STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 000	Initial Comments The Adult Care Licensure Section and the Lincoln County Department of Social Services completed and annual and follow up survey from 01/28/25 through 01/29/25.	D 000	"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State"	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered to 1 of 3 sampled residents (#1) related to a brand specific nutritional supplement. The findings are: Review of Resident # 1's current FL2 dated 05/07/24 revealed there were diagnoses that included breast cancer history, chronic kidney disease, anxiety, protein calorie malnutrition and dementia. Review of Resident #1's Resident Register revealed an admission date of 08/25/23. Review of Resident #1's record revealed: -A diet order for a mechanical soft ground diet and "Mighty Shakes" or "Magic Cup" supplements dated 03/19/24. -A diet order for one brand-specific nutritional supplement "Ensure" twice daily dated 12/04/24.	D 310	Facility Executive Director will inservice the Dining Service Director, Resident Care Coordinator along with Care and Dietary staff responsible for serving residents on the rule area found non compliant: 10A NCAC 13F .0904(e)(4) Nutrition and Food service. Facility Executive Director and/or Designee will complete an audit on current nutritional supplement orders for accuracy Facility Executive Director and or Designee will clarify any supplemental orders found in need with the residents PCP for understood orders to be served. Facility Executive Director and or Designee will audit current supplement orders for accuracy through daily reporting and weekly cart audits. Facility Executive Director and or Designee will update the Diet order sheet located in the dining room on a weekly basis for accuracy	Facility expected compliance: 4/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Felicia Miles — TITLE: Executive Director — (X6) DATE: 3/7/2025

Reviewed and acknowledged by MH 03/10/25

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 310	Continued From page 1 Observations during the initial tour of the kitchen on 01/28/25 at 9:45am revealed there was a resident diet order list posted on the wall with Resident #1 listed as requiring nutritional supplements ("Mighty Shakes" or "Magic Cup"). Observation of the afternoon snack cart revealed two "Magic Cups" for Resident #1. Interview with the Medication Aide (MA) and the Dietary Manager (DM) on 01/28/25 at 4:48pm revealed Resident #1 received "Mighty Shakes" or "Magic Cups" twice daily and they were not aware the order was changed to specify "Ensure". Interview with Resident #1's physician on 01/29/25 at 9:52am revealed she expected staff to follow the order for brand specific "Ensure" instead of "Mighty Shakes" or "Magic Cup." Interview with the Resident Care Coordinator (RCC) on 01/29/25 at 4:45pm revealed: -The contracted pharmacy was not responsible for dispensing the "Ensure" for Resident #1. -Resident #1's family was responsible for purchasing "Ensure." -She did not know Resident #1 was receiving "Mighty Shakes" or "Magic Cups." -She was ultimately responsible for ensuring diet orders were followed. Interview with the Administrator on 01/29/25 at 6:30pm revealed she expected diet orders to be followed and/or clarified.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 2 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered to 4 of 5 sampled residents (#2, #3, #4, #5) including medication used to prevent heart attack or stroke, vitamin deficiency, pyschosis, and chronic pain (#2), medications used to treat itching, allergies, fungal infections and a rash (#3), medications used to treat depression, ulcer, enlarged prostrate, over active bladder and depression (#4) and a medication used for constipation and a medication used for breathing difficulties (#5). Review of the facility's medication policy dated September 2021 revealed: -The facility should ensure that Residents always have all current orders in the facility: 1. Facilty will develop a schedule so that all Residents Medications Orders are checked on a weekly basis by completing a cart audit. 2. Staff will check to see that all medications are available using a copy of the Physician Orders. 3. Staff will reorder as needed and the reorder will be placed in the Order Processing System for follow up. 4. Staff will check expiration dates on medications and remove any expired medications and reorder as needed an place in the Order Processing System for follow up.	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 3 5. Staff will date/sign the physician orders once the cart audit is complete and leave for review by the Supervisor or Care Coordinator. The findings are: 1. Review of Resident #2's FL2 dated 01/07/25 revealed diagnoses of Alzheimer's/dementia, anxiety, bipolar disorder hypothyroidism and major depressive disorder. a. Review of Resident #2's signed Physician's orders on 01/07/25 revealed an order for aspirin 81mg (a medication to prevent a heart attack or stroke) one tablet by mouth daily. Review of Resident #2's December 2024 eMAR revealed: -There was an entry for aspirin 81mg one tablet daily. -Aspirin 81mg was documented as not administered 12/01/24-12/04/24 and 12/12/24-12/18/24 with a reason waiting on delivery. Observation of medications on hand for Resident #2 on 01/29/25 at 4:30pm revealed there was a bottle of aspirin 81mg that was half full. Interview with the Pharmacist with the facility's contracted pharmacy on 01/29/25 at 1:25pm revealed: -The Pharmacy dispensed Resident #2's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications. -Resident #2's aspirin 81mg was profile only and the family was to bring it into the facility. b. Review of Resident #2's signed Physician's	D 358	Executive Director will inservice Care Coordinator on the rule found to be non compliant: 10 NCAC 13F .1004(a) Medication Administration as well as the following policies: Cart Audit/Medications on hand Executive Director, Care Coordinators and/or designee to complete medication cart audits to ensure all prescribed medications are available for use. Clinical Nurse Consultant, RN to inservice all medication aide staff, to include, Executive Director and Care Coordinators on resupply of medication within an appropriate time frame to ensure no lapse in administration. Executive Director, Care Coordinator and/or designee will conduct weekly medication cart audits.	Facility expected compliance 4/7/25

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 4	D 358		

orders on 01/07/25 revealed an order for vitamin D3 600mg (to treat vitamin deficiency) one tablet by mouth twice a day.

Review of Resident #2's December 2024 eMAR revealed:
-There was an entry for vitamin D3 600mg one tablet daily.
-Vitamin D3 was documented as not administered 12/12/24-12/18/24 with a reason waiting on delivery.

Observation of medications on hand for Resident #2 on 01/29/25 at 4:30pm revealed there were six pills of vitamin D3 left in a multi-dose pack.

Interview with the Pharmacist with the facility's contracted pharmacy on 01/29/25 at 1:25pm revealed:
-The Pharmacy dispensed Resident #2's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications.
-Resident #2's vitamin D3 600mg was dispensed on 12/03/24 with a seven-day cycle pack and 12/17/24 with a seven-day cycle pack.

c. Review of Resident #2's signed Physician's orders on 01/07/25 revealed an order for gabapentin 100mg (a medication for chronic pain) two tablets by mouth three times a day.

Review of Resident #2's December 2024 eMAR revealed:
-There was an order for gabapentin 100mg two tablets three times a day.
-Gabapentin 100mg was documented as not administered 12/12/24-12/16/24 with a reason waiting on delivery.

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 5 Observation of medications on hand for Resident #2 on 01/29/25 at 4:30pm revealed there were twelve pills of gabapentin 100mg left in a multi-dose pack. Interview with the Pharmacist with the facility's contracted pharmacy on 01/29/25 at 1:25pm revealed: -The Pharmacy dispensed Resident #2's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications. -Resident #2's gabapentin 100mg was dispensed in a seven-day cycle packs on 12/12/24 and 12/17/24. d. Review of Resident #2's signed Physician's orders on 01/07/25 revealed an order for aripiprazole 2mg (a medication to treat pyschosis) one tablet by mouth at bedtime. Review of Resident #2's December 2024 eMAR revealed: -There was an order for aripiprazole 2mg, one tablet at bedtime. -Aripiprazole 2mg was documented as not administered 12/12/24-12/16/24 with a reason waiting on delivery. Observation of medications on hand for Resident #2 on 01/29/25 at 4:30pm revealed there were six pills of aripiprazole 2mg left in a multi-dose pack. Interview with the Pharmacist with the facility's contracted pharmacy on 01/29/25 at 1:25pm revealed: -The Pharmacy dispensed Resident #2's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications.	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 6	D 358		

-Resident #2's aripiprazole 2mg was dispensed on 12/03/24 with a seven-day cycle pack and the facility knew a new prescription was needed.

Telephone interview with Resident #2's Primary Care Physician (PCP) on 01/29/25 at 4:10pm revealed:
-She was not made aware of Resident #2's aspirin 81mg, vitamin D3 600mg, gabapentin 100mg and aripiprazole 2mg was not administered as ordered in December 2024.
-When physician orders are signed the orders should provide refills for 11 months.

Refer to the interview with the MA supervisor on 01/29/25 at 10:50am.

Refer to the interview with the RCC on 01/29/25 at 4:42pm.

Refer to the interview with the Corporate Nurse on 01/29/25 at 6:00pm.

Refer to the interview with the Administrator on 01/29/25 at 6:30pm.

2. Review of Resident # 3's current FL2 dated 01/14/25 revealed diagnoses included hypertension, arthritis, dermatitis, metabolic encephalopathy, urinary incontinence, and vitamin D deficiency.

Review of Resident #3's Resident Register revealed an admission date of 05/31/24.

a. Review of Resident #3's physician order dated 11/23/24 revealed there was an order for hydrocortisone 1% topical cream 28 grams (a medication used for itching) apply a small amount to the affected area three times a day for five

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D 358	Continued From page 7 days, 11/23/24 to 11/28/24. Review of Resident #3's November 2024 electronic medication administration (eMAR) revealed: -There was an order for hydrocortisone 1% topical cream 28 grams (used for skin conditions); apply a small amount to the affected area three times a day to start on 11/23/24, for five days from 11/23/24 to 11/28/24. -There was documentation that hydrocortisone was not administered three times a day from 11/23/24 to 11/28/24. b. Review of Resident #3's current physician's orders dated 01/14/25 revealed there was an order for triamcinolone acetonide cream .1% (used to treat a rash) apply to the affected area twice daily at 8:00am and 8:00pm. Review of Resident #3's November 2024 electronic medication administration (eMAR) revealed: -There was an entry for triamcinolone acetonide cream.1% apply to the affected area twice daily at 8:00am at 8:00pm. -There was documentation triamcinolone acetonide cream was not administered due to waiting on pharmacy/ waiting on delivery/ waiting on family or refused, on forty-five occasions from 11/15/24 to 11/29/24 at 8:00am and 8:00pm. Review of Resident #3's December 2024 eMAR revealed: -There was an entry for triamcinolone acetonide cream.1% apply to affected area twice daily at 8:00am and 8:00pm. -There was documentation triamcinolone acetonide cream was not administered due to waiting on pharmacy/ waiting on delivery/ waiting	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 8	D 358		

on family or refused on fifty-one occasions from 12/02/24 to 12/31/24 at 8:00am and 8:00pm.

Review of Resident #3's January 2024 eMAR from 01/01/25 to 01/21/25 revealed:
There was an entry for triamcinolone acetonide cream 1% applied to affected areas twice daily at 8:00am and 8:00pm.
-There was documentation triamcinolone acetonide cream was not administered/refused/waiting on delivery/ waiting on family or discontinued on forty-one occasions from 01/01/25 to 01/21/25 at 8:00am and 8:00pm.

c. Review of Resident #3's current physician's orders dated 01/14/25 revealed there was an order for Nyamyc powder 100,000 unit/gram (to treat fungal infections); apply topically twice daily under breasts as directed at 8:00am and 8:00pm.

Review of Resident #3's November 2024 electronic medication administration (eMAR) revealed:
-There was an entry for Nyamyc powder; apply topically twice daily under breasts as directed at 8:00am and 8:00pm.
-Nystatin powder was documented as not administered on 37 occasions from 11/03/24 to 11/30/24 at 8:00am and 8:00pm with the reason as refused/waiting on family/waiting on delivery or pharmacy.

Review of Resident #3's December 2024 eMAR revealed:
There was an entry for Nyamyc powder; apply topically twice daily under breasts as directed at 8:00am and 8:00pm.
-There was documentation nystatin powder was not administered/ refused or other, on fifty-nine occasions from 12/01/24 to 12/31/24 at 8:00 and

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 9	D 358		

8:00pm.
-There was documentation nystatin powder was discontinued on 12/06/24, 12/19/24, 12/23/24, 12/25/24, and 12/26/24.

Review of Resident #3's January 2024 eMAR from 01/01/25 to 01/21/25 revealed:
There was an entry for Nyamyc powder; apply topically twice daily under breasts as directed at 8:00am and 8:00pm.
-There was documentation nystatin powder was not administered/ refused/ discontinued/ waiting on delivery/ or other, from 01/01/25 to 01/21/25 at 8:00am and 8:00pm.

d. Review of Resident #3's current physician's orders dated 01/14/25 revealed there was an order for Banophen 25mg oral tablet (used to treat allergy symptoms) to take one-half tablet by mouth twice daily at 8:00am and 8:00pm.

Review of Resident #3's November 2024 electronic medication administration (eMAR) revealed:
There was an entry for Banophen tablets; take one-half tablet by mouth twice daily at 8:00am and 8:00pm.
-There was documentation Banophen was scheduled to start on 11/23/24 but was not administered from 11/23/24 to 11/30/24 at 8:00am and 8:00pm due to waiting on delivery/ waiting on family or others.

Review of Resident #3's December 2024 eMAR revealed:
There was an entry for Banophen tablets; take one-half tablet by mouth twice daily at 8:00am and 8:00pm.
-There was documentation Banophen was not administered due to waiting on family/ waiting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10	D 358		

delivery/refused on forty-eight occasions from 12/01/24 to 12/31/24 at 8:00am and 8:00pm.

Review of Resident #3's January 2024 eMAR from 01/01/25 to 01/21/25 revealed:
There was an entry for Banophen tablets; take one-half tablet by mouth twice daily at 8:00am and 8:00pm.
-There was documentation that Banophen was not administered due to waiting on family/ waiting on delivery/ waiting on pharmacy/ discontinued/ other on thirty-two occasions from 01/01/25 to 01/21/25 at 8:00am and 8:00pm.

Telephone interview with the facility's contracted pharmacy technician on 01/29/25 at 12:37pm revealed:
-Resident #3's medications were profiled on the eMAR by their pharmacy and obtained from a different pharmacy of Resident #3's choice.
-Resident #3's hydrocortisone, triamcinolone acetonide cream, nystatin cream, and Banophen were never dispensed from their pharmacy.

A review of the facility's Medication Acceptance Forms revealed:
-Resident #3's POA delivered and signed nystatin powder into the facility on 10/30/24.
-Resident #3's POA delivered and signed hydrocortisone and Banophen into the facility on 11/06/24.

Telephone interview with the Power of Attorney (POA) on 01/29/25 at 4:30pm revealed:
-Resident #3 preferred to obtain her medications from a pharmacy other than the facility-contracted pharmacy.
-He picked up and delivered all medications to the facility as soon as he was notified the medications were ready to be picked up from the

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D 358	Continued From page 11	D 358		

outside pharmacy.
-There was never an occasion when the Resident's medications were delayed being filled.

Interview with the RCC on 01/29/25 at 4:45pm revealed:
-She did not know why Resident #3's medications were not administered as ordered although the POA delivered them to the facility.
-Resident #3's medication bag containing Banophen, triamcinolone acetonide cream, nystatin cream, and hydrocortisone that was delivered to the facility by the POA may have been placed in the medication room and not labeled appropriately.
-She expected all medications delivered by family members to be inventoried appropriately and administered to residents according to the eMAR.

Refer to the interview with the MA supervisor on 01/29/25 at 10:50am.

Refer to the interview with the RCC on 01/29/25 at 4:42pm.

Refer to the interview with the Corporate Nurse representative on 01/29/25 at 6:00pm.

Refer to the Interview with the Administrator on 01/29/25 at 6:30pm.

3. Review of Resident #4's current FL2 dated 01/14/25 revealed diagnoses of Diabetes mellitus 2, dysphagia following a cerebral infarction and polyneuropathy.

a. Review of Resident #4's signed Physician orders on 01/14/25 revealed there was an order for trazodone 50mg, (used to treat depression)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE	3900 WEXFORD LANE DENVER, NC 28037

(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 12	D 358		

one tablet at bedtime.

Review of Resident #4's December 2024 eMAR's revealed:
-There was an entry for trazadone 50mg, one tablet at bedtime
-Trazadone 50mg was documented as not administered on 12/03/24-12/05/24 with a reason waiting on delivery, waiting on pharmacy and waiting on PCP.

Observation of medications on hand for Resident #4 on 01/29/25 at 4:30pm revealed there were four pills of trazadone 50mg on hand.

Interview with the Pharmacist at the facility's contracted pharmacy on 01/29/25 at 1:09pm revealed:
-The Pharmacy dispensed Resident #4's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications.
-Resident #4's trazadone 50mg was dispensed on 12/01/24 in a six-day cycle pack.

b. Review of Resident #4's signed Physician orders on 01/14/25 revealed there was an order for famotidine 20mg, (used to an ulcer) one tablet daily.

Review of Resident #4's December 2024 eMAR's revealed:
-There was an entry for famotidine 20mg, one tablet daily.
-Famotidine 20mg was documented as not administered on 12/03/24-12/06/24 and 12/12/24-12/16/24 with a reason waiting on delivery.

Observation of medications on hand for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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WEXFORD HOUSE	3900 WEXFORD LANE DENVER, NC 28037

(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 13 #4 on 01/29/25 at 4:30pm revealed there were four pills of Famotidine 20mg on hand. Interview with the Pharmacist at the facility's contracted pharmacy on 01/29/25 at 1:09pm revealed: -The Pharmacy dispensed Resident #4's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications. -Resident #4's famotidine 20mg multi-dose card was sent for 12/01/24-12/05/24 and a new prescription was needed for 12/12/24-12/16/24. c. Review of Resident #4's signed Physician orders on 01/14/25 revealed there was an order for finasteride 5mg, (used to treat a enlarged prostrate) one tablet daily. Review of Resident #4's December 2024 eMAR's revealed: -There was an order for finasteride 5mg, one tablet daily. -Finasteride 5mg was documented as not administered on 12/03/24-12/06/24 and 12/12/24-12/16/24 with a reason waiting on delivery. Observation of medications on hand for Resident #4 on 01/29/25 at 4:30pm revealed there were four pills of finasteride 5mg on hand. Interview with the Pharmacist at the facility's contracted pharmacy on 01/29/25 at 1:09pm revealed: -The Pharmacy dispensed Resident #4's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications. -Resident #4's finasteride 5mg was dispensed on	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 14	D 358		

12/01/24-12/06/24 in a seven-day cycle pack and a new prescription was needed for 12/12/24-12/16/24.

d. Review of Resident #4's signed Physician orders on 01/14/25 revealed there was an order for oxybutynin chloride 5mg,(used for an overactive bladder) one-half tablet twice a day.
-There was an order for oxybutynin chloride 5mg, one-half tablet twice a day.
-Oxybutynin chloride 5mg, one-half tablet was documented as not administered 12/03/24-12/06/24 and 12/11/24-12/16/24 with a reason waiting on delivery.

Review of Resident #4's December 2024 eMAR's revealed:

Observation of medications on hand for Resident #4 on 01/29/25 at 4:30pm revealed there were five pills of oxybutynin chloride 5mg on hand.

Interview with the Pharmacist at the facility's contracted pharmacy on 01/29/25 at 1:09pm revealed:
-The Pharmacy dispensed Resident #4's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications.
-Resident #4's oxybutynin chloride 5mg was dispensed on 12/01/24 in a six-day cycle pack and a new prescription was needed for 12/11/24-12/15/24.

e. Review of Resident #4's signed Physician orders on 01/14/25 revealed there was an order for sertraline 50mg, (used to treat depression) one tablet daily.

Review of Resident #4's December 2024 eMAR's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 358	Continued From page 15	D 358		

revealed:
-There was an order for sertraline 50mg, one tablet daily.
-Sertraline 50mg was documented as not administered 12/12/24-12/16/24 with a reason waiting on delivery.

Observation of medications on hand for Resident #4 on 01/29/25 at 4:30pm revealed there were four pills of sertraline 50mg on hand.

Interview with the Pharmacist at the facility's contracted pharmacy on 01/29/25 at 1:09pm revealed:
-The Pharmacy dispensed Resident #4's medication in a multi-dose card, if the facility ran out of medications, it was because a refill was needed on each of the medications.
-Resident #4's sertraline 50mg was dispensed on 12/13/24 in a three-day cycle pack and on 12/16/24 in a four-day cycle pack.

Telephone interview with Resident #4's PCP on 01/29/25 at 4:10pm revealed:
-She was not made aware of Resident #4's medications were not administered as ordered in December 2024.
-When physician orders are signed the orders should provide refills for 11 months.

Refer to the interview with the MA supervisor on 01/29/25 at 10:50am.

Refer to the interview with the RCC on 01/29/25 at 4:42pm.

Refer to the interview with the Corporate Nurse on 01/29/25 at 6:00pm.

Refer to the interview with the Administrator on

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 16 01/29/25 at 6:30pm. 4. Review of Resident's #5 current FL2 dated 10/14/24 revealed diagnoses of chronic obstructive pulmonary disease, cerebrovascular disease, hypertension, and history of falling. Review of Resident #5's resident register revealed she was admitted to the facility on 10/21/24 after a respite stay beginning 10/14/24. a. Review of Resident's #5 current FL2 dated 10/14/24 revealed there was an order for albuterol sulfate take 1.25mg (solution for nebulization) three times a day at 6:00am, 2:00pm, and 10:00pm. Review of Resident #5's November electronic Medication Administration (eMAR) revealed: a.There was an entery for aluterol sulfate solution for nebulization; 1.25mg/3ml; three times a day. -The albuterol sulfate 1.25mg/3ml was documented as not administered on 11/28/24 at 2:00pm due to resident being unavailable. Review of Resident #5's December eMAR revealed: -There was an entry for albuterol sulfate solution for nebulization; 1.25mg/3ml; three times a day. -The albuterol sulfate 1.25mg/3ml was documented as not administered on 12/04/24 through 12/8/24 at 8:00am, 2:00pm, and 8:00pm, 12/09/24 at 8:00am and 2:00pm, 12/12/24 through 12/20/24 at 8:00am, 2:00pm,8:00pm. 12/24/24 at 2:00pm, 12/30/24 at 8:00pm and 12/31/24 at 8:00am with an exception code of waiting on delivery. Review of Resident #5's January eMAR revealed: There was an entry for albuterol sulfate solution	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 358	Continued From page 17	D 358		

for nebulization; 1.25mg/3ml; three times a day.
-The albuterol sulfate 1.25mg/3ml was documented as not administered on 01/10/25 at 8:00pm, 01/11/25 through 01/13/25 at 8:00am, 2:00pm, and 8:00pm, 01/14/25 at 8:00am,01/16/25 at 8:00am, 2:00pm, and 8:00pm, 01/17/25 at 8:00am and 2:00pm 01/21/25 at 2:00pm, and 8:00pm, 01/22/25 at 8:00am, 2:00pm and 8:00pm and 01/23/25 8:00am, 2:00pm.
-Exception codes for all dates in January 2025 not being administered read as waiting on delivery/pharmacy.

Observation of medication on hand for Resident #5 on 01/29/25 at 4:10pm revealed there were 24 vials of Albuterol Sulfate 1.25mg/3ml.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 01/29/25 at 12:47pm revealed:
-On 10/21/24, the facility faxed over Resident #5's medication list.
-Resident #5's albuterol sulfate 1.25mg/3ml was filled on 12/06/24 for a five-day supply and delivered on 12/07/24
a six-day supply was filled on 12/20/24 and delivered on 12/21/24, a two-day supply was filled on 12/27/24 and delivered on 12/28/24,a six-day supply was filled on 01/27/25 and delivered on 01/28/25.
-He thought the prescription may had been filled at another pharmacy in January of 2025.
-There were multiple times the eMAR was coded under special instructions as "Need Script".

Interview with Resident #5 on 01/29/25 at 10:15am revealed:
-She does get her nebulizer three times a day except when they had ran out.

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 18 -She knew something was wrong with the prescription and her daughter was helping with the insurance plan and had gotten some through a grocery store pharmacy. -She thought her prescription was corrected and had been getting her nebulizer. -She did not have trouble breathing. Interview with a medication aide Supervisor (MA) on 01/29/25 at 10:50am revealed: -Resident #5's family had brought the albuterol sulfate to the facility when she was admitted. -If she would run out the pharmacy will only send a weeks supply. -If a Resident is out of a medication and the family did not bring in the medications, the facility will order them through the pharmacy and bill the family. -When Resident #5 ran out of the albuterol sulfate it was reordered through the pharmacy, but the pharmacy would only send a few doses at a time. -She did not recall if Resident #5 did not receive the alubterol sulfate if she had trouble breathing, and if so would have given her a different medication she had for, as needed, for shortness of breath. Interview with the RCC on 01/29/25 at 4:42pm revealed: Resident #5's family had brought the albuterol sulfate when she was admitted and on other occassions. -She had made hospice aware that Resident #5 was out of the albuterol sulfate, and she would get a prescription for two days and then run out again. -The wrong quantity was entered on the prescription. -She was responsibile to notify hospice by calling	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 19	D 358		

the triage line and they will get the message to the Primary Care Physician (PCP).

b. Review of Resident #5's physicians order dated 10/21/24 revealed an order for stool softener-laxative (sennosides-docusate sodium) 8.6-50mg, two times daily for constipation.

Review of Resident #5's November electronic Medication Administration (eMAR) revealed:
-There was an entry for stool softener (sennosides-docusate sodium) 8.6-50mg two times daily for constipation.
-Sennosides-docusate sodium 8.6-50mg two times daily was documented as not administered from 11/01/24-11/30/24 with an exception reason as other, waiting on pharmacy, waiting on family.

Review of Resident #5's December eMAR revealed:
-There was an entry for stool softener (sennosides-docusate sodium) 8.6-50mg two times daily for constipation.
-Sennosides-docusate sodium 8.6-50mg two times daily was documented as not administered on 12/01/24 through 12/07/24 at 8:00am and 8:00pm, 12/08/24 at 8:00am, 12/09/24 and 12/12/24 at 8:00am and 8:00pm, 12/12/24 at 8:00am and 8:00pm,12/14/24 at 8:00pm,12/15/24 and 12/16/24 at 8:00am and 8:00pm.

Observation of medication on hand for Resident #5 on 01/29/25 at 4:10pm revealed there were 22 tablets of sennosides-docusate sodium.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 01/29/25 at 12:47pm revealed:
-On 10/21/24, the facility faxed over Resident #5's medication list.

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 20	D 358		

-The sennosides-docusate sodium 8.6-50mg two times daily was not filled until 12/07/24 as the prescription that was sent to the pharmacy was not signed.

Interview with a medication aide Supervisor (MA) on 01/29/25 at 10:50am revealed:
-Resident #5 needed a prescription for the stool softener and received the stool softener from the pharmacy.
-We should have called the family or the pharmacy to make sure she did not miss any doses of the albuterol sulfate and the stool softner.

Interview with the RCC on 01/29/25 at 4:42pm revealed:s he was not aware why Resident #5 did not get her stool softener and was not made aware that she was out.

Telephone interview with the hospice Registered Nurse (RN) on 01/29/25 at 2:17pm revealed:
-They did not have access to Resident #5's eMAR.
-She was not aware of Resident #5 had medications that were not being administered. the Sennosides-docusate sodium or the albuterol sulfate solution medication.
-She was aware that Resident #5 had consecutive days without a bowel movement.
-When she had saw Resident #5 she requested to be physically dis-impacted.
-When she was dis-impacted her bowel movement was soft and she was not constipated.
-If the facility needed a prescription they should have called our hospice triage telephone number.

Telephone interview with Resident #5's Primary Care Physician (PCP) with hospice revealed:
-She was not aware Resident #5 had missed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 358	Continued From page 21	D 358		

several doses of the sennosides-docusate sodium or the albuterol sulfate solution medication.
-The facility should have notified the hospice Case Manager or the RN about missing medications.
-Resident #5 had been getting other medications for her pulmonary disease and by not getting the albuterol sulfate would not present her to be at detrimental risk, she would be more symptomatic.
-Resident #5 would have discomfort if not getting her sennosides-docusate sodium.
-She expected all medication orders to be given as ordered.

Telephone interview with Resident #5's Responsible Party for on 01/29/25 at 3:30pm revealed:
-When Resident #5 was admitted she did bring in her medications from home.
-She was made aware the original prescription for the albuterol sulfate an sennosides-docusate sodium was not written properly.
-She was instructed by the facility to call hospice regarding Resident #5's prescription but could not recall for which medication.
-She had been working with the her mother's insurance plan and had been getting some medications from a different pharmacy.
-She had not been called to bring in any prescriptions to the facility.

Refer to interview with a MA supervisor on 01/29/25 at 10:50am.

Refer to interview with the RCC on 01/29/25 at 4:42pm.

Refer to interview with the Corporate Nurse representative on 01/29/25 at 6:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 22 Refer to interview with the Administrator on 01/29/25 at 6:30pm. _____ Telephone interview with a Pharmacist from the facility's contracted pharmacy on 01/29/25 at 12:47pm revealed: -On 10/21/24, the facility faxed over Resident #5's medication list. -The sennosides-docusate sodium 8.6-50mg two times daily was not filled until 12/07/24 as the prescription that was sent to the pharmacy was not signed.Interview with a MA supervisor 01/29/25 at 10:50am revealed: -Cart audits were to be done 1 time a week. -They started to do them last week and had not done them for about a month. -They were supposed to chart in the Resident record if a Resident is out of a medication and the action they took regarding the medication such as call the family or reordered the medication. -MA's were to follow up on the medication status with the RCC. -The MA's need to ensure they documented correctly on the eMAR and in Resident records, because it is not being done at all or it is being done incorrectly. Interview with the RCC on 01/29/25 at 4:42pm revealed: -If a medication is running low the MA's were responsible to enter reorder on the eMAR. -If the medication did not come in the next two days the MA should call the pharmacy. -MA's should of done cart audits every week. -The MA's should look at the physician order every week and randomly select one to three residents until all residents are reviewed for medications. -The MA's were responsible for highlighting the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 23 audit summary if certain medications is needed or missing and to put in a mail slot in the nurses station. -She had noticed she had not received any audit sheets for the last two to three weeks and was not sure why. Interview with the Corporate Nurse on 01/29/25 at 6:00pm revealed: -She was not aware medications had not been given as ordered. -If medication cart audits had been done this may not have happened. -The RCC and the Administrator were responsible to make sure medication cart audits were completed. -The RCC and the Administrator were responsible for making sure these errors do not occur. Interview with the Administrator on 01/29/25 at 6:30pm revealed: -The MA's were responsible to contact the pharmacy when medications are low or to contact the family if medications were brought in privately. -The MA's and the MA Supervisor should completeb medication cart audits weekly. -The RCC was responsible for monitoring the medication cart audits.	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	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 367	Continued From page 24 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the electronic Medication Administration Records (eMAR) were accurate for 2 of 5 sampled residents (#1 & #5) related to an order for a brand-specific nutritional supplement (#1) and an order for oxygen (#5). The findings are: 1. Review of Resident # 1's current FL2 dated 05/07/24 revealed there were diagnoses that included breast cancer history, chronic kidney disease, anxiety, protein calorie malnutrition and dementia. Review of Resident #1's Resident Register revealed an admission date of 08/25/23. Review of Resident #1's physician's order dated 12/4/24 revealed an order for "Ensure Original"	D 367	Facility Executive Director will inservice Care Coordinator on the following rule area found to be non compliant:10A NCAC 13F. 1004 (j) Facility Executive Director and or designee will inservice Care Coordinator and med aide staff on the following policies 1. Medication Orders 2.Verification of existing orders 3. New Order for Therapy/Equipment 4. Discontinue Medication Order 5. Discontinue Therapy/Equipment Community Executive Director, Clinical Nurse Consultant and /or care coordinators will conduct medication pass observation with different medication staff for no less than twice a month. Facility Care Coordinator will run reportings on a daily and weekly basis to review medication administration to ensure accuracy to the emars to include missed medications,medication erros and needs for clarification by the PCP.	Facility expected compliance 4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055008	A. BUILDING: _____ B. WING _____	R 01/29/2025

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D 367	Continued From page 25	D 367		

liquid .04-1.05 gram-kcal/mL; (a dietary supplement used for malnourishment); Drink one shake by mouth twice daily at 9:00am and 9:00pm.

Review of Resident #1's November 2024 electronic medication administration (eMAR) revealed:
-There was an entry for "Ensure Original" liquid .04-1.05 gram-kcal/mL; Drink one shake by mouth twice daily.
-There was documentation "Ensure" was administered twice daily from 11/01/24-11/30/24.
-There was not an entry that "Mighty Shakes" or "Magic Cup" were administered.

Review of Resident #1's December 2024 eMAR revealed:
-There was an entry for "Ensure Original" liquid .04-1.05 gram-kcal/mL; Drink one shake by mouth twice daily.
-There was documentation "Ensure" was administered twice daily from 12/01/24-12/05/24 and once on 12/06/24.
-There was an entry "Ensure" was discontinued on 12/06/24.
-There was not an entry that "Mighty Shakes" or "Magic Cup" were administered.

Review of Resident #1's January 2024 eMAR revealed:
-There was no entry for "Ensure" or any other brand specific dietary supplement.
-There was no documentation that "Ensure", or any other brand specific dietary supplement was administered in January 2024.

Observation of medications on hand for Resident #1 on 01/29/25 at 3:15pm revealed:
-There was no "Ensure" available for

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D 367	Continued From page 26	D 367		

administration.
-There were "Mighty Shakes" and "Magic Cups" located in the nourishment room and kitchen refrigerator.

Interview with the Dietary Manager (DM) on 01/28/25 at 4:48pm revealed:
-Resident #1 received "Mighty Shakes" or "Magic Cups" twice daily and she was not aware the order was changed to specify "Ensure".
-She referred to a list that was posted in the kitchen and indicated Resident #1 was to receive "Mighty Shakes" or "Magic Cups" twice daily.

A telephone interview with the facility's contracted pharmacy technician on 01/28/25 at 1:00pm revealed:
-Resident #1's order for "Ensure" may have been inadvertently discontinued on the eMAR on 12/06/24.
-Resident #1's "Ensure" was never dispensed from their pharmacy.
-The pharmacy only profiled Resident #1's medications by adding them to the eMAR for the facility to utilize when administering medications.

Interview with a Medication Aide (MA) on 01/28/25 at 4:48pm revealed:
-Resident #1 was currently receiving "Mighty Shakes" or "Magic Cups" twice daily and had been receiving them for past three months.
-She did not know the order was changed to specify "Ensure" twice daily starting 04/22/24.
-She did not know the "Ensure" was discontinued on 12/06/24 on the eMar.

Interview with Resident #1's Primary Care Provider (PCP) on 01/29/25 at 9:52am revealed:
-She expected staff to follow the order for Resident #1 to receive brand specific "Ensure"

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D 367	Continued From page 27	D 367		

not "Mighty Shakes" or "Magic Cups."
-She did not discontinue "Ensure" and she did not know why there was an entry on the eMAR that "Ensure" was discontinued on 12/06/24.

Interview with the Resident Care Coordinator (RCC) on 01/29/25 at 4:45pm revealed:
-Resident #1's family was responsible for providing "Ensure".
-She was aware Resident #1 was receiving a dietary supplemental drink but was not aware the order was brand specific (Ensure Original liquid).
-She did not know Resident #1 was receiving "Mighty Shakes" or "Magic Cups" instead of "Ensure" as ordered.
-She did not know why there was an entry on the eMAR that "Ensure" was discontinued on 12/06/24.
- "Ensure" may have mistakenly flagged on the eMAR as discontinued on 12/06/24.
-Her expectation was for "Ensure" to be administered as ordered or the order to be clarified.

Interview with the Administrator on 01/29/25 at 6:20pm revealed it was her expectation the RCC and MAs should make sure medications were in the building and the eMAR was documented appropriately.

2. Review of Resident #5's current FL2 dated 10/14/24 revealed:
-Diagnoses of chronic obstructive pulmonary disease, cerebrovascular disease, hypertension, and history of falling.
-There was an order for Oxygen 2 liters via nasal canula as needed.

Review of Resident #5's record revealed there was a signed order dated 01/28/25 for continuous

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D 367	Continued From page 28 Oxygen 2 liters via nasal canula. Review of Resident #5's November 2024 electronic medication administration record (eMAR) revealed there was no entry for oxygen. Review of Resident #5's December 2024 electronic medication administration record (eMAR) revealed there was no entry for oxygen. Review of Resident #5's January 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen. Observation of Resident #5 on 01/29/25 at 10:15am revealed she was wearing oxygen. Interview with a medication aide (MA) Supervisor on 01/29/25 at 4:15pm revealed: -When Resident #5 was on oxygen as needed, we did not document this on the eMAR because oxygen was not listed on the eMAR and we did not document in Resident #5's record. -Resident #5 was on continuous oxygen at 2 liters via nasal cannula since 01/28/25 and it is now entered on the eMAR. Interview with the RCC on 01/29/25 at 4:42pm revealed: -The RCC was responsible for putting oxygen on the eMAR. -She was not aware oxygen should be on the eMAR. -Oxygen had not been put on the eMAR when prescribed on a as needed status. -She was not used to resident's who had continuous oxygen. -Resident #5 was very independent and would put her oxygen on herself. -Her expectation was that it should be checked	D 367		

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D 367	Continued From page 29 every shift to ensure Resident #5 was wearing it continuously and that it was on the eMAR. Interview with the Administrator on 01/29/25 at 6:30pm revealed it was her expectation the RCC should enter the oxygen on the eMAR.	D 367		
D 412	10A NCAC 13F .1010 (e) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide pharmaceutical services that ensured accurate records of the receipt of medications were maintained in the facility for 1 of 5 sampled residents (#5) related to a medication to treat shortness of breath.. The findings are: Review of Resident's #5 FL2 dated 10/14/24 revealed: -Diagnoses of chronic obstructive pulmonary disease, cerebrovascular disease, hypertension, and history of falling. -There was an order for albuterol sulfate take 1.25mg (a medication to treat shortness of breath) three times a day at 6:00am, 2:00pm, and 10:00pm.	D 412	Facility Executive Director and or Designee will complete an inservice to the Care Coordinator and Med aides responsible for ensuring the facility maintains accurate records of receipt, use and disposition of medications in the facility and available upon request for review. Facility Executive Director will also inservice the Care Coordinator and Med aides on the following policy: 1. Pharmacy Deliveries 2. Receiving Medications from outside Pharmacy Facility Med Aides will be responsible for ensure the delivery slip is signed upon delivery , compare packaged meds to the delivery manifest, note any found discrepancies on the delivery manifest, sign date the manifest and fax to pharmacy within 24 hours Facility Resident Care Coordinator will be responsible for auditing pharmacy receipts and that the above policy is compliant. Facility Executive Director will audit compliance weekly.	Facility expected compliance 4/7/25

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D 412	Continued From page 30	D 412		

Review of Resident #5's resident register revealed she was admitted to the facility on 10/21/24.

Review of the facility's medication policy dated September 2021 revealed;
-When a pharmacy delivers medications, the following steps are to be taken for both daily and medication prescription and delivery:
1. Sign the delivery slip.
2. Open package and remove delivery manifest sheet.
3. Compare all medication in package to the delivery manifest.
4. Note any discrepancies on the delivery manifest.
5. Sign and date the delivery manifest and fax to pharmacy within 24 hours.
6. If discrepancies were noted place in order process system for care coordinator.

Review of Resident #5's record revealed there were no medication delivery reciepts for albuterol sulfate.

Observation of medication on hand for Resident #5 on 01/29/25 at 4:10pm revealed there were 24 vials of albuterol sulfate 1.25mg/3ml.

Interview with a medication aide (MA) Supervisor on 01/29/25 at 10:50am revealed Resident #5's family brought albuterol sulfate to the facility when the resident was admitted to the facility.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/29/25 at 12:47pm revealed:
-On 10/21/24, the facility faxed over Resident #5's medication list.
-Resident #5's albuterol sulfate 1.25mg/3ml was

Reviewed and acknowledged by MH 03/10/25

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D 412	Continued From page 31	D 412		

filled on 12/06/24 for a five-day supply and delivered on 12/07/24.
-A six-day supply was filled on 12/20/24 and delivered on 12/21/24.
-A two-day supply was filled on 12/27/24 and delivered on 12/28/24.
-A six day supply was filled on 01/27/25 and delivered on 01/28/25.
-He thought the prescription was filled at another pharmacy in early January of 2025.

Telephone interview with Resident #5's Responsible Party on 01/29/25 at 3:30pm revealed:
-When Resident #5 was admitted to the facility she brought medications from home.
-She could not recall if the medications were counted by the staff.

Interview with the RCC on 01/29/25 at 4:42pm revealed:
-Resident #5's family brought in albuterol sulfate when she first came to the facility in October 2024.
-She thought she had documented the count of Resident #5's medications when she was admitted.

Interview with the Administrator on 01/29/25 at 6:30pm revealed the MA Supervisor and the RCC were responsible for ensuring the requisitions for medications were completed.

Reviewed and acknowledged by MH 03/10/25