Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal012043	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BERKELEY	330 JUNIPER STREET MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 11/04/25 - 11/05/25.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with state laws.	
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to have a matching therapeutic diet menu for the guidance of food service staff for 2 of 2 sampled residents (#3 and #4) who had a physician ordered regular, mechanical soft chopped diet (#3) and a regular, mechanical soft, pureed diet with honey thickened liquids (#4). The findings are: 1. Review of Resident #3's current FL2 dated 09/22/25 revealed: -Diagnoses include dementia, anxiety, pain, and high blood pressure. -There was an order for a regular, mechanical soft chopped diet.	D 296	Executive Director and Dietary Manager will be inserviced on the cited rule area, .0904 (c)(7). The Executive Director and Dietary Manager will be in-serviced on locating and accessing the facility's current menus, including all diet extensions. A designated and clearly identified location will be established for storing these menus so they are consistently available for staff reference. Facility dietary staff will be in-serviced on how and where to locate the facility's current menus, including all diet extensions, to ensure they are consistently referenced when preparing resident meals. The Executive Director and/or designee will conduct routine checks no less than once weekly for 60 days to ensure that the facility menus, including all diet extensions are consistently maintained in the kitchen and readily accessible for staff reference.	12/22/2025

Acknowledged and Reviewed - LMJ - 12/08/25

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D 296	Continued From page 1 Review of Resident #3's Resident Register revealed she was admitted to the facility on 01/01/24. Review of the therapeutic diet list dated 10/21/25 that was posted in the kitchen revealed Resident #3 received a regular, mechanical soft chopped diet. Observation of the kitchen on 11/04/25 at 11:44am revealed there was no therapeutic diet menu available for a regular, mechanical soft, chopped diet. Refer to interview with the cook on 11/04/25 at 2:00pm. Refer to interview with the Dietary Manager (DM) on 11/04/25 at 2:06pm. Refer to interview with the Administrator on 11/04/25 at 2:28pm. 2. Review of Resident #4's current FL2 dated 09/22/25 revealed: -Diagnoses included Barrett's esophagus (a condition caused by chronic exposure to stomach acid that can damage the esophagus by changing the structure of the esophageal tissue) without dysplasia, vascular dementia, hypercholesterolemia, hypertension, and hypothyroidism. -There was an order for regular, mechanical soft, pureed diet. Review of Resident #3's Resident Register revealed he was admitted to the facility on 04/07/23. Review of Resident #4's physician orders dated	D 296		

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D 296	Continued From page 2 07/22/25 revealed a honey thickened liquid diet. Review of the therapeutic diet list dated 10/21/25 that was posted in the kitchen revealed Resident #4 received a regular, mechanical soft, pureed, and honey thickened diet. Observation of the kitchen on 11/04/25 at 11:44am revealed there was no therapeutic diet menu available for a regular, mechanical soft, pureed, and honey thickened liquid diet. Refer to interview with the cook on 11/04/25 at 2:00pm. Refer to interview with the Dietary Manager (DM) on 11/04/25 at 2:06pm. Refer to interview with the Administrator on 11/04/25 at 2:28pm. Interview with a cook on 11/04/25 at 2:00pm revealed: -She referred to a list of residents' names posted in the kitchen to determine which residents had orders for therapeutic diets. -She prepared the food listed on the regular menu to the consistency required. Interview with the Dietary Manager (DM) on 11/04/25 at 2:06pm revealed: -He referred to the list of residents who had physician's orders for therapeutic diets posted in the kitchen. -He did not have a therapeutic diet menu for the physician ordered regular, mechanical soft chopped or mechanical soft pureed honey thickened diet. -He and food service staff prepared the food on the regular menu for residents ordered	D 296		

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D 296	Continued From page 3 therapeutic diets to the required consistency. -He would refer to a food preparation manual located in the kitchen for guidance on preparing therapeutic diets. -He was not aware that therapeutic diet menus for each variation of diet needed to be available for guidance for food service staff. Interview with the Administrator on 11/04/25 at 2:28pm revealed: -The DM was responsible for looking up menus from the dietary management contractor to ensure nutrition for residents. -There was no Dietician or Physical Therapist on staff. -The DM and food service staff should refer to a food preparation manual located in the kitchen. -He was not aware that therapeutic diet menus were to be available for guidance for food service staff.	D 296		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#1) related to medications to treat	D 358	Facility RN will provide training to Medication staff, to include Executive Director and Care Coordinators on the importance of administering physician prescribed medications as directed. Facility Care Corrdinators or designee will conduct MAR to cart audits no less than once weekly for 30 days to ensure physician ordered medications are administered per physician instructions. Resident Care Coordinator will observed no less than 10 medication administrations per week for 60 days to ensure medications are being administered as ordered by the residents physician.	12/22/2025

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D 358	Continued From page 4	D 358		

cholesterol, dry eyes, memory impairment, uric acid, eye inflammation, and pain.

The findings are:

Review of the facility's Medication Services undated policy and procedure revealed:
-The facility provided medication administration, ordering and reordering of medications.
-The Executive Director (ED), Resident Care Coordinator (RCC) or designee would ensure that medication administration services for each resident were provided.

Review of Resident #1's current FL2 dated 04/02/25 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease, mild dementia, macular degeneration, and right knee osteoarthritis.
-Resident #1 was intermittently disoriented and ambulated with a rollator.

Review of Resident #1's Resident Register revealed an admission date of 01/31/25.

Review of physician's orders for Resident #1 revealed:
-There were medication orders dated 04/02/25 for pravastatin 40mg at bedtime (treats high cholesterol), Preservision AREDs 2 take 1 capsule daily (treats dry eyes), donepezil 10mg daily (treats memory impairment) and difluprednate 0.05% eye drops 1 drop both eyes twice daily (treats inflammation).
-There was a medication order dated 05/30/25 for Allopurinol 100mg tablet give ½ tablet (50mg) daily (treats uric acid).
-There was a medication order dated 08/22/25 for diclofenac 1% gel (treats pain) 2gm to both knees

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D 358	Continued From page 5 twice daily. a. Pravastatin 40mg at bedtime. Review of Resident #1's electronic Medication Administration Records (eMARs) for 07/01/25 - 09/30/25 revealed: -There was an entry for pravastatin 40mg at bedtime with an administration time of 9:00pm. -There was documentation the pravastatin was not administered 07/08/25, 07/21/25, 07/25/25, 07/27/25, 07/28/25 and 07/31/25 due to on hold. -There was documentation the pravastatin was not administered 08/02/25, 08/03/25, 08/08/25, 08/12/25, 08/15/25 - 08/17/25, and 08/19/25 - 08/31/25 due to on hold or family provides. -There was documentation the pravastatin was not administered 09/03/25, 09/05/25 - 09/07/25, 09/09/25 - 09/12/25, 09/14/25 - 09/18/25, and 09/23/25 - 09/25/25 due to on hold or family provided. Observation of Resident #1's medications available for administration 11/04/25 at 4:49pm revealed there was one bottle labeled pravastatin 80mg take ½ tablet daily and 45 tablets were dispensed on 10/01/25. Interview with the facility's contracted Nurse Practitioner (NP) on 11/04/25 at 4:00pm revealed: -The pravastatin was prescribed for high cholesterol. -The facility should be ordering and administering medications as prescribed. Refer to the interview with Resident #1 on 11/04/25 at 3:50pm. Refer to the telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at	D 358		

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D 358	Continued From page 6 12:02pm. Refer to the interview with a medication aide (MA) on 11/04/25 at 4:10pm. Refer to the interview with a second MA on 11/05/25 at 8:23am. Refer to the telephone interview with a third MA on 11/05/25 at 12:46pm. Refer to the interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am. Refer to the interview with the Administrator on 11/05/25 at 10:20am. b. Preservision AREDs 2 Review of Resident #1's electronic Medication Administration Records (eMARs) for 07/01/25 - 08/01/25 revealed: -There was an entry for Preservision AREDs 2 take 1 capsule daily with an administration time of 9:00am. -There was documentation the Preservision AREDs 2 was not administered 07/17/25 - 07/19/25, 07/22/25 - 07/28/25, and 07/31/25 due to on hold or waiting on family. -There was documentation the Preservision AREDs 2 was not administered 08/01/25, and 08/03/25 - 08/04/25 due to on hold. Observation of Resident #1's medications available for administration on 11/04/25 at 4:49pm revealed there was one over the counter bottle labeled Prevision AREDs 2 containing 210 mini soft gel capsules. Interview with the facility's contracted Nurse	D 358		

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D 358	Continued From page 7 Practitioner (NP) on 11/04/25 at 4:00pm revealed: -The Prevision AREDs 2 was a vitamin for treatment of dry eyes. -The facility should be ordering and administering medications as prescribed. Refer to the interview with Resident #1 on 11/04/25 at 3:50pm. Refer to the telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at 12:02pm. Refer to the interview with a medication aide (MA) on 11/04/25 at 4:10pm. Refer to the interview with a second MA on 11/05/25 at 8:23am. Refer to the telephone interview with a third MA on 11/05/25 at 12:46pm. Refer to the interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am. Refer to the interview with the Administrator on 11/05/25 at 10:20am. c. Donepezil 10mg Review of Resident #1's electronic Medication Administration Records (eMARs) for 08/01/25 - 09/30/25 revealed: -There was an entry for donepezil 10mg daily with an administration time of 8:00pm. -There was documentation donepezil 10mg was not administered on 08/20/25 - 08/31/25 due to on hold and waiting on pharmacy. -There was documentation donepezil 10mg was not administered on 09/03/25, 09/05/25 -	D 358		

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D 358	Continued From page 8 09/07/25, 09/09/25 - 09/18/25, 09/22/25 - 09/25/25, and 09/30/25 due to on hold and family provided. Observation of Resident #1's medications available for administration on 11/04/25 at 4:49pm revealed there was one bottle labeled donepezil 10mg daily and 90 tablets were dispensed on 10/01/25. Interview with the facility's contracted Nurse Practitioner (NP) on 11/04/25 at 4:00pm revealed: -The donepezil was ordered for dementia related adverse behaviors. -The facility should be ordering and administering medications as prescribed. Refer to the interview with Resident #1 on 11/04/25 at 3:50pm. Refer to the telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at 12:02pm. Refer to the interview with a medication aide (MA) on 11/04/25 at 4:10pm. Refer to the interview with a second MA on 11/05/25 at 8:23am. Refer to the telephone interview with a third MA on 11/05/25 at 12:46pm. Refer to the interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am. Refer to the interview with the Administrator on 11/05/25 at 10:20am. d. Difluprednate 0.05% eye drops	D 358		

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D 358	Continued From page 9 Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2025 revealed: -There was an entry for diflupredrnate 0.05% 1 drop to both eyes twice daily with administration times of 9:00am and 9:00pm. -There was documentation the diflupredrnate was not administered on 10/14/25 - 10/19/25 at 9:00pm due to on hold and waiting on family. Observation of Resident #1's medications available for administration on 11/04/25 at 4:44pm revealed there was one bottle labeled diflupredrnate 0.05% instill 1 drop in both eyes twice daily and it was dispensed on 10/17/25. Interview with the facility's contracted Nurse Practitioner (NP) on 11/05/25 at 2:35pm revealed: -The diflupredrnate eye drops were ordered for inflammation of the eyes. -The facility should be ordering and administering medications as prescribed. Refer to the interview with Resident #1 on 11/04/25 at 3:50pm. Refer to the telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at 12:02pm. Refer to the interview with a medication aide (MA) on 11/04/25 at 4:10pm. Refer to the interview with a second MA on 11/05/25 at 8:23am. Refer to the telephone interview with a third MA on 11/05/25 at 12:46pm.	D 358		

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D 358	Continued From page 10 Refer to the interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am. Refer to the interview with the Administrator on 11/05/25 at 10:20am. e. Allopurinol 100mg ½ tablet (50mg) Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2025 revealed: -There was an entry for Allopurinol 100mg ½ tablet (50mg) daily with an administration time of 8:00am. -There was documentation the Allopurinol was not administered 10/03/25 through 10/09/25 and 10/11/25 through 10/12/25 due to family provided, on hold, and awaiting family. Observation of Resident #1's medications available for administration on 11/04/25 at 4:49pm revealed there was one bottle labeled Allopurinol 100mg take ½ tablet daily and 45 tablets were dispensed on 09/30/25. Interview with the facility's contracted Nurse Practitioner (NP) on 11/05/25 at 2:35pm revealed: -The Allopurinol was ordered for uric acid build up in the joints. -The facility should be ordering and administering medications as prescribed. Refer to the interview with Resident #1 on 11/04/25 at 3:50pm. Refer to the telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at 12:02pm. Refer to the interview with a medication aide (MA)	D 358		

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D 358	Continued From page 11 on 11/04/25 at 4:10pm. Refer to the interview with a second MA on 11/05/25 at 8:23am. Refer to the telephone interview with a third MA on 11/05/25 at 12:46pm. Refer to the interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am. Refer to the interview with the Administrator on 11/05/25 at 10:20am. f. Diclofenac gel 1% Interview with Resident #1's family member on 11/04/25 at 3:40pm revealed: -She asked the MA if Resident #1 could have the diclofenac gel applied to his knees. -The MA dispensed some diclofenac gel into a medication cup and handed it to the family member to apply. -The family member knew that diclofenac gel should be measured out on a measuring stick that was provided in the packaging to ensure the correct dose and wondered why the MA did not do that but did not ask her. Interview with the MA on 11/05/25 at 9:36am revealed: -She did not know that the diclofenac gel should be measured out on a measuring stick. -She did not know how she would determine the correct dose without a measuring stick. -She always dispensed out the gel onto her gloved hand and then applied it to Resident #1's knees. -She did not remember giving the medication in a medication cup to the family member to apply.	D 358		

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D 358	Continued From page 12 Review of Resident #1's electronic Medication Administration Records (eMARs) for 09/01/25 - 11/03/25 revealed: -There was an entry for diclofenac gel 1% apply 2gm topically twice daily with administration times of 9:00am and 9:00pm. -There was documentation the MA administered the diclofenac on 09/01/25 -09/03/25, 09/05/25 - 09/06/25, 09/10/25 - 09/12/25, 09/16/25, 09/20/25 - 09/24/25, 09/26/25 - 09/27/25, and 09/30/25 at 9:00am. -There was documentation the MA administered the diclofenac on 10/02/25, 10/05/25 - 10/06/25, 10/08/25 - 10/11/25, 10/13/25, 10/16/25 - 10/17/25, 10/19/25 - 10/21/25, 10/27/25 and 10/31/25 at 9:00am. -There was documentation the MA administered the diclofenac on 11/01/25 - 11/02/25, and 11/04/25 at 9:00am. Observation of Resident #1's medications available for administration on 11/04/25 at 4:49pm revealed: -There was one box labeled diclofenac 1% apply 2gm topically twice daily and 3 tubes were dispensed on 05/13/25. -There was one plastic measuring stick located inside the box. Interview with a Pharmacist at the facility's contracted pharmacy on 11/05/25 at 2:00pm revealed: -Diclofenac is an anti-inflammatory medication and the dose should be measured out using the measuring stick that comes in the box. -Administering the medication without measuring the correct dose would cause the medication to be not as effective.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BERKELEY	330 JUNIPER STREET MORGANTON, NC 28655

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D 358	Continued From page 13 Interview with the RCC on 11/05/25 at 10:33am revealed: -She knew that diclofenac gel dose was to be measured with a stick that came with the gel in the box. -She did not know that the MA did not know to use the measuring stick. _____ Telephone interview with Resident #1's power of attorney (POA) on 11/04/25 at 12:02pm revealed: -Resident #1 informed her that he was not always getting his medications. -She met with the Administrator and reviewed Resident #1's medication records. -There were multiple medications that were documented as on hold when they were not on hold. -His medications were to be ordered by the facility from a hospital pharmacy and that pharmacy would mail the medications to the POA and she delivered them to the facility. -Some of his medications were not reordered by the facility for months. -The facility staff did not know the process for ordering medications. Interview with Resident #1 on 11/04/25 at 3:50pm revealed: -Sometimes staff administered his medications. -He did not know what medications staff administered to him. Interview with a medication aide (MA) on 11/04/25 at 4:10pm revealed: -She administered medications to Resident #1. -She had been requesting refills for Resident #1's medications via the eMAR by using the resupply button and she was informed recently that was incorrect. -She was informed that Resident #1's	D 358		

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medications were filled by a pharmacy other than the facility's contracted pharmacy.
-She documented on hold when a medication was not available.
-The MAs were responsible for medication cart audits but the audits had not been completed in 2 or 3 months.

Interview with a second MA on 11/05/25 at 8:23am revealed:
-Resident #1's POA ensured his medications were refilled and delivered to the facility.
-She would inform the POA via a telephone call when his medications were low, but she did not document the telephone calls.

Interview with a third MA on 11/05/25 at 9:36am revealed:
-She administered medications to Resident #1.
-She documented on hold when the medications were not available, and the family needed to bring the medications to the facility.
-The POA was responsible for requesting refills of the medications.
-She telephoned the POA before medications were out so that the POA could request refills.

Telephone interview with a fourth MA on 11/05/25 at 12:46pm revealed:
-She worked second and third shift and administered medications to Resident #1.
-She would document on hold if a medication was not available.
-She would not telephone the pharmacy for refills because it was after hours.
-She left notes for the day shift to telephone the pharmacy.
-She knew it "took forever" to get medications refilled from Resident #1's chosen pharmacy.

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D 358	Continued From page 15 Interview with the RCC on 11/04/25 at 2:20pm and 11/05/25 at 10:33am revealed: -Resident #1 was admitted in late January 2025 with medication orders and an FL2 signed by a physician. -Resident #1's medications were dispensed from a pharmacy other than the facility's contracted pharmacy. -The facility was responsible for telephoning Resident #1's chosen pharmacy for medication refills and then the pharmacy mailed the medications to the POA and she would deliver them to the facility. -There was a 4 to 10 day period from the telephone call for refills until the medications were delivered to the facility. -Resident #1 ran out of medications due to delays of the pharmacy requesting a new prescription, or the medications were mailed to the POA, or the time it took the POA to deliver the medications to the facility. -The MAs were responsible for telephoning the pharmacy for refills or she would do it when she completed weekly medication cart audits. -There were staff that did not know the process for refilling Resident #1's medications. Interview with the Administrator on 11/05/25 at 10:20am revealed: -The MAs should not have documented "on hold" when medications were not available. -He knew Resident #1's medications were dispensed from a pharmacy chosen by the resident. -He did not know what the agreement was with Resident #1's POA as to who would order refills of medications. -The MA or RCC would "typically" telephone a pharmacy for refill of medications. -He thought the staff telephoned Resident #1's	D 358		

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D 358	Continued From page 16 chosen pharmacy for resupply of medications but there was a delay because the medications were mailed to the POA. Attempted telephone interview with Resident #1's chosen pharmacy on 11/05/25 at 7:51am and 11:14am was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367	Facility RN will provide training to Medication staff, to include Executive Director and Care Coordinators on the importance of administering physician prescribed medications as directed. Facility Care Corrdinators or designee will conduct MAR to cart audits no less than once weekly for 30 days to ensure physician ordered medications are administered per physician instructions. Executive Director and/or Facility Care Coordinators will review no less than 5 residents eMAR's weekly, for 60 days to ensure compliance with documentation and to ensure medications being available for staff to administer per the residents Physician. Resident Care Coordinator will observed no less than 10 medication administrations per week for 60 days to ensure medications are being administered as ordered by the residents physician.	12/22/2025

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D 367	Continued From page 17	D 367		

review, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 1 of 5 residents (#5) related to no documentation for weekly administration of cholecalciferol (used to maintain healthy bones and muscles).

The findings are:

Review of Resident #5's current FL2 dated 07/29/25 revealed:
-Diagnoses included muscle wasting and atrophy, Parkinson's disease, and history of a stroke.
-There was an order for cholecalciferol 1,250mcg every week on Friday.

Review of Resident #5's eMAR for September 2025 revealed there was no entry for or documentation of administration of cholecalciferol 1,250mcg on 09/05/25, 09/12/25, 09/19/25 and 09/26/25.

Review of Resident #5's eMAR for October 2025 revealed there was no entry for or documentation of administration of cholecalciferol 1,250mcg on 10/03/25, 10/10/25, 10/17/25, 10/24/25 and 10/31/25. .

Observation of medications available for administration on 11/04/25 at 3:37pm revealed:
-There was cholecalciferol 1,250mcg available for administration for the weekly dose on Friday, 11/07/25.
-The pharmacy label indicated the cholecalciferol 1,250mcg was to be administered weekly on Fridays.

Interview with the medication aide (MA) at 3:37pm revealed:
-Resident #5 was administered cholecalciferol

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D 367	Continued From page 18 weekly on Fridays. -She had not realized Resident #5's cholecalciferol was not on the monthly eMARs. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/04/25 at 3:51pm revealed: -The original order for Resident #5's cholecalciferol was dated 02/19/25 for 1,250mcg weekly. -The cholecalciferol had been dispensed from the pharmacy and delivered to the facility weekly since the order was received. -The cholecalciferol had always been available from the pharmacy. Interview with the Resident Care Coordinator (RCC) on 11/04/25 at 4:09pm revealed: -The facility's contracted provider put new orders and order changes on the eMAR. -She had to verify the order before the pharmacy would place the order on the eMAR. -She had verified the cholecalciferol order to be given weekly. -Because she did not verify the day of the week to be given, it did not populate on the eMAR. -It was an oversight on her part. Interview with the Administrator on 11/04/25 at 4:14pm revealed: -The MAs should be comparing the medications to be administered to the order on the eMAR. -He was unsure why the MAs had not discovered this problem. -He and the RCC were ultimately responsible to ensure the eMAR documentation of medication administration was recorded accurately.	D 367		

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D 375	Continued From page 19	D 375		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure 2 of 2 sampled residents (#6 and #7) had a physician's order to self-administer fluticasone nasal spray (#6) and calcium carbonate (#7). The findings are: 1. Observation of Resident #6's room on 11/04/25 at 9:40am revealed fluticasone (used to treat allergies) nasal spray was present on her bedside table. Interview with Resident #6 on 11/04/25 at 9:40am revealed: -She had sinus problems and self-administered the fluticasone to "ease them." -She self-administered the fluticasone 4 times daily.	D 375	Care Coordinators will identify any residents with medications on their person and remove until a self-administration evaulation is completed and an order for self-administration is obtained by the residents physician. Executive Director and/or Resident Care Coordinators will educate identified residents and/or their responsible parties on the importance of bringing medications into the facility without prior consulting facility management to ensure orders and assessments are obtained. Facility RN will inservice facility staff on the importance or notifying management when medications are found in a residents room to ensure self-administration orders and assessments have been completed. RN will also inservice staff on the importance of not leaving medications in a residents room unless appropriate documentation has been obtained.	12/22/2025

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D 375	Continued From page 20 -She most recently self-administered the fluticasone on the morning of 11/04/25. Review of Resident #6's current FL2 dated 08/05/25 revealed: -Diagnoses included mild cognitive impairment and high blood pressure. -She was intermittently disoriented. -There was not an order for fluticasone nasal spray four times daily. Review of Resident #6's electronic medication administration record (eMAR) for September 2025 revealed there was no entry for and no documentation of administration of fluticasone four times a day from 09/01/25 through 09/30/25. Review of Resident #6's electronic medication administration record (eMAR) for October 2025 revealed there was no entry for and no documentation of administration of fluticasone four times a day from 10/01/25 through 10/31/25. Review of Resident #6's electronic medication administration record (eMAR) for November 2025 revealed there was no entry for and no documentation of administration of fluticasone four times a day from 11/01/25 through 11/03/25. Interview with the medication aide (MA) on 11/04/25 at 2:02pm revealed: -Resident #6 did not have an order to self-administer any medications. -She administered Resident #6's morning medications on 11/04/25 but did not enter Resident #6's room. -She was unaware Resident #6 had fluticasone nasal spray in her bedroom and was self-administering it.	D 375		

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D 375	Continued From page 21 Refer to interview with the Resident Care Coordinator (RCC) on 11/04/25 at 2:09pm. Refer to interview with the Administrator on 11/04/25 at 2:18pm. 2. Observation of Resident #7's bedroom on 11/04/25 at 10:25am revealed an over-the-counter container of calcium carbonate (used to treat heartburn) tablets were present on her bedside table. Interview with Resident #7 on 11/04/25 at 10:25am revealed: -She took calcium carbonate when her stomach was upset. -She most recently took a calcium carbonate tablet last week when she was nauseated. Review of Resident #7's current FL2 dated 08/04/25 revealed: -Diagnoses included dementia and unspecified Parkinsonism. -She was constantly disoriented. -There was not an order for calcium carbonate tablets. Review of Resident #7's electronic medication administration record (eMAR) for September 2025 revealed there was no entry for and no documentation of administration of calcium carbonate. Review of Resident #7's electronic medication administration record (eMAR) for October 2025 revealed there was no entry for and no documentation of administration of calcium carbonate. Review of Resident #7's electronic medication	D 375		

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D 375	Continued From page 22 administration record (eMAR) for November 1 - 3, 2025 revealed there was no entry for and no documentation of administration of calcium carbonate. Interview with the medication aide (MA) on 11/04/25 at 2:02pm revealed: -Resident #7 did not have an order to self-administer any medications. -She administered Resident #7's morning medications on 11/04/25 and observed the bottle of calcium carbonate in the room. -Resident #7's family member used to share the room, but he had passed away a month earlier and she thought the calcium carbonate belonged to him. -She was not aware Resident #7 was self-administering calcium carbonate. Refer to interview with the Resident Care Coordinator (RCC) on 11/04/25 at 2:09pm. Refer to interview with the Administrator on 11/04/25 at 2:18pm. Interview with the RCC on 11/04/25 at 2:09pm revealed: -Resident #6 and Resident #7 did not have orders to self-administer any medication. -She was not aware they were keeping medications in their bedrooms. -They should not be self-administering medications without a physician's order and an assessment to evaluate if they can self-administer safely. Interview with the Administrator on 11/04/25 at 2:18pm revealed: -No resident should be self-administering medications without a physician's order.	D 375		

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D 375	Continued From page 23 -He was not aware that Resident #6 or Resident #7 were self-administering medication.	D 375		