Adult Care Home Corrective Action Report (CAR)

I. Facility Name: **New Hanover House**
Address: 3915 Stedwick Court Wilmington, NC 28412
County: New Hanover
License Number: HAL-065-036

II. Date(s) of Visit(s): 07/16/25, 07/17/25, 07/29/25, 08/05/25, 08/14/25, 08/19/25, 08/26/25, and 09/10/25
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: **09/10/25**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0403 Rule/Statutory Reference: 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled medication aides (MA) who administered medications to residents had a medication aide employment verification or the required documentation of the state approved 5-hour and 10-hour or 15-hour medication administration training for adult care homes (Staff A, B, and C). Level of Non-Compliance: Standard Deficiency The findings are:	☒ POC Accepted RA, BSW S D *DSS Initials* Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or the conclusions set forth in the corrective action report;the plan of correction is prepared solely as a matter of compliance with State Law.	

Review of the facility's Medication Aide Training Policy dated September 2021 revealed: -The employee would be required to complete the 5-hour test at the time of the checkoff. If they cannot pass the test or do not pass the skills portion, they will not be deemed to have completed the check. -The Registered Nurse (RN) would observe employee in full medication pass and meet with employee and discuss items related to medication administration as the skills checkoff form is completed. -The Medication Aide (MA) would need to complete an in-person medication aide training class conducted by the RN with 30-60 days of the MA checkoff. -A pre-test and a final exam would be given. -A 10-hour certificate would be provided at the completion of the course. 1. Review of Staff A's personnel record on 08/26/25 revealed: -Staff A was hired on 12/23/24. -Staff A passed the medication aide examination on 01/25/25. -There was a medication administration clinical skills checklist dated 02/10/25. -There was a continuing education certificate dated 02/08/25 for 15 continuing education hours for a medication training course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. Review of a Resident's May 2025, June 2025, July 2025 and August 2025 electronic Medication Administration Record (eMAR) revealed there was documentation Staff A administered medications. Attempted telephone interview with Staff A on 08/26/26 at 3:06pm was unsuccessful. 2. Review of Staff B's personnel record on 08/26/25 revealed: -Staff B was hired on 05/06/25. -Staff B passed the medication aide examination on 10/19/09. -There was a medication administration clinical skills checklist dated 06/09/25. -There was no documentation of a medication aide employment verification or the required documentation of the state approved 5-hour and 10-hour or 15-hour medication administration training for adult care homes. Review of a Resident's June 2025 and July 2025 eMAR revealed there was documentation Staff B administered medications.	BOC has audited medication aide personnel files for the 5 & 10 hour or 15-hour training certificate. Any noted files found without the training have been provided to the CNC. CNC and Special Operations Clinical Nurse will complete a 2-day medication aide training by 10/25/25. BOC and ED were re-educated on the importance of ensuring all required trainings have been completed and training certificates remain in the staff files.	10-25-25 10/25/25 10/3/25

Telephone interview with Staff B on 08/26/25 at 3:57pm revealed:
-She took the 15-hour medication administration training course online.
-The online course consisted of watching videos and answering test questions.
-There was no part of the 15-hour medication training that was completed in person with an instructor.
-After she finished the online course and answered questions she was able to print a certificate for her personnel record.

3. Review of Staff C's personnel record on 08/26/25 revealed:
-Staff C was hired on 03/28/25.
-Staff C passed the medication aide examination on 12/16/24.
-There was a medication administration clinical skills checklist dated 04/07/25.
-There was a continuing education certificate dated 03/28/25 for 15 continuing education hours for a medication training course.
-There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes.

Review of a Resident's May 2025, June 2025 and July 2025 eMAR revealed there was documentation Staff C administered medications.

Telephone interview with Staff C on 08/26/25 at 3:12pm revealed:
-She recalled taking the 15-hour medication administration training online.
-She recalled the medication administration training consisted of watching videos and taking a test at the end of the videos.
-There was no part of the 15-hour medication training that was completed in person with an instructor.

Interview with the facility's Clinical Nurse Consultant (CNC) on 07/17/25 at 3:12pm revealed:
-The MAs were to have 5-hours of the medication aide training before they could pass medications.
-The MA training was an online class done on the computer that consisted of watching videos and answering questions.
-The facility's corporate office felt the online MA training was acceptable.
-She believed the facility's corporate office was looking to make changes about the MA training but she was not sure what those changes would be.
-She was aware the online MA training was not state approved as the corporate office was also aware.

Interview with the Administrator on 08/26/25 at 4:48pm revealed:

-The 5-hour, 10-hour, and 15-hour MA training were done online, which consisted of watching videos and taking a test. -A certificate was printed after the MA completed the videos for the 15-hour MA training. -She was aware the MA training should be taught in person and not done online. -She indicated she had spoken with the CNC about the MA trainings and that they needed to be done in person but could not recall the date. -The CNC started doing the 5-hour, 10-hour, and 15-hour MA trainings in person in July. -The CNC did not go back to do the 5-hour, 10-hour, and 15-hour MA trainings in person for Staff A, B, and C.		
Rule/Statute Number: 10A NCAC 13F .0406	☒ POC Accepted RA, BSW SD DSS Initials	
Rule/Statutory Reference: Test for Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 5 sampled staff (Staff A,C, D, and E) were tested for tuberculosis (TB) related to control measures adopted by the Commission for Public Health as specified in 10A NCAC 13F 41A .0205.	BOC has audited personnel files for TB testing results. Any files found to be out of compliance has been reported to the CNC. CNC will administer all TB's noted to be out of compliance and the documentation will be placed in the personnel file.	10/25/25 10/25/25
Level of Non-Compliance: Standard Deficiency		
The findings are: Review of the facility's Tuberculosis Screenings Policy dated September 2021 revealed: -Prior to employment all candidates for employment would be tested for tuberculosis disease (per 10A NCAC 41A .0205) following the guidelines effective July 2, 2012: -If the candidate does not have a documented two-step negative tuberculosis (TB) skin test, a two-step would be required. -If the candidate has one documented negative two-step TB skin test in the past 12 months, the candidate must have a one-step TB skin test on or before date of hire.		

-If the candidate has a single documented negative TB skin test within the previous 1 months, a single TB test is required on or before date of hire.
-In the event of a positive TB skin test or if a two-step TB skin test cannot be given (documented positive skin test, prior reaction to test or history of TB), the candidate would be referred to the local health department for further TB screening. The community would request a report signed by the physician showing further testing (i.e., chest x-ray/assay) was negative for TB disease. All testing would be documented in the candidate's file.
-Whenever a two-step TB skin test is required, the 2nd TB skin test is repeated 7-21 days after the 1st TB skin test reads negative.
-A single interferon gamma release assay replaces either one-step or two-step TB skin testing.

1. Review of Staff A's personnel record revealed:
-Staff A was hired on 12/23/24.
-Staff A was a medication aide (MA).
-Staff A had a TB test that was administered on 12/27/24 and read on 12/30/24 with a measurement of 0 millimeters (mm).
-Staff A had a second TB test that was administered on 01/20/25 and read on 01/23/25 with a measurement of 0mm.

2. Review of Staff C's personnel record revealed:
-Staff C was hired on 03/28/25.
-Staff C was a MA.
-Staff C had a TB test that was administered on 03/26/25 and read on 03/28/25 as negative.
-Staff C had a second TB test that was administered on 04/14/25 and read on 04/16/25 but did not document the results.

3. Review of Staff D's personnel record revealed:
-Staff D was hired on 06/19/25.
-Staff D was a MA.
-Staff D had a TB test that was administered on 06/23/25 and read on 06/26/25 with a measurement of 0mm.
-There was no documentation Staff D had a TB skin test done after the one read on 06/26/25.
-There was a sticky note on the outside of the personnel record that indicated "Needs TB."

Interview with Staff D on 08/19/25 revealed:
-He got his first TB test after being hired in June 2025, which was negative.
-He had not gotten a 2nd TB skin test since he received the 1st TB skin test in June 2025.

Interview with the Business Office Manager (BOM) on 08/19/25 at

3:08pm revealed: -He was responsible for the oversight of maintaining staff personnel records to ensure they had the required information. -He had not received a 2nd TB skin test for Staff D since June 2025. -He received the clinical information (such as the TB skin test) from the facility's Clinical Nurse Consultant (CNC) or staff, which was to be filed in the staff's personnel records. -He did not follow up with the CNC or Staff D regarding Staff D's 2nd TB skin test. Interview with the Administrator on 08/26/25 at 4:48pm revealed: -Staff were expected to have the 1st TB skin test upon hire. -Documentation of a TB skin test done within the last 12 months was acceptable. -Staff were expected to have the 2nd TB skin test done within 14 days of being hired after having had the 1st TB skin test. -Staff D should have had the 2nd TB skin test.		
Rule/Statute Number: 10A NCAC 13F .0801 Rule/Statutory Reference: Resident Assessments (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#4 and #5) in Assisted Living (AL) had a care plan completed within 30 days following admission. Level of Non-Compliance: Standard Deficiency The findings are: Review of the facility's Resident Assessment and Care Planning Policy dated September 2021 revealed: -Residents were assessed on admission and ongoing based on their individual needs in the care planning process, and the care plan is updated to reflect significant changes in resident care planning. -The individual assessment was completed by the Director of Resident Care, Resident Care Coordinator (RCC), or Memory Care Coordinator as assigned. -The Executive Director will complete the assessment in the absence of the other members of the management team. -A resident is assessed on admission using the Resident Register and a full assessment with care planning is completed within 30	☒ POC Accepted RA, BSW SD DSS Initials ED and Care Manager have completed a chart audit on all AL charts to ensure a resident assessment has been completed. Any assessments found to be out of compliance have been completed and uploaded to the residents EHR. Care Managers will utilize the resident tickler to ensure ongoing compliance. ED will review the tickler weekly during manager meeting.	10/25/25 10/25/25 10/25/25 10/25/25

days of admission, annually and as needed based on significant changes.

1. Review of Resident #4's current FL-2 dated 07/03/25 revealed:
-Diagnoses included moderate dementia with anxiety, overactive urinary bladder, hypothyroidism, atrial fibrillation, pace maker, stage 2 chronic kidney disease, and hyperlipidemia.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident was continent of bowel and incontinent of bladder.
-The resident's recommended level of care was documented as domiciliary/assisted living facility.

Review of Resident #4's Resident Register revealed an admission date of 07/07/25.

Review of Resident #4's care plan dated 08/12/25 revealed:
-The observation details were documented as initial resident assessment plan.
-The resident was ambulatory with a wheelchair.
-The resident was incontinent of bowel and bladder.
-The resident was intermittently disoriented and needed reminders.
-The resident required total assistance with eating, bathing, dressing, grooming, and transferring.
-The resident required supervision with toileting and ambulation/locomotion.
-The care plan was scheduled for 07/24/25 and due by 08/03/25.
-The care plan was completed by the Resident Care Coordinator (RCC)on 08/12/25.

Review of Resident #4's record revealed there was no care plan assessment completed prior to 08/12/25.

2. Review of Resident #5's current FL-2 dated 08/07/25 revealed:
-Diagnoses included fracture of carpal bone, muscle weakness, repeated falls, iron deficiency anemia, bipolar, and chronic obstructive pulmonary disease.
-The resident was semi-ambulatory.
-There was no information related to the resident's orientation.
-The resident's level of care was documented as domiciliary.

Review of Resident #5's Resident Register revealed an admission date of 06/06/25.

Review of Resident #5's care plan dated 08/12/25 revealed:
-The observation details were documented as initial resident assessment plan.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident was oriented and needed reminders.
-The resident required limited assistance with eating.
-The resident required supervision with toileting, bathing, dressing, grooming, transferring, and ambulation/locomotion.
-The care plan was scheduled for 08/12/25 and due by 08/22/25.
-The care plan was completed by the RCC on 08/12/25.

Review of Resident #5's record revealed there was no care plan assessment completed before 08/12/25.

Interview with the RCC on 08/19/25 at 3:15pm revealed:
-She started her role as RCC the end of May 2025.
-She was responsible for completing the resident care plans for the assisted living side of the building.
-She did not realize care plans were to be completed within 30 days of a resident being admitted.
-She thought the system would alert her when the care plan was to be completed once a resident was admitted to the facility.
-She completed Resident #4 and Resident #5's initial resident care plan on 08/12/25.

Interview with the Administrator on 08/26/25 at 4:48pm revealed:
-The RCC was responsible for completing the care plans for residents on the assisted living side of the building.
-She expected care plans to be completed within 30 days after a resident was admitted to the facility, yearly, and when there was a significant change.
-She was not aware Resident #4 and Resident #5's care plans were not completed until requested by the Adult Home Specialist.
-The RCC completed Resident #4 and Resident #5's initial resident care plans on 08/12/25.

Rule/Statute Number: 10A NCAC 13F .0902

Rule/Statutory Reference: Health Care

(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

☒ POC Accepted RA, BSW S D
DSS Initials

This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow up with health care providers to meet the routine and acute health care needs for 2 of 5 sampled residents (#1 and #4), related to a not completed chest x-ray when the resident (#1) had a productive wet cough and there was a concern the resident could have pneumonia and the Primary Care Provider (PCP) was not notified that the resident was sent out to the hospital on 07/07/25, and failure to notify the PCP of a resident's (#4) multiple missed medications, including a stroke prevention medication, thyroid medication, and medications for mood and depression.	SOCN re-educated all care staff on the importance of Health Care Referral and Follow-Up to meet the routine and acute health care needs of residents. An emphasis was placed on documentation of notifications made to the PCP.	9/23/25
Level of Non-Compliance: Type A1 Violation	ED and Care Managers will review the facility activity report daily during morning managers meeting to ensure notifications to PCP's have been documented.	10/10/25
The findings are: 1. Review of the facility's Health Care Referral and Follow-Up Policy dated September 2021 revealed: -It is the policy of the Community to assure referral and follow up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident record. -Documentation in the resident's record will include contacts with the physician/provider, other support licensed service providers, family, responsible parties, and guardians, when there are illnesses, incidents, accidents, and routine care or follow up as needed. -Visits to providers or onsite visits by providers including any new orders, for medications, treatments, or procedures. -Labs, vitals and parameters, falls and any other routine or acute health care need of the resident. 1. Review of Resident #1's current FL-2 dated 04/29/25 revealed: -Diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, urinary incontinence, thrombophilia, and paroxysmal atrial fibrillation. -The resident was constantly disoriented and the documented level of care was documented as special care unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 10/24/24.	Any noted discrepancies will be followed up on and a documented in the residents EHR.	10/10/25

Review of Resident #1's Primary Care Provider's (PCP) visit note dated 07/01/25 revealed: -Resident #1's chief complaint was documented as productive cough and dementia. -Resident #1 had a productive cough on 07/01/25 and reported she had not felt well that day. -Resident #1's oxygen saturation level was slightly low at 94%. -Resident #1's treatment plan included an order for a chest x-ray with 2 views and Cefdinir (used to treat bacterial infection) 300mg capsule, take one capsule by mouth every 12 hours for 7 days. Review of physician's orders for Resident #1 revealed there was an order dated 07/01/25 for a chest x-ray with 2 views. Review of Resident #1's electronic facility progress notes dated 06/01/25-07/07/25 revealed: -On 07/07/25 at 6:15pm, the reason for the progress note was antibiotic therapy. -There were no adverse effects from the antibiotic therapy seen. -The resident had a fever of 101.4° F. -The resident's change in behavior since the antibiotic therapy began was documented as fatigue. -The provider and responsible party were notified of changes on 07/07/25. -There was no other documentation other than 07/07/25. Review of Resident #1's emergency department (ED) encounter dated 07/07/25 revealed: -The resident's chief complaint on arrival at 4:04pm was weakness. -Staff at the facility noticed that the resident was coughing and had not been acting like herself for the last 1-2 days. -The resident presented to the ED with complaints of shortness of breath and generalized weakness for two days and found to be in rapid atrial fibrillation (heart rate of 177) and positive for human meta pneumovirus in the ED. -The resident experienced possible stroke like symptoms with mild right droop and dysarthria. -The resident had temperature of 101° F and had a cough. -The resident had a single view chest x-ray on 07/07/25 at the hospital that showed mildly heterogeneous interstitial predominant opacities (indicating lung abnormalities).		

-The resident's acute respiratory failure was high and the resident was admitted to the hospital.

Review of Resident #1's hospital discharge summary dated 07/09/25 revealed:
-The resident had a rapid response called due to bradycardia.
-The resident was examined at bedside and found to be pulseless.
-The resident's time of death was at 12:45am on 07/09/25.

Interview with a Personal Care Aide on (PCA) 07/17/25 at 4:52pm revealed:
-On 07/03/25, she informed the Medication Aide (MA) that Resident #1 wasn't feeling well, as the resident was wheezing and in bed.
-It was unusual for Resident #1 to be in bed, as the resident was usually up and walking around.

Interview with a second PCA on 07/17/25 at 4:57pm revealed:
-Resident #1 was usually up walking around the unit.
-Resident #1 definitely had a change of condition the last week of June 2025/1st week of July 2025, as the resident was drowsy and stayed in bed more.
-During this time, the resident's eyes were watery and she had no appetite.
-She knew Resident #1 did not feel good when she did not want to eat, as the resident was usually a good eater.
-She could not recall the Medication Aide (MA) she told that Resident #1 was not feeling well.
-On 07/07/25, she had to convince Resident #1 to get up to get a shower, as the resident was weak , congested and had tissue stuffed in her nose while her eyes were red and puffy.
-During the shower, Resident #1 kept saying she was cold when the water was warm and steamy.
-After the shower she informed the MA that Resident #1 was sick and did not feel good.
-Resident #1 was sent out to the hospital later that day.

Interview with a MA on 07/16/25 at 4:03pm revealed:
-The MA noticed that Resident #1 had a cough on 07/07/25, as she went back to her room after breakfast.
-When the MA went to Resident #'1's room about 9:00am to

administer medications, the resident was blowing her nose.
-The MA noticed that Resident #1 had spit mucus in some tissue.
-The MA asked Resident #1 if she felt well at which time the resident replied she did not.
-The MA, Resident Care Coordinator (RCC), and the facility's Clinical Nurse Consultant (CNC) went to Resident #1's room, as the resident was observed to be wheezing, coughing, and had a temperature of 101.4° F and was sent out to the hospital.

Telephone interview with Resident #1's Responsible Party (RP) 08/13/25 at 2:06pm revealed:
-She visited Resident #1 at the facility at least one time a week.
-When she saw Resident #1 on 07/03/25, the resident did not look like she felt good and looked tired.
-The resident was in bed that day, which was uncommon, as she was usually up and walking around.
-She was not concerned and did not report anything to the staff during her visit on 07/03/25.
-She was surprised when staff called her on 07/07/25 to let her know Resident #1 was being sent out to the hospital, as the resident looked pale and was having some respiratory issues.
-She indicated that Resident #1 had pneumonia which aggravated her heart.
-The hospital could not get Resident #1's heart rate down and the resident died on 07/09/25.
-She had not received a call from the facility prior to 07/07/25 to report the resident was not feeling well.
-She did not know Resident #1 was on an antibiotic (Cefdinir) until she received Resident #1's pharmacy bill.

Interview with the RCC on 07/16/25 at 4:35pm revealed:
-Resident #1 was seen by the resident's PCP on 07/01/25.
-The PCP put a folder on the RCC's desk on 07/01/25, which contained written orders for Resident #1.
-She faxed the written orders for Resident #1 to the pharmacy on 07/01/25, as she needed to have the orders faxed to the pharmacy before the 1:00pm cut off time for the medication to be delivered to the facility the next day.
-Once she faxed Resident #1's order to the pharmacy she did not look at the written order to realize the order for the chest x-ray was written on the same order as the Cefdinir.

-She uploaded Resident #1's written order for Cefdinir and chest x-ray to the resident's record on 07/03/25, but she did not review the order and did not realize the a chest x-ray had been ordered. -She learned that Resident #'1 had not received the chest x-ray ordered on 07/07/25 when the resident was sent out to the hospital for evaluation. -She would have been the one responsible to call to schedule the chest x-ray for Resident #1. -She was trained by the former Special Care Coordinator (SCC) to look at the order, read the order, put order in progress notes, fax order to the pharmacy, and upload order to the resident's file/record, which she did not do because she was in a rush. -She failed Resident #1 by not scheduling the chest x-ray, because she was busy and did not read the order. -The MA should have notified Resident #4's PCP on 07/07/25 with notification the resident was being sent out to the hospital. Interview with the facility's CNC on 07/17/25 at 3:12pm revealed: -Resident #1's PCP ordered a chest x-ray for the resident on 07/01/25. -The PCP thought Resident #4 had a respiratory infection, as the resident had a really bad cough. -The RCC would have been responsible for making sure the chest x-ray was done, as the order should have been implemented. -Resident #1 never got the chest x-ray that was ordered, which was an order that was not implemented. Interview with the Administrator on 07/17/25 at 5:10pm revealed: -The PCP usually met with the RCC after facility visit to go over her visit and any orders. -According to the RCC, on 07/01/25, she did not meet with the PCP and just put the PCP's notes on her desk because she was busy. -According to the RCC, she was in a rush to get the orders from 07/01/25 faxed to the pharmacy by 1:00pm to get medications delivered the next day. -The RCC did not look at the orders from 07/01/25 in detail and there was no follow up to review those orders. -The RCC would have been responsible for scheduling Resident #1's chest x-ray ordered by the PCP, documenting the order and the appointment for the chest x-ray in the resident's progress notes. -She would have expected that Resident #1's chest x-ray to be		

scheduled within 24 hours after the order was received and implemented and felt that the facility's failure was neglectful.
-She would have expected the MA to call Resident #1's PCP on 07/07/25 to notify her that the resident was being sent out to the hospital.

Interview with Resident #1's PCP on 07/29/25 at 10:56am revealed:
-She saw Resident #1 at the facility on 06/24/25 for anxiety and there were no concerns of a cough.
-From 06/24/25 to 07/01/25, there was no communication from facility staff that Resident #1 was not feeling well and had a cough.
-She saw Resident #1 at the facility on 07/01/25, at which time the resident was lying in bed and did not feel well.
-She ordered a chest x-ray (2 views) for Resident #1 on 07/01/25, to determine if the resident had pneumonia.
-On 07/01/25, Resident #1 had a productive wet sounding cough, as auscultation was difficult.
-Resident #1 was not taking deep breaths and she could not hear well enough to tell if the resident had a rattle in lungs.
-When the RCC called her on 07/07/25 to ask why Resident #1 was on an antibiotic, she asked the RCC about the chest x-ray as she had not received results of the x-ray.
-The RCC asked her if she had ordered the chest x-ray the same day as the antibiotic, at which time she told the RCC the chest x-ray and the Cefdinir were written on the same order.
-When she spoke with the RCC on 07/07/25, the RCC did not mention that Resident #1 was not doing well and did not mention that the resident had been sent out to the hospital.
-If she would have had chest x-ray results that showed pneumonia, she would have followed up with the resident on 07/08/25.
-She would not have necessarily sent Resident #1 out the hospital for results of pneumonia since she had ordered Cefdinir assuming the resident had received the Cefdinir as ordered.
-Since the resident had not received Cefdinir as ordered, she could have come up with a treatment plan with results that showed the resident had pneumonia.
-She spoke with the facility's CNC on 07/08/25, at which time she was informed that Resident #1 had been sent to the hospital on 07/07/25.

-Resident #1's chest x-ray findings taken at the hospital suggested pulmonary edema verses atypical pneumonia.
-She would have expected Resident #1 to have chest x-ray as ordered and she would have expected the facility to call her to let her know the resident was not doing well and was being sent out to the hospital on 07/07/25.

Review of Resident #1's death certificate revealed:
-The date of death was 07/09/25.
-The immediate cause of death was chronic atrial fibrillation with the second cause being community acquired pneumonia.

2. Review of the facility's Missed or Refused Medication Policy dated September 2021 revealed:
-No resident can be forced to take any medication. Steps will be taken to avoid missed or refused doses of medication as per the medication policy.
-Missed/refused medications are documented on the resident's medication administration record (MAR) and the provider, responsible party/guardian are notified and documented.
-The Medication Aide (MA) and/or the Resident Care Coordinator (RCC) notifies the prescribing provider of missed/refused medications immediately using the medication notification form after 3 consecutive refusals unless the medications are related to diabetic, coumadin, and seizure disorders.
-The RCC evaluates the resident refusals and contacts the physician and responsible party (RP) if the resident is continually refusing a medication(s) and documents the communication on the Care Coordinator Meeting Progress Note.

Review of Resident #4's current FL-2 dated 07/03/25 revealed:
-Diagnoses included moderate dementia with anxiety, overactive urinary bladder, hypothyroidism, atrial fibrillation, pace maker, stage 2 chronic kidney disease, and hyperlipidemia.
-The resident was intermittently disoriented.
-The resident's recommended level of care was documented as domiciliary/assisted living facility.
-There was an order for Buspar (used to treat anxiety) 10mg twice daily.
-There was an order for Eliquis (used to prevent blood clots in people with atrial fibrillation and other disorders) 2.5mg twice daily.
-There was an order for Sertraline (used to treat depression) 100mg daily.
-There was an order for Levothyroxine (used to treat underactive

thyroid) 150mcg daily.

Review of Resident #4's Resident Register revealed an admission date of 07/07/25.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Buspirone 10mg, one tablet twice daily, scheduled for 8:00am and 9:00pm.
-Buspirone was documented as refused 12 of 24 opportunities at 8:00am.
-Buspirone was documented as refused 17 of 24 opportunities at 9:00pm.
-There was an entry for Eliquis 2.5mg, one tablet by mouth twice daily scheduled for 8:00am and 9:00pm.
-Eliquis was documented as refused 11 of 24 opportunities at 8:00am.
-Eliquis was documented as refused 18 of 24 opportunities at 9:00pm.
-There was an entry for Sertraline 100mg, one tablet daily, scheduled for 8:00am.
-Sertraline was documented as refused 12 of 24 opportunities at 8:00am.
-There was an entry for Levothyroxine 150mg, one tablet every morning at 6:00am.
-Levothyroxine was documented as refused 16 of 24 opportunities at 6:00am.

Review of Resident #4's August 2025 eMAR revealed:
-There was an entry for Buspirone 10mg, one tablet twice daily, scheduled for 8:00am and 9:00pm.
-Buspirone was documented as refused 11 of 14 opportunities at 8:00am.
-Buspirone was documented as refused 11 of 13 opportunities at 9:00pm.
-There was an entry for Eliquis 2.5mg, one tablet by mouth twice daily scheduled for 8:00am and 9:00pm.
-Eliquis was documented as refused 11 of 14 opportunities at 8:00am.
-Eliquis was documented as refused 13 of 13 opportunities at 9:00pm.
-There was an entry for Sertraline 100mg, one tablet daily,

scheduled for 8:00am.
-Sertraline was documented as refused 11 of 14 opportunities at 8:00am.
-There was an entry for Levothyroxine 150mg, one tablet every morning at 6:00am.
-Levothyroxine was documented as refused 14 of 14 opportunities at 6:00am.

Review of Resident #4's electronic facility progress notes on 08/14/25 revealed:
-On 07/09/25 at 5:34pm, the resident's Primary Care Provider (PCP) and RP were notified on 07/09/25 about the resident's medication refusals.
-There was no other documentation the PCP had been notified about Resident #4's medication refusals after 07/09/25.

Interview with a MA on08/05/25 at 1:25pm revealed:
-Resident #4 refused her medications often.
-It was the facility's policy to notify the PCP after 3 consecutive refusals.
-She could not say way she had not called Resident #4's PCP about her medication refusals.

Interview with a second MA on 08/14/25 at 1:20pm revealed:
-Resident #4 did not like to take her medications and refused them a lot.
-She was not sure what the facility's policy was regarding medication refusals and contacting the PCP.
-She thought the facility would need to let the PCP know about a resident who refused their medications.
-She had not called Resident #4's PCP about medication refusals nor had she informed the RCC about Resident #4's medication refusals, as she was not aware she needed to.
-She assumed the RCC would be responsible for notifying the PCP about a resident's medication refusals.

Telephone interview with a third MA on 08/26/25 at 3:12pm revealed:
-Resident #4 had refused her medications a lot since being admitted to the facility.
-She was not sure what the facility's policy was related to medication refusals.
-She had not called Resident #4's PCP or family about the resident medication refusals.
-Resident #4 had a right to refuse her medications as they could not make the resident take her medications.

Telephone interview a fourth MA on 08/26/25 at 4:24pm revealed: -Resident #4 was known to refuse her medications. -The facility's policy was to call the resident's PCP and family after 3 consecutive medication refusals and document the notifications in the resident's progress notes. -She called Resident #4's PCP and family member once about the resident's medication refusals to make them aware. -She documented call with Resident #4's PCP and family member in the resident's progress notes and did not notify RCC of phone calls. Interview with Resident #4 on 08/14/25 at 1:04pm revealed she did refuse her medications at times but did not give a reason why she refused them. Telephone interview with Resident #4's RP on 08/26/25 at 2:40pm revealed: -Shortly after the resident was admitted to the facility, a staff member called to inform her the resident was refusing her medications and had not had any other communication with facility staff since that call about resident's medication refusals. -Resident #4 had a history of not wanting to take medications, but how staff approached the resident was very important to get the resident to take medications. -Telling the resident what she was taking and that the PCP prescribed it were things that could get the resident to take medications, and she did not know if staff knew to do that. -She felt that resident's dementia/mood and thyroid medications were the most important and she would expect medications to be given if ordered by the PCP. -She would expect the facility to call the resident's PCP about the resident's medication refusals. Interview with the RCC on 08/19/25 at 5:06pm revealed: -She was not sure what the facility's policy was about medication refusals but believed after 3 consecutive refusals, the PCP was to be notified. -The MA's would be responsible for calling the PCP about medication refusals, as they are the ones administering medications and would know when the resident was at 3 consecutive refusals. -The MA's should let her know they called the PCP about medication refusals so she is aware and can follow up with the PCP if needed. -She was aware Resident #4 had been refused her medications at times according to the MA's. -She had not reviewed Resident #4's eMAR to look at the number of medication refusals.		

-She was not aware she was to evaluate Resident #4's medication refusals and that she was responsible for calling Resident #4's PCP about medication refusals, according the facility's Missed or Refused Medication Policy.
-According to Resident #4's progress notes, Resident #4's PCP had not been notified of the resident's medication refusals since 07/09/25.

Interview with the Administrator on 08/14/25 at 3:10pm revealed:
-She was aware Resident #4 had refused some of her medications, but she did not know the number of refusals.
-The PCP was to be notified after a resident refused 3 consecutive medications and a progress note of the notification was to be completed.
-A MA could call the PCP about a resident's medication refusals and let the RCC know.
-The RCC would ultimately be responsible for ensuring the PCP was notified when a resident refused a medication 3 consecutive times.
-She was not aware the PCP had not been notified about Resident #4's medication refusals since 07/09/25.
-After looking at Resident #4's July 2025 and August 2025 eMAR, Resident #4's PCP should have been notified about the resident's medication refusals.

Telephone interview with Resident #4's PCP on 08/20/25 at 4:27pm revealed:
-She saw Resident #4 for the first time on 07/08/25, at which time the resident was really confused.
-A MA notified her on 07/09/25 that the resident had refused some medications, at which time she told the MA to keep trying and to let the resident's family member know.
-Since 07/09/25 she had not been notified about the resident's medication refusals until 08/19/25.
-The RCC made her aware on 08/19/25 that Resident #4 had been refusing her medications.
-Resident #4 was on Eliquis for Atrial Fibrillation and expected staff to administer Eliquis as ordered for stroke prevention.
-By not administering Resident #4's Eliquis as ordered increased the resident's risk for a stroke.
-Resident #4 was on Levothyroxine due to thyroid issues.
-By not administering Resident #4's Levothyroxine as ordered could explain why the resident felt tired and maybe was part of the reason the resident did not want to get up out of bed.
-Resident #4 was on Buspar for her mood.
-By not administering Resident #4's Buspar as ordered increased the risk that her mood would not be stabilized.
-Resident #4 was on Sertraline for depression.
-By not administering Resident #4's Sertraline as ordered increased

the chance of withdrawals causing the resident to feel bad and would not be effective to help resident's depression. -Sertraline was a medication that need to be tapered if stopped. -She would expect to be notified if a resident had 3 consecutive medication refusals to that she could evaluate the situation and determine a course of action and treatment plan for the resident. The facility failed to ensure referral and follow up to meet the acute health care needs of a resident (#1) who was ordered a chest x-ray on 07/01/25 which the facility never scheduled. The resident was noticed to have wheezing and was lying in bed and appeared to not feeling well on 07/03/25. The resident was sent out to the hospital without notification to primary care provider (PCP) on 07/07/25, which resulted in the resident being admitted to the hospital with fever, increased heart rate, and respiratory failure. The resident (#1) died on 07/9/25 with the second cause of death being community acquired pneumonia. The facility failed to notify the PCP about a resident's (#4) continuous refusal of medications order for atrial fibrillation, thyroid function, mood and depression. The facility's failure resulted in neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/25. **CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 10, 2025.**		
Rule/Statute Number: 10A NCAC 13F .1004 Rule/Statutory Reference: 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 administer medications as ordered for 1 of 5 residents sampled (#1), who was ordered an antibiotic for respiratory symptoms. Level of Non-Compliance: Type A1 Violation	☒ POC Accepted RA, BSW SD *DSS Initials*	

The findings are: Review of the facility's Medication Services/Pharmaceutical Care Services Policy dated September 2021 revealed: -The community provides medication administration, ordering, and reordering of medication and medication administration services. -The Executive Director, Resident Care Coordinator (RCC) or designee will ensure that medication administration services required for each resident is provided. -All medications that staff members administer, handle, store, and administer will be documented on the Medication Administration Record (MAR) and in accordance with state regulations and the Community's preferred pharmacy standard and procedure manual. -All medications for residents who receive medication administration will be stored in the designated medication storage area of each community. Review of the facility's Medication Errors Policy dated September 2021 revealed: -A medication error is defined as: the wrong medication, the wrong person, the wrong dose, the wrong route, missed dose, missing documentation, not initiating an order. -Medications are handled in a way that minimizes the risk of medication error; should a medication error occur, the following procedures are followed to ensure the safety of the resident: the individual identifying the medication error immediately reports it to the RCC. If the RCC is not available, the report is made to the nurse on duty or Executive Director; The resident's prescribing physician is immediately notified of the medication error. When reporting the error to the physician, do not speculate as to how the error occurred, simply report the facts of the situation; Document and follow instructions given by the resident's physician; Monitor the resident for signs and symptoms of a serious adverse reaction (e.g., shortness of breath, allergic reaction, change in cognitive, pale skin color, rash, nausea, vomiting, diarrhea, etc.) vital signs will be taken and reported to the physician; If signs and symptoms of adverse reaction as noted, immediately contact emergency medical services; The responsible party is notified of the error; and an internal incident report is completed and presented to the RCC. Review of Resident #1's current FL-2 dated 04/29/25 revealed:	SOCN re-educated all Medication Aides, RCC, SCC and ED on the importance of assuring that medications are administered as ordered, the order processing system and documentation of medications administered. CNC will conduct random med pass observations during site visits to ensure medications administered are being documented. ED and Care Managers will complete random weekly MAR to Cart audits to follow up with ongoing compliance. Medication aides will complete daily cart audits per facility schedule. Cart audits will be reviewed by care managers. ED and Care managers will review cart audits during morning meeting. Any issues found will be followed up and documented in the residents EHR.	9/23/25 10/10/25 10/10/25 10/10/25 10/10/25

-Diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, urinary incontinence, thrombophilia, and paroxysmal atrial fibrillation.
-The resident's level of care was documented as special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 10/24/24.

Review of Resident #1's Primary Care Provider's (PCP) visit note dated 07/01/25 revealed:
-Resident #1's chief complaint was documented as productive cough and dementia.
-Resident #1 had a productive cough on 07/01/25 and reported she had not felt well that day.
-Resident #1's oxygen saturation level was slightly low at 94%.
-Resident #1's treatment plan included an order for a chest x-ray with 2 views and Cefdinir (used to treat bacterial infection) 300mg capsule, take one capsule by mouth every 12 hours for 7 days.

Review of physician's orders for Resident #1 revealed there was an order dated 07/01/25 to start Cefdinir (used to treat bacterial infection) 300mg, take one capsule by mouth every 12 hours for 7 days.

Review of Resident #1's July 2025 electronic Medication Administration Record (eMAR) revealed:
-Cefdinir 300mg was documented as administered at 9:00am on 07/03/25, 07/04/25, and 07/07/25.
-Cefdinir 300mg was documented as administered at 9:00pm on 07/02/25, 07/03/25, 07/04/25, 07/05/25, and 07/06/25.
-On 07/05/25 and 07/06/25, there was no documentation that Cefdinir 300mg was administered at 9:00am with the reason documented as awaiting pharmacy.

Based on record review and observation of Resident #1's medications on hand at the facility on 07/16/25 at 4:25pm revealed only 3 of the 14 doses of Cefdinir had been administered.

Review of Resident #1's electronic facility progress notes dated 06/01/25-07/07/25 revealed:

-On 07/07/25 at 6:15pm, the reason for the progress note was antibiotic therapy.
-There were no adverse effects from the antibiotic therapy seen.
-The resident had a fever of 101.4° F.
-The resident's change in behavior since the antibiotic therapy began was documented as fatigue.
-The provider and responsible party were notified of changes on 07/07/25.
-There was no other documentation other than 07/07/25.

Review of a Medication Error Report for Resident #1 dated 07/07/25 at 1:51pm revealed:
-The dates of the medication errors were documented as 07/02/25 and 07/03/25.
-The total number of errors were documented as 7.
-The name of the medication was Cefdinir 300mg.
-The dosage and frequency of the medication was documented as 1 capsule by mouth every 12 hours.
-The description of the medication error was documented as incorrect documentation.
-The reason for the making the error was that the employee did not administer the medication.
-The resident was sent to the emergency department (ED).
-The medication error was discovered on 07/08/25 at 9:00am by another employee who notified the Administrator.
-A medication aide (MA) notified Resident #1's PCP on 07/09/25 at 1:00pm.
-The physician's order given for Resident Care was documented as none as the resident had expired.
-The precaution to be taken to prevent similar errors was that all medications must be given in a timely manner.
-The medication error was completed on 07/15/25 at 2:03pm by the Administrator.

Review of Resident #1's emergency department (ED) encounter dated 07/07/25 revealed:
-The resident's chief complaint on arrival at 4:04pm was weakness.
-Staff at the facility noticed that the resident was coughing and had not been acting like herself for the last 1-2 days.
-The resident presented to the ED with complaints of shortness of breath and generalized weakness for two days and found to be in

rapid atrial fibrillation (heart rate of 177) and positive for human meta pneumovirus in the ED.
-The resident experienced possible stroke like symptoms with mild right droop and dysarthria
-The resident had temperature of 101° F and had a cough.
-The resident had a single view chest x-ray on 07/07/25 that showed mildly heterogeneous interstitial predominant opacities.
-The resident's acute respiratory failure was high and the resident was admitted to the hospital.

Review of Resident #1's hospital discharge summary dated 07/09/25 revealed:
-The resident had a rapid response called due to bradycardia.
-The resident was examined at bedside and found to be pulseless.
-The resident's time of death was at 12:45am on 07/09/25.

Interview with a Personal Care Aide on (PCA) 07/17/25 at 4:52pm revealed:
-On 07/03/25, she informed the MA that Resident #1 wasn't feeling well, as the resident was wheezing and in bed.
-It was unusual for Resident #1 to be in bed, as the resident was usually up and walking around.

Interview with a second PCA on 07/17/25 at 4:57pm revealed:
-Resident #1 was usually up walking around the unit.
-Resident #1 definitely had a change of condition the last week of June 2025/1st week of July 2025, as the resident was drowsy and stayed in bed more.
-During this time, the resident's eyes were watery and she had no appetite.
-She knew Resident #1 did not feel good when she did not want to eat, as the resident was usually a good eater.
-She could not recall the MA she told that Resident #1 was not feeling well and when.
-On 07/07/25, she had to convince Resident #1 to get up to get a shower, as the resident was weak , congested and had tissue stuffed in her nose while her eyes were red and puffy.
-During the shower, Resident #1 kept saying she was cold when the water was warm and steamy.
-After the shower she informed the MA that Resident #1 was sick and did not feel good.

-Resident #1 was sent out to the hospital later that day.

Interview with a MA on 07/17/25 at 4:34pm revealed:
-On 07/03/25, Resident #1 seemed fine and showed no symptoms of respiratory concerns.
-She administered Resident #1 the first dose of Cefdinir on 07/03/25 at 9:00am and initialed the blister pack to indicate medication was administered.
-When a resident was on an antibiotic, the MA was to complete a progress note each time the antibiotic is administered but she could not recall if she had completed a progress note on 07/03/25.

Telephone interview with a second MA on 07/18/25 at 6:35pm revealed:
-She was not aware Resident #1 was on Cefdinir as she was not informed during shift change.
-She called another MA on 07/04/25 to ask about Resident #1 being on Cefdinir, who was not aware Resident #1 had an order for Cefdinir.
-Once she did not see Resident #1's Cefdinir with the narcotics she did not check the cart, because by law antibiotics were to be stored with the narcotics.
-She documented she administered Resident #1 the Cefdinir when she did not administer the medication to the resident on 07/04/25, 07/05/25, and 07/06/25 at 9:00pm, because it was the safest thing to do since she could not find the medication on the cart instead of saying the medication was not available and awaiting on pharmacy.

Telephone interview with a former MA on 07/29/25 at 5:21pm revealed:
-She received a call from another MA on 07/04/25 asking why Resident #1 was on Cefdinir and stayed on the phone with the MA while she looked for the medication on the cart.
-The MA indicated that she was just going to click on that medication to indicate it was given because the Administrator had gotten on her about her medications being late.
-She was not aware Resident #1 was on Cefdinir until she came to work on 07/05/25 and saw the medication on the eMAR.
-She searched the entire medication cart for Resident #1's Cefdinir, which she could not locate on 07/05/25 and 07/06/25, as antibiotics were to be kept with narcotics.

-When she could not locate Resident #1's Cefdinir, she documented on the eMAR that the medication was not administered due to awaiting pharmacy on 07/05/25 and 07/06/25 at 9:00am.
-She did not call the RCC or the Administrator when she could not find Resident #1's Cefdinir on 07/05/25 and 07/06/25.
-The Administrator had a meeting with MA's and RCC on 07/15/25 about Resident #1 not receiving her Cefdinir as ordered, at which time they acknowledged they were not aware the resident was on the antibiotic.

Interview with a fourth MA on 07/16/25 at 4:03pm revealed:
-The MA's first day out of training to work independently on the medication cart was on 07/07/25, as the MA was assigned to work in the Special Care Unit (SCU).
-The MA noticed that Resident #1 had a cough on 07/07/25, as she went back to her room after breakfast.
-When the MA went to Resident #'1's room about 9:00am to administer medications, the resident was blowing her nose.
-The MA noticed that Resident #1 had spit mucus in some tissue.
-The MA asked Resident #1 if she felt well at which time the resident replied she did not.
-When the MA looked at Resident #1's electronic medication administration record eMAR he noticed the resident was on an antibiotic.
-Resident #1's antibiotic was found on the medication cart with the regular medications, as the facility's protocol was that antibiotics were to be kept with the narcotics.
-He looked throughout the medication cart for Resident #1's antibiotic as it was found with the regular medications, as the facility's policy was that antibiotics were to be kept with the narcotics.
-After the MA gave Resident #1 her antibiotic, the progress note did not come up to document about the antibiotic, which he thought was weird.
-The MA indicated that a progress note was to be completed every time an antibiotic was administered.
-The MA was able to eventually complete a progress note about Resident #1's antibiotic that he had administered.
-After the MA completed the medication pass, the MA went to ask the RCC about Resident #1 being on an antibiotic.
-The RCC was not aware Resident #1 was on an antibiotic and did

not know why it had been ordered.
-The MA, RCC, and the facility's Clinical Nurse Consultant (CNC) went to Resident #'1 room, as the resident was observed to be wheezing, coughing, and had a temperature of 101.4° F and was sent out to the hospital.
-The MA did not know Resident #1 was on an antibiotic until 07/07/25 when he went to administer the medication as he was not informed of the antibiotic during shift change report with the previous MA.
-The Administrator held a meeting on 07/15/25 with several MA's and the RCC about Resident #1 and how the resident did not receive her antibiotic as ordered.
-During the meeting, one MA indicated that she could not find Resident #1's antibiotic in the narcotic box on the medication cart, but she documented the Cefdinir was administered because it was the safest thing for her to do to cover herself.
-During the meeting, another MA indicated she documented waiting on the pharmacy since she did not see Resident #1's antibiotic in the narcotic box on medication cart.
-If he could not find a medication on the medication cart he would call the RCC or the pharmacy verses documenting that it was administered or awaiting on pharmacy.
-On 07/07/25, Resident #1 still had 11 antibiotics on hand, which indicated she had not received her medication as ordered.
-Resident #1 should have received her antibiotic as ordered.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/05/25 at 4:54pm revealed:
-The pharmacy received a fax on 07/01/25 at 2:44pm for Resident #1 for Cefdinir 300mg 1 capsule by mouth every 12 hours for 7 days.
-A total of 14 Cefdinir capsules were dispensed to the facility on 07/02/25 at 2:39pm, at which time a MA signed for the medication.

Interview with the RCC on 07/16/25 at 4:35pm revealed:
-Resident #1 was seen by the resident's PCP on 07/01/25.
-The PCP put a folder on the RCC's desk on 07/01/25, which contained written orders for Resident #1.
-She faxed the written orders for Resident #1 to the pharmacy on 07/01/25, as she needed to have the orders faxed to the pharmacy

before the 1:00pm cut off time for the medication delivered to the facility the next day. -Once she faxed Resident #1's order to the pharmacy she did not look at the written order to realize the Cefdinir was ordered. -She uploaded Resident #1's written order to the resident's record on 07/03/25, but she did not review the order. -She was trained by the former Special Care Coordinator (SCC) to look at the order, read the order, put order in progress notes, fax order to the pharmacy, and upload order to the resident's file/record, which she did not do because she was in a rush. -She was not aware Resident #1 was order Cefdinir until 07/07/25 and that the resident had not received medication as ordered. Interview with the Administrator on 07/17/25 at 5:10pm revealed: -The PCP usually met with the RCC after facility visit to go over her visit and any orders. -According to the RCC, on 07/01/25, she did not meet with the PCP and just put the PCP's notes on her desk because she was busy. -According to the RCC, she was in a rush to get the orders from 07/01/25 faxed to the pharmacy by 1:00pm to get medications delivered the next day. -The RCC did not look at the orders from 07/01/25 in detail and there was no follow up to review those orders. -She called the facility's contracted pharmacy on 07/15/25 was told that the 14 tablets of Cefdinir were dispensed to the facility on 07/02/25 at 2:39pm and that a MA signed for the medication. -She had a meeting on 07/15/25 with the RCC and MA's about Resident #1 not receiving Cefdinir as ordered. -During the 07/15/25 meeting, she had one MA who indicated she documented Resident #1's Cefdinir was administered when it was not because it was the right thing to do as she did not want to say medication was not administered and awaiting pharmacy. -She was not aware Resident #1 was on Cefdinir until 07/07/25, when a MA discovered the resident had not received medication as ordered. -After Resident #1 was sent out to the hospital on 07/07/25, it was discovered that 11 Cefdinir tablets were on hand. -Staff should have called her if they could not find Resident #1's Cefdinir on the medication cart. -Staff failed Resident #1 and were neglectful, as the resident was not administered her Cefdinir as ordered.		

-She expected residents to receive medications as ordered, as they are ordered for a reason related to their diagnoses.

Interview with Resident #1's PCP on 07/29/25 at 10:56am revealed:
-She saw Resident #1 at the facility on 07/01/25, at which time the resident was lying in bed and did not feel well.
-On 07/01/25, Resident #1 had a productive wet sounding cough, as auscultation was difficult.
-Resident #1 was not taking deep breaths and she could not hear well enough to tell if the resident had a rattle in lungs.
-On 07/01/25, Resident #1 was ordered a chest x-ray and Cefdinir 300mg capsules, one capsule every 12 hours for 7 days, as she was concerned the resident could have pneumonia.
-She wanted to start Resident #1 on an antibiotic as the resident looked really sick.
-The RCC called her on 07/07/25 to ask why Resident #1 was on an antibiotic.
-She did not learn that Resident #1 had not received her Cefdinir as ordered until 07/08/25 when the facility's CNC informed her that the resident had been sent out to the hospital.
-She would expect medications to be administered as ordered.
-Resident #1 died on 07/09/25 at the hospital from a cardiac event, which was not related to her lungs.
-An infection can contribute to other health factors.
-She could not say 100% that Resident #1's death was related to the medication error but at the same time could not say it was not either.

Review of Resident #1's death certificate revealed:
-The date of death was 07/09/25.
-The immediate cause of death was chronic atrial fibrillation with the second cause being community acquired pneumonia.

The facility failed to ensure a diagnostic chest x-ray was obtained and an antibiotic was administered as ordered to a resident (#1) who had a cough and respiratory symptoms on 07/01/25. When the resident was sent out to the hospital on 07/07/25, the resident had received 3 of 14 doses of Cefdinir (antibiotic) that were ordered on 07/01/25. Resident #1 died on 07/09/25, as the second cause of death was listed as community acquired

pneumonia. This failure resulted in neglect of the resident and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/25.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 10, 2025.

Rule/Statute Number: 10A NCAC 13F .1004

☒ POC Accepted RA, BSW SD
DSS Initials

Rule/Statutory Reference: 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 review the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3) including inaccurate documentation for a medication used to treat high blood pressure, heart failure and a build up of fluid in the body.

Level of Non-Compliance: Standard Deficiency

The findings are:

Review of Resident #3's current FL-2 dated 04/29/25 revealed:
-Diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, urinary incontinence,

hypertension, and osteoarthritis. -There was an order for Furosemide (treat high blood pressure, heart failure and a build up of fluid in the body) 20mg one tablet once a week on Monday and once a week on Thursday. Observation of Resident #3's medications on hand on 08/05/25 at 2:45pm revealed there was a multiple dose blister pack that contained Furosemide 20mg to be administered one tablet once a week on Monday and once a week on Thursday. Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 20mg one tablet by mouth once a week on Monday and once a week on Thursday scheduled for 9:00am. -Furosemide 20mg was documented as administered 12 times on days other than Monday and Thursday. -Furosemide 20mg was documented as not administered due to awaiting pharmacy 7 times on days other than Monday and Thursday. Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 20mg one tablet by mouth once a week on Monday and once a week on Thursday scheduled for 9:00am. -Furosemide 20mg was documented as administered 7 times on days other than Monday and Thursday. -Furosemide 20mg was documented as not administered due to waiting/awaiting pharmacy 5 times on days other than Monday and Thursday. Interview with a Medication Aide (MA) on 08/05/25 at 12:20pm revealed: -Resident #3 had an order for Furosemide to be administered on Monday and Thursday. -She could not explain why she documented medication was not administered due to awaiting pharmacy on 06/20/25, 06/29/25, and 07/13/25 when the medication was not scheduled. -On days the medication is not scheduled the MA's should document on the eMAR the medication not scheduled. Interview with a second MA on 08/05/25 at 2:51pm revealed: -Resident #3 had an order for Furosemide to be administered on Monday and Thursday. -She had informed the Resident Care Coordinator (RCC) that she had noticed MA's were documenting Resident #3 was administered Furosemide on days not scheduled and not	Care Managers will pull the administration compliance report daily and bring to the morning managers meeting for review with the ED. All noted issues will be followed up on documented in the residents EHR. Medication Aides, RCC, SCC were re-educated on the 6 rights of medication administration by the SOCN. ED and Care managers will complete a weekly MAR to Cart audit to assure accuracy of MARs.	10/25/25 9/23/25 10/25/25

administered due to awaiting pharmacy, but she could not recall the date she informed the RCC.

Interview with a third MA on 08/19/25 at 11:16am revealed:
-Resident #3 had an order for Furosemide to be administered on Monday and Thursday.
-He documented Furosemide was administered on 07/16/25, 07/22/25, and 07/23/25 when he shouldn't have as those were days other than Monday and Thursday.
-He should have documented the Furosemide was not administered on 07/16/25, 07/22/25, and 07/23/25, as it was not due to be administered.

Interview with the RCC on 08/05/25 at 2:25pm revealed:
-Resident #3 had an order Furosemide 20mg to be administered on Monday and Thursday.
-She did not recall the date, but a MA asked her about Resident #3's Furosemide and the documentation on the eMAR as MA's were documenting medication not administered due to awaiting pharmacy on days other than Monday and Thursday.
-The MA's should document Furosemide not administered as medication is not due on days other than Monday and Thursday.
-She indicated that she constantly told MA's to pay attention to the order on the eMARs and document correctly.

A second interview with the RCC on 08/19/25 at 5:06pm revealed:
-She documented Resident #3 was administered Furosemide on 06/07/25 and 07/02/25 would be an error, as those were days the medication was not scheduled.
-She could not explain why she documented Furosemide was administered on 06/07/25 and 07/02/25.
-The MA's are not reading the order on the eMAR to see that Resident #3's Furosemide is to be administered on Monday and Thursday.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 08/20/25 at 4:27pm revealed:
-Resident #3 was ordered Furosemide 20mg to be administered on Monday and Thursday due to edema.
-The RCC called her on 08/19/25 about making the eMAR reflect the order.
-She told the RCC the order was correct and to try to call the pharmacy to see if they could block off the days the medication was not scheduled on the eMAR.
-She would expect the MA's to accurately document the eMAR to indicate Furosemide was not administered on days other than Monday and Thursday as it was not due to be administered.
-She did not have any concerns regarding edema for Resident #3.

Interview with the Administrator on 08/26/25 at 4:48pm revealed: -Resident #3 had an order for Furosemide 20mg to be administered on Monday and Thursday. -She was not aware MA's had documented Furosemide was administered on days other than Monday and Thursday and/or not administered due to awaiting on pharmacy on days other than Monday and Thursday. -She expected the MA's to document the eMAR correctly to indicate medications are given as ordered.		

IV. Delivered Via:	Hand Delivered	Date: 09/12/25
DSS Signature:	Janella Lee, SWS Regina Anderson, BSW	Return to DSS By: **10/03/25**

V. CAR Received by:	Administrator/Designee (print name): Shaqueala Beel	
	Signature: SBeel	Date: 9.12.25
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ ***POC Not Accepted***	By:	Date:
Comments:		
☒ ***POC Accepted***	By: Sean Dwyer	Date: 10/6/25
Comments:	Regina Anderson, BSW	

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*