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CEDARBROOK RESIDENTIAL CENTER	1267 PINNACLE CHURCH ROAD NEBO, NC 28761

(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 and the McDowell County Department of Social Services conducted an annual survey and complaint investigation on 11/04/25 - 11/07/25, 11/10/25, and 11/12/25 - 11/14/25.	D 000		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are 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 observations and interviews the facility failed to ensure one common hall bathroom toilet, walls and shower stall were kept clean as evidence by the toilet and wall in one common bathroom had brown matter on and around the toilet seat and smeared on the wall, and the shower stall had a thick black looking substance	D 074		

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that appeared to be feces on the wall of the shower and in the grout and walls, the dining room ceiling fans had brown gray thick dust on the blades of the ceiling fans which were in use while residents ate their food.

The findings are:

Observation of a shared common bathroom on the 100 hall on 11/04/25 from 9:29am to 10:15am revealed:
-There was a toilet, sink, bathtub, and shower.
-The shower had tiles on the wall and floor.
-There was a black substance on the grout, which was on over 40 tiles in the shower.
-The bottom base grout along the bottom of the shower tiles had black dots along the edge and in the grout.
-The base of the shower floor was dirty.
-The toilet seat had a brown substance on the toilet seat and a yellowish-brown substance around the toilet seat.
-There was feces in the toilet.
-The bottom wall near the toilet had a brown substance smeared on the wall that appeared to be feces.
-The tub faucet had a right missing handle.
-At 9:33am the housekeeper was observed in the hall outside the bathroom, and he did not go inside the bathroom.

Observation of the dining room on 11/04/25 at 10:02am revealed:
-There were three ceiling fans in the main dining room area that were turned on and coated with thick grayish, brown dust.
-The residents had been eating breakfast in the dining room.

Interview with a housekeeper on 11/04/25 at

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D 074	Continued From page 2 12:16pm revealed: -He started his day at 7:00am and would start on the 100 hall and start cleaning the hall bathrooms. -He had not been aware of any complaints about dirty bathrooms. -The residents would tell him if the bathroom needed to be cleaned due to a mess or a clogged toilet and he would take care of it right away. -He had not cleaned the 100-hall bathroom today (11/04/25) and no one told him it was dirty. -He thought someone was in the bathroom when he went by and he did not clean it. -He was not aware of the black substance in the shower area but did clean the showers every day. -If an area was not coming clean, he would notify someone from maintenance. -He had not notified anyone about the black substance in the shower. -He was not responsible for cleaning the dining room unless something spilled and a housekeeper was needed for assistance. Interview with a second Housekeeper on 11/04/25 at 3:32pm revealed: -When she started her cleaning routine she would start on the 100 hallway. -She would clean the communal and employee bathrooms and resident rooms. -When she got to the 100-hall bathroom today on 11/04/25 it seemed fine and was not dirty. -Some residents will let her know if a bathroom was dirty. -If things needed repair she would tell someone in maintenance. -She was not sure if cleaning the dining room was her responsibility or not. Interview with the Maintenance Assistant on 11/14/25 at 10:22am revealed:	D 074		

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-He was responsible for the plumbing in the bathrooms and would sometimes help out with cleaning the bathrooms if they were short-staffed.
-He would complete a walk-through of the building daily to check for items in need of repair.
-The tub knob had been broken for a couple of weeks, and it had been fixed.
-He had thought the mildew (black substance) in the 100 shower had been there for a while and the housekeeping staff were responsible for taking care of cleaning the showers.
-A bathroom could be cleaned and in the next few minutes, someone would use it, and it would become dirty again.
-The residents would let the housekeeping staff know if there was an issue but not always.
-The kitchen ceiling fans required a joint effort between housekeeping and maintenance.

Interview with the Clinical Manager/Housekeeping Manager on 11/13/25 at 4:11pm revealed:
-She had been assigned to oversee housekeeping about a month ago.
-The housekeepers were responsible for getting their assignment sheets each day which would include their assigned hall.
-Housekeeping staff were to clean the bathrooms, mop, clean resident rooms such as emptying the trash, cleaning and wiping down bathrooms as well as deep clean resident rooms when needed.
-If there was a mess such as feces on the toilet and someone would bring it to the staff's attention, and it was to be cleaned right away.
-The kitchen/dining area was primarily done on third shift which would include mopping that area.
-Third shift housekeeping was also responsible for cleaning the day room and hall bathrooms.
-She monitored the housekeeping staff by reviewing the cameras, and before the

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D 074	Continued From page 4 housekeepers leave, they should go to their supervisor and have them sign off on their daily duties. -Maintenance was responsible for cleaning the mold and mildew in the bathrooms. -Maintenance would be responsible for cleaning the ceiling fans in the dining area. Interview with the Operations Manager on 11/13/25 at 11:47am revealed: -They had a lot of turnover of housekeeping staff and were trying to hire more staff. -They had a deep cleaning checklist for things like cleaning the ceiling fans. -The Housekeepers were responsible for cleaning the dining room. Interview with the Administrator on 11/14/25 at 10:46am revealed: -She would do walk-throughs through the facility, and if areas need to be cleaned, she would call housekeeping. -The ceiling fans should have been cleaned but she had decided to go ahead and replace the ceiling fans in the dining area. -She expected the building to be kept up with the cleanliness.	D 074		
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	D 344		

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(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 record.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to clarify medication orders for 2 of 7 sampled residents (Resident #3 and #6) related to orders for a medication to treat substance use disorder.

The findings are:

1. Review of Resident #3's current FL2 dated 09/03/25 revealed a diagnosis of schizoaffective disorder.

Review of Resident #3's physician order dated 10/15/25 revealed:
-An order for Buprenorphine hydrochloride (HCL) (a medication used to treat substance use disorder) 4 mg sublingual (SL), wait 30 minutes then reassess, may increase Buprenorphine HCL 2 mg daily as needed until a maximum dose of 10 mg starting on 10/16/25.
-The order was from a Substance Use Disorder Outpatient Clinic (SUDOC).
-There were no additional orders for Buprenorphine.

Review of Resident #3's October 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buprenorphine HCL 10mg take one SL daily starting on 10/16/25.
-There was no documentation Buprenorphine HCL 10mg was administered 10/16/25 to

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D 344	Continued From page 6 10/31/25. Review of Resident #3's November 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buprenorphine HCL 10mg take one SL daily, documented as administered 11/01/25 to 11/04/25 at 8:00am. -There was no documentation Buprenorphine HCL 10mg was administered 11/05/25 to 11/14/25. Observation of Resident #3's medications on hand on 11/06/25 revealed: -There was a small lockbox with Resident #3's name on it, the lockbox was kept behind locked doors in the medication room. -Inside the lockbox were six pill bottles labeled Buprenorphine HCL 14mg with a dispense date on 11/03/25, each bottle was dated for each day of the week for six days 11/04/25 through 11/09/25, each bottle was dated each day of the week and each individual pill bottle was sealed with a foil seal. -Inside the box was a form titled MAT (Medication Assisted Treatment) chain of custody daily documentation dated 11/03/25 and the dosage for the Buprenorphine was 12mg. Review of Resident #3's October 2025 and November 2025 Substance Use Disorder Clinic (SUDOC) notes revelaed: -On 10/15/25, Resident #3 received and initial dose of Buprenorphine HCL 4mg at the clinic. -On 10/16/25, Resident #3 received and 2mg increase of Buprenorphine HCL at the clinic. -On 10/17/25, Resident #3 received a 2mg increase of Buprenorphine HCL at the clinic. -On 10/18/25, Resident #3 was dosed at the clinic and was sent home with one Buprenorphine HCL	D 344		

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dose to take on 10/19/25.
-On 10/20/25, Resident #3 was dosed at the clinic.
-On 10/21/25, Resident #3 was dosed at the clinic.
-On 10/22/25, Resident #3 was increased to Buprenorphine HCL 16mg and dosed at the clinic.
-On 10/23/25, Resident #3 was dosed at the clinic.
-On 10/24/25, Resident #3 was dosed at the clinic.
-On 10/25/25, Resident #3 was dosed at the clinic and received a take home dose of Buprenorphine HCL to take on 10/26/25.
-On 10/27/25, Resident #3 was dosed at the clinic.
-On 10/28/25, Resident #3 was dosed at the clinic.
-On 10/29/25, Resident #3 was dosed at the clinic and received four take home doses of Buprenorphine HCL to take from 10/30/25 to 11/03/25.
-On 11/03/25, Resident #3 was dosed at the clinic and received six take home doses of Buprenorphine HCL to take from 11/04/25 to 11/09/25.
-On 11/10/25, Resident #3 was dosed at the clinic and received six take home doses of Buprenorphine HCL to take from 11/11/25 to 11/16/25.

Telephone interview with a nurse at Resident #3's SUDOC on 11/03/25 at 9:45am revealed:
-On 10/15/25, Resident #3 was started on Buprenorphine HCL 6mg and his dose would gradually be increased.
-On 10/18/25, Resident #3 received a dose of Buprenorphine HCL 10mg and a "take home" dose of Buprenorphine 10mg to take on 10/19/25 because the clinic was closed on Sundays.

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D 344	Continued From page 8 -On 10/25/25, Buprenorphine HCL 12mg one day supply was sent with Resident #3 to the facility. -On 11/03/25, Buprenorphine HCL 14mg six day supply was sent with Resident #3 to the facility. -The MAT chain of custody form sent on 11/03/25 had the wrong dosage on it of 12 mg and that was an error on the clinic, it should have read Buprenorphine 14mg. -Most of the communication with the facility was completed through the facility transport staff. -Resident #3's initial prescription for Buprenorphine HCL 4mg every day and an initial assessment should have been sent to the facility with the facility transport staff. -The facility did not reach out to her to get clarification related to Resident #3's Buprenorphine HCL. Review of Resident #3's record revealed: -There was no order dated 10/15/25 for Buprenorphine HCL SL 4mg on Sundays. -There was no order dated 10/18/25 for Buprenorphine HCL SL 10mg on Sundays. -There was no order dated 10/25/25 for Buprenorphine HCL SL 12mg on Sundays. -There was no order dated 10/29/25 for Buprenorphine HCL SL 12mg from 10/30/25 to 11/03/25. -There was no order dated 11/03/25 for Buprenorphine HCL SL 14mg from 11/04/25 to 11/09/25. Interview with the medication aide (MA) on 11/13/25 at 9:55am revealed: -She gave the lockbox to Resident #3, and he opened it and took the medication. -She looked at the medications and compared them to the eMAR. -Sometimes she would compared the medications to the order on the MAT.	D 344		

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D 344	Continued From page 9 Interview with the MA Supervisor on 11/12/25 at 2:35pm revealed: -Resident #3 used to dose every day except Sunday at the SUDOC but now he would dose every Monday and would bring back six take home pill bottles for each day until the following Monday. -The Resident would sign on the chain of custody form that he took the medication, and the MA would also sign off on the same form that Resident #3 took the medication. -She would not have administered Buprenorphine if the dosage on the bottle did not match what was listed on the eMAR. Interview with the Operations Manager 11/13/25 at 10:54am and 3:46pm revealed: -She did not believe the facility had requested any new orders for Resident #3 from the SUDOC. -We should have gotten the order changes and not just go by the initial order in the Resident #3's record. Refer to telephone interview with a nurse at the SUDOC on 11/03/25 at 9:45am. Refer to telephone interview with the Program Manager at the SUDOC on 11/14/25 at 8:42am. Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm. Refer to interview with the facility Transporter on 11/13/25 at 3:46pm. Refer to interview with the Residential Care Coordinator on 11/13/25 at 3:27pm. Refer to interview with the Operations Manager	D 344		

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on 11/13/25 at 10:54am and 3:46pm, and on 11/14/25 at 10:46am.

Refer to interview with the Administrator on 11/14/25 at 10:46am.

2. Review or Resident #6's FL2 dated 08/24/25 revealed:
-Diagnoses included substance use disorder, schizoaffective disorder order, bipolar type and severe depression.
-There was an order for Buprenorphine HCL 2mg (a medication used to treat substance use disorder) sublingual (SL-to be applied under the tongue), take 6mg three times a day.

Review of Resident #6's signed physician orders dated 09/18/25 revealed an order for Buprenorphine HCL 2mg, take 6mg three times a day.

Interview with a Nurse from Resident #6's SUDOC on 11/13/25 at 9:45am revealed:
-On 9/15/25, Resident #6 started Buprenorphine HCL 18mg every day at the clinic except for the Sunday dose.
-Resident #6's Buprenorphine HCL dosage could be increased 2mg per day to a max of 24mg per day upon request from Resident #6.
-On 9/16/25, Resident #6 was prescribed Buprenorphine HCL 20mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 20mg at the facility out of the lockbox.
-On 9/17/25, Resident #6 was prescribed Buprenorphine HCL 22mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 22mg at the facility out of the lockbox.
-On 9/18/25, Resident #6's order was for

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Buprenorphine HCL 24mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 24mg at the facility out of the lockbox.
-Resident #6 received Buprenorphine as a take home on Saturdays for Sunday's dose until she was considered stable by the physician.
-It was the facility's responsibility to clarify the take home order of Buprenorphine for Resident #6.
-There were no phone calls from the facility staff clarifying the take home orders of Buprenorphine for Resident #6.
-Most of the communication with the facility was completed through the facility transport staff.
-Resident #6's initial prescription for Buprenorphine HCL 18mg every day and an initial assessment should have been sent to the facility with the facility transport staff.

Review of Resident #6's record revealed:
-There was no order dated 09/16/25 for Buprenorphine HCL SL 20mg to be administered on Sundays.
-There was no order dated 09/17/25 for Buprenorphine HCL SL 22mg to be administered on Sundays.
-There was no order dated 09/18/25 for Buprenorphine HCL SL 24mg to be administered on Sundays.

Review of Resident #6's September 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buprenorphine 2mg SL, take three tablets every day, (suspended 09/12/25 to 09/19/25, on hold until seen by prescriber for refills) documented as administered 09/01/25 to 09/12/25 at 8:00am, 2:00pm and 8:00pm.

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D 344	Continued From page 12 -On 09/19/25 at 8:00pm, 09/20/25 to 09/29/25 the Buprenorphine was documented as "medication not in the facility", "withheld per orders", "received at offsite clinic", and "new order medication not arrived from pharmacy", at 8:00am, 2:00pm and 8:00pm. -On 09/30/25 at 8:00am and 8:00pm, the Buprenorphine was documented as administered at the offsite clinic and at 2:00pm administered by a medication aide. -There was no entry for Buprenorphine HCL SL 20mg every day. -There was no entry for Buprenorphine HCL SL 22mg every day. -There was no entry for Buprenorphine HCL SL 24mg every day. Telephone interview with a representative from the facility's contracted pharmacy on 11/19/25 at 10:24am revealed: -On 08/24/25, the pharmacy received an order for Buprenorphine 2mg SL, take three tablets every day as a clarification order from the facility, for Resident #6's FL2. -The pharmacy dispensed 60 tablets of Buprenorphine 2mg (a 30-day supply). -On 10/29/25, the next order received for Buprenorphine 8mg was received, take three tablets three times a day and 21 tablets of Buprenorphine 8mg was dispensed (a 7-day supply) to the facility. -The pharmacy did not receive an order dated 09/16/25 for Buprenorphine 20mg every day. -The pharmacy did not receive an order dated 09/17/25 for Buprenorphine 22mg every day. -The pharmacy did not receive an order dated 09/18/25 for Buprenorphine 24mg every day. Interview with the medication aide (MA) on 11/13/25 at 9:55am revealed:	D 344		

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-She gave the locked box to Resident #6, and after Resident #6 opened the lockbox, she put the contents of the bottle in a medication cup and Resident #6 took the medication.
-She compared the medication bottle to the eMAR.
-Sometimes she would compare medication bottle to the order on the MAT.

Refer to telephone interview with a nurse at the SUDOC on 11/03/25 at 9:45am.

Refer to telephone interview with the Program Manager at the SUDOC on 11/14/25 at 8:42am.

Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm.

Refer to interview with the facility Transporter on 11/13/25 at 3:46pm.

Refer to interview with the Residential Care Coordinator on 11/13/25 at 3:27pm.

Refer to interview with the Operations Manager on 11/13/25 at 10:54am and 3:46pm, and on 11/14/25 at 10:46am.

Refer to interview with the Administrator on 11/14/25 at 10:46am.

Telephone interview with a nurse at the SUDOC on 11/03/25 at 9:45am revealed:
-The SUDOC communicates the orders with the transport driver, and all doses was on the prescription bottle and on the MAT chain of custody form.
-The MAT chain of custody form was to be signed each day by the resident and the MA at the facility

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documenting they gave the medication.
-The SUDOC does not routinely send a prescription with each change as the prescription was written for a range to increase to a certain amount.
-The facility was responsible to clarify new orders or concerns about the medications.
-The facility did not ask for clarification of the orders.

Telephone interview with the Program Manager at the SUDOC on 11/14/25 at 8:42am revealed:
-The ALF had not requested an updated order.
-The prescription label on the bottle has the medication name, dosage and instructions.
-He would be glad to get a release of information and send to the facility's contracted pharmacy so they could have a record of the prescription even though it was dispensed by the SUDOC.

Interview with the MA Supervisor on 11/12/25 at 2:35pm revealed:
-The MAs were responsible to verify the medication label on the bottle and eMAR before administration.
-If medication label on the bottle did not match the eMAR, then the MA was responsible to contact her and or clarify the order with the provider or SUDOC.

Interview with the facility Transporter on 11/13/25 at 3:46pm revealed:
-She received the lockbox with the MAT chain of custody form and medications from staff at SUDOC.
-Staff at the SUDOC clinic let her know when the dose had changed but did not give her a new order for the medication change.
-The staff at the SUDOC were aware the residents were living at an ALF.

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D 344	Continued From page 15 Interview with the Residential Care Coordinator on 11/13/25 at 3:27pm revealed: -She was aware of the lockbox from the SUDOC but had not administered any of the medications. -The MA should pull the eMAR, look at it, document it, look for the prescription bottle and the label and if it does not match, they should let their supervisor know. Interview with the Operations Manager 11/13/25 at 10:54am, 3:46pm and on 11/14/25 at 10:46am revealed: -They should have documented appropriately on the eMAR based on what Resident #3 was being administered at the SUDOC. -Residents were transported daily to the SUDOC. -The MA should verify that everything matches the pill bottle, the order and eMAR. -She did not believe the facility had requested any new orders for the residents from the SUDOC. -She knew that the residents who went to the SUDOC have different orders. -She was not aware of the frequent order changes. -The MA most likely thought what was on the eMAR was what the resident was to be taking. -She assumed the SUDOC was like an outside provider and would notify us of any changes, and if there was no new prescription we assumed that was the most recent accurate order. -She had not administered any of the medications herself, but the MA was responsible for comparing the prescription bottle to the eMAR. -The facility should have gotten the order changes and not just go by the initial order in the resident's record. -The facility did not received updated orders from the SUDOC. -They should have looked at the pre-filled pill	D 344		

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D 344	Continued From page 16 bottles and comparing this to the order and clarify the order. Interview with the Administrator on 11/14/25 at 10:46am revealed she expected the orders would be clarified.	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 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 interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 7 sampled residents related to a medication used to treat seizures and to help with sleep (#1). The findings are: Review or Resident #1's current FL2 dated 05/19/25 revealed: -Diagnoses included schizoaffective disorder, bipolar type. -Resident #1 had a history of seizures. -There was an order for gabapentin (used to treat seizures and to help with sleep) 600mg by mouth at bedtime. Review of Resident #1's physician order dated	D 358		

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D 358	Continued From page 17 09/11/25 revealed there was an order for gabapentin 600mg by mouth at bedtime. Review of Resident #1's Mental Health Nurse Practitioners (NP) progress note dated 09/05/25 revealed there was an order to continue gabapentin 600mg by mouth at bedtime. Review of Resident #1's September 2025 electronic medication administration record (eMAR) revealed there was no entry for gabapentin 600mg by mouth at bedtime. Review of Resident #1's October 2025 eMAR revealed there was no entry for gabapentin 600mg by mouth at bedtime. Review of Resident #1's November 2025 eMAR revealed there was no entry for gabapentin 600mg by mouth at bedtime. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/05/25 at 10:38am revealed: -The pharmacy received a physician's order for gabapentin 600mg by mouth at bedtime on 08/25/25. -The pharmacy discontinued Resident #1's gabapentin 600mg by mouth at bedtime by mistake. -The facility had to approve or decline all orders entered on the eMAR by the pharmacy. -The medication aide (MA) supervisor did approve to discontinue Resident #1's gabapentin 600mg at bedtime. -Resident #1 could experience increased stiffness if she did not receive her gabapentin as ordered. Interview with the MA supervisor on 11/14/25 at	D 358		

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D 358	Continued From page 18 10:33am revealed: -She did not know Resident #1's gabapentin 600mg at bedtime had been discontinued without a physician's order. -She, the Resident Care Coordinator (RCC) and Operations Manager were responsible for ensuring all orders were sent to the pharmacy and entered correctly onto the eMAR. -She, the RCC and Operations Manager had access to the eMAR system to approve or decline orders entered by the pharmacy. -She did not recall approving to discontinue Resident #1's gabapentin. Interview with the Administrator on 11/06/25 at 10:54am revealed: -She did not know Resident #1's gabapentin 600mg at bedtime had been discontinued without a physician's order. -She expected the staff to follow the facility's policies and procedures to ensure medication orders were complete and accurate.	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;	D 367		

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D 367	Continued From page 19 (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 medication administration records were accurate for 3 of 7 sampled residents (#3, #6 & #1) related to a medication to treat substance use disorder (#3 & #6) and a medication to treat agitation (#1). The findings are: 1. Review of Resident #3's current FL2 dated 09/03/25 revealed a diagnosis of schizoaffective disorder. Review of Resident #3's physician order dated 10/15/25 revealed: -An order for Buprenorphine hydrochloride (HCL) (a medication used to treat substance use disorder) 4 mg sublingual (SL), wait 30 minutes then reassess, may increase Buprenorphine HCL 2 mg daily as needed until a maximum dose of 10 mg starting on 10/16/25. -The order was from a Substance Use Disorder Outpatient Clinic (SUDOC). -There were no additional orders for Buprenorphine.	D 367		

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D 367	Continued From page 20 Review of Resident #3's October 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buprenorphine HCL 10mg daily starting on 10/16/25. -There was no documentation that Buprenorphine 10mg was given during the month of October 2025. Review of Resident #3's record revealed the was no October 2025 MAT Sheets. Review of Resident #3's November 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buprenorphine HCL 10mg daily. -There was documentation Buprenorphine HCL 10mg was administered on 11/01/25 through 11/04/25. Review of Resident #3 MAT sheet revealed there was one MAT (Medication Assisted Treatment) chain of custody daily documentation sheet dated 11/03/25 with and order for Buprenorphine 12mg every day 11/04/25 to 11/09/25. Observation of Resident #3's medications on hand on 11/06/25 at 12:06pm revealed: -There was a small lockbox with Resident #3's name on it, the lockbox was kept behind locked doors in the medication room. -Inside the lockbox were six pill bottles labeled Buprenorphine HCL 14mg with a dispense date on 11/03/25, each bottle was dated for each day of the week for six days 11/04/25 through 11/09/25, each bottle was dated each day of the week and each individual pill bottle was sealed with a foil seal.	D 367		

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-Inside the box was a form titled MAT dated 11/03/25 and the dosage for the Buprenorphine was 12mg.

Interview with the medication aide (MA) on 11/13/25 at 9:55am revealed:
-She gave the lockbox to Resident #3, and he opened it and took the medication.
-She looked at the medications and compared them to the eMAR.
-Sometimes she would compared the medications to the order on the MAT.

Telephone interview with a representative from the facility's contracted pharmacy on 11/11/25 at 11:07am revealed:
-The Buprenorphine HCL 10mg was was a medication that was not dispensed by their pharmacy, and it was added to the eMAR by a staff member at the facility.
-The eMAR indicated the Resident did not receive the medication at the facility.

Interview with the MA Supervisor on 11/12/25 at 2:35pm revealed there was confusion on eMAR on how to sign off on it as Resident #3 had taken some doses at the SUDOC initially and now he takes the Buprenorphine at the facility Tuesday through Sunday and would take one dose at the clinic on Mondays.

Telephone interview with a nurse from the SUDOC on 11/13/25 at 9:45am revealed:
-She was aware that Resident #3 lived in an Assisted Living Facility (ALF).
-Resident #3's current order was for Buprenorphine 14mg.
-Resident #3 received take home doses for 11/03/25 through 11/09/25.
-Resident #3's Buprenorphine HCL could be

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increased to 16mg.
-The form was then returned to the clinic when Resident #3 would come on Monday's, and it was scanned in his record.

Interview with the Operations Manager 11/13/25 at 10:54am and 3:46pm revealed:
-They should have documented appropriately on the eMAR based on what Resident #3 was being administered at the SUDOC.
-She did not believe the facility had requested any new orders for Resident #3 from the SUDOC.
-They were not aware of the frequent order changes.

Refer to interview with the Residential Care Coordinator on 11/13/25 at 3:27pm.

Refer to interview with a representative from the facility's contracted pharmacy on 11/11/25 at 11:07am.

Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm.

Refer to interview from the Nurse from the SUDOC on 11/13/25 at 9:45am.

Refer to interview with the Operations Manager on 11/13/25 at 10:54am and 3:46pm.

Refer to interview with the Administrator on 11/14/25 at 10:46am.

2. Review or Resident #6's FL2 dated 08/24/25 revealed:
-Diagnoses included substance use disorder, schizoaffective disorder order, bipolar type and severe depression.
-There was an order for Buprenorphine HCL 2mg

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(a medication to treat substance use disorder) SL (under the tongue), take 6mg three times a day.

Review of Resident #6's signed physician orders dated 09/18/25 revealed an order for Buprenorphine HCL 2mg, take 6mg three times a day.

Telephone interview with a Nurse from the SUDOC on 11/13/25 at 9:45 revealed:
-On 9/15/25, Resident #6 started Buprenorphine HCL 18mg every day at the clinic except for the Sunday dose.
-On 9/16/25, Resident #6's order was for Buprenorphine HCL 20mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 20mg at the facility out of the lockbox.
-On 9/17/25, Resident #6's order was for Buprenorphine HCL 22mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 22mg at the facility out of the lockbox.
-On 9/18/25, Resident #6's order was for Buprenorphine HCL 24mg every day at the clinic except Sundays which Resident #6 would have received Buprenorphine HCL 24mg at the facility out of the lockbox.

Review of Resident #6's September 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buprenorphine 2mg SL, take three tablets every day, (suspended 09/12/25 to 09/19/25, on hold until seen by prescriber for refills) documented as administered 09/01/25 to 09/12/25 at 8:00am, 2:00pm and 8:00pm.
-On 09/19/25 at 8:00pm, 09/20/25 to 09/29/25 the Buprenorphine was documented as "medication

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not in the facility", "withheld per orders", "received at offsite clinic", and "new order medication not arrived from pharmacy", at 8:00am, 2:00pm and 8:00pm.
-On 09/30/25 at 8:00am and 8:00pm, the Buprenorphine was documented as administered at the offsite clinic and at 2:00pm administered by a medication aide.
-There was no entry for Buprenorphine HCL SL 20mg every day.
-There was no entry for Buprenorphine HCL SL 22mg every day.
-There was no entry for Buprenorphine HCL SL 24mg every day.

Review of Resident #6's October 2025 eMAR revealed:
-There was an entry for Buprenorphine 2mg SL, take three tablets every day, documented as received "at offsite clinic" and "order complete" 10/01/25 to 10/29/25 at 8:00am, 2:00pm and 8:00pm and on 10/30/25 at 8:00am.
-There was an entry for Buprenorphine 8mg SL, take three tablets every day for seven days documented as administered 10/30/25 to 10/31/25 at 8:00am.

Review of Resident #6's record revealed there was no October 2025 MAT sheet available for review.

Review of Resident #6's November 2025 eMAR revealed:
-There was an entry for Buprenorphine 8mg SL, take three tablets every day for seven days documented as administered 11/01/25 to 11/05/25 at 8:00am.
-There was no entry for Buprenorphine HCL 24mg every day documented after 11/05/25.

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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 367	Continued From page 25 Review of Resident #6's record revealed there was no November 2025 MAT sheet available for review. Observation of Resident #6's medications on hand on 11/06/25 at 12:06pm revealed: -There was a small lockbox with Resident #6's name on it, the lockbox was kept behind locked doors in the medication room. -Inside the lockbox was a empty prescription bottle with a dispense date of 09/27/25 and a label with Buprenorphine HCL 24mg every day to administer on 09/28/25. -There was a second empty prescription bottle with a dispense date of 10/18/25 and a label with Buprenorphine HCL 24mg every day to administer on 10/19/25. Telephone interview with a representative from the facility's contracted pharmacy on 11/19/25 at 10:24am revealed: -On 08/24/25, the pharmacy received an order for Buprenorphine 2mg SL, take three tablets every day as a clarification order from the facility, for Resident #6's FL2. -The pharmacy dispensed 60 tablets of Buprenorphine 2mg (a 30-day supply). -On 10/29/25, they received an order for Buprenorphine 8mg was received, take three tablets three times a day and 21 tablets of Buprenorphine 8mg was dispensed (a 7-day supply) to the facility. -The pharmacy did not receive an order dated 09/16/25 for Buprenorphine 20mg every day. -The pharmacy did not receive an order dated 09/17/25 for Buprenorphine 22mg every day. -The pharmacy did not receive an order dated 09/18/25 for Buprenorphine 24mg every day. -It was the facility's responsibility to send all updated/new orders to the pharmacy for "profile	D 367		

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only" so that the eMAR matched the current order and to clarify with the prescribing provider
-The facility staff could make changes to the eMAR and an eMAR report would have generated notifying the pharmacy of a change in the eMAR system.
-The pharmacy would have contacted the facility after the report was generated and requested an order to put in Resident #6's profile.
-Resident #6's eMAR should match the order and the entry on the eMAR should match the medications received from the pharmacy.

Refer to interview with the Residential Care Coordinator on 11/13/25 at 3:27pm.

Refer to interview with a representative from the facility's contracted pharmacy on 11/11/25 at 11:07am.

Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm.

Refer to interview with the Operations Manager on 11/13/25 at 10:54am and 3:46pm.

Refer to interview with the Administrator on 11/14/25 at 10:46am.

Interview with the Residential Care Coordinator on 11/13/25 at 3:27pm revealed:
-She was aware of the lock boxes from the SUDOC but had not administered any of the medications.
-The MA should be matching the medication with what was on the eMAR prior to administering the medication to ensure the medication was correct and document what was administered.
-If it did not match they should let their supervisor

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D 367	Continued From page 27	D 367		

know.

Telephone interview with a representative from the facility's contracted pharmacy on 11/11/25 at 11:07am revealed:
-The pharmacy would key in the medication orders, and the facility would have to approve the order for the medications.
-If the pharmacy had an order from an outside clinic, the pharmacy could key it into the eMAR for the facility.
-Although the pharmacy was not dispensing the medication, the offsite clinic could fax us the medication order and we could enter it on the eMAR, so it was consistent with Residents' profile.

Interview with the MA Supervisor on 11/12/25 at 2:35pm revealed:
-The process of Residents dosing at an offsite clinic was a new process to the facility.
-The MA should look at the Buprenorphine bottle for dosage amount and compare it to the order on the MAT.
-She would not have administered Buprenorphine if the dosage on the bottle did not match what was listed on the eMAR.

Interview with the Operations Manager 11/13/25 at 10:54am and 3:46pm revealed:
-The MA should verify that everything matches the prescription bottle, the order and eMAR.
-The MA most likely thought what was on the eMAR was what the resident was to be taking.
-They were not aware of the frequent order changes.
-They should have gotten the order changes and not just go by the initial order.

Interview with the Administrator on 11/14/25 at

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D 367	Continued From page 28 10:46am revealed: -The facility should be following the rules and regulations and if there were discrepancies with the prescription bottle and what was entered on the eMAR, the MA should be asking questions. -The eMAR should match the order and the medication that was administered to the resident. 3. Review or Resident #1's current FL2 dated 05/19/25 revealed: -Diagnoses included schizoaffective disorder, bipolar type. -Resident #1 had a history of seizures. Review of Resident #1's Mental Health Nurse Practitioners (NP) progress note dated 09/05/25 revealed there was an order to discontinue haloperidol (used to treat agitation) 5mg by mouth as needed. Review of Resident #1's record revealed there was a physician's order dated 10/21/25 to discontinue Resident #1's haloperidol 5mg. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for haloperidol 5mg by mouth every six hours as needed for agitation. -Haloperidol 5mg was documented as administered on 09/14/25. Review of Resident #1's October 2025 eMAR revealed: -There was an entry for haloperidol 5mg by mouth every six hours as needed for agitation. -There was no documentation of haloperidol 5mg being administered. Review of Resident #1's November 2025 eMAR revealed:	D 367		

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D 367	Continued From page 29 -There was an entry for haloperidol 5mg by mouth every six hours as needed for agitation. -There was no documentation of haloperidol 5mg being administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/05/25 at 10:38am revealed: -The pharmacy received a physician's order dated 08/21/25 for haloperidol 5mg by mouth every six hours as needed for agitation. -The pharmacy did not receive any orders from the facility to discontinue Resident #1's haloperidol. Interview with the MA supervisor on 11/14/25 at 10:33am revealed: -She did not know there were orders to discontinue Resident #1's haloperidol. -She, the Resident Care Coordinator (RCC) and Operations Manager were responsible for ensuring all orders were sent to the pharmacy and entered correctly onto the eMAR. Interview with the Administrator on 11/06/25 at 10:54am revealed: -She did not know there had been orders to discontinue Resident #1's haloperidol 5mg. -She expected the staff to follow the facility's policies and procedures to ensure medication orders were complete and accurate.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be	D 392		

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D 392	Continued From page 30 maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the administration of controlled substances for 2 of 2 sampled residents (#3 & #6) who received a medication used to treat substance use disorder. The findings are: 1. Review of Resident #3's current FL2 dated 09/03/25 revealed a diagnosis of schizoaffective disorder. Review of Resident #3's physician order dated 10/15/25 revealed: -An order for Buprenorphine hydrochloride (HCL) (a medication used to treat substance use disorder) 4 mg sublingual (SL), wait 30 minutes then reassess, may increase Buprenorphine HCL 2 mg daily as needed until a maximum dose of 10 mg starting on 10/16/25. -The order was from a Substance Use Disorder Outpatient Clinic (SUDOC). -There were no additional orders for Buprenorphine. Review of Resident #3's October 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buprenorphine HCL 10mg daily starting on 10/16/25. -There was no documentation that Buprenorphine 10mg was given during the month of October 2025.	D 392		

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D 392	Continued From page 31 Review of Resident #3's November 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buprenorphine HCL 10mg daily. -There was documentation Buprenorphine HCL 10mg was administered on 11/01/25 through 11/04/25. Observation of Resident #3's medications on hand on 11/06/25 at 3:28pm revealed: -There was a small lockbox with Resident #3's name on it, the lockbox was kept behind locked doors in the medication room. -Inside the lockbox were six individual pill bottles titled Buprenorphine HCL 14mg dispensed on 11/03/25. -Each pill bottle was for each day of the week for six days 11/04/25 through 11/09/25. -Each individual pill bottle was sealed with a foil seal. Review of the MAT chain of custody daily documentation form on 11/06/25 revealed: -Inside the lockbox was a form titled MAT (Medication Assisted Treatment) chain of custody daily documentation. -The form listed the date of 11/03/25, Residents #3's name and birth date, name of medication Buprenorphine HCL and dosage 12mg. -There were columns on the form with a date range for the days of the week to correspond with each prescription bottle that was in the lockbox. -The daily date range was documented as 11/04/25 through 11/09/25. -There were instructions which read: 'The patient and person dispensing the above identified medication must initial daily that the medication was dispensed and consumed'. -There were no initials documented on the MAT	D 392		

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chain of custody form for Resident #3 and the medication aide (MA).

Interview with the medication aide (MA) on 11/06/25 at 3:32pm revealed she would wait until the end of the week and then document on Resident #3's MAT chain of custody form.

Interview with the MA Supervisor on 11/06/25 at 3:32pm revealed that Resident #3's MAT chain of custody form must be filled out daily by the residents and the MA.

Interview with the MA on 11/07/25 at 2:40pm revealed:
-She would usually sign Resident #3's MAT chain of custody form at the end of the shift.
-It must have slipped her mind as to why her initials and the Resident #3's initials were not on the form.

Interview with the MA on 11/13/25 at 9:55am revealed:
-She would give the lockbox to Resident #3, and they open it and she would give the resident the medication for that day.
-She looked at the medication and compares it to the eMAR and sometimes would compare it to the order.
-The facility did not keep a copy of the MAT chain of custody form.
-She had not had any training about the process of when Residents would receive take home medications from a SUDOC.

A second observation of Resident #3's MAT chain of custody daily documentation form on 11/13/25 at 3:28pm revealed:
-Inside the lockbox was a form titled MAT chain of custody daily documentation.

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D 392	Continued From page 33 -The form listed the date of 11/10/25, the residents name and birth date, name of medication Buprenorphine HCL and dosage 14mg. -There were columns on the form with a date range for the days of the week to correspond with each prescription bottle. -The daily date range was documented as 11/11/25 through 11/16/25. -There were instructions which read: "The patient and person dispensing the above medication-identified medication must initial daily that the medication was dispensed and consumed". -Resident #3 did not document his initials from 11/13/25 to 11/16/25. -The MA did not document her initials from 11/14/25 to 11/16/25. Interview with Resident #3 on 11/13/25 at 3:28pm revealed that the MA forgot to have him sign the MAT chain of custody form. Refer to Interview with the Pharmacy Consultant on 11/11/25 at 12:07pm. Refer to interview with the Residential Care Coordinator on 11/13/25 at 3:27pm Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm Refer to interview with the Operations Manager on 11/13/25 at 10:54am Refer to interview with the Administrator on 11/14/25 at 10:46am 2. Review or Resident #6's FL2 dated 08/24/25 revealed diagnoses included substance use	D 392		

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disorder, schizoaffective disorder order, bipolar type and severe depression.

Interview with Resident #6 on 11/13/25 at 3:28pm revealed:
-Resident did go to a SUDOC every Monday through Saturday to receive her medication.
-The SUDOC did send a locked box with her every Saturday containing her Buprenorphine (a medication to treat substance use disorder) dose for the next day (Sunday).

Interview with the Resident Care Coordinator on 11/13/25 at 3:30pm revealed:
-She was aware that Resident #6 was being sent back to the facility on Saturdays with a locked black box with Sunday's dose.
-She knew staff were to sign a form provided by the SUDOC, when staff had administered the medication to Resident #6.
-She did not know Resident #6's Buprenorphine had not been entered onto the eMAR.
-Staff should not be administering any medications that were not on the eMAR.
-MAs should be matching the medication with what was on the eMAR prior to administering the medication to ensure the medication was correct.

Review of Resident #6's September 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buprenorphine 2mg SL, take three tablets every day, (suspended 09/12/25 to 09/19/25, on hold until seen by prescriber for refills) documented as administered 09/01/25 to 09/12/25 at 8:00am, 2:00pm and 8:00pm.
-On 09/19/25 at 8:00pm, 09/20/25 to 09/29/25 the Buprenorphine was documented as "medication not in the facility", "withheld per orders", "received

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at offsite clinic", and "new order medication not arrived from pharmacy", at 8:00am, 2:00pm and 8:00pm.
-On 09/30/25 at 8:00am and 8:00pm, the Buprenorphine was documented as administered at the offsite clinic and at 2:00pm administered by a medication aide.
-There was no entry for Buprenorphine HCL SL 20mg every day.
-There was no entry for Buprenorphine HCL SL 22mg every day.
-There was no entry for Buprenorphine HCL SL 24mg every day.

Review of Resident #6's record revealed there was no signed MAT chain of custody daily documentation form dated 09/21/25, 09/28/25, 10/05/25, 10/19/25, 10/26/25, 11/02/25 and 11/09/25.

Observation of Resident #6's medications on hand on 11/06/25 at 12:06pm revealed:
-There was a small lockbox with Resident #6's name on it, the lockbox was kept behind locked doors in the medication room.
-Inside the lockbox was a empty prescription bottle with a dispense date of 09/27/25 and a label with Buprenorphine HCL 24mg every day to administer on 09/28/25.
-There was a second empty prescription bottle with a dispense date of 10/18/25 and a label with Buprenorphine HCL 24mg every day to administer on 10/19/25.
-There was no MAT chain of custody daily documentation in Resident #6's lockbox.

Refer to Interview with the Pharmacy Consultant on 11/11/25 at 12:07pm.

Refer to interview with the Residential Care

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D 392	Continued From page 36 Coordinator on 11/13/25 at 3:27pm Refer to interview with the MA Supervisor on 11/12/25 at 2:35pm Refer to interview with the Operations Manager on 11/13/25 at 10:54am Refer to interview with the Administrator on 11/14/25 at 10:46am _____ Interview with the a representative from the facility's contracted pharmacy on 11/11/25 at 12:07pm revealed: -He goes to the facility to complete a review every three months. -The controlled substance counts were on the computer and he checks that to make sure they were accurate. -He did not review any documents or medications from the SUDOC. -If the staff at the facility were documenting on the MAT chain of custody form it would be the same as documenting on a narcotic count sheet at the facility. -If the count sheet meets the same criteria, it should be fine. Interview with the Residential Care Coordinator on 11/13/25 at 3:27pm revealed: -She was aware of the lock boxes from the SUDOC but had not administered any of the medications. -She knew staff were to sign a form provided by the SUDOC. Interview with the MA Supervisor on 11/12/25 at 2:35pm revealed: -The person administering the medication should	D 392		

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D 392	Continued From page 37 sign their initials each day on the MAT chain of custody form as well as the resident should also sign their initials, and the form goes back in the box. -She was not sure why the MAT chain of custody form for 11/4/25 through 11/6/25 did not have any initials on it. Interview with the Operations Manager on 11/13/25 at 10:54am revealed the facility should be keeping a copy of the MAT chain of custody form. Interview with the Administrator on 11/14/25 at 10:46am revealed the facility should be making copies of the MAT chain of custody form so we have a record.	D 392		
D 411	10A NCAC 13F .1010 (d) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For	D 411		

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D 411	Continued From page 38 the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; and (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence; (3) the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.	D 411		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059021	A. BUILDING: _____ B. WING _____	C 11/14/2025

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D 411	Continued From page 39	D 411		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the provision of medication for 1 of 1 sampled residents who went on temporary leave from the facility for two days without instructions for all medications to be administered (#2).

The findings are:

Review of Resident #2's current FL2 dated 11/01/24 revealed:
-Diagnoses included pneumonia and pulmonary embolism.
-An order for Eliquis (a blood thinner) 10mg two times a day through 11/05/24, then 5mg two times a day through 02/01/25.
-An order for aripiprazole (used to treat mood disorders) 20mg daily.
-An order for buspirone (used to treat anxiety) 10mg, three times a day.
-An order for clozapine (used to treat though disorders) 100mg, three tablets at bedtime.
-An order for fluoxetine (used to treat mood symptoms) 20mg daily.
-An order for gabapentin (used to treat pain) 600mg, four times a day.
-An order for nicotine (used to stop smoking) 2mg lozenge every hour as needed for smoking cessation.
-An order for pantoprazole (used to treat increased stomach acid) 40mg daily.
-An order for polyethylene glycol 3350 (used to treat constipation) 17gm daily.
-An order for propranolol (used to treat blood pressure) 80mg daily.
-An order for topiramate (used to treat) 25mg,

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D 411	Continued From page 40	D 411		

take two tablets, three times a day.

Review of Resident #2's November 2024 electronic medication administration record (eMAR) revealed Resident #2's medications were documented as Resident #2 was on "therapeutic leave overnight" from 11/21/24 to 11/22/24.

Review of Resident #2's record revealed there was no signed Medication Release Form dated 11/21/25 to 11/22/25 that contained a list of all Resident #2's medication orders and instructions.

Interview with the medication aide (MA) Supervisor on 11/12/25 at 2:35pm revealed:
-The MA Supervisor was responsible to complete a list of Resident #2 medications that were to be administered while he was out of the facility for an over night visit with his family.
-All medications to be administered would be signed out with the list of medications that included instructions related to the administration of the medications.
-She could not remember if the list of medications and the medications were dispensed to Resident #2 on 11/21/24.

Interview with the Operations Manager on 11/14/25 at 10:56am revealed:
-The MA Supervisor was responsible to complete a Medication Release form with a list of all medications with instructions the resident was to receive while on leave.
-She was not able to locate the Medication Release form for Resident #2 should have had in his record for the therapeutic leave dated 11/21/24 to 11/22/24.

Interview with the Administrator on 11/14/25 at 10:56am revealed:

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D 411	Continued From page 41 -The MA Supervisor was responsible for completing the Medication Release form and send all Resident #2's medications home with Resident #2 while on therapeutic leave.	D 411		