STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on February 11, 2026.	{C 000}		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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, record reviews, and interviews, the facility failed to administer medications as ordered by the prescribing practitioner for 2 of 2 sampled residents (#1, #2) including a medication used to treat constipation (#2), and medications used to treat pain (#1). The findings are: Review of the undated facility's Medication Policy and Procedure Manual revealed: -Medications would be discontinued only upon the order of the physician. -All orders to discontinue medication would be written in the resident's record and signed by the physician. -When a medication order is changed, a discontinue order would be obtained from the physician for the previous order unless the physician stated to increase, decrease, or change a previous medication order.	C 330		

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-The medication aide (MA) would "never" guess what the physician intended or may have written.
-Staff would routinely check the drug administration record against the current written physician orders to ensure that new, discontinued, and altered drug orders were followed.

1. Review of Resident #1's current FL-2 dated 09/17/25 revealed diagnoses included rhabdomyolysis, and shoulder and leg pain.

Review of Resident #1's Resident Register revealed an admission date of 12/09/10.

a. Review of Resident #1's physician orders dated 09/17/25 revealed there was an order for Gabapentin (used to treat nerve pain) 600mg tablet twice daily.

Review of Resident #1's December 2025 medication administration record (MAR) revealed:
-There was a printed entry for Gabapentin 600mg tablet two times a day, scheduled at 8:00am and 8:00pm.
-There was no documentation of administration for the Gabapentin 600mg tablet at 8:00am from 12/01/25 through 12/31/25.
-There was a horizontal line drawn through the dates of 12/01/25 through 12/05/25, 12/07/25 through 12/16/25, and 12/19/25 through 12/28/25, in the section for documenting the administration of the Gabapentin 600mg tablet.
-There was no documentation of administration for the Gabapentin 600mg tablet at 8:00pm for 12/20/25 and 12/21/25.

Review of Resident #1's January 2026 MAR revealed:
-There was a printed entry for Gabapentin 600mg

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tablet two times a day, scheduled at 8:00am and 8:00pm.
-There was no documentation of administration for the Gabapentin 600mg tablet at 8:00am from 01/01/26 through 01/31/26.
-There was a horizontal line drawn through the dates of 01/01/26 through 01/28/26 with the word "refuse, refuse, refused" handwritten beneath the horizontal line in the section for documenting the administration of the Gabapentin 600mg tablet.
-There was no documentation of administration for the Gabapentin 600mg tablet at 8:00pm for 01/01/26, 01/26/26, and 01/29/26.

Review of Resident #1's February 2026 MAR revealed:
-There was a printed entry for Gabapentin 600mg tablet two times a day, scheduled at 8:00am and 8:00pm.
-There was no documentation of administration for the Gabapentin 600mg tablet at 8:00am from 02/01/26 through 02/11/26.
-There was a horizontal line drawn through the dates of 02/01/26 through 02/10/26 with the word "refused" handwritten twice beneath the horizontal line in the section for documenting the administration of the Gabapentin 600mg tablet.

Observation of Resident #1's medication on hand on 02/11/26 revealed there was a pharmacy labeled blister pack for Gabapentin 600mg one tablet two times a day dispensed 04/16/25, quantity of 60 tablets, with 30 tablets remaining on hand.

Interview with Resident #1 on 02/11/26 at 9:00am revealed:
-He did not know the names or kind of medications he was prescribed.
-The Administrator prepared his medications, and

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C 330	Continued From page 3 he took them. -He denied and questions or concerns. Telephone interview with a pharmacist at the contracted pharmacy provider on 02/11/26 at 2:55pm revealed: -Medications for Resident #1 were dispensed to the facility on a cycle fill plan. -Gabapentin 600mg two times daily was the current order in the pharmacy profile for the Gabapentin for Resident #1. -The most current prescription for the Gabapentin 600mg tablet was dated 02/06/25. -On 04/16/25, 07/16/25, 08/13/25, 09/12/25, and 10/14/25 a quantity of 60 tablets of Gabapentin 600mg tablets were dispensed to the facility. -There were no refills for the Gabapentin 600mg after 10/14/25. -If the facility still had a medication container dated 04/16/25, it would mean that the facility was not using the dispensed medications in the correct order. -Refusals of the Gabapentin 600mg tablet would explain the reason for there to still be Gabapentin on hand. -If the Gabapentin was not administered as ordered to Resident #1, the resident could have pain. -Continued refusals of the Gabapentin might need to be addressed. Interview with the Administrator on 02/11/26 at 4:20pm revealed: -Resident #1 would not take medications in the morning. -Resident #1 would only take the Gabapentin 600mg tablet at night. -It was well documented that Resident #1's primary care provider (PCP) knew about Resident #1 refusing the Gabapentin in the mornings.	C 330		

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C 330	Continued From page 4 Telephone interview with a physician at Resident #1's PCP office on 02/11/26 at 4:48pm revealed: -Resident #1 was last seen by the PCP on 12/11/25. -There was a current order for Resident #1's Gabapentin 600mg tablet two times a day. -On 04/29/24, there was a provider note indicating caregiver advised PCP that Resident #1 was not taking some of his medications that made him feel dizzy, and Gabapentin was on the list of medications not being taken. -The PCP restarted the Gabapentin and did not want Resident #1 to be off the medication and would want Resident #1 to take the Gabapentin. -The physician did not see any further notation regarding the Gabapentin refusals after 04/29/24. -The facility brought the residents' MARs to resident appointments for physicians to review, and he felt Resident #1's PCP was aware of Resident #1 not being administered the 8:00am dose of Gabapentin. -Typically, the Gabapentin was dosed three times a day but would not affect the resident negatively if Resident #1 was not taking it during the day. Attempted second interview with Resident #1 on 02/11/26 was not successful. b. Review of Resident #1's physician orders dated 09/17/25 revealed there was an order for Diclofenac (a topical ointment used to treat pain) 1% gel apply two grams topically four times daily. Review of Resident #1's December 2025 medication administration record (MAR) revealed: -There was a printed entry for Diclofenac Sodium 1% gel apply two grams topically four times a day, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm.	C 330		

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C 330	Continued From page 5 -There was no documentation of administration for the Diclofenac Sodium 1% gel at 8:00am, 12:00pm, 4:00pm or 8:00pm from 12/01/25 through 12/31/25. Review of Resident #1's January 2026 MAR revealed: -There was a printed entry for Diclofenac Sodium 1% gel apply two grams topically four times a day, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation of administration for the Diclofenac Sodium 1% gel at 8:00am, 12:00pm, 4:00pm or 8:00pm from 01/01/26 through 01/31/26. Review of Resident #1's February 2026 MAR revealed: -There was a printed entry for Diclofenac Sodium 1% gel apply two grams topically four times a day, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was a handwritten notation for "PRN" entered in the medication instructions section (PRN is an abbreviation meaning as needed). -There was no documentation of administration for the Diclofenac Sodium 1% gel at 8:00am, 12:00pm, 4:00pm or 8:00pm from 2/01/26 through 2/11/26. Observation of Resident #1's medication on hand on 02/11/26 revealed there was an unopened sealed tube of Diclofenac 1% gel inside a pharmacy labeled plastic bag for Diclofenac Sodium 1% Gel apply two grams topically four times a day dispensed 04/30/24. Interview with Resident #1 on 02/11/26 at 9:00am revealed: -He did not know the names or kind of	C 330		

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medications he was prescribed.
-The Administrator prepared his medications, and he (Resident #1) took them.
-He denied and questions or concerns.

Telephone interview with a pharmacist at the contracted pharmacy provider on 02/11/26 at 3:12pm revealed:
-Medications for Resident #1 were dispensed to the facility on a cycle fill plan.
-The Diclofenac 1% gel had not been dispensed to the facility for Resident #1 since 2024.
-One tube of Diclofenac Gel would last 12 - 13 days if being applied four times a day.

Interview with the Administrator on 02/11/26 at 4:20pm revealed:
-Resident #1's Diclofenac Gel 1% was supposed to be as needed (prn).
-The PCP order for prn usage of the Diclofenac was probably with other documentation about Resident #1 refusing medications.
-Resident #1 would not take medications in the morning.

Telephone interview with a physician at Resident #1's PCP office on 02/11/26 at 4:48pm revealed:
-Resident #1 was last seen by the PCP on 12/11/25.
-A physician order for Diclofenac Gel 1% four times a day was written on 04/30/24.
-The Diclofenac Gel 1% should be prescribed as needed and was always as needed.
-He expected the Diclofenac Gel 1% to be prescribed on an as needed basis.
-He had no concern that the Diclofenac Gel 1% gel had not been administered as ordered four times a day.

Attempted second interview with Resident #1 on

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C 330	Continued From page 7 02/11/26 was not successful. Attempted interview with Resident #1's primary care provider (PCP) was unsuccessful on 02/11/26 at 3:55pm. 2. Review of Resident #2's current FL-2 dated 04/01/25 revealed: -Diagnoses included gastro-esophageal reflux disease, hypotension, malaise, fatigue, mental retardation, and tobacco abuse. -There was a physician order for Polyethylene Glycol (generic for Miralax and used to treat constipation) 3350 take 17 grams daily as needed. Review of a physician order sheet for Resident #2 dated 04/02/25 revealed there was an order for Miralax 17 gram/1 dose powder daily. Review of Resident #2's December 2025 medication administration record (MAR) revealed: -There was a printed entry for Miralax 17 grams daily, scheduled at 8:00am. -There was no documentation of administration for the Miralax at 8:00am. Review of Resident #2's January 2026 MAR revealed: -There was a printed entry for Miralax 17 grams daily, scheduled at 8:00am. -There was no documentation of administration for the Miralax at 8:00am. Review of Resident #2's February 2026 MAR revealed: -There was a printed entry for Miralax 17 grams daily, scheduled at 8:00am. -There was a handwritten notation for "PRN" entered in the medication instructions section	C 330		

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C 330	Continued From page 8 (PRN is an abbreviation meaning as needed). -There was no documentation of administration for the Miralax powder at 8:00am from 2/01/26 through 2/11/26. Observation of Resident #2's medication on hand on 02/11/26 revealed there was a pharmacy labelled unopened sealed bottle of Miralax powder 17 grams daily with a dispense date of 01/02/26. Telephone interview with a pharmacist at the contracted pharmacy provider on 02/11/26 at 3:12pm revealed: -The most current physician order in Resident #2's pharmacy profile was Miralax 17 gram daily dated 01/20/26 and received from the physician. -A prior prescription for Miralax 510-gram package for a 30-day supply was received on 05/29/25 but had not been dispensed. -The Miralax could be purchased over the counter. -Resident #2 could become constipated if not being administered the Miralax as ordered. Interview with the Administrator on 02/11/26 at 1:48pm revealed: -Resident #2's Miralax powder was supposed to be administered as needed. -He did not know why there were two orders for the Miralax with one dated 04/01/25 and the second one dated 04/02/25. -He thought the PCP may have made an error in documenting the date on the 04/02/25 physicians order copy. Second interview with the Administrator on 02/11/26 at 3:42pm revealed: -He did not have any additional physician orders for Resident #2's Miralax.	C 330		

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C 330	Continued From page 9 -The PCP would be able to provide clarity regarding the dates of the orders. Telephone interview with a physician at Resident #2's PCP office on 02/11/26 at 4:32pm revealed: -Resident #2 was seen by the PCP on 05/29/25. -A physician order for Miralax daily and Colace (used to treat constipation) as needed was written on 05/29/25. -He did not have any concerns that the Miralax was not administered daily as ordered. -A lot of the times, the Miralax order was written as daily, and the PCP would tell staff that if the resident was having a lot of bowel movements that the Miralax could be administered as needed. Based on observations, interviews, and record review, Resident #2 was not interviewable. Attempted interview with Resident #2's primary care provider (PCP) was unsuccessful on 02/11/26 at 3:55pm.	C 330		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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	{C 342}		

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{C 342}	Continued From page 10 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, record reviews, and interviews, the facility failed to ensure accurate documentation of medication administration on the medication administration records (MAR) for 1 of 2 sampled residents (#1). The findings are: Review of the undated facility's Medication Policy and Procedure Manual revealed: -The medication aide (MA) would adhere to the procedure for handling refusal of medications. -The letter "R" would be placed in the appropriate time block on the MAR to indicate the resident refused the drug. -Medications would be discontinued only upon the order of the physician. -All orders to discontinue medication would be written in the resident's record and signed by the physician. -Documentation of medication administration would contain the name of person administering the medication and if initials were used, a signature equivalent to those initials would be entered on the medication administration record. Review of Resident #1's current FL-2 dated	{C 342}		

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{C 342}	Continued From page 11 09/17/25 revealed diagnoses included schizophrenia, high blood pressure, high cholesterol, rhabdomyolysis, stage 3 kidney failure, and shoulder and leg pain. Review of Resident #1's Resident Register revealed an admission date to the facility of 12/09/10. a. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Tamsulosin (used to treat disorders of the kidney) HCL 0.4mg capsule daily. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Tamsulosin HCL 0.4mg capsule daily and scheduled for administration at 8:00am. -There was documentation of administration for the Tamsulosin HCL 0.4mg capsule with the same initials on the MAR for 12/01/25 through 12/09/25, 12/12/25 through 12/19/25, and 12/22/25 through 12/31/25. -There were horizontal lines in the area for documenting the administration of the Tamsulosin HCL 0.4mg capsule on 12/10/25, 12/11/25, 12/20/25, and 12/21/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Tamsulosin HCL 0.4mg capsule daily and scheduled for	{C 342}		

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administration at 8:00am.
-There was documentation of administration for the Tamsulosin HCL 0.4mg capsule with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26.
-There were horizontal lines in the area for documenting the administration of the Tamsulosin HCL 0.4mg capsule on 01/01/26, 01/26/26, and 01/29/26.
-There was no signature on the MAR to correspond to the initials documented in the section for administration of medications.
-There was no documentation notating the meaning of the horizontal line documented on the MAR.

Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm.

Refer to the interview with the Administrator on 02/11/26 at 4:08pm.

Refer to the second interview with the Administrator on 02/11/26 at 4:30pm.

b. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Atorvastatin (used to treat high cholesterol levels) Calcium F/C 40mg tablet nightly.

Review of Resident #1's December 2025 medication administration records (MARs) revealed:
-There was a printed entry for Atorvastatin Calcium F/C 40mg tablet daily and scheduled for administration at 8:00pm.
-There was documentation of administration for the Atorvastatin Calcium F/C 40mg tablet with the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 342}	Continued From page 13 same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25. -There were horizontal lines in the area for documenting the administration of the Atorvastatin Calcium F/C 40mg tablet on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Atorvastatin Calcium F/C 40mg tablet daily and scheduled for administration at 8:00pm. -There was documentation of administration for the Atorvastatin Calcium F/C 40mg tablet with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Atorvastatin Calcium F/C 40mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm.	{C 342}		

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{C 342}	Continued From page 14 Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the Administrator on 02/11/26 at 4:30pm. c. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Amlodipine Besylate (used to treat high blood pressure) 5mg tablet daily. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Amlodipine Besylate 5mg tablet daily and scheduled for administration at 8:00pm. -There was documentation of administration for the Amlodipine Besylate 5mg tablet with the same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25. -There were horizontal lines in the area for documenting the administration of the Amlodipine Besylate 5mg tablet on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Amlodipine Besylate 5mg tablet daily and scheduled for administration at 8:00pm. -There was documentation of administration for the Amlodipine Besylate 5mg tablet with the same	{C 342}		

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{C 342}	Continued From page 15	{C 342}		

initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26.
-There were horizontal lines in the area for documenting the administration of the Amlodipine Besylate 5mg tablet on 01/01/26, 01/26/26, and 01/29/26.
-There was no signature on the MAR to correspond to the initials documented in the section for administration of medications.
-There was no documentation notating the meaning of the horizontal line documented on the MAR.

Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm.

Refer to the interview with the Administrator on 02/11/26 at 4:08pm.

Refer to the second interview with the Administrator on 02/11/26 at 4:30pm.

d. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Rexulti (used to treat schizophrenia and agitation in Alzheimer's) 2mg tablet nightly.

Review of Resident #1's December 2025 medication administration records (MARs) revealed:
-There was a printed entry for Rexulti 2mg tablet at bedtime and scheduled for administration at 8:00pm.
-There was documentation of administration for the Rexulti 2mg tablet with the same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25.
-There were horizontal lines in the area for documenting the administration of the Rexulti

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{C 342}	Continued From page 16 2mg tablet on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Rexulti 2mg tablet at bedtime and scheduled for administration at 8:00pm. -There was documentation of administration for the Rexulti 2mg tablet with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Rexulti 2mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm. Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the Administrator on 02/11/26 at 4:30pm. e. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Benztropine	{C 342}		

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{C 342}	Continued From page 17 (generic for Cogentin and used to treat side effect of psychotropic medications) 1mg take two tablets at bedtime. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Benztropine 1mg take two tablets at bedtime and scheduled for administration at 8:00pm. -There was documentation of administration for the Benztropine 1mg two tablets with the same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25. -There were horizontal lines in the area for documenting the administration of the Benztropine 1mg two tablets on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Benztropine 1mg two tablets at bedtime and scheduled for administration at 8:00pm. -There was documentation of administration for the Benztropine 1mg two tablets with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Benztropine 1mg two tablets on 01/01/26, 01/26/26, and 01/29/26.	{C 342}		

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{C 342}	Continued From page 18 -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm. Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the Administrator on 02/11/26 at 4:30pm. f. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Depakote ER (used to treat high seizures and behaviors) 500mg tablet with 250mg tablet (total of 750mg) at bedtime. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Depakote ER 500mg tablet at bedtime with Depakote ER 250mg tablet at bedtime and scheduled for administration at 8:00pm. -There was a second printed entry for Depakote ER 250mg tablet take one tablet at bedtime and scheduled for 8:00pm. -There was documentation of administration for the Depakote ER 500mg tablet with Depakote 250mg tablet and documentation of administration of the second entry for Depakote 250mg tablet with the same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25.	{C 342}		

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{C 342}	Continued From page 19 -There were horizontal lines in the area for documenting the administration of the Depakote 750mg and Depakote 250mg tablet on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Depakote ER 500mg tablet at bedtime with Depakote ER 250mg tablet at bedtime and scheduled for administration at 8:00pm. -There was a second printed entry for Depakote ER 250mg tablet take one tablet at bedtime and scheduled for 8:00pm. -There was documentation of administration for the Depakote ER 500mg tablet with Depakote 250mg tablet and documentation of administration of the second entry for Depakote 250mg tablet with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Depakote 750mg and Depakote 250mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the	{C 342}		

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contracted provider pharmacy on 02/11/26 at 2:42pm.

Refer to the interview with the Administrator on 02/11/26 at 4:08pm.

Refer to the second interview with the Administrator on 02/11/26 at 4:30pm.

g. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Haloperidol (used to treat behaviors) 10mg tablet at bedtime.

Review of Resident #1's December 2025 medication administration records (MARs) revealed:
-There was a printed entry for Haloperidol 10mg tablet daily and scheduled for administration at 8:00pm.
-There was documentation of administration for the Haloperidol 10mg tablet with the same initials on the MAR for 12/01/25 through 12/09/25, 12/13/25 through 12/19/25, and 12/23/25 through 12/31/25.
-There were horizontal lines in the area for documenting the administration of the Haloperidol 10mg tablet on 12/10/25, 12/11/25, 12/12/25, 12/20/25, 12/21/25, and 12/22/25.
-There was no signature on the MAR to correspond to the initials documented in the section for administration of medications.
-There was no documentation notating the meaning of the horizontal line documented on the MAR.

Review of Resident #1's January 2026 MARs revealed:
-There was a printed entry for Haloperidol 10mg tablet daily and scheduled for administration at 8:00pm.

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{C 342}	Continued From page 21 -There was documentation of administration for the Haloperidol 10mg tablet with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Haloperidol 10mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm. Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the Administrator on 02/11/26 at 4:30pm. h. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Sertraline HCL F/C (generic for Zoloft and used to treat depression and behaviors) 50mg tablet at bedtime. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Sertraline HCL 50mg tablet at bedtime and scheduled for administration at 8:00pm. -There was documentation of administration for the Sertraline HCL 50mg tablet with the same initials on the MAR for 12/01/25 through 12/09/25, 12/12/25 through 12/19/25, and 12/22/25 through	{C 342}		

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{C 342}	Continued From page 22 12/31/25. -There were horizontal lines in the area for documenting the administration of the Sertraline HCL 50mg tablet on 12/10/25, 12/11/25,12/20/25, and 12/21/25. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Sertraline HCL 50mg tablet daily and scheduled for administration at 8:00pm. -There was documentation of administration for the Sertraline HCL 50mg tablet with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26. -There were horizontal lines in the area for documenting the administration of the Sertraline HCL 50mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm. Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the	{C 342}		

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{C 342}	Continued From page 23 Administrator on 02/11/26 at 4:30pm. i. Review of Resident #1's physician orders dated 09/17/25 revealed an order for Gabapentin (used to treat pain) 600mg tablet twice daily. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Gabapentin 600mg tablet twice daily and scheduled for administration at 8:00am and 8:00pm. -There was documentation of administration for the Gabapentin 600mg tablet at 8:00pm only with the same initials on the MAR for 12/01/25 through 12/09/25, 12/12/25 through 12/19/25, and 12/22/25 through 12/31/25. -There were horizontal lines in the area for documenting the administration of the Gabapentin 600mg tablet on 12/10/25, 12/11/25,12/20/25, and 12/21/25. -The word refuse was handwritten in the area above the 12/10/25 and 12/11/25 date. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Review of Resident #1's January 2026 MARs revealed: -There was a printed entry for Gabapentin 600mg tablet twice daily and scheduled for administration at 8:00am and 8:00pm. -There was documentation of administration for the Gabapentin 600mg tablet at 8:00pm only with the same initials on the MAR for 01/02/26 through 01/25/26, 01/27/26, 01/28/26, 01/30/26, and 01/31/26.	{C 342}		

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{C 342}	Continued From page 24 -There were horizontal lines in the area for documenting the administration of the Gabapentin 600mg tablet on 01/01/26, 01/26/26, and 01/29/26. -There was no signature on the MAR to correspond to the initials documented in the section for administration of medications. -There was no documentation notating the meaning of the horizontal line documented on the MAR. Refer to the interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm. Refer to the interview with the Administrator on 02/11/26 at 4:08pm. Refer to the second interview with the Administrator on 02/11/26 at 4:30pm. _____ Telephone interview with the pharmacist at the contracted provider pharmacy on 02/11/26 at 2:42pm revealed: -The pharmacy printed monthly MARs for residents at the facility. -The pharmacy could not discontinue medication from the MAR without a physician's order. -The pharmacy received physician orders by escript from the PCP and did not get copies of the FL-2's from the facility. -There should be accurate documentation of medication administration so medication effectiveness could be determined. Interview with the Administrator on 02/11/26 at 4:08pm revealed he was the only person that administered medication at the facility. Second interview with the Administrator on	{C 342}		

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{C 342}	Continued From page 25 02/11/26 at 4:30pm revealed: -The horizontal line on the MAR in the section for documenting administration of medication meant the resident refused the medication. -He would sometimes see duplicate medication entries on the MARs and would cross them out.	{C 342}		