STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R 04/01/2026

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CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

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D 000	Initial Comments The Adult Care Licensure Section and Cleveland County Department of Social Services conducted an annual, follow-up survey and complaint investigations from March 30, 2026 through April 1, 2026. The compliant investigations were initiated by the Cleveland County Department of Social Services on March 5, 2026.	D 000	The response in the cited statement of 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 solely as a matter of compliance with state laws.	
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure the sprinkler system was maintained in a safe operating condition since August 2025. The findings are: Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2026, revealed:	D 105		

Reviewed and acknowledged by *Melissa J. Jones*, 05/08/26.

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D 105	Continued From page 1 -The facility was licensed for a capacity of 72 beds for an Adult Care Home. -The current census was 49. Review of the Construction Section Biennial Survey completed on 07/09/25 revealed: -A copy of the current Fire Official's Annual Inspection report was not available for review. -A copy of the current fire alarm system inspection report was not available for review. -A copy of the current fire sprinkler system inspection report was not available for review. Review of the fire protection systems inspection report dated 09/29/25 revealed: -The facility needed to relocate sprinkler heads in the remodeled rooms as soon as possible. -Rooms with blocked sprinkler heads shall not be occupied unless the residents could self-evacuate. -Systems to be inspected and tested for proper operation at 12-month intervals. Telephone interview with the local Fire Marshal on 03/30/26 at 4:08pm revealed: -He completed an inspection of the facility on 08/29/25. -The facility hired a construction company to complete a remodel of resident rooms who built walls that obstructed sprinkler heads. -The facility needed to relocate the sprinkler heads and move any residents who could not self-evacuate to another room that did not have obstructed sprinkler heads. -The fire alarms worked without the sprinkler heads working and would alarm the fire department. -He expected the facility to correct the issue by 09/29/25.	D 105	Facility Executive Director, Maintenance Technician, and/or designee will contact the licensed fire safety vendor as needed to request services and repairs to the fire sprinkler system to ensure continued compliance with the cited rule area and all applicable life safety requirements. The Facility Executive Director and Maintenance Technician will receive in-service education regarding the proper procedure for submitting and tracking work orders within the company's work order system to ensure timely follow-up and resolution of all identified life safety concerns. The Facility Maintenance Technician and/or designee will monitor the fire panel no less than twice weekly for a period of 60 days to ensure the system is functioning properly and operating as intended. Thereafter, the fire panel will be monitored no less than monthly in conjunction with scheduled facility fire drills to ensure ongoing compliance and functionality.	5-16-2026 5-16-2026 5-16-2026

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D 105	Continued From page 2 Interview with the Maintenance Director on 03/30/26 at 3:31pm revealed: -The last sprinkler system inspection report was completed on 09/27/23. -The last fire protection system inspection was completed on 08/29/25. -The pump for the sprinkler system had not been working since August of 2025 when the facility had hired a company to complete a remodel of the facility. -During the remodel of the facility, walls were built obstructing 16 sprinkler heads. -The facility had been waiting on their corporate office to review and approve a quote obtained on 11/10/25 to replace the pump. Interview with the Maintenance Director on 04/01/26 at 1:24pm revealed: -A company began work on replacing the sprinkler system pump the first week of February 2026. -Another company began work on moving the sprinkler heads the first week of March 2026. -There was no need for staff to complete a fire watch because the fire alarm system was operational. -If the fire alarm system alarmed, the local fire department would be notified automatically by the alarm system. Interview with the Administrator on 03/30/26 at 3:31pm revealed: -The pump for the sprinkler system had not been working since August of 2025 when the facility had hired a company to complete a remodel of the facility. -During the remodel of the facility, walls were built obstructing 16 sprinkler heads. -The Fire Marshal notified her that any residents who were located in the rooms with the	D 105		

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D 105	Continued From page 3 obstructed sprinkler heads that were non-ambulatory needed to be moved to another room. -There was only one resident that was non-ambulatory that was immediately moved to another room that did not have an obstructed sprinkler head although the sprinkler system was not operational. -The facility was waiting on their corporate office to review and approve a quote obtained on 11/10/25 to replace the pump. -A company began work on replacing the sprinkler system pump the first week of February 2026. -Another company began work on moving the sprinkler heads the first week of March 2026. -There was no need for staff to complete a fire watch because the fire alarm system was operational. -If the fire alarm system alarmed, the local fire department would be notified automatically by the alarm system. The facility failed to ensure the sprinkler system was maintained in a safe operating condition since August of 2025 which placed the residents of risk if a fire broke out in the facility. This failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2026.	D 105		

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D 228	Continued From page 4	D 228		
D 228	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility administrator or their designee shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this Rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a safe and orderly discharge for 1 of 1 sampled resident (#8). The findings are: Review of the facility's Discharge Policy dated 04/01/24 revealed: -Upon discharge, the community was to assist the Resident to assure a safe and orderly discharge by following procedures required by law, including notifying the Department of Social Services (DSS) of the discharge, explaining to the Resident/Representative why the discharge is necessary, and informing the Resident/Representative of the appropriate discharge destination. -Upon discharge, the Resident or Representative	D 228	The Facility Executive Director, Care Coordinator, and/or designee will ensure that all future discharges include documented contacts with potential discharge locations, responses received from those locations, and supporting documentation demonstrating the appropriateness and safety of the discharge setting based on the resident's assessed level of care and needs. The Facility Executive Director and Care Coordinator will receive in-service education regarding state discharge requirements, including requirements for updated FL2s, assessments, documentation of discharge planning efforts, communication with residents and responsible parties, and identification of appropriate discharge placements prior to issuing discharge notices. The Facility Executive Director and/or designee will audit resident discharges monthly for 90 days to ensure compliance with discharge documentation requirements and safe discharge planning practices. Any identified concerns will be addressed immediately through corrective action and additional staff education as needed.	5-16-2026 5-16-2026 5-16-2026

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D 228	Continued From page 5 was to be provided with a copy of the FL2, the most recent assessment and resident service plan, most current physician orders, copy of a current medication list, all medications belonging to the resident, a copy of vaccinations, TB screening, and any other documentation that may be required for transfer to a different care setting. Review of Resident #8's current FL2 dated 06/13/25 revealed: -Diagnoses included chronic embolism and thrombosis of lower extremity, venous insufficiency, chronic kidney disease, hypomagnesemia, bipolar disorder, obstructive sleep apnea, hypothyroidism, and essential hypertension. -Resident #8 was semi-ambulatory and used a rollator. -Resident #8's current level of care was Assisted Living Facility (ALF). Review of Resident #8's Resident Register revealed an admission date of 05/06/25. Review of Resident #8's Care Plan dated 05/16/25 revealed she required total assistance with eating, and limited assistance with bathing, dressing, and grooming. Review of one Notice of Discharge dated 08/12/26 revealed: -The date of discharge would be 09/15/26 to a local shelter. -The reason for the discharge notice was Resident #8 had failed to pay the facility. -The Administrator signed the notice on 08/12/26. Review of a second Notice of Discharge dated 12/09/25 revealed: -The date of discharge would be 01/09/26.	D 228		

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D 228	Continued From page 6 -The reason for the discharge notice was Resident #8 had failed to pay the facility. -The Administrator signed the notice on 12/09/25. Telephone interview with Resident #8 on 04/01/26 at 1:11pm revealed: -She had stopped paying the facility and was issued two discharge notices. -She decided to leave on her own and was currently trying another facility out. -She did not think she could get the care she needed at a shelter, which was her discharge plan from the facility. -She had a clotting disorder and had clots in her legs and used a rollator. -She needed assistance with bathing, cooking, and cleaning. -She had a tough time standing for extended periods of time. -She was often in pain from swelling in her lower legs. -She had an open wound about a month ago that was fully healed now and had services with home health including physical therapy and nursing care, and she was discharged from those services about a month ago. Telephone interview with the facility's contracted home health agency on 04/01/26 at 8:47am revealed: -Physical therapy and nursing care was started for Resident #8 on 01/13/26. -Resident #8 received physical therapy once a week and nursing care three times a week. -Resident #8 had been treated for a wound on her left lower leg by nursing staff and physical therapy had been working with gait training and fall prevention. -Physical therapy noted Resident #8 was independent with transfers and was mobile when	D 228		

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D 228	Continued From page 7 they ended services. -Nursing noted Resident #8's wound was healed when they ended services. -Physical therapy was discontinued on 02/17/26 and nursing care was discontinued on 02/19/26. -They preferred not to do services at the shelters due to residents often not being there during the day and it being difficult to find a private area to work with the residents in, but they had done services in the past at the shelters. -Due to the difficulty of finding a time to meet with them or talk to the shelter's staff members, it was hard to schedule and do therapy with residents at the shelter.	D 228		
	Telephone interview with the Primary Care Physician (PCP) on 04/01/26 at 3:07pm revealed: -She was aware Resident #8 was not paying for her stay at the facility and Resident #8 was given two discharge notices to go to a shelter. -She wrote a letter stating she felt Resident #8 would be able to manage at the shelter if home health services could be provided at the shelter. Interview with the Administrator on 03/31/26 at 2:43pm and on 04/01/26 at 9:57am and at 3:57pm revealed: -Resident #8 was not paying her bills and owed the facility over $9,000.00. -She had stopped paying her bills in May or June of 2025. -Resident #8 received two discharge notices with a plan to go to a local shelter. -She had reached out to department of social services (DSS) for assistance and was unsuccessful. -Section 8 housing was also brought up as an option, but Resident #8 did not want to go there. -She also reached out to other facilities, but due to Resident #8's age, she was difficult to place.			

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D 228	Continued From page 8 -She felt her only option was to place her in a local shelter. -She had reached out to the shelter both times to ask if they had open beds. -She had two appeals for the discharges with the first appeal stating it was not a safe discharge for Resident #8, and the results were not back yet from the second appeal. -She did not change the place for her discharge because she felt it was a safe discharge. -She had talked to a representative from Home Health who told her they could provide services at the shelter. -Resident #8 left on her own to try another facility out so she never discharged her from the facility. -She was keeping Resident #8's bed open for 15 days to see if she was going to come back. -Resident #8's FL2 was not updated, and her level of care was ALF. -She did not think to have Resident #8's FL2 updated and that was an oversight. -She should have told the Resident Care Coordinator (RCC) to update Resident #8's FL2 to show her level of care could be to a less restrictive setting. Attempted interview with the local shelter on 04/01/26 at 8:34am was unsuccessful.	D 228		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews the	D 273		

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D 273	Continued From page 9 facility failed to ensure referral and follow-up for 2 of 2 sampled residents (#1 & #4) related to a resident who was not administered a medication to prevent blood clots (#4) and an order to notify the Primary Care Practitioner (PCP) of blood sugar readings less than 70 or greater than 450 (#1). The findings are: 1. Review of Resident #4's current FL2 dated 05/27/25 revealed diagnoses included dysarthria following cerebral infarction (difficulty speaking after a stroke) and atherosclerotic heart disease (narrowing of the heart arteries due to plaque build-up). Review of Resident #4's ED visit note dated 01/12/26 revealed: -Resident #4 had a blood clot in his left lower leg. -Resident #4 was sent back to the facility with a "take-home" Eliquis (a medication to prevent blood clots) pack. Telephone interview with a hospital Pharmacist on 04/01/26 at 1:02pm revealed: -Resident #4 was seen in the ED on 01/12/26 for a deep vein thrombosis (DVT)(blood clot). -Resident #4 was discharged back to the facility with Eliquis 5mg, 74 tablets (30-day supply) from the hospital's pharmacy. Review of Resident #4's Nurse Practitioner's (NP) progress note dated 03/20/26 revealed: -Resident #4 had a recent DVT of his left lower leg a couple months ago and was prescribed Eliquis 5mg, one tablet twice daily. -Facility staff reported Resident #4 had been without his Eliquis 5mg, one tablet twice daily for approximately one week.	D 273	The Facility Executive Director and/or designee will complete weekly audits of resident records for a period of 90 days to ensure healthcare follow-up documentation is complete, timely, and compliant with all applicable regulatory requirements. Facility medication staff, including the Executive Director and Resident Care Coordinator, will receive in-service education regarding the importance of timely physician referrals, healthcare follow-up, and proper communication procedures. Education will include ensuring medications are available as ordered, timely notification of appropriate healthcare providers and responsible parties regarding medication refill needs, and prompt reporting of vital signs outside physician-ordered parameters or changes in resident condition requiring further medical evaluation.	5-16-2026 5-16-2026

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D 273	Continued From page 10 Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #4 had an order dated 01/14/26 for Eliquis 5mg, one tablet twice daily. -Resident #4's Eliquis order was "profiled" only on the resident's eMAR. -The pharmacy had not dispensed Eliquis 5mg for Resident #4. Telephone interview with Resident #4's NP on 04/01/26 at 10:37am revealed: -She received a message on 03/18/26 that Resident #4 was out of Eliquis 5mg, one tablet twice daily. -She had not received any notification prior to 03/18/26 that Resident #4 was not receiving Eliquis 5mg, one tablet twice daily. -She expected to be notified if Resident #4 did not receive his Eliquis as he could suffer another blood clot. Interview with a medication aide (MA) on 04/01/26 at 12:17pm revealed: -She did not know when Resident #4 ran out of his Eliquis but thought he had been without it about two to three weeks. -She did not know the date but she told the Resident Care Coordinator (RCC) that Resident #4 was out of his Eliquis. -The RCC was responsible to notify Resident #4's PCP he was out of his Eliquis. Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to notify the RCC if there were issues getting a resident's medication from the pharmacy. -She thought the facility's contracted pharmacy	D 273		

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D 273	Continued From page 11 had filled Resident #4's Eliquis. -She was notified by a MA that Resident #4 was out of his Eliquis about one and a half weeks after he ran out and she notified his PCP. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -The MAs were responsible to contact the pharmacy and notify the RCC if medication was not available for administration. -The RCC was responsible for notifying the PCP when residents did not receive medications. -She was unaware Resident #4 PCP was not notified immediately when he ran out of his medication to prevent blood clots. 2. Review of Resident #1's current FL2 dated 08/04/25 revealed: -Diagnoses included seizures, chronic obstructive pulmonary disease and diabetes mellitus Type II. -He was constantly disoriented. Review of Resident #1's physician order dated 12/02/25 revealed: -There was an order to use Resident #1's Dexcom (continuous glucose monitor) device to check blood sugar (BS) three times daily. -There was an order for Humalog KwikPen (fast-acting insulin used to improve blood sugar control) inject 5 units subcutaneously three times daily before meals and to notify the PCP if BS was less than 70 or great than 450. Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry to use Resident #1's Dexcom device to check blood sugar three times daily. -There was documentation of recorded blood	D 273		

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D 273	Continued From page 12 sugar checks three times daily at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen inject 5 units subcutaneously three times daily before meals and to notify the PCP if BS was less than 70 or great than 450. -There was documentation that Resident #1's BS readings were greater than 450 on 18 occasions. -There was no documentation on the eMAR the PCP was notified of Resident #1's elevated BS. Review of Resident #1's February 2026 eMAR revealed: -There was an entry to use Resident #1's Dexcom device to check blood sugar three times daily. -There was documentation of recorded blood sugar checks three times daily at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen inject 5 units subcutaneously three times daily before meals and to notify the PCP if BS was less than 70 or great than 450. -There was documentation that Resident #1's BS readings were greater than 450 on 10 occasions. -There was no documentation on the eMAR the PCP was notified of Resident #1's elevated BS. Review of Resident #1's electronic progress notes revealed there was no documentation the PCP was notified of Resident #1's BS readings greater than 450. Telephone interview with Resident #1's PCP on 04/01/26 at 3:47pm revealed: -The last time the facility notified her of Resident #1's BS reading over 450 was in November 2025. -She expected the facility to follow all physician orders. -High blood sugar could cause hyperglycemia	D 273		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

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D 273	Continued From page 13 (high blood glucose levels), which could lead to long-term complications such as kidney and vision damage. Interview with a medication aide (MA) on 03/31/26 at 10:12am revealed: -She thought she had always notified the PCP when Resident #1's BS were greater than 450. -She thought she had sent a message to the PCP's office every time his BS was great than 450. -She did not have any documentation of notification to the PCP office. Interview with the RCC on 03/13/26 at 3:55pm revealed: -She did not know the PCP had not been notified of Resident #1's BS being greater than 450. -She expected the MA to reach out to the PCP when Resident #1's BS was greater than 450. -There was no type of audit in place to ensure the MAs were notifying the PCP when Resident #1's BS was greater than 450. Interview with the Administrator on 0304/01/26 at 3:58pm revealed: - She did not know the PCP had not been notified of Resident #1's BS being greater than 450. -She expected the MAs to follow the order and call the PCP when Resident #1's BS was greater than 450.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional;	D 276		

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D 276	Continued From page 14 and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician orders for 2 of 5 sampled residents related to orders for a fiber laxative to prevent constipation (#2) and for sliding scale insulin (SSI) orders with meals (#1). The findings are: 1. Review of Resident #2's current FL2 dated 03/13/26 revealed diagnoses included history of colon polyps and history of constipation. Review of Resident #2's hospital discharge summary dated 03/13/26 revealed an order for methylcellulose powder (a fiber laxative to treat constipation), one gram twice daily. Review of Resident #2's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for methylcellulose powder, one gram twice daily scheduled at 8:00am and 8:00pm. -Methylcellulose powder, one gram was documented administered at 8:00am and 8:00pm from 03/17/26 through 03/30/26 at 8:00am, except at 8:00am on 03/17/26 and 03/26/26 and at 8:00pm on 03/23/26. Observations of medications on hand for	D 276	The Executive Director, Care Coordinator and/or Designee will complete an audit of current resident medication orders, physician orders, and recent hospital discharge orders to ensure: physician orders were accurately transcribed into the eMAR, medication orders were accepted timely within the eMAR system, and ordered medications were available for administration. The facility medication staff, including medication aides, Care Coordinator, and Executive Director, will be re-educated on the facility medication management process with emphasis on: implementation of physician orders timely and accurately, reconciliation of hospital discharge orders, ensuring medications are available for administration, timely follow-up with pharmacies regarding unavailable medications, verification and acceptance of pharmacy-entered orders within the eMAR system, and notification to the Care Coordinator and prescribing practitioner for any delay, discrepancy, or unavailable medication. The Executive Director, Care Coordinator and/or Designee will complete weekly audits of: newly received physician orders, hospital discharge orders, eMAR order acceptance, and medication availability for 60 days to ensure compliance with physician orders and regulatory requirements.	5-16-2026 5-16-2026 5-16-2026

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D 276	Continued From page 15 Resident #2 on 03/31/26 at 11:25am revealed there was no methylcellulose powder available for administration. Telephone interview with a Pharmacist at Resident #2's pharmacy on 04/01/26 at 9:33am revealed: -Resident #2 had an order dated 03/13/26 for methylcellulose powder one gram twice daily. -The methylcellulose powder order for Resident #2 was not dispensed. -He was unsure why the methylcellulose powder was not dispensed but thought it possible the resident did not want it.	D 276		
	Telephone interview with a representative at Resident #2 Primary Care Physician's (PCP) office on 04/01/26 at 2:37pm revealed: -Resident #2's PCP was not aware the resident was not being administered methylcellulose according to the hospital discharge order. -A new order was sent that day, 04/01/26, for the methylcellulose to be administered as needed. Interview with a medication aide (MA) on 03/31/26 at 11:29am revealed: -There was no methylcellulose powder on the medication cart for Resident #2. -She was unsure when, but she told the Resident Care Coordinator (RCC) that Resident #2's methylcellulose powder was not on the medication cart. Interview with the RCC on 04/01/26 at 2:38pm revealed: -Resident #2 used an outside pharmacy and, at times, picked up her own medications. -Resident #2's discharge orders were sent to the facility's pharmacy to "profile" only on the resident's eMAR which meant the facility			

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D 276	Continued From page 16 pharmacy placed the order on the eMAR but did not send the medication to the facility. -The MAs were responsible to reach out to the resident's pharmacy if medication was not available and to notify the RCC. -She was not aware Resident #2's methylcellulose was not available for administration. Interview with the Administrator on 04/01/26 at 3:57pm revealed the MAs were responsible contact the pharmacy and notify the RCC if medication was not available for administration. 2. Review of Resident #1's current FL2 dated 08/04/25 revealed: -Diagnoses included seizures, chronic obstructive pulmonary disease and diabetes mellitus Type II. -He was constantly disoriented. a. Review of Resident #1's physician order dated 02/12/26 revealed an order for Humalog (fast-acting insulin used to improve blood sugar control) per sliding scale, inject insulin subcutaneously per sliding scale; BS 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and BS greater than 400 = 14U. Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry dated 02/17/26 through 02/28/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and BS greater than 400 = 14U. -There was documentation of Humalog being administered from 02/17/26 through 02/08/26.	D 276		

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D 276	Continued From page 17 -There was not an entry for Humalog prior to 02/17/26. Telephone interview with the facilities contracted Pharmacist on 04/01/26 at 12:46pm revealed: -A physician order was received on 03/12/26 to discontinue previous Humalog orders and start Humalog per sliding scale, inject insulin subcutaneously per sliding scale; BS 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U. -Pharmacy staff added orders onto the facility's eMARs. -Once the Pharmacy entered all orders, the facility had to accept or decline the order for the medication to appear or discontinue on the eMAR system. Review of Resident #1's March 2026 eMAR revealed: -There was an entry on 03/01/26 through 03/30/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; BS 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and BS greater than 400 = 14U. b. Telephone interview with the facilities contracted Pharmacist on 04/01/26 at 12:46pm revealed: -A physician order was received on 03/12/26 to discontinue previous Humalog orders and start Humalog per sliding scale, inject insulin subcutaneously per sliding scale; BS 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U.	D 276		

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D 276	Continued From page 18 Review of Resident #1's March 2026 eMAR revealed: -There was entry dated 03/17/26 through 03/30/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; BS 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U. -There was documentation of Humalog per sliding scale, inject insulin subcutaneously (SQ) per sliding scale; BS 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U being administered from 03/17/26 through 03/30/26. Telephone interview with the Registered Nurse (RN) at Resident #1's Endocrinology Office on 04/01/26 at 2:33pm revealed: -The facility should have followed the physician orders due to Resident #1 being a brittle diabetic. -If Resident #1 had received both doses of his sliding scale insulin, he could have experienced low blood sugar which could have resulted in dizziness, lethargy, fatigue, sweating and increased heart rate. Interview with the Resident Care Coordinator (RCC) on 04/01/26 at 2:10pm revealed: -She did not know Resident #1 insulin orders were not accurate and did not start until days after ordered. -She was responsible for accepting or declining medication orders from the pharmacy. -Medication orders were left as is on the eMAR until she had accepted the order from the pharmacy. -She must not have accepted Resident #1's orders until days after the pharmacy had been	D 276		

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D 276	Continued From page 19 sent to be approved. Interview with the Administrator on 04/01/26 at 3:58pm revealed: -She did not know Resident #1 insulin orders were not accurate and did not start until days after the order was received. -She and the RCC were responsible for accepting or declining medication orders from the pharmacy. -She had not seen Resident #1's Humalog orders.	D 276		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications and treatments as ordered for 4 of 8 sampled residents related to a medication to prevent blood clots (#4), daily weights and heart rates (#2), a resident with an order for blood sugar (BS) checks 3 times a day and sliding scale insulin (SSI) orders with meals (#1), and medications to lower blood sugar levels and treat breast cancer (#3).	D 358		

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D 358	Continued From page 20 The findings are: Review of the facility's undated Medication Administration Record (MAR) policy revealed: -The MAR was to contain the initials of the staff administering medication with each administration. -Refusals or medication not given were indicated by the staff person's initials with a circle around them. 1. Review of Resident #4's current FL2 dated 05/27/25 revealed diagnoses included dysarthria following cerebral infarction (difficulty speaking after a stroke) and atherosclerotic heart disease (narrowing of the heart arteries due to plaque build-up). a. Review of Resident #4's incident report dated 01/12/26 revealed the resident was sent to the emergency department (ED) due to swelling in both of his legs. Review of Resident #4's ED visit note dated 01/12/26 revealed: -Resident #4 had a blood clot in his left lower leg. -Resident #4 was sent back to the facility with a "take-home" Eliquis (a medication to prevent blood clots) pack. -Resident #4 was to take Eliquis 5mg daily. Telephone interview with a hospital Pharmacist on 04/01/26 at 1:02pm revealed: -Resident #4 was seen in the ED on 01/12/26 for a deep vein thrombosis (DVT)(blood clot). -Eliquis 5mg, 74 tablets (30-day supply) was dispensed and sent with Resident #4 when he was discharged from the ED. -The Eliquis directions were to administer Eliquis	D 358	The facility medication staff, including medication aides and Care Coordinator, were re-educated on the facility medication management process with emphasis on: medication administration procedures, medication order processing and implementation, physician order transcription and eMAR order acceptance, charting and progress note documentation requirements, medication/vital sign parameters and required follow-up, medication error reporting and follow-up procedures, ensuring medications are available for .administration, timely pharmacy communication regarding unavailable medications, and notification to the Care Coordinator and prescribing practitioner for any delay, discrepancy, unavailable medication, or order clarification. Education also included review of high-risk medication monitoring processes including insulin administration and physician notification requirements related to abnormal blood sugar results along with Coumadin to include lab orders as prescribed by the residents physician. The facility Executive Director, Care Coordinator and/or Designee will conduct weekly eMAR and medication cart audits for 60 days to ensure medications are available for administration as ordered by the resident's physician. Audits will include review of medication availability, physician orders, eMAR accuracy, medication reorder status, pharmacy follow-up documentation, and identification of medications with low supply to prevent interruption in medication administration. Any identified discrepancies will be addressed immediately with the pharmacy, prescribing practitioner, and facility medication staff as indicated. The facility implemented a hospital return order reconciliation process requiring the Care Coordinator and/or designee to review hospital discharge paperwork, physician orders, medication changes, and treatment orders upon a resident's return to the facility. Orders will be reconciled with the eMAR to ensure all medications, treatments, and monitoring parameters are accurately entered, accepted, and implemented timely. Facility Executive Director, Care Coordinator and/or Designee will conduct weekly audits of residents returning from the hospital will be completed for 60 days to ensure discharge orders are accurately processed, new orders are implemented, documented, and available for administration as ordered by the physician. Any identified concerns will be addressed through corrective action and/or staff re-education as indicated.	5-1-2026 5-1-2026 5-1-2026 5-1-2026

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D 358	Continued From page 21 5mg, two tablets twice daily for seven days followed by Eliquis 5mg, one tablet twice daily. Review of Resident #4's Nurse Practitioner's (NP) progress note dated 03/20/26 revealed: -Resident #4 had a recent DVT of his left lower leg a couple months ago and was prescribed Eliquis 5mg, one tablet twice daily. -Facility staff reported Resident #4 had been without his Eliquis 5mg, one tablet twice daily for approximately one week. -There was a new order to discontinue Resident #4's Eliquis 5mg, one tablet twice daily. -There was an order to start warfarin (a medication to prevent blood clots) 1mg, one tablet daily. Review of Resident #4's January 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 01/15/26 for Eliquis 5mg, two tablets twice daily for seven days. -There was documentation Eliquis 5mg, two tablets were administered at 8:00am and 8:00pm from 01/15/26 through 01/21/26. -There was an entry dated 01/22/26 for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 01/22/26 through 01/31/26. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 02/01/26 through 02/28/26. Review of Resident's #4 March 2026 eMAR	D 358		

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D 358	Continued From page 22 revealed: -There was an entry for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 03/01/26 through 03/20/26. -The entry for Eliquis 5mg, one tablet twice daily was discontinued on 03/21/26. Interview with Resident #4 on 04/01/26 at 12:00pm revealed: -He was unsure of what medications he was administered. -He received all his medications through the facility's contracted pharmacy. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #4 had an order dated 01/14/26 for Eliquis 5mg, one tablet twice daily. -Resident #4's Eliquis order was "profiled" only on the resident's eMAR. -The pharmacy had not dispensed Eliquis 5mg for Resident #4. Telephone interview with Resident #4's NP on 04/01/26 at 10:37am revealed: -She received a message on 03/18/26 that Resident #4 was out of Eliquis 5mg, one tablet twice daily and the pharmacy was unable to dispense due to the cost of the medication. -She had not received any notification prior to 03/18/26 that Resident #4 was not receiving Eliquis 5mg, one tablet twice daily. -Resident #4 had a previous DVT and if he did not receive Eliquis 5mg, one tablet twice daily as ordered he was at increased risk of having an additional blood clot.	D 358		

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D 358	Continued From page 23 Interview with a medication aide (MA) on 04/01/26 at 12:17pm revealed: -Resident #4's Eliquis came to the facility in a box and may have been a "sample". -Resident #4 sometimes refused medications but he did not refuse his Eliquis. -Resident #4's Eliquis was discontinued and he was started on warfarin (a medication to prevent blood clots) on 03/20/26. -She was unsure when Resident #4 ran out of his Eliquis but he had gone two to three weeks without Eliquis or warfarin. -She was unsure of the date but she told the Resident Care Coordinator (RCC) that Resident #4 was out of his Eliquis. -The MAs were responsible to reorder resident medications that were not cycle-filled. Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs and the RCC were responsible to reorder resident medications when there was a seven-day supply of medication remaining. -The MAs were responsible to notify the RCC if there were issues getting a resident's medication from the pharmacy. -The MAs were responsible to notify the RCC before a medication was not available to administer. -She was unsure of the date but she was notified by a MA that Resident #4 was out of his Eliquis about one and a half weeks after he ran out. -The pharmacy sent a prior authorization form for Resident #4's Eliquis but it was not completed because the family did not have the funds for the medication. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -The MAs were responsible to reorder	D 358		

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D 358	Continued From page 24 medications when there was a seven-day supply remaining of the medication. -The MAs were responsible to contact the pharmacy and notify the RCC if a medication was not available for administration. -She was unaware Resident #4 was not being administered his medication to prevent blood clots. b. Review of Resident #4's incident report dated 01/12/26 revealed the resident was sent to the emergency department (ED) due to swelling both of his legs. Review of Resident #4's ED visit note dated 01/12/26 revealed: -Resident #4 had a blood clot in his left lower leg. -Resident #4 was sent back to the facility with a "take-home" Eliquis (a medication to prevent blood clots) pack. -Resident #4 was to take Eliquis 5mg daily. Review of Resident #4's Nurse Practitioner's (NP) progress note dated 03/20/26 revealed: -Resident #4 had a recent deep vein thrombosis (DVT) (blood clot) of his left lower leg a couple months ago and was prescribed Eliquis 5mg, one tablet twice daily. -Facility staff reported Resident #4 had been without Eliquis 5mg, one tablet twice daily for approximately one week. -There was a new order to discontinue Resident #4's Eliquis 5mg, one tablet twice daily. -There was an order to start warfarin (a medication to prevent blood clots) 1mg, one tablet daily. -There was an order to check Resident #4's INR (a blood test to determine how long it takes the blood to clot) on Monday (03/23/26).	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 Review of a Home Health Coordination Note dated 03/28/26 at 9:14pm revealed: -The Registered Nurse (RN) completed an INR blood test for Resident #4 and the result was 1.0 (normal INR results are 1.0 in patients not receiving medications to prevent blood clots). -The RN contacted Resident #4's NP and spoke with the medication aide (MA) regarding Resident #4's warfarin. -The RN discovered Resident #4's warfarin 1mg, one tablet daily was being documented as administered but the warfarin 1mg bubble pack was intact with none of the medications administered. Review of Resident #4's March 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry with a start date of 03/21/26 for warfarin 1mg, one tablet daily scheduled at 8:00am. -There was documentation warfarin 1mg was administered at 8:00am from 03/22/26 through 03/30/26. Observations of medications available for administration for Resident #4 on 03/31/26 at 11:18am revealed: -There was a bubble pack of warfarin 1mg tablets for Resident #4. -The label indicated warfarin 1mg, 29 tablets were dispensed on 03/20/26 with directions to administer one tablet daily. -There were 23 tablets of warfarin 1mg remaining in the bubble pack of the 29 tablets dispensed. -Two of the six bubbles that had medication removed from the pack had dates and initials next to them. -The earliest of the two dates was 03/25/26.	D 358		

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D 358	Continued From page 26 Telephone interview with a representative with the home health agency on 04/01/26 at 10:21am revealed the RN's Coordination Note dated 03/28/26 was a "late entry" to the RN's visit to Resident #4 on 03/23/26. Telephone interview with the home health RN on 04/01/26 at 2:31pm revealed: -She checked Resident #4's INR on 03/23/26 and the result was 1.0. -She notified Resident #4's NP of the result and was instructed to check his medication on hand and his eMAR to ensure the resident was being administered the warfarin 1mg daily. -Resident #4's eMAR indicated warfarin 1mg daily was being administered. -When she observed Resident #4's warfarin 1mg medication bubble pack, the bubble pack was intact with no medication removed from the bubble pack. -She informed the Administrator and Resident #4's NP that Resident #4 was not being administered his warfarin 1mg, one tablet daily as ordered. Interview with a MA on 04/01/26 at 12:17pm revealed: -MAs were responsible to compare the medication label with the order in the eMAR to ensure medications were administered and documented correctly. -She worked the day the RN saw Resident #4 for his INR and asked to see his eMAR and warfarin medication. -Resident #4's eMAR showed warfarin 1mg was administered but no warfarin 1mg was dispensed from the bubble pack. -Resident #4 went two to three weeks without administration of his warfarin or Eliquis.	D 358		

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D 358	Continued From page 27 Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #4 had an order dated 03/20/26 for warfarin 1mg, one tablet daily. -On 03/20/26, warfarin 1mg, 29 tablets were dispensed for Resident #4. -The pharmacy received a new order dated 03/31/26 to discontinue warfarin 1mg, one tablet daily and start warfarin 3mg, one tablet daily. -On 03/31/26, warfarin 3mg, 30 tablets were dispensed for Resident #4. Telephone interview with Resident #4's NP on 04/01/26 at 10:37am revealed: -Resident #4's medication to prevent blood clots was changed from Eliquis to warfarin 1mg one tablet daily on 03/20/26 due to the cost of the medication. -On 03/23/26 she was contacted by the home health RN and informed Resident #4's INR was 1.0. -She instructed the RN to investigate if Resident #4 received warfarin 1mg, one tablet daily over the previous weekend (03/21/26-03/22/26). -The RN informed her the warfarin 1mg bubble pack was not opened but was initialed as administered on Resident #4's eMAR. -Resident #4 had a previous DVT and if he did not receive warfarin as ordered he was at increased risk of having another blood clot. Interview with the Resident Care Coordinator (RCC) on 04/01/26 at 2:11pm revealed: -The pharmacy was responsible for entering medication orders into the eMAR system. -All orders entered by the pharmacy into the eMAR system had to be approved before they showed on the eMAR for the MAs to administer the medication.	D 358		

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D 358	Continued From page 28 -She was the only staff member responsible for approving orders in the eMAR system. -Medications could be delayed getting on the eMAR if she was not available to approve the order. -MAs were responsible for comparing the medication label with the order in the eMAR system when administering medications. -She was unsure why the MA marked Resident #4's warfarin as administered on the eMAR when it had not been administered. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -The MAs were responsible to administer resident medications according to the orders on the eMAR. -She expected the MAs to compare the medication label with the order on the eMAR before administering the medication. -She expected MAs to accurately document medications administered on the residents' eMARs. -She was unaware Resident #4 was not being administered his medication to prevent blood clots. 2. Review of Resident #2's current FL2 dated 03/13/26 revealed diagnoses included hypertension and paroxysmal atrial fibrillation. a. Review of Resident #2's Physician Orders dated 01/27/26 revealed: -There was an order for metoprolol ER (a medication to treat high blood pressure) 25mg, one-half tablet at bedtime. -There was an order to check Resident #2's blood pressure every evening before administering metoprolol and to hold metoprolol ER if systolic blood pressure (SBP) was less than 110 or if	D 358		

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D 358	Continued From page 29 heart rate was less than 55. Review of Resident #2's January 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check Resident #2's blood pressure every evening before administering metoprolol and hold metoprolol if SBP was less than 110 or heart rate was less than 55. -There was documentation Resident #2's blood pressure was checked at 7:00pm from 01/01/26 through 01/31/26. -There was an entry for metoprolol ER 25mg, one-half tablet at bedtime. -There was documentation metoprolol ER 25mg, one-half tablet was administered at 8:00pm from 01/01/26 through 01/31/26. -There was no documentation Resident #2's heart rate was checked. Review of Resident #2's February 2026 eMAR revealed: -There was an entry to check Resident #2's blood pressure every evening before administering metoprolol and hold metoprolol if SBP was less than 110 or heart rate was less than 55. -There was documentation Resident #2's blood pressure was checked at 7:00pm from 02/01/26 through 02/28/26. -There was an entry for metoprolol ER 25mg, one-half tablet at bedtime. -There was documentation metoprolol ER 25mg, one-half tablet was administered at 8:00pm from 02/01/26 through 02/28/26. -There was no documentation Resident #2's heart rate was checked. Review of Resident #2's March 2026 eMAR revealed: -There was documentation Resident #2 was out	D 358		

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D 358	Continued From page 30 of the facility from 03/02/26 through 03/12/26. -There was an entry to check Resident #2's blood pressure every evening before administering metoprolol and hold metoprolol if SBP was less than 110 or heart rate was less than 55. -There was documentation Resident #2's blood pressure was checked at 7:00pm on 03/01/26 and from 03/13/26 through 03/29/26. -There was an entry for metoprolol ER 25mg, one-half tablet at bedtime. -There was documentation metoprolol ER 25mg, one-half tablet was administered at 8:00pm on 03/01/26 and from 03/13/26 through 03/29/26. -There was no documentation Resident #2's heart rate was checked. Interview with Resident #2 on 03/31/26 at 2:25pm revealed: -The medication aides (MA) check her blood pressure each evening before administering her metoprolol. -She had her own blood pressure machine and that was the one the MAs typically used to check her blood pressure. -If the MAs used her personal blood pressure machine, it additionally indicated her heart rate. Interview with a MA on 04/01/26 at 12:17pm revealed: -She typically did not work evening shift when Resident #2's blood pressure was checked but she had a few times. -She could not recall if there were data boxes on the eMAR for Resident #2's heart rate results. -If there was no box to enter the heart rate, the MA had the ability to put it in a note in the resident's chart. Telephone interview with a representative at Resident #2 Primary Care Physician's (PCP)	D 358		

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D 358	Continued From page 31 office on 04/01/26 at 2:37pm revealed: -The staff should be checking Resident #2's heart rate prior to administering her metoprolol. -Resident #2 could experience bradycardia (low heart rate), pass out or have weakness if her metoprolol was administered when her heart rate was less than 55. -He was not aware facility staff were not checking Resident #2's heart rate before administering her metoprolol. Interview with the Resident Care Coordinator (RCC) on 04/01/26 at 2:10pm and 2:38pm revealed: -She and the Administration were responsible for ensuring all documentation was present and available in the eMAR system. -She was not aware there was not a place on Resident #2's eMAR for documenting the resident's heart rate. -The MAs were responsible to check Resident #2's heart rate even if there was no place to enter it on the eMAR. -The MAs had the capability of adding a note to the resident's eMAR documenting Resident #2's heart rate. -There was no audits of residents' eMARs. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -The MAs were responsible for following the orders on the residents' eMARs. -She expected the MAs to check Resident #2's heart rate as ordered and document the result. -She expected the MAs to notify the RCC if the eMAR did not have an area for documenting Resident #2's heart rate. b. Review of Resident #2's Physician Orders dated 01/27/26 revealed there was an order to	D 358		

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D 358	Continued From page 32 weigh Resident #2 daily at 6:30am and notify the doctor of weight gain of 3 pounds in 24 hours or 5 pounds in a week. Review of Resident #2's January 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry to weigh Resident #2 daily and notify the MD of weight gain of 3 pounds in 24 hours or 5 pounds in a week. -The entry was documented completed daily at 6:30am except on 01/12/26 where the entry had a dash (-) instead of the medication aide's (MA) initials. -There was documentation Resident #2's weight was not done on 01/04/26, 01/13/26 and 01/27/26 because the resident refused stating the scales were not accurate. -The entry was documented as completed with the MAs initials but there was no documentation of Resident #2's weight. -There was documentation of Resident #2's weight on 01/26/26 under an entry for weight in the vitals section of the eMAR. Review of Resident #2's February 2026 eMAR revealed: -There was an entry to weigh Resident #2 daily and notify the MD of weight gain of 3 pounds in 24 hours or 5 pounds in a week. -The entry was documented completed daily at 6:30am except on 02/17/26, 02/22/26, 02/24/26, 02/25/26 and 02/26/26 where the entry had a dash (-) instead of the MAs initials. -There was documentation Resident #2's weight was not done 02/02/26, 02/04/26, 02/09/26, 02/15/26, 02/16/26, 02/19/26 to 02/21/26 and 02/23/26 because the resident refused. -The entry was documented as completed with the MAs initials but there was no documentation	D 358		

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D 358	Continued From page 33 of Resident #2's weight. -There was documentation of Resident #2's weight on 02/28/26 under an entry for weight in the vitals section of the eMAR. Review of Resident #2's March 2026 eMAR revealed: -There was an entry to weigh Resident #2 daily and notify the MD of weight gain of 3 pounds in 24 hours or 5 pounds in a week. -There was documentation Resident #2 was out of the facility from 03/03/26 to 03/13/26. -The entry was documented completed daily at 6:30am except on 03/02/26 and 03/15/26 where the entry had a dash (-) instead of the MAs initials. -There was documentation Resident #2's weight was not done on 03/16/26, 03/18/26, 03/20/26, from 03/22/26 to 03/24/26 and from 03/27/26 to 03/29/26 because the resident refused. -The entry was documented as completed with the MAs initials but there was no documentation of Resident #2's weight on the entry. -There was documentation of Resident #2's weight on 03/01/26, 03/19/26 and 03/30/26 under an entry for weight in the vitals section of the eMAR. Interview with Resident #2 on 03/31/26 at 2:25pm revealed: -The medication aides (MA) were checking her weight daily but they "slacked off" and stopped checking it. -About a year ago the scale stopped being accurate so she refused to be weighed on it. Interview with a MA on 04/01/26 at 12:17pm revealed: -Resident #2's weight was done in the morning by the night shift staff.	D 358		

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D 358	Continued From page 34 -Resident #2 often refused to be weighed. Telephone interview with a representative at Resident #2 Primary Care Physician's (PCP) office on 04/01/26 at 2:37pm revealed: -Resident #2's PCP was not aware the resident was refusing daily weights. -Since the resident was refusing the daily weights, the PCP discontinued them. Interview with the Resident Care Coordinator (RCC) on 04/01/26 at 2:38pm revealed: -The MAs were responsible to check Resident #2's weight daily. -She was aware Resident #2 refused to be weighed at times. -She expected the MAs to continue to attempt to weigh Resident #2 daily and to call her PCP if she refused. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -The MAs were responsible for weighing Resident #2 daily as ordered. -She was aware Resident #2 refused being weighed at times. -The MAs were responsible to tell the RCC if Resident #2 refused her daily weights. -The RCC was responsible to notify Resident #2 PCP after three refusals. 3. Review of Resident #1's current FL2 dated 08/04/25 revealed: -Diagnoses included seizures, chronic obstructive pulmonary disease and diabetes mellitus type II. -He was constantly disoriented. Review of Resident #1's physician order dated 12/02/25 revealed an order to use Resident #1's Dexcom (continuous glucose monitor) device to	D 358		

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D 358	Continued From page 35 check blood sugar three times daily. Review of Resident #1's physician order dated 02/12/26 revealed an order for Humalog (fast-acting insulin used to improve blood sugar control) per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and BS greater than 400 = 14U. Telephone interview with the facilities contracted Pharmacist on 04/01/26 at 12:46pm revealed: -A physician order was received on 03/12/26 to discontinue previous Humalog orders and to start Humalog per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U. -Pharmacy staff added orders onto the facility's eMARs. -Once the Pharmacy entered all orders, the facility had to accept or decline the order in order for the medication to appear or discontinue on the eMAR system. -The facility was responsible for adding an entry for documentation of the number of units of SSI administered, the BS results, BS and the location Resident #1's insulin was administered. Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry to use Resident #1's Dexcom device to check blood sugar three times daily. -There was documentation of blood sugar checks	D 358		

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D 358	Continued From page 36 three times daily at 7:30am, 11:30am and 4:30pm. -There was an entry on 02/17/26 through 02/28/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and greater than 400 = 14U. -There was documentation of Humalog being administered from 02/17/26 through 02/28/26. -There was no documentation of the number of Humalog units administered, no documentation of the location of administration and no documentation of Resident #1 blood sugar readings. Review of Resident #1's March 2026 eMAR revealed: -There was an entry use Resident #1's Dexcom device to check blood sugar three times daily. -There was documentation of blood sugar checks three times daily at 7:30am, 11:30am and 4:30pm. -There was an entry on 03/01/26 through 03/30/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 8 units(U); BS 150-200 = 9U; BS 201-250 = 10U; BS 251-300 = 11U; BS 301-350 = 12U; BS 351-400 = 13U and BS greater than 400 = 14U. -There was entry on 03/17/26 through 03/30/26 for Humalog per sliding scale, inject insulin subcutaneously per sliding scale; blood sugar (BS) 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U. -There was documentation of Humalog per sliding scale, inject insulin subcutaneously per	D 358		

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D 358	Continued From page 37 sliding scale; blood sugar (BS) 100-149 inject 7 units(U); BS 150-200 = 8U; BS 201-250 = 9U; BS 251-300 = 10U; BS 301-350 = 11U; BS 351-400 = 12U and BS greater than 400 = 13U being administered from 03/17/26 through 03/30/26. -There was no documentation of the number of Humalog units administered, no documentation of the location of administration and no documentation of Resident #1 blood sugar readings. Review of Resident #1's laboratory results on 12/15/25 revealed, the HgbA1C (normal value is below 5.7%) value was 14. Interview with a Medication Aide (MA) on 03/31/26 at 10:12am revealed: -She knew there was no place on Resident #1's eMAR to document the number of units of insulin she administered. -She knew there was no place on the eMAR to document the location of where she administered Resident #1's insulin. -She never documented the number of insulin units she administered to Resident #1 because there was nowhere on the eMAR system to document. -She knew there were two separate orders for sliding scale insulin in the month of March. -She only administered insulin for one of the two orders but did not remember which order. -She did not report there were two separate sliding scale insulin orders for Resident #1 to anyone. -She did not try to clarify the sliding scale insulin orders. -She could have documented the number of insulin given to Resident #1 in the eMAR system but did not because no one instructed her to.	D 358		

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	HAL023045	A. BUILDING: _____ B. WING _____	R 04/01/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38 Telephone interview with the Registered Nurse (RN) at Resident #1's Endocrinology Office on 04/01/26 at 2:33pm revealed: -The facility should have followed all physician orders. -If Resident #1 had received both doses of his sliding scale insulin, he could have experienced low blood sugar which could have resulted in dizziness, lethargy, fatigue, sweating and increased heart rate. Interview with the Resident Care Coordinator (RCC) on 04/01/26 at 2:10pm revealed: -She did not know Resident #1 insulin orders were not accurate. -She knew there was nowhere to document the number of insulin units that were given, the blood sugar reading or the location for Resident #1 on the eMAR system. -She was responsible for accepting or declining medication orders from the pharmacy. -She and the Administration were responsible for ensuring all documentation was present and available in the eMAR system that was implemented in November of 2025. -The eMAR system was new and she had not added an entry for the number of units, readings or location given for the MAs to complete for Resident #1. Interview with the Administrator on 04/01/26 at 3:58pm revealed: -She did not know Resident #1 insulin orders were not accurate. -She knew there was nowhere to document the number of insulin units that were given or location for Resident #1 on the eMAR system. -The MAs should have reported this to the RCC. -She and the RCC were responsible for accepting or declining medication orders from the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 39 pharmacy. -She expected the MAs to follow all physician orders. 4. Review of Resident #3's current FL2 dated 07/08/25 revealed diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea and diabetes type II. a. Review of Resident #3's current FL2 dated 07/08/25 revealed an order for Ozempic (a medication used to help lower fasting blood sugar) 4mg/3ml, inject 1mg subcutaneously (SQ) every 7 days. Review of Resident #3's signed physician's order dated 03/20/26 revealed an order for Ozempic 4mg/3ml, inject 1mg SQ every 7 days. Observation of Resident #3's medications available for administration on 03/31/26 at 10:50am revealed there was an Ozempic pen labeled inject 1mg SQ every 7 days (once a week), with a dispense date of 02/21/26, with 0ml's left to administer. Review of Resident #3's January 2026 electronic Medication Record (eMAR) revealed: -There was an entry for Ozempic 4mg/3ml, inject 1mg SQ every 7 days with an original date of 12/01/25 on Fridays at 8:00am. -There was documentation the Ozempic was administered on 01/02/26, 01/09/26, 01/16/26, 01/23/26 and 01/30/26. Review of Resident #3's February 2026 eMAR revealed: -There was an entry for Ozempic 4mg/3ml, inject 1mg SQ every 7 days with an original date of 12/01/25 on Fridays at 8:00am.	D 358		

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D 358	Continued From page 40 -There was documentation the Ozempic was administered on 02/06/26, 02/13/26, 02/20/26, and 02/27/26. Review of Resident #3's March 2026 eMAR revealed: -There was an entry for Ozempic 4mg/3ml, inject 1mg SQ every 7 days with an original date of 12/01/25 on Fridays at 8:00am. -There was documentation the Ozempic was administered on 03/06/26, 03/13/26, 03/20/26, 03/27/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/31/26 at 11:27am revealed: -There was an order for Ozempic 4mg/3ml, inject 1mg SQ every 7 days for Resident #3. -On 12/13/25, an Ozempic pen 4mg/3ml was dispensed and should have been administered on 12/19/26 through 01/09/26. -On 01/09/26, an Ozempic pen 4mg/3ml was dispensed and should have been administered on 01/16/26 through 02/06/26. -On 02/21/26, an Ozempic pen 4mg/3ml was dispensed and should have been administered on 02/27/26 through 03/20/26. -According to the dispense record, the Ozempic would not have been available for administration on 02/13/26, 02/20/26 and 03/27/26. Interview with medication aide (MA) on 03/31/26 at 12:20pm revealed: -She administered Ozempic to Resident #3, 10 out of the 13 times documented on eMAR December 2025 through March 2026. -She verified the Ozempic orders in the eMAR before administration and documented the administration immediately after. -Resident #3 never ran out of the Ozempic.	D 358		

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D 358	Continued From page 41 -She could not explain how a mediation was administered that was not in the facility to administer. Interview with the Resident Care Coordinator (RCC) on 03/31/26 at 2:55am revealed: -She did not know Resident #3's Ozempic was not administered as ordered. -Because the Ozempic was documented as administered every Friday January 2026 through March 2026, there was no indication there was an issue. -The MAs were responsible to follow the physician's order for the Ozempic and only document the Ozempic when it was actually administered. -It was the MAs responsibility to re-order the Ozempic within 7-days of being out because it was not a cycle fill that automatically refilled and delivered it. Interview with Resident #3's Nurse Practitioner (NP) on 03/31/26 at 4:05pm revealed: -Resident #3 was last seen on 03/13/26. -Resident #3 was being treated with Ozempic to keep her HgbA1c (an average level of blood glucose over two to three months) less than 8% (diabetes is a A1C greater than 6.5%). -Resident #3's last A1C was 6.5% in November 2025. -Resident #3 required Ozempic to help keep her FSBS readings less than 300 in order to keep her diabetes under control. -When Resident #3 was not getting the Ozempic consistently, it could cause her FSBS to be greater than 300 resulting in her diabetes being out of control. Interview with the Administrator on 04/01/26 at 4:25pm revealed:	D 358		

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D 358	Continued From page 42 -She did not know Resident #3 was not getting the Ozempic as ordered. -The MAs were responsible to administer the Ozempic as ordered and re-order within 7-days of being out of the Ozempic. b. Review of Resident #3's current FL2 dated 07/08/25 revealed there was an order for tamoxifen (a prophylactic medication used to treat breast cancer) 20mg every day. Review of Resident #3's signed physician's orders revealed: -There was an order for tamoxifen 20mg every day dated 01/23/26 to hold tamoxifen and restart on 02/05/26. -There was an order for tamoxifen 20mg every day dated 03/20/26. Observation of Resident #3's medications available for administration on 03/31/26 at 10:50am revealed there was no tamoxifen available for administration. Review of Resident #3's January 2026 eMAR revealed there was an entry for tamoxifen 20mg every day with an original date of 01/27/26 documented as on hold 01/27/26 to 01/31/26. Review of Resident #3's February 2026 eMAR revealed: -There was an entry for tamoxifen 20mg every day with an original date of 01/27/26 documented as on hold 02/01/26 to 02/05/26. -There was documentation the tamoxifen was administered 02/06/26 to 02/28/26 at 8:00am. Review of Resident #3's March 2026 eMAR revealed: -There was an entry for tamoxifen 20mg every	D 358		

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D 358	Continued From page 43 day with an original date of 01/27/26 to be administered at 8:00am. -There was documentation the tamoxifen was administered 03/01/26 to 03/31/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/31/26 at 11:27am revealed: -There was an order for tamoxifen 20mg every day dated 01/19/26 and 7 tablets were dispensed to the facility. -There was a hospital after visit summary order to discontinue tamoxifen 20mg every day. -The pharmacy records did not show any other orders. Interview with medication aide (MA) on 03/31/26 at 12:20pm revealed: -She administered tamoxifen to Resident #3 in February and March 2026. -The tamoxifen was packaged in a multi-dose pack. -She verified the tamoxifen with the eMAR before administration and documented the administration immediately after. -She could not explain how a medication was administered that was not in the facility to administer. Interview with the RCC on 03/31/26 at 2:55am revealed: -She did not know Resident #3's tamoxifen was not administered as ordered. -The MAs were responsible to follow the physician's order for the tamoxifen and only document the tamoxifen when it was actually administered. -It was the MAs responsibility to re-order the tamoxifen within 7-days of being out because it was not on cycle fill that automatically refilled and	D 358		

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D 358	Continued From page 44 delivered it. Telephone interview with Resident #3's Oncology Nurse Practitioner on 04/01/26 at 8:21am revealed: -Resident #3 had taken tamoxifen since June 2023 after a diagnosis of ductal carcinoma in situ (a noninvasive, stage 0 breast cancer) for 5 years to prevent the full development of breast cancer. -Resident #3 was instructed to stop the tamoxifen for two week after an emergency surgery on 01/21/26 because tamoxifen could increase the risk of blood clots while taking the medication. -Resident #3 was to restart the tamoxifen after the two weeks was completed. -Resident #3's PCP continued to write the orders for the tamoxifen. and she did not know Resident #3 had not received tamoxifen since 01/21/26. -She expected the staff to administer the tamoxifen as ordered to help prevent an occurrence of breast cancer. Interview with Resident #3's NP on 03/31/26 at 4:05pm revealed: -Resident #3 was last seen on 03/13/26. -Resident #3 was being treated with tamoxifen to help prevent an occurrence of breast cancer. -When Resident #3 was not getting the tamoxifen consistently, it could cause Resident #3 to develop breast cancer. Interview with the Administrator on 04/01/26 at 4:25pm revealed: -She did not know Resident #3 was not getting the tamoxifen as ordered. -The MAs were responsible to administer the tamoxifen as ordered and re-order within 7-days of being out of the tamoxifen. The facility failed to administer medications as	D 358		

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D 358	Continued From page 45 ordered for 4 of 8 residents including a resident who had a blood clot in his left leg, was prescribed medications to prevent blood clots and did not receive the medication for more than a month increasing the risk of having another blood clot form (#4), a resident whose heart rate was not checked prior to administration of medication to lower blood pressure increasing the risk of passing out, a resident who had inaccurate insulin orders increasing the risk of low blood sugars that could result in dizziness, fatigue and increased heart rate (#1), and a resident who did not receive a medication to reduce blood sugar levels increasing her risk for uncontrolled diabetes and a medication to treat breast cancer increasing her risk of full development of breast cancer (#3). This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on ?????????. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 1, 2026.	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;	D 367		

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D 367	Continued From page 46 (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 reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 5 of 6 residents related to inaccurate documentation of a medication used to treat constipation (#2), medications to prevent blood clots (#4), supplements to treat low sodium, low chloride and low vitamin B-12 levels (#13), and a prophylactic medication to treat breast cancer (#3). The findings are: 1. Review of Resident #2's current FL2 dated 03/13/26 revealed diagnoses included history of colon polyps and history of constipation. Review of Resident #2's hospital discharge summary dated 03/13/26 revealed an order for methylcellulose powder (a fiber laxative to treat constipation), one gram twice daily. Review of Resident #2's March 2026 electronic	D 367		

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D 367	Continued From page 47 medication administration record (eMAR) revealed: -There was an entry for methylcellulose powder, one gram twice daily scheduled at 8:00am and 8:00pm. -Methylcellulose powder, one gram was documented administered at 8:00am and 8:00pm from 03/17/26 through 03/30/26 at 8:00am, except at 8:00am on 03/17/26 and 03/26/26 and at 8:00pm on 03/23/26. Observations of medications on hand for Resident #2 on 03/31/26 at 11:25am revealed there was no methylcellulose powder available for administration. Interview with a medication aide (MA) on 03/31/26 at 11:29am revealed: -There was no methylcellulose powder on the medication cart for Resident #2. -She must have accidentally documented she administered methylcellulose powder one gram at 8:00am on 03/19/26 and 03/30/26 when she did not administer the medication. -She was unsure when, but she told the Resident Care Coordinator (RCC) that Resident #2's methylcellulose powder was not on the medication cart. Telephone interview with a Pharmacist at Resident #2's pharmacy on 04/01/26 at 9:33am revealed: -Resident #2 had an order dated 03/13/26 for methylcellulose powder one gram twice daily. -The methylcellulose powder order for Resident #2 was not dispensed. -He was unsure why the methylcellulose powder was not dispensed but thought it possible the resident did not want it.	D 367	The Executive Director, Care Coordinator and/or Desingee will complete an audit of resident eMARs, physician orders, medication administration documentation, pharmacy communication records, and medication cart contents to ensure: physician orders were accurately reflected in the eMAR, medications documented as administered were available on the medication cart, omissions and refusals were documented appropriately; medication administration documentation was accurate and complete, and equired documentation for insulin administration, anticoagulants, treatments, vital signs, and PRN medications was completed appropriately. The facility medication staff, including medication aides and Care Coordinator were re-educated on: accurate eMAR documentation requirements, medication administration documentation, charting and progress note documentation, medication error identification and reporting, medication order processing and implementation, medication/vital sign parameters and required documentation, documentation of medication refusals and omissions, physician notification requirements, and ensuring medications documented as administered are available on the medication cart and administered as ordered.	5-16-2026 5-16-2026

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D 367	Continued From page 48 Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to accurately document medication administration on the eMAR. -She did not know why MAs were documenting Resident #2's methylcellulose powder was administered when it was not on the medication cart. -If a medication was unavailable for administration, the MA was to document it was not administered and contact the pharmacy and the RCC. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. 2. Review of Resident #4's current FL2 dated 05/27/25 revealed diagnoses included dysarthria following cerebral infarction (difficulty speaking after a stroke) and atherosclerotic heart disease (narrowing of the heart arteries due to plaque build-up). a. Review of Resident #4's ED visit note dated 01/12/26 revealed: -Resident #4 had a blood clot in his left lower leg. -Resident #4 was sent back to the facility with a "take-home" Eliquis (a medication to prevent blood clots) pack. Telephone interview with a hospital Pharmacist on 04/01/26 at 1:02pm revealed: -Resident #4 was seen in the ED on 01/12/26 for a deep vein thrombosis (DVT)(blood clot). -Eliquis 5mg, 74 tablets (30-day supply) was dispensed and sent with Resident #4 when he was discharged from the ED. -The Eliquis directions were to administer Eliquis 5mg, two tablets twice daily for seven days	D 367		

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D 367	Continued From page 49 followed by Eliquis 5mg, one tablet twice daily. Review of Resident #4's January 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 01/15/26 for Eliquis 5mg, two tablets twice daily for seven days. -There was documentation Eliquis 5mg, two tablets were administered at 8:00am and 8:00pm from 01/15/26 through 01/21/26. -There was an entry dated 01/22/26 for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 01/22/26 through 01/31/26. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 02/01/26 through 02/28/26. Review of Resident's #4 March 2026 eMAR revealed: -There was an entry for Eliquis 5mg, one tablet twice daily. -There was documentation Eliquis 5mg, one tablet was administered at 8:00am and 8:00pm from 03/01/26 through 03/20/26. -The entry for Eliquis 5mg, one tablet twice daily was discontinued on 03/21/26. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #4 had an order dated 01/14/26 for Eliquis 5mg, one tablet twice daily. -Resident #4's Eliquis order was "profiled" only on	D 367		

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D 367	Continued From page 50 the resident's eMAR. -The pharmacy had not dispensed Eliquis 5mg for Resident #4. Interview with a medication aide (MA) on 04/01/26 at 12:17pm revealed: -Resident #4 sometimes refused medications but he did not refuse his Eliquis. -She must have accidentally documented she administered Resident #4's Eliquis 5mg, one tablet after 02/13/26 when the 30-day supply would have run out. Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to accurately document medication administration on the eMAR. -She did not know why MAs were documenting Resident #4's Eliquis 5mg was administered after the 30-day supply ran out. -If a medication was unavailable for administration, the MA was to document it was not administered and contact the pharmacy and the RCC. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. b. Review of Resident #4's Nurse Practitioner's (NP) progress note dated 03/20/26 revealed there was an order to start warfarin (a medication to prevent blood clots) 1mg, one tablet daily. Review of a Home Health Coordination Note dated 03/28/26 at 9:14pm revealed: -The Registered Nurse (RN) reviewed Resident #4's electronic Medication Administration Record (eMAR) and his medications available for administration.	D 367		

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	HAL023045	A. BUILDING: _____ B. WING _____	R 04/01/2026

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D 367	Continued From page 51 -The RN discovered Resident #4's warfarin 1mg, one tablet daily was being documented as administered but the warfarin 1mg bubble pack was intact with none of the medications administered. Review of Resident #4's March 2026 eMAR revealed: -There was an entry with a start date of 03/21/26 for warfarin 1mg, one tablet daily scheduled at 8:00am. -There was documentation warfarin 1mg was administered at 8:00am from 03/22/26 through 03/30/26. Observations of medications available for administration for Resident #4 on 03/31/26 at 11:18am revealed: -There was a bubble pack of warfarin 1mg tablets for Resident #4. -The label indicated warfarin 1mg, 29 tablets were dispensed on 03/20/26 with directions to administer one tablet daily. -There were 23 tablets of warfarin 1mg remaining in the bubble pack of the 29 tablets dispensed. -Two of the six bubbles that had medication removed from the pack had dates and initials next to them. -The earliest of the two dates was 03/25/26. Telephone interview with a representative with the home health agency on 04/01/26 at 10:21am revealed the RN's Coordination Note dated 03/28/26 was a "late entry" to the RN's visit to Resident #4 on 03/23/26. Telephone interview with the home health RN on 04/01/26 at 2:31pm revealed: -She reviewed Resident #4's eMAR and his medications on the medication cart on 03/23/26.	D 367		

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D 367	Continued From page 52 -Resident #4's eMAR indicated warfarin 1mg daily was being administered. -When she observed Resident #4's warfarin 1mg medication bubble pack, the bubble pack was intact with no medication removed from the bubble pack. Interview with a MA on 04/01/26 at 12:17pm revealed: -She was working on 03/23/26 when the RN asked to see Resident #4's eMAR and warfarin medication. -Resident #4's eMAR showed warfarin 1mg was administered but no warfarin 1mg was dispensed from the bubble pack. -She did not know why another MA had documented Resident #4's warfarin 1mg was administered when the warfarin 1mg bubble pack was still full. Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to accurately document medication administration on the eMAR. -She did not know why the MA documented Resident #4's warfarin 1mg was administered when it was not. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. 3. Review of Resident #13's current FL2 dated 08/15/25 revealed diagnoses included dementia, depression, and diabetes type 2. a. Review of Nurse Practitioner's (NP) order dated 03/03/26 revealed there was an order for sodium chloride (a supplement to treat low sodium and chloride levels) 1gram, one tablet	D 367		

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D 367	Continued From page 53 twice daily for five days. Observation of the morning medication pass on 03/31/26 at 7:46am revealed: -The medication aide reviewed Resident #13's medications contained in the morning multidose pack with the orders on the resident's electronic Medication Administration Record (eMAR). -Resident #13's eMAR indicated sodium chloride 1gram, one tablet was to be administered. -Resident #13's morning multidose medication pass did not contain sodium chloride 1gram, one tablet. Review of Resident #13's March 2026 eMAR revealed: -There was an entry for sodium chloride 1gram, one tablet twice daily. -Sodium chloride 1gram, one tablet was documented as administered at 8:00am and 8:00pm from 8:00pm on 03/03/26 to 8:00pm on 03/30/26. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #3 had an order dated 03/03/26 for sodium chloride 1gram, one tablet twice daily. -The pharmacy dispensed the quantity of 10 tablets on 03/03/26, the quantity that was indicated on the order. -The order the pharmacy received did not indicate the sodium chloride 1gram, one tablet twice daily was for five days. Interview with the medication aide (MA) on 03/31/26 at 3:28pm revealed Resident #13's sodium chloride 1gram was not in the multidose medication pack that morning because it needed a new prescription.	D 367		

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D 367	Continued From page 54 Second interview with the medication aide (MA) on 04/01/26 at 12:17pm revealed: -The MAs were responsible to compare the medication labels with the orders on the eMAR when administering medications. -She sometimes was very busy administering medications from four medication carts and may have marked a medication was administered when it was not. -She must have accidentally documented she administered Resident #13's sodium chloride 1gram, one tablet to Resident #13 when she had not.	D 367		
	Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to accurately document medication administration on the eMAR. -She did not know why the MA documented Resident #13's sodium chloride 1gram was administered when it was not. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. b. Review of Resident #13's physician orders dated 12/12/25 revealed there was an order for vitamin B-12 (a supplement to treat lower vitamin B levels) 500mcg, one tablet daily. Review of Nurse Practitioner's (NP) order dated 03/03/26 revealed there was an order to discontinue Resident #13's vitamin B-12, 500mcg one tablet daily. Observation of the morning medication pass on 03/31/26 at 7:46am revealed: -The medication aide reviewed Resident #13's			

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D 367	Continued From page 55 medications contained in the morning multidose pack with the orders on the resident's electronic Medication Administration Record (eMAR). -Resident #13's eMAR indicated vitamin B-12 500mcg one tablet was to be administered. -Resident #13's morning multidose medication pass did not contain vitamin B-12 500mcg, one tablet. Review of Resident #13's March 2026 eMAR revealed: -There was an entry for vitamin B-12 500mcg, one tablet daily. -Vitamin B-12 500mcg, one tablet was documented as administered at 8:00am from 03/01/26 through 03/30/26. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/01/26 at 11:03am revealed: -Resident #3 had a previous order for vitamin B-12 500mcg, one tablet daily. -The pharmacy received an order dated 03/03/26 to discontinue Resident #13's vitamin B-12 500mcg, one tablet daily. -The pharmacy last dispensed vitamin B-12 500mcg, seven tablets for Resident #13 on 03/02/26. Interview with the medication aide (MA) on 04/01/26 at 12:17pm revealed: -The MAs were responsible to compare the medication labels with the orders on the eMAR when administering medications. -She sometimes was very busy administering medications from four medication carts and may have marked a medication was administered when it was not. -She must have accidentally documented she administered Resident #13's vitamin B-12 50mcg,	D 367		

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D 367	Continued From page 56 one tablet to Resident #13 when she had not. Interview with the RCC on 04/01/26 at 2:11pm revealed: -The MAs were responsible to accurately document medication administration on the eMAR. -She did not know why the MAs documented Resident #13's vitamin B-12 was administered when it was not. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. 4. Review of Resident #3's current FL2 dated 07/08/25 revealed: -Diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea and diabetes type II. -There was an order for tamoxifen (a prophylactic medication used to treat breast cancer) 20mg every day. Review of Resident #3's signed physician's orders revealed: -There was an order for tamoxifen 20mg every day dated 01/23/26 to hold tamoxifen and restart on 02/05/26. -There was an order for tamoxifen 20mg every day dated 03/20/26. Observation of Resident #3's medications available for administration on 03/31/26 at 10:50am revealed there was no tamoxifen available for administration. Review of Resident #3's January 2026 eMAR revealed there was an entry for tamoxifen 20mg every day with an original date of 01/27/26 documented as on hold 01/27/26 to 01/31/26.	D 367		

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D 367	Continued From page 57 Review of Resident #3's February 2026 eMAR revealed: -There was an entry for tamoxifen 20mg every day with an original date of 01/27/26 documented as on hold 02/01//26 to 01/05/26. -There was documentation the tamoxifen was administered 01/06/26 to 02/28/26 at 8:00am. Review of Resident #3's March 2026 eMAR revealed: -There was an entry for tamoxifen 20mg every day with an original date of 01/27/26 to be administered at 8:00am. -There was documentation the tamoxifen was administered 03/01/26 to 03/31/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/31/26 at 11:27am revealed: -There was an order for tamoxifen 20mg every day dated 01/19/26 and 7 tablets were dispensed to the facility. -There was a hospital after visit summary order to discontinue tamoxifen 20mg every day. -The pharmacy records did not show any other orders. Interview with medication aide (MA) on 03/31/26 at 12:20pm revealed: -She administered tamoxifen to Resident #3 in February and March 2026. -The tamoxifen was in a multi dose pack. -She verified the tamoxifen with the eMAR before administration and documented the administration immediately after. -She could not explain how a mediation was administered that was not in the facility to administer.	D 367		

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D 367	Continued From page 58 Interview with the RCC on 03/31/26 at 2:55am revealed: -She did not know Resident #3's tamoxifen was documented as administered but was not available for administration. -The MAs were responsible to follow the physician's order for the tamoxifen and only document the tamoxifen when it was actually administered. Interview with the Administrator on 04/01/26 at 4:25pm revealed: -She did not know staff were documenting the tamoxifen when it was not available for administration. -The MAs were responsible to document tamoxifen only when it was administered. Refer to the interview with the Administrator on 04/01/26 at 3:57pm. Interview with the Administrator on 04/01/26 at 3:57pm revealed: -MAs were responsible to accurately document medications administered on the eMAR. -She expected MAs to not document a medication was administered if the medication was not available to administer.	D 367		