STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL057011	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARS HILL RETIREMENT COMMUNITY	170 SOUTH MAIN STREET MARS HILL, NC 28754

(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 anuual survey 02/25/26 - 02/26/26.	D 000		
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 administer medications as ordered for 1 of 5 sampled residents (#2) related to a medication to prevent blood clots, two supplements for bone health, and a medication to treat disordered sleep. The findings are: Review of Resident #2's current FL2 dated 02/18/26 revealed: -Diagnoses included gait abnormality, muscle weakness and hypertension. -An order for calcium carbonate (a supplement used for bone health) 600mg daily. -An order for Eliquis (used to prevent blood clots) 5mg twice daily. -An order for Vitamin D3 (a supplement used for bone health), 2000iu daily. -An order for melatonin (used for disordered sleep) 3mg every night.	D 358		

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D 358	Continued From page 1	D 358		

Review of Resident #2's physician's order summary dated 01/08/26 revealed:
-An order for calcium citrate (a supplement used for bone health) 250mg twice daily.
-An order for Eliquis 2.5mg twice daily.
-An order for Vitamin D3 1000iu daily.

Review of Resident #2's January 2026 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for calcium citrate 250mg twice daily.
-There was an entry for Eliquis 2.5mg twice daily
-There was an entry for Vitamin D3 1000iu daily.
-There was documentation Resident #2 was in the hospital from 01/27/26 through 01/31/26.

Review of Resident #2's February 2026 eMAR revealed:
-There was documentation Resident #2 was in the hospital from 02/01/26 through 02/18/26.
-There was an entry for calcium carbonate 250mg at 8:00pm and there was documentation it was administered on 02/19/26 through 02/24/26.
-There was an entry for Eliquis 5mg twice daily at 9:00am and 8:00pm and there was documentation it was administered at 8:00pm on 02/19/26, at 9:00am and 8:00pm on 02/20/26 - 02/24/26 and at 9:00am on 02/25/26.
-There was an entry for Vitamin D3 2000iu at 2:00pm and there was documentation it was administered at 2:00pm on 02/20/26 - 02/24/26.
-There was an entry for melatonin 3mg at 8:00pm and there was documentation it was administered on 02/21/26, 02/22/26, and 02/24/26.
-There was documentation melatonin 3mg was not available to administer on 02/19/26, 02/20/26 and 02/23/26.

Observation of Resident #2's medications on

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D 358	Continued From page 2	D 358		

hand on 02/25/26 at 2:18pm revealed:
-Calcium carbonate 600mg was not available to administer.
-Calcium citrate 250mg was still available to administer.
-Eliquis 5mg was not available to administer.
-Eliquis 2.5mg was still available to administer.
-Vitamin D3 2000iu was not available to administer.
-Vitamin D3 1000iu was available to administer.
-Melatonin 3mg was not available to administer.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/25/26 at 2:28pm revealed:
-When she received Resident #2's FL2 dated 02/19/26 she was told by the facility's Health and Wellness Director (HWD) not to send any medications because all Resident #2's medications were still available at the facility and they would reorder when refills were necessary.
-She updated the eMAR with the medication changes.

Interview with a Medication Aide (MA) on 02/25/26 at 2:18pm and 4:05pm revealed:
-When Resident #2 returned from the hospital in the afternoon of 02/19/26 her medications were still in the medication cart so they resumed administering her medications.
-She did not notice when she administered medications that the dose changed on the Eliquis, and Vitamin D3 and that the type of calcium was changed.
-When she administered medications she did not confirm the dose, she only confirmed the medication name.
-There was a bottle of calcium in the cart that Resident #2 was administered prior to the hospital admission so that is what she

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	HAL057011	A. BUILDING: _____ B. WING _____	02/26/2026

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D 358	Continued From page 3	D 358		

administered, not realizing it was a different type of calcium.
-She did not use the medication scanner when she administered medications.

Interview with a second MA on 02/26/26 at 8:38am revealed:
-Most of the time she scanned the medications when she was administering medications but some times she manually clicked them off.
-She did not notice Resident #2 had medication changes when she returned tot he facility on 02/19/26.
-She did not confirm dose when she administered medications, only the name of the medication.
-She was trained to check the name of the medication and the dose when she administered medications and did not know why she did not do that when she administered Resident #2's medications.

Telephone interview with a third MA on 02/26/26 at 11:37am revealed:
-She made a mistake when she documented she administered melatonin when it was not available.
-She used the medication scanner sometimes when she administered medications but not all the time.

Interview with the HWD on 02/25/26 at 2:54pm revealed:
-When Resident #2 returned to the facility on 02/19/26 a new FL2 was completed and faxed to the pharmacy.
-She informed the pharmacy that Resident #2 still had all her medications and not to send any of the medications.
-She did not realize there were medication changes.
-She had a lot of responsibilities and she

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D 358	Continued From page 4 "probably got distracted" when she was reviewing the new FL2. Interview with Resident #2's Nurse Practitioner (NP) on 02/26/26 at 8:58am revealed: -Resident #2 returned to the facility after an admission to a rehabilitation facility related to a fall resulting in a hematoma (blood clot). -Resident #2 was on Eliquis for atrial fibrillation prior to the fall and she did not know why it was increased at the rehabilitation facility since she did not have access to those progress notes. -There was a risk of sleep disturbance since she was not consistently being administered melatonin. -Receiving a different type of calcium impacted the absorption rate. -Receiving half the ordered amount of Vitamin D3 for 5 days would not cause harm but she was glad the proper dose was now being administered. -The MAs should have checked both the name of the medication as well as the dose when they administered medications. -She expected the MAs to administer medications as ordered. Interview with the Administrator on 02/25/26 at 3:52pm revealed: -All MAs were properly trained to administered medications, including confirming the name of the medication as well as the dose of the medications. -The facility started utilizing a medication scanner about a month ago that the MAs had an option of using. -The scanner would confirm the correct medication was being administered. -She expected MAs to administered medications as they were trained.	D 358		

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D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 1 sampled residents (Resident #1) take her medications related to a cup with 4 medication tablets left in the resident's room. The findings are: Review of the facility's undated medication pass policy and procedure revealed medications administered to a resident would be recorded in the medication administration record after administration. Review of Resident #1's current FL2 dated 02/27/25 revealed: -Diagnoses included aphasia (communication disorder that impairs the ability to express or understand language), dysphagia (difficulty swallowing), and Crohn's disease (a chronic inflammatory bowel disease). -The resident was ambulatory and intermittently	D 366		

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D 366	Continued From page 6	D 366		

disoriented.

Review of Resident #1's record revealed additional diagnoses of Alzheimer's Disease (a progressive brain disorder that affects thinking and memory), depression, anxiety, and insomnia.

Review of Resident #1's Resident Register revealed an admission date of 03/06/25.

Review of Resident #1's physician's orders revealed:
-There was an order for metoprolol (treats high blood pressure) ER 100mg daily dated 03/07/25.
-There was an order for vitamin D3 (supplement) 5000IU daily dated 03/07/25.
-There was an order for acetaminophen (pain reliever) 500mg 2 tablets three times daily dated 03/11/25.

Observation of Resident #1's room during the initial tour on 02/25/26 at 8:50am revealed:
-There was a clear medication cup next to a cup of water on the counter in the kitchenette.
-The medication cup contained one round white tablet, one small round white tablet, and two oblong white tablets.

Interview with Resident #1 on 02/25/26 at 8:50am revealed:
-The medications in the cup were her morning medications.
-She must have been in the dining room for breakfast when the medication aide (MA) came to her room with the medicine and left it for her.
-Sometimes the MAs would watch her take her medications but that did not happen on 02/25/26.

Review of Resident #1's electronic medication administration record (eMAR) for 02/25/26

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D 366	Continued From page 7	D 366		

revealed:
-There was an entry for metoprolol 100mg daily with an administration time of 9:00am and documentation the metoprolol was administered.
-There was an entry for vitamin D3 5000IU daily with an administration time of 9:00am and documentation the vitamin D3 was administered.
-There was an entry for acetaminophen 500mg 2 tablets daily with an administration time of 9:00am and documentation the acetaminophen was administered.

Interview with the MA on 02/25/26 at 11:14am revealed:
-She administered all of Resident #1's medications the morning of 02/25/26.
-She knew not to leave medications in residents' rooms.
-She did not know who left the medications in Resident #1's room.

Interview with a second MA on 02/25/26 at 3:47pm revealed:
-She was trained to observe residents swallow their medications before documenting the administration.
-She knew never to leave medications in residents' rooms and did not know why they were left.

Interview with a third MA on 02/25/26 at 3:50pm revealed she always observed the residents swallow their medications before she documented the administration.

Interview with the Resident Care Coordinator (RCC) on 02/25/26 at 12:10pm revealed:
-The MAs were trained to observe the residents swallow their medications.
-Residents' medications should never be left in

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	HAL057011	A. BUILDING: _____ B. WING _____	02/26/2026

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D 366	Continued From page 8 rooms and she did not know why it happened. Interview with the Administrator on 02/25/26 at 12:40pm revealed: -The MAs received frequent training about watching the residents swallow their medications. -Residents' medications should never be left in their rooms.	D 366		