and problematic to leave a spoon and plastic medication cup with particles of medication, including a controlled substance, in a trash can accessible to others. -A resident could decide to eat the left-over applesauce with medication particles which could cause side effects. -A staff person or family/visitors would also have access to the left-over medication if left in a trash can in a common bathroom. -It was important for the MAs to document when a medication was refused and destroyed because she made medical decisions based on documentation of administration of medications.	D 398		
D 613	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule.	D 613		

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D 613	Continued From page 206	D 613		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the facility's policies and procedures for infection prevention and control was completed for 6 of 6 sampled staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) within 30 days of hire.

The findings are:

1. Review of Staff B's personnel record revealed:
-Staff B was hired as a medication aide (MA) on 09/02/25.
-There was no documentation Staff B completed the facility's Infection Prevention and Control training within 30 days of hire.

Observation of the medication pass on 10/08/25 at 8:00am revealed Staff B administered medications to residents.

Review of the September and October 2025 electronic medication administration records (eMAR) revealed there was documentation Staff B administered medications.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

2. Review of Staff F's personnel record revealed:
-Staff F was hired as a medication aide (MA) on

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06/30/25.
-There was no documentation Staff F completed the facility's Infection Prevention and Control training within 30 days of hire.

Observation of the medication pass on 10/08/25 at 8:00am revealed Staff F administered medications to residents.

Review of the July, August, September, and October 2025 electronic medication administration records (eMAR) revealed there was documentation Staff F administered medications.

Interview with Staff F on 10/08/25 at 1:19pm revealed:
-There was hand sanitizer available on the medication carts.
-She did not recall being trained on when to wash and/or sanitize her hands during the medication pass.
-She usually washed or sanitized her hands at the end of the medication pass.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

3. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 08/27/25.
-There was no documentation Staff A completed the facility's Infection Prevention and Control training within 30 days of hire.

Review of the September and October 2025 electronic medication administration records

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(eMAR) revealed there was documentation Staff A administered medications.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

4. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 07/08/25.
-There was no documentation Staff C completed the facility's Infection Prevention and Control training within 30 days of hire.

Review of the July, August, and September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff F administered medications.

Interview with Staff C on 10/15/25 at 1:25pm revealed:
-She had worked as a MA at the facility since the end of June or first part of July.
-She had not completed any sort of MA training since she began working at the facility.

Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm.

Refer to the interview with the Director on 10/14/25 at 3:04pm.

5. Review of Staff D's personnel record revealed:
-Staff D was hired as a medication aide (MA) on 09/10/25.
-There was no documentation Staff D completed the facility's Infection Prevention and Control training within 30 days of hire.

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D 613	Continued From page 209 Review of the September and October 2025 eMAR revealed there was documentation Staff D administered medications. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. 6. Review of Staff E's personnel record revealed: -Staff E was hired as a medication aide (MA) on 08/18/25. -There was no documentation Staff E completed the facility's Infection Prevention and Control training within 30 days of hire. Review of the August and September 2025 electronic medication administration records (eMAR) revealed there was documentation Staff E administered medications. Refer to the telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. Refer to the interview with the Director on 10/14/25 at 3:04pm. [Refer to tag D371 10A NCAC 13F .1004 (n) Medication Administration] _____ Telephone interview with the facility's MA training nurse on 10/14/25 at 6:17pm. -The Director would call her to come perform any training that the pharmacy had not done. -She had been called one day last week but could not remember which day; but she was unable to come out until this week. -She came to the facility yesterday evening and did the 5-hour training for the MAs who came but	D 613		

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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 613	Continued From page 210 had not done infection control and prevention training. Interview with the Director on 10/14/25 at 3:04pm revealed: -She could not find any MA training certificates for infection control for the sampled staff. -She did not know if the previous Director had completed MA training certificates for infection control for staff hired prior to her becoming the Director. -She was responsible for maintaining the staff records. -She had not done audits of the staff records since she became the Director about 5 months ago. -Her duties were being the Director, the acting Resident Care Coordinator as well as the acting business office manager.	D 613		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031023	A. BUILDING: _____ B. WING _____	C 10/14/2025

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D992	Continued From page 211 substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening was completed for the presence of controlled substances for 1 of 6 sampled staff (Staff B). The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/02/25. -There was no documentation Staff B had a controlled substance screen (drug test) prior to being hired on 09/02/25. Observation on 10/08/25 during the 8:00am medication pass revealed Staff B administered medications to residents. Interview with the Director on 10/14/25 at 3:04pm revealed:	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D992	Continued From page 212 -She could not find any controlled substance screening for Staff B. -She was responsible for performing the drug tests and maintaining the staff records. -Her duties were being the Director, the acting Resident Care Coordinator (RCC) as well as the acting Business Office Manager (BOM).	D992		