

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/02/2025
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NAME OF PROVIDER OR SUPPLIER SEVEN LAKES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 292 MCDOUGALL DRIVE WEST END, NC 27376
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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 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up and complaint investigation from 09/30/25 to 10/02/25.	D 000	Responsible to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts in the Statement of deficiencies of Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	11/16/25
D 076	10A NCAC 13F .0306 (a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture that is clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure 7 of 15 chairs in the living room of the special care unit (SCU) used by residents were clean. The findings are: Review of the facility's census report dated September 2025 and received on 09/30/25 revealed: -The facility's current census was 50 residents. -There were 28 residents residing in the special care unit (SCU) of the facility. Observation of the living room in the SCU on 10/01/25 from 7:57am - 8:04am revealed: -There were 13 cloth chairs, 2 dining room chairs,	D 076		
			The ED will complete a weekly audit of all common area furniture for cleanliness and condition .	11/16/25
			Maintenance Tech and housekeeping will be in-serviced on proper cleaning procedures for furniture and the protocol for immediately reporting and removing soiled or damaged furniture.	11/16/25

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

Shaneshia Rawkins TITLE *Executive Director* (X6) DATE *11-11-25*

STATE FORM

Reviewed/Acknowledged J. Kepl 11/13/25

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D 076	Continued From page 1 and a black leather sofa in the living room. -There were 6 residents sitting in cloth chairs and 1 resident sitting in a dining room chair. -There was a gray cloth chair near a window that had multiple dark circular stains that covered the entire seat of the chair. -The back and seat of the gray cloth chair had white scattered stains. -There was a blue patterned cloth chair with discolored, worn, and thinning fabric on the arms of the chair. -There was a second blue patterned cloth chair in the left corner of the living room with a dried, dark brown lumpy substance on the left side of the seat. -There were also scattered white stains on the right side of the seat of the second blue patterned cloth chair. -There was a blue cloth chair with large dark circular stain in the seat and a white stain about 6 inches long on the left side of the seat. -There was a second blue cloth chair with a large, dark circular stain that covered most of the seat. -There was a third blue cloth chair with small scattered brown stains on the seat. -There was a dining room chair with a large, dark circular stain on the vinyl seat. -At 8:01am, a staff person removed the stained dining room chair from the living room and put the chair in the hallway outside of the living room in the SCU. -At 8:03am, a staff person guided a male resident into the living room and assisted the resident with sitting in the blue patterned cloth chair with the dried, dark brown lumpy substance in the seat of the chair. Second observation of the living room in the SCU on 10/01/25 from 11:50am - 11:55am revealed: -There were 16 residents sitting in the living	D 076	Maintenace Tech or designee will complete the weekly furniture audit in all common areas, submitting the completed checklists to the ED weekly. The ED will conduct random checks of all common areas weekly for 4 weeks, then bi-weekly for 2 months, to verify compliance.	11/16/25 11/16/25

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D 076	Continued From page 2 room. -There were 12 residents sitting in the chairs in the living room, including the soiled, unclean chairs. -At 11:55am, a staff person guided and assisted a female resident in the living room with sitting in the blue patterned cloth chair with the dried, dark brown lumpy substance in the seat of the chair. Third observation of the living room in the SCU on 10/01/25 from 3:25pm - 3:32pm revealed: -There were 17 residents sitting in the living room. -There were 13 residents sitting in the chairs in the living room, including the soiled, unclean chairs. Interview with a personal care aide (PCA) in the living room of the SCU on 10/01/25 at 3:27pm revealed: -She had worked at the facility for two months and the chairs had been stained since she started working there. -The PCAs sprayed disinfectant on the chairs every day. -The housekeepers also tried to clean the chairs but could not remove the stains. -There was no fabric cleaner available to clean the chairs. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 3:39pm revealed: -The furniture in the living room in the SCU looked better than what they had in the past. -They got a new sofa and matching chair last month for the living room in the SCU. -The previous sofa was faded and had stains and a urine odor. -The PCAs used disinfectant spray to wipe down the furniture in the mornings.	D 076		

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D 076	Continued From page 3 -The Maintenance Manager would clean the furniture when requested if he had cleaning supplies available for the fabric. Interview with the Maintenance Manager on 10/01/25 at 3:55pm revealed: -They replaced the sofa in the living room of the SCU about 2 weeks ago because the previous sofa had urine odor and they could not get the odor out. -The blue cloth chairs had been in the living room of the SCU for about 2 years. -He usually pressure washed the furniture in the living room of the SCU, but he had not done that in the last 6 months. -The facility staff had disinfectant sprays they could use to disinfect the furniture. -They would have to get approval from the facility's corporate office to order new furniture. Interview with the facility's Business Office Manager (BOM) on 10/01/25 at 4:04pm revealed: -They requested new furniture from the corporate office on 04/23/25. -They received 2 blue chairs and 1 gray chair a few months ago. Interview with the Administrator on 10/01/25 at 4:04pm revealed: -The facility staff used their own money to buy a new sofa for the living room in the SCU recently. -The facility staff should be using disinfectants to clean the chairs, and they could wash the zipped covers of the chairs with cushions. -Her supervisor reached out to the corporate office today, 10/01/25, to get more furniture for the living room in the SCU.	D 076		

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D 338	Continued From page 4	D 338			
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with dignity and respect as related to the manner and tone in which staff spoke to residents; requiring all residents in the assisted living side of the facility to isolate in their rooms after two residents and staff tested positive for COVID-19; and failing to provide proper meal set up for residents eating meals in their rooms. The findings are: a. Review of the facility's COVID-19 policy and procedure dated 08/13/24 revealed: -If a resident or staff member tested positive for COVID-19 and they were asymptomatic, they may resume normal activities. -It was recommended that they use standard infection control precautions (suggested they wear a mask for 5 days). -If a resident or staff member tested positive for COVID-19 and they were symptomatic, they may resume normal activities once they were non-symptomatic without the aid of fever-reducing medications for more than 24 hours. -It was recommended that they use standard infection control precautions (suggested they	D 338		11/16/25	
			The facility has immediately stop the confinement and has educated staff on current NCDHHS and CDC guidance which encourages resident movement while utilizing appropriate infection control measures in the community.	11/16/25	
			The ED will meet with the affected residents and inform them of their rights and the revised facility procedure.	11/16/25	
			The ED will ensure that Resident's Rights Declaration has been re-posted and residents have been re-educated on their rights to movement is respected.	11/16/25	

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D 338	Continued From page 5 wear a mask for 5 days). -Residents with symptoms consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in their current room, pending results of testing. Interview with a resident on 09/30/25 at 8:52am revealed: -Facility staff treated the resident "like a prisoner". -The resident could not leave the room because the resident was "being held prisoner". -The resident was confined and could only smoke outside when staff said the resident could smoke. -Staff said it was because of COVID-19. -The resident did not have COVID-19. Interview with a second resident on 09/30/25 at 9:04am revealed: -The resident was only allowed to leave the room every 2 hours to go outside to smoke for the last 2 weeks. -Staff told the resident it was because of COVID-19. Interview with a third resident on 09/30/25 at 9:10am revealed: -It was "not good" at the facility. -The residents had to stay in their rooms. -The residents who smoked were allowed to go outside to smoke. -The residents who did not smoke were not allowed to go outside. -It was not fair. -The resident would like to go and sit outside. -The residents were on "lockdown", and they needed two more negative COVID-19 tests before the residents would be allowed out of their rooms. -It "drives me crazy" and the resident was "bored out of my mind".	D 338	Staff was re-trained by the Ombudsman on Declaration of Residents Rights on 11/6/25. ED or designee will conduct daily checks for 4 weeks to ensure compliance that residents' rights to movement are respected. The ED will re-implement communal dining and activities for residents who are not in isolation or quarantine. Residents will be encourage to follow the community infection control guidelines. ED will reach out to their local health department for guidance. The ED will ensure that positive residents with no symptoms can resume regular activites but wear a mask for 5 days. Positive residents with symptoms may resume normal activites once no signs or symptoms are present. ED and Care Managers will ensure residents who meet COVID positive or COVID negative criteria will resume normal activites based on policy.	11/16/25 11/16/25 11/16/25 11/16/25

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D 338	Continued From page 6 -When the resident asked about stepping outside of the room, the staff would tell the resident to get back in the room. Interview with a fourth resident on 09/30/25 at 9:33am revealed: -The residents were confined to their rooms. -It was "getting to be too much in here". -They had been confined to their rooms for a couple of weeks. -Staff had not said why the residents could not leave their rooms. -The resident wanted to go out and walk in the hallway but they were not allowed. Interview with a fifth resident on 09/30/25 at 9:46am revealed: -The residents could not come out of their rooms because of COVID-19. -They had been on "lockdown" for about 2 weeks. -It was difficult because the resident's knee pain had gotten worse because the resident was not allowed to walk in the hallway. -Walking up and down the hall usually helped the resident's knee pain. -When the resident did not get to walk in the hallway, the resident's right knee would "buckle" more often. -This made it more difficult for the resident to walk to the bathroom in the resident's room. -The resident did not understand why the residents who smoked were allowed to go outside but other residents were not allowed. -The resident would like to go outside to get some fresh air but they were not allowed to by staff. Interview with a sixth resident on 09/30/25 revealed: -Once residents and staff were diagnosed with COVID-19 "all [expletive] broke loose".	D 338			

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D 338	Continued From page 7 -If residents came out of their rooms, they were told to go back. -She was diagnosed with a neurodisease and wanted to walk in the hallway for exercise but was told to get back to her room. -Residents who smoked were allowed to come out of their rooms to smoke. -She felt she should be allowed out of her room if smokers were allowed to come out. Interview with the Resident Care Coordinator (RCC) on 10/01/25 at 8:29am revealed: -She thought it was best to separate the residents in the assisted living (AL) unit because staff had tested positive for COVID-19. -She did not know the COVID-19 protocol. -She isolated the residents in the AL unit for 4 days after 09/12/25. -The residents in the AL unit were retested on 09/16/25 and were able to come out of their rooms. -On 09/22/25, residents in the AL unit were placed back on isolation because staff and residents tested positive for COVID-19. -The isolation consisted of smokers being able to come out to smoke, residents could come out of their rooms for showers but they had to stay in their rooms and eat in their rooms. -After 5 days, residents were able to come out of their rooms. -She did not release the 'lockdown' on 09/29/25 because she wanted to retest the residents. -She had not read the facility's COVID-19 policy and procedure. -She made a bad judgment call by isolating all the residents in the AL unit. -She should have only isolated the residents who were COVID-19 positive. Interview with the Administrator on 10/01/25 at	D 338		

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D 338	Continued From page 8 8:56am revealed: -The facility isolated all the residents in the AL unit to prevent the spread of COVID-19. -The residents in the AL unit were able to come out of their rooms after 09/17/25 but returned to quarantine on 09/22/25 after another resident and staff tested positive for COVID-19. -She had not read the facility's COVID-19 policy before today, 10/01/25. -She did not feel she was violating the residents' rights by preventing them from coming out of their rooms. -She thought she was keeping the residents in the AL unit safe from COVID-19. Telephone interview with the communicable disease nurse at the local health department (LHD) on 10/01/25 at 8:00am revealed: -The facility notified the LHD of the COVID-19 positive cases. -When she spoke to the facility there were 3 residents who were positive for COVID-19 and staff. -She informed the facility to ensure they were cleaning the facility, allowing residents who were COVID-19 positive to eat in their rooms except residents who were in the special care unit (SCU). -Her responsibility was to keep track of the outbreak and offer environmental cleaning to the facility if they needed it. -It was the responsibility of the facility to maintain the outbreak and follow their facility's policy. -She never informed the facility to isolate all residents in the AL unit. Interview with the facility's contracted primary care provider (PCP) on 10/02/25 at 9:55am revealed: -Requiring residents to stay in their rooms	D 338		

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D 338	Continued From page 9 unnecessarily could cause residents to have increased pain due to lack of mobility. -The residents should get outside and get some sunshine. -The facility staff had not contacted her to inquire about quarantining or isolating residents. -The facility staff could have contacted her anytime for quarantine information. b. Interview with a resident on 09/30/25 at 8:52am revealed: -Staff were sometimes rude and disrespectful. -One staff person had a "hostile" attitude, a rude tone, and got in the resident's face when speaking to the resident. -The resident had reported it to a staff person, but the resident could not recall when or which staff person it was reported to. -The staff person told the resident to report it to facility management. -The resident had not reported it to facility management because the resident did not think it would do any good. Interview with a second resident on 09/30/25 at 9:33am revealed: -The staff could sometimes be "ill" based on the tone of their voices and the looks on their faces. -It would not do any good to report staff because nothing would be done about it. Interview with a third resident on 09/30/25 at 9:54am revealed: -The facility had some "very snappy personnel, very wounding". -When the resident was not wearing a face mask, a staff person said, "mask up, I've said it before, mask up". -The tone of voice was "so rude and cutting". -It was most often staff on day shift and it was	D 338	The ED will ensure that an in-service training with all staff will be conducted regarding Residents' Rights, of abuse and mandatory reporting procedures. This training will focus on professional communication with the residents at all times. The ED or designee will ensure that all new hires will receive training on Residents' Rights and abuse prevention as part of their initial orientation before working on the floor.	11/16/25 11/16/25

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D 338	Continued From page 10 more than one staff person. -Staff would say "get in your room" in an ugly tone of voice. -It made the resident feel like they were being treated like they were 4 years old. -"I wouldn't talk to my dog that way, it's very cutting." Interview with the Resident Care Coordinator (RCC) on 10/01/25 at 2:54pm revealed: -Two residents came to her on 09/29/25 and informed her a (named) staff was rude, had an attitude and cursed at them. -On 10/01/25, a staff person came to her and told her she witnessed the same (named) staff yell and curse at residents. -She informed the Administrator and Regional Vice President of Operations (RVPO) of the complaints from the residents and staff. Interview with the Administrator on 10/01/25 at 3:19 pm revealed: -The RCC informed her of the complaints from residents and a staff person. -She consulted with the RVPO and was provided guidance as to what to do about the allegations from the residents and staff related to staff cursing at the residents, having an attitude and being rude. c. Observation during the breakfast meal on 10/01/25 between 7:26am and 7:43am revealed: -There was a breakfast meal in a disposable container sitting on a resident's rollator. -There was a breakfast meal in a disposable container placed on the foot of a resident's bed. -There were multiple residents sitting on the edge of their beds holding their breakfast in their hands while they were eating.	D 338		

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D 338	Continued From page 11 Interview with a resident on 10/01/25 at 7:33am revealed: -She was uncomfortable holding her breakfast in her hands and eating. -She preferred to have a bedside table. Interview with the Administrator on 10/01/25 at 8:56am revealed: -There were no bedside tables in the residents' rooms. -She did not consider the meal setup for residents while they were eating in their rooms. The facility failed to ensure residents were treated with respect, consideration and dignity related to cursing at residents and speaking to them rudely, as well as residents being confined to their rooms due to two residents being diagnosed with COVID-19 which caused the residents to experience pain from not being able to physically walk the halls and being treated differently because residents who smoked were allowed to come out of their rooms; and not providing a proper meal setup for the residents while eating in their rooms. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2025.	D 338			
D 358	10A NCAC 13F .1004 (a) Medication Administration	D 358			

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D 358	Continued From page 12 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#9, #11) observed during the medication passes including errors with an inhaler for chronic obstructive pulmonary disease (#9) and a medication for diabetes (#11). The findings are: The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 7:30am - 9:00am medication passes on 10/01/25. a. Review of Resident #9's current FL-2 dated 07/07/25 revealed diagnoses included chronic obstructive pulmonary disease (COPD), moderate dementia with anxiety, hypertension, gastroesophageal reflux disease, anemia due to blood loss, hyperlipidemia, cervical nerve root disorder, bipolar affective disorder, and psoriatic arthritis. Review of Resident #9's primary care provider (PCP) order dated 08/19/25 revealed an order for Spiriva Respimat 2.5mcg/actuation inhale 2 puffs daily. (Spiriva Respimat is an inhaler used to treat COPD.)	D 358	Med Aides will be re-trained by the LHPS nurse on NC regulation for medication administration and facility policies and procedures, with an emphasis on the "six rights" of medication administration and the importance of administering all ordered medications. Care managers will review MARs for completeness and accuracy daily for two weeks, then weekly for a month, then twice monthly.	11/16/25 11/16/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/02/2025
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NAME OF PROVIDER OR SUPPLIER SEVEN LAKES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 292 MCDOUGALL DRIVE WEST END, NC 27376
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D 358	Continued From page 13 Observation of Resident #9's medications on hand on 10/01/25 at 7:50am revealed: -There was one Spiriva Respimat 2.5mcg/actuation inhaler dispensed on 09/15/25. -The instructions were to inhale 2 puffs once daily. -There was a handwritten open date of 09/15/25. -There were 44 of 60 doses remaining (only 16 doses had been used from 09/15/25 - 09/30/25). -There should have been 32 doses used if 2 puffs per day were administered. Observation of the 8:00am medication pass on 10/01/25 revealed: -The medication aide (MA) retrieved Resident #9's Spiriva Respimat 2.5mcg/actuation inhaler from the medication cart. -The MA administered 1 puff of Spiriva Respimat to the resident instead of 2 puffs as ordered at 7:52am. Review of Resident #9's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Spiriva Respimat 2.5mcg/actuation inhale 2 puffs once daily scheduled at 8:00am. -Spiriva Respimat 2 puffs once daily were documented as administered on 10/01/25. Interview with Resident #9 on 10/01/25 at 11:28am revealed: -She thought she usually received just 1 puff of the Spiriva Respimat inhaler. -The inhaler helped with her breathing problems. Interview with the MA on 10/01/25 at 11:39am revealed: -She thought she usually administered 2 puffs of Spiriva Respimat inhaler to Resident #9.	D 358	The Care Managers and ED will conduct random direct medication pass observations a minimum of twice weekly for three months, to ensure compliance with proper administration handling and documentation.	11/16/25

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D 358	Continued From page 14 -She did not know why she only administered 1 puff that morning on 10/01/25. -Resident #9 sometimes had wheezing and the inhaler usually helped with the wheezing. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 11:44am revealed: -The MAs should administer medications according to the instructions. -Resident #9 sometimes had wheezing and shortness of breath. -Resident #9 currently had a cough and was supposed to see the PCP tomorrow. Interview with the Administrator on 10/01/25 at 12:18pm revealed: -The MAs were supposed to use the six rights of medication administration when administering medications. -The MAs should follow the instructions on the eMAR and medication label. -Resident #9 had some baseline shortness of breath. Interview with Resident #9's PCP on 10/02/25 at 9:55am revealed: -Resident #9 had COPD and Spiriva Respimat was recently ordered for maintenance of her symptoms. -The Spiriva Respimat inhaler seemed to have helped the resident's breathing problems. -The dose should be 2 puffs daily. -Not receiving 2 puffs daily could cause the resident's COPD not to be as well controlled which could lead to increased shortness of breath and increased sputum and secretions. b. Review of Resident #11's current FL-2 dated 06/30/25 revealed: -Diagnoses included essential hypertension,	D 358		

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D 358	Continued From page 15 hyperlipidemia, tardive dyskinesia, insomnia, psychosis, schizophrenia, and adjustment disorder. -There was an order for Januvia 50mg 1 tablet once daily. (Januvia is used to lower blood sugar in diabetes.) Review of Resident #11's primary care provider (PCP) visit notes dated 08/11/25 revealed: -The resident's hemoglobin A1C (a blood test used to measure average blood sugar levels over 2 to 3 months) was stable at 5.4 in April 2025 and 5.6 in July 2025. -There was an order to discontinue Januvia. Observation of the 9:00am medication pass on 10/01/25 revealed: -The medication aide (MA) prepared and administered medications to Resident #11, including one Januvia 50mg tablet. -Resident #11 was administered Januvia 50mg after it had been discontinued by the PCP in August 2025. Review of Resident #11's August 2025 - October 2025 electronic medication administration records (eMARs) revealed: -There were entries for Januvia 50mg 1 tablet daily scheduled at 9:00am on each of the eMARs. -Januvia 50mg was documented as administered from 08/01/25 - 10/01/25. -Januvia was not discontinued on 08/11/25 as ordered. Observation of Resident #11's medications on hand on 10/01/25 at 12:00pm revealed: -Resident #11's medications were packaged in multi-dose packs (MDPs) with a weekly supply. -Resident #11's MDP had a printed date of 09/22/25.	D 358		

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D 358	Continued From page 16 -The morning MDPs included one Januvia 50mg tablet. -The instructions on the MDP were to take one Januvia 50mg tablet once daily. Interview with the MA on 10/01/25 at 11:42am revealed: -The Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) were responsible for sending discontinued orders to the pharmacy. -She was not aware Resident #11's Januvia had been discontinued. -She administered Januvia to Resident #11 because it was included on the eMAR and in the resident's morning MDP. -There was nothing flagged on the eMAR to indicate the Januvia had been discontinued. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/01/25 revealed: -The pharmacy staff usually entered all orders into the eMAR system including discontinued orders. -The pharmacy did not receive an order dated 08/11/25 to discontinue Resident #11's Januvia 50mg tablet. -The pharmacy continued to dispense Januvia 50mg tablets in the weekly cycle fills of the MDPs because they did not have an order to discontinue it. Interview with the RCC on 10/01/25 at 11:59am revealed: -She or the SCC or the MAs were responsible for faxing discontinued orders to the pharmacy. -The pharmacy usually entered orders into the eMAR system and either she or the SCC had to approve the orders in the eMAR system for the	D 358		

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STATE FORM

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D 358	Continued From page 17 orders to become active. -She thought she remembered approving the discontinue order For Resident #11's Januvia in the eMAR system. -The facility switched eMAR systems around the middle of August 2025. -She thought maybe the order for Januvia may have been carried over to the new eMAR system in error in August 2025. Interview with the Administrator on 10/01/25 at 12:22pm revealed: -The RCC and SCC usually sent discontinued orders to the pharmacy. -The pharmacy usually entered orders into the eMAR system. -The RCC, SCC, and MAs were still learning the new eMAR system the facility switched to in August 2025. Interview with Resident #11's PCP on 10/02/25 at 9:55am revealed: -Resident #11's Januvia should have been discontinued as ordered. -Resident #11's random glucose levels had been good, so she had no immediate concerns that the resident continued to receive Januvia.	D 358		