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D 000	Initial Comments The Adult Care Licensure Section and Currituck County Department of Social Services conducted a follow-up survey on 06/04/25 and 06/05/25.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 residents (#6) observed during medication pass for a medication used to prevent fluid from building up in the body to treat heart failure and 1 of 5 sampled resident related to a medication used to treat anxiety (#1). The findings are: 1. Review of Resident #6's current FL-2 dated 10/30/24 revealed: -Diagnoses included dementia, chronic kidney disease, hypertension, type 2 diabetes and history of a pulmonary embolus. -There was an order for spironolactone 25mg to	D 344		

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D 344	Continued From page 1 be administered daily at 8:00am. Review of Resident #6's physician's order dated 01/24/25 revealed there was an order to hold Spironolactone 25mg daily for 2 weeks and start spironolactone 25mg 1/2 tablet everyday. Review of Resident #6's physician's order report dated 12/30/24-01/30/25 revealed: -Spironolactone 25mg was to be administered once daily at 8:00am. -Spironolactone 25mg, 1/2 tab (12.5mg) was to be administered daily at 8:00am. Review of Resident Resident #6's physician's order dated 06/04/25 revealed there was a clarification for spironolactone 25mg, 1/2 tablet was to be administered daily times 7 days 01/24/25. Observation of the 8:00am medication pass on 06/04/25 revealed: -The medication aide pulled a multidose pack of medications that contained 5 and 1/2 tablets for Resident #6. -Each medication was listed on the multidose pack which included 1 tablet of spironolactone 25mg. -The top tab of the weekly dose packets listed each medication contained in the multidose packs and the physician's order on how to administer each medication including spironolactone 25mg, 1/2 tablet (12.5mg) to be administered each day. -She compared each medication in the multidose pack to the electronic medication administration record (eMAR) on the the computer, emptied all the medications into a medication cup and handed the medication cup to Resident #6 at 8:50am for him to take when she stopped	D 344		

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because the discrepancy between the order on the pack and what was in the pack was brought to her attention.
-The spironolactone whole tablet was not scored and was removed from the medication cup and was not administered.

Review of Resident #6's electronic medication administration record (eMAR) for June 2025 revealed:
-There was an electronic entry for Spironolactone 25 mg, 1/2 tablet (12.5mg) to be administer each day and scheduled for 8:00am.
-There was documentation spironolactone 25 mg, 1/2 tablet (12.5mg) was administered each day on 06/01/25 to 06/03/25.
-There was documentation spironolactone 25mg, 1/2 tablet (12.5mg) was not administered on 06/04/25 because of the wrong dosage.
-There was no entry for spironolactone 25 mg to be administered each day.

Interview with the medication aide (MA) on 06/04/25 at 12:56pm revealed:
-She had not noticed the discrepancy in what was ordered and what was dispensed.
-She administered a whole tablet of spironolactone as long as she could remember.

Interview with Resident #6's primary care provider on 06/04/25 at 3:58pm revealed:
-She expected Resident #6 to receive Spironolactone 25mg each day.
-Resident #6 had some decreased blood pressure readings in January 2025 and she was not sure if it was the medication or due to infection.
-She wrote an order to hold his spironolactone 25mg for 1 week and to start Spironolactone 25mg 1/2 tablet each day.

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-She thought the order said to administer spironolactone 25mg 1/2 tablet each day for 7 days then resume spironolactone 25mg each day.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed:
-She was made aware spironolactone 25 mg was dispensed instead of a 1/2 tablet on 06/04/25.
-Multidose medication packages were dispensed each week by automation and sometimes technical errors occurred.
-Spironolactone 25mg whole tablets had been dispensed each week since 02/05/25.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am revealed:
-MAs were responsible for weekly cart audits which included comparing orders to the medications on hand for each resident and provided to RCC by Wednesdays.
-Medications were dispensed weekly with the new packages to begin each Tuesday.
-There was not process in place to review medications that arrived for administration but some MAs would take the time to ensure all medications were delivered.
-The RCC was responsible for approving orders on the eMAR for administration.

Interview with the Administrator on 06/05/25 at 4:13pm revealed:
-The order dated 01/24/25 was not clear and should state to resume another dose and when to begin a different dose if that was what the provider wanted.
-The RCC was responsible for contacting the providers for medication order clarification when it was needed.

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Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.

2. Review of Resident #1's current FL-2 dated 04/23/25 revealed diagnoses included dementia and hypertension.

Review of Resident #1's physician order sheet dated 04/23/25 revealed there was an order for Lorazepam Intensol 2mg/ml, give 0.5ml (1mg) once a day as needed for agitation.

Review of a physician order for Resident #1 dated 05/23/25 revealed:
-There was a progress note by Resident #1's mental health provider (MHP) dated 05/23/25.
-There was an order that Lorazepam solution would no longer be available, to change Lorazepam "l tablet" daily as needed.
-There was not a dosage listed for the Lorazepam as needed.

Review of Resident #1's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam Intensol 2mg/ml, give 0.5ml (1mg) once daily as needed for agitation, not to exceed 0.5ml (1mg) in a 24 hour period.
-Lorazepam Intensol 0.5ml (1mg) was documented as administered once on 05/09/25 and 05/10/25.
-Lorazepam Intensol 0.5ml (1mg) was documented as administered once daily from 05/12/25 to 05/28/25.

Review of a physician order for Resident #1 dated 05/30/25 revealed:

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-There was a progress note by Resident #1's MHP dated 05/30/25.
-There was an order to discontinue Lorazepam solution 2mg /1ml, give 0.5ml (1mg) daily for anxiety and agitation.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/05/25 at 1:47pm revealed:
-The pharmacy dispensed Lorazepam 0.5mls (1mg) which was a total of 10 syringes on 04/28/25 and on 05/06/25.
-The pharmacy received a discontinue order for Lorazepam 0.5ml (1mg) daily as needed on 05/30/25.

Interview with a medication aide (MA) on 06/05/25 at 3:13pm revealed:
-She never saw an order from Resident #1's MHP to discontinue Lorazepam 0.5ml (1mg) as needed.
-She was not aware that there was a new order from the resident's MHP on 05/23/25.
-There were no changes on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am revealed:
-If there was an order in progress note, she scanned the progress note to the pharmacy.
-If an order needed clarification, it was her responsibility to contact the primary care provider (PCP) or MHP.
-MAs were responsible for weekly cart audits which included comparing orders to the medications on hand for each resident and provided it to the RCC by Wednesdays.
-MAs were expected to administer medications as ordered.

Interview with Resident #1's PCP on 06/04/25 at

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D 344	Continued From page 6 3:58pm revealed: -Resident #1 received Lorazepam to help decrease her agitation and anxiety. -The resident's MHP prescribed her Lorazepam. -MAs or the RCC should contact the prescribing physician to obtain a clarification of orders. Interview with the Administrator on 06/05/25 at 4:13pm revealed: -The RCC should have ensured that the pharmacy had the updated order from Resident #1's MHP. -The pharmacy evidently had not received the MHPs order 05/23/25. -The RCC was expected to contact the MHP to obtain a clarification order. Attempted telephone interview with Resident #1's MHP on 6/5/2025 at 3:06pm was unsuccessful.	D 344		
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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in substantial risk for serious physical harm to the residents.	D 358		

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D 358	Continued From page 7 THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#6) observed during the medication pass including errors with medications used to treat diabetes, heart failure, high blood pressure and prevent the blood from clotting and for 3 of 5 sampled residents sampled for record review including a medication used to treat anxiety and agitation, a medication for schizophrenia or bipolar disorder (#1), a medication to treat anxiety and a medication used to treat gastroesphageal reflux disease (GERD) (#3), and a medication used to decrease ammonia levels (#4) . The findings are: 1.The medication error rate was 13% as evidenced by 5 errors out of 27 opportunities during the 8:00am medication pass on 06/04/25 and 06/05/25. Review of Resident #6's current FL-2 dated 10/30/24 revealed: -Diagnoses included dementia, chronic kidney disease, hypertension, type 2 diabetes and history of a pulmonary embolus. -There was an order for carvedilol 6.25mg to be administered twice each day. (Carvedilol is a medication used to treat heart failure.) -There was an order for Eliquis 5mg to be administered twice each day. (Eliquis is used to prevent clots from forming in the blood.) -There was an order for Entresto 24-26mg to be administered twice each day. (Entresto is used to treat heart failure.) -There was an order for furosemide 40mg to be	D 358		

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administered twice each day. (Furosemide is a medication used to prevent excess fluid from accumulating in the body.)
-There was an order for Jardiance 10mg to be administered each day. (Jardiance is used to control blood glucose levels.)

Observation of the 8:00am medication pass on 06/04/25 revealed:
-Carvedilol 6.25mg was not administered.
-Eliquis 5mg was not administered.
-Entresto 24-26mg was not administered.
-Furosemide 40mg was not administered.
-Jardiance 10mg was not administered.

Interview with the medication aide (MA) on 06/04/25 at 8:56am revealed she was unable to locate the carvedilol, Eliquis, Entresto, furosemide and Jardiance to administer the medications to Resident #6.

Observations of medications on hand for Resident #6 on 06/04/25 at 8:56am revealed:
-Carvedilol 6.25mg was not available for administration.
-Eliquis 5mg was not available for administration.
-Entresto 24-26mg was not available for administration.
-Furosemide 40mg was not available for administration.
-Jardiance 10mg was not available for administration.

Review of Resident #6's electronic medication administration record (eMAR) for June 2025 revealed:
-There was an electronic entry for carvedilol 6.25mg to be administered twice each day and scheduled for 8:00am and 5:00pm.
-There was documentation carvedilol 6.25mg was

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not administered on 06/04/25 at 8:00am because it was on hold.
-There was an electronic entry for Eliquis 5mg to be administered twice each day and scheduled for 8:00am and 8:00pm.
-There was documentation Eliquis 5mg was not administered on 06/04/25 at 8:00am because it was on hold.
-There was an electronic entry for Entresto 24-26mg to be administered twice each day and scheduled for 8:00am and 8:00pm.
-There was documentation Entresto 24-26mg was not administered on 06/04/25 at 8:00am because it was on hold.
-There was an electronic entry for furosemide 40mg to be administered twice each day and scheduled for 8:00am and 2:00pm.
-There was documentation furosemide 40mg was not administered on 06/04/25 at 8:00am because it was on hold.
-There was an electronic entry for Jardiance 10mg to be administered each day and scheduled for 8:00am.
-There was documentation Jardiance 10mg was not administered on 06/04/25 at 8:00am because it was on hold.

Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 06/05/25 at 1:46pm revealed:
-A quantity of 26 carvedilol 6.25mg tablets was last dispensed on 06/04/25 for a 13 day supply.
-A quantity of 14 carvedilol 6.25mg tablets was dispensed on 05/21/25 for a 7 day supply to start on 05/27/25.
-A quantity of 26 Eliquis 5mg tablets was last dispensed on 06/04/25 for a 13 day supply.
-A quantity of 14 Eliquis 5mg tablets was dispensed on 05/21/25 for a 7 day supply to start on 05/27/25.

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-A quantity of 26 Entresto 24-26mg tablets was last dispensed on 06/04/25 for a 13 day supply.
-A quantity of 14 Entresto 24-26mg tablets was dispensed on 05/21/25 for a 7 day supply to start on 05/27/25.
-A quantity of 26 furosemide 40mg tablets was last dispensed on 06/04/25 for a 13 day supply.
-A quantity of 14 furosemide 40mg tablets was dispensed on 05/21/25 for a 7 day supply to start on 05/27/25.
-A quantity of 26 Jardiance 10mg tablets was last dispensed on 06/04/25 for a 13 day supply.
-A quantity of 14 Jardiance 10mg tablets was dispensed on 05/21/25 for a 7 day supply to start on 05/27/25.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 1:46pm revealed:
-They recieved updated orders from the facility on 03/30/25 but they had not been signed by a provider.
-They notified the facility on 03/30/25 and on 04/10/25 that a signed order was needed.
-They recieved signed physician's orders on 05/13/25.

Interview with Resident #6's primary care provider (PCP) on 06/04/25 at 3:58pm revealed:
-Resident #6 was prescribed carvedilol, furosemide and Entresto for heart failure.
-Heart failure meant the heart did not pump as it should and fluid could build up in the lungs.
-Furosemide was a diuretic medication and not taking the furosemide could cause fluid to build up and cause shortness of breath and exacerbate his heart failure.
-Resident #6 had a history of a pulmonary embolus and was prescribed Eliquis to prevent a clot from forming.

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D 358	Continued From page 11 -Resident #6 was prescribed Jardiance to treat diabetes. -She sent a new prescription to the facility's contracted pharmacy on 05/28/25 and again that morning (06/04/25) after the Resident Care Coordinator (RCC) called to tell her about the medications not being available for administration. -The facility's contracted pharmacy told her they did not get the prescription that was sent on 05/28/25. -Resident #6 needed to take his medications as prescribed to prevent complications from increased blood sugar levels and heart failure and prevent another blood clot in the lung from occuring. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am revealed: -Medications were dispensed from the pharmacy weekly and were to begin each Tuesday. -There was no process in place to review medications that arrived for administration but some MAs would take the time to ensure all medications were delivered. -She was not made aware some medications were not available to be administered to Resident #6 when the new packages started on 06/03/25. Refer to interview with a medication aide (MA) on 06/05/25 at 3:13pm. Refer to interview with a second MA on 06/05/25 at 3:20pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am. Refer to second interview with the RCC on 06/05/25 at 4:00pm	D 358		

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D 358	Continued From page 12 Refer to interview with the Administrator on 06/05/25 at 4:13pm. 2. Review of Resident #3's current FL-2 dated 03/12/25 revealed diagnoses included depression and anxiety, panic disorder, schizophrenia, chronic muscle spasms and gastroesophageal reflux disease (GERD). a. Review of Resident #3's current FL-2 dated 03/12/25 revealed there was an order to administer Olanzapine 15mg once daily. (Olanzapine is a medication used to treat agitation and stablize mood.) Review of Resident #3's physician order sheet dated 05/21/25 revealed there was an order for Olanzapine 15mg tablet 8:00pm dose was to be held from 05/07/25 to 05/20/25. Review of Resident #3's physician order dated 05/23/25 revealed: -Resident #3's Mental Health Provider (MPH) ordered Olanzapine 15mg each night at bedtime to be discontinued. -There was an order to begin Olanzapine 15mg to be administered every morning. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Olanzapine 15mg to be administered each day at bedtime and scheduled for 8:00pm with documentation of end date 05/24/25. -Olanzapine 15mg was documented as "T" on 05/03/25 at 8:00pm with no exception note. -Olanzapine 15mg was documented as not administered on 05/07/25 to 05/09/25 at 8:00pm	D 358		

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because it was on hold.
-Olanzapine 15mg was documented as not administered on 05/10/25 at 8:00pm because Resident #3 was unavailable.
-Olanzapine 15mg was documented as "T" on 05/11/25 at 8:00pm with no exception note.
-Olanzapine 15mg was documented as not administered on 05/12/25 at 8:00pm because it was on hold.
-Olanzapine 15mg was documented as not administered on 05/14/25 at 8:00pm because it was on hold.
-Olanzapine 15mg was documented as not administered on 05/16/25 at 8:00pm because it was on hold.
-Olanzapine 15mg was documented as "T" on 05/17/25 at 8:00pm with no exception note.
-Olanzapine 15mg was documented as not administered on 05/20/25 at 8:00pm because it was on hold.
-There was a second electronic entry for Olanzapine 15mg to be administered at bedtime beginning 05/24/25 through 05/26/2025 and scheduled for 8:00pm.
-Olanzapine 15mg was documented as "T" on 05/24/25 to 05/26/25 at 8:00pm with no exception note.
-There was a third electronic entry for Olanzapine 15mg to be administered each morning beginning 05/27/25 and scheduled for 8:00am.
-Olanzapine 15mg was documented as "T" on 05/27/25 at 8:00am with no exception note.
-15 of 31 doses of Olanzapine 15mg was not administered.

Observation of Resident #3's medications on hand on 06/05/25 at 1:30pm revealed there was one bubble card with 4 Olanzapine 15mg tablets on hand.

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D 358	Continued From page 14 Interview with the Resident Care Coordinator (RCC) on 06/4/2025 at 2:25pm revealed "T" was documented on the eMAR to indicate the medication was not administered due to therapeutic leave. Review of Resident #3's progress note dated 05/23/25 revealed: -Resident #3 was feeling panicky. -The MHP reviewed Resident #3's May 2025 eMAR which indicated that Resident #3's Olanzapine was placed on hold for unknown reasons for several days and that it may account for Resident #3's mood changes. -Resident #3's sleep had been disrupted recently, possibly due to Olanzapine being placed on hold by the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/05/25 at 2:52pm revealed: -The pharmacy dispensed 7 tablets of Olanzapine 15mg for Resident #3 on 04/21/25 for a 7 day supply. -The pharmacy did not receive any orders for Olanzapine 15mg for Resident #3 from 05/07/25-05/21/25. -The pharmacy received an order from Resident #3's MHP on 5/23/25 for Olanzapine 15mg to be taken every morning. -The pharmacy dispensed 10 tablets of Olanzapine 15mg for Resident #3 on 05/24/25 for a 10 day supply. -The pharmacy dispensed 7 tablets of Olanzapine 15mg for Resident #3 on 05/28/25 for a 7 day supply. -The pharmacy dispensed 7 tablets of Olanzapine 15mg for Resident #3 on 06/04/25 for a 7 day supply.	D 358		

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D 358	Continued From page 15 Second interview with RCC on 06/5/25 at 3:15pm revealed she could not explain why Olanzapine 15mg for Resident #3 had been put on hold for dates 05/07/25-05/20/25. Attempted telephone interview with Resident #3's MHP on 06/05/25 at 3:06pm was unsuccessful. b. Review of Resident #3's current FL-2 dated 03/12/25 revealed there was an order to administer Omeprazole 40mg once daily 30 mins before breakfast. (Omeprazole is a medication used to treat gastroesophageal reflux disease (GERD). Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Omeprazole 40mg, take 1 capsule 30 minutes before breakfast at 6:00am. -Omeprazole 40mg was documented as not administered on 06/03/25 and 06/04/25 at 6:00am because it was on hold. Observation of Resident #3's medications on hand on 06/05/25 at 1:30pm revealed there was a medication card with 29 Omeprazole 40mg tablets available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/05/25 at 2:35pm revealed: -A refill for Resident #3's Omeprazole 40mg on was requested on 05/28/25 and signed by primary care provider (PCP) on 06/04/25. -The pharmacy dispensed 30 capsules of Omeprazole 40mg for Resident #3 on 06/04/25 for a 30 day supply.	D 358		

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D 358	Continued From page 16 Interview with Resident #3 on 06/04/25 at 8:57am revealed: -She found out she was out of her Omeprazole on Monday 06/02/25. -She noticed when the medication aide (MA) gave her medications on Monday that the Omeprazole was missing. -The MA informed her that the medication had been ordered but it had not come in by 06/04/25. -She informed the Resident Care Coordinator (RCC) that she had been out of her Omeprazole since Monday and the RCC told her she would contact the pharmacy and request a four hour delivery status on the medication. -She still had not received her Omeprazole on 06/04/25. -She had a history of an eroding esophagus. -She felt sick last night and this morning, and stated "now acid is all the way up to my ears." -She had to sleep with her head elevated on a pillow last night but had difficulty sleeping due to her stomach acid. -She was not able to bend over and had vomited several times that morning. Interview with Resident #3's primary care provider (PCP) on 06/04/25 at 3:58pm revealed: -She had not provided any hold orders for the Omeprazole. -The MAs or RCC should have notified her that Resident #3 was out of Omeprazole. -Resident #3 was prescribed Omeprazole to help decrease her symptoms of GERD. -MAs needed to document the correct information on the eMAR to ensure the resident received the correct medication as ordered. Interview with the RCC on 06/05/25 at 8:20am revealed:	D 358		

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-The PCP ordered Omeprazole for Resident #3 and the facility was waiting on the pharmacy to deliver the medication.
-She contacted the pharmacy to follow up on Resident #3's Omeprazole and the pharmacy reported the medication should arrive at the facility on 06/04/25 at 12:00pm.
-Omeprazole was not administered on 06/03/25 or 06/04/25 because the medication was on hold from the pharmacy.

Refer to interview with a MA on 06/05/25 at 3:13pm.

Refer to interview with a second MA on 06/05/25 at 3:20pm.

Refer to interview with the RCC on 06/05/25 at 10:45am.

Refer to second interview with the RCC on 06/05/25 at 4:00pm

Refer to interview with the Administrator on 06/05/25 at 4:13pm.

3. Review of Resident #4's current FL-2 dated 05/28/25 revealed:
-Diagnoses included Parkinson, frontotemporal neurocognitive disorder and metabolic encephalopathy.
-There was an order for lactulose 10GM/15ml to administer 15ml twice daily for ammonia level. (Lactulose is a medication used to decrease ammonia buildup in the blood that impairs brain function due to liver issues.)

Review of Resident #4's previous FL-2 dated 04/02/25 revealed there was an order for lactulose 10GM/15ml to administer 15ml twice

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daily.

Review of Resident #4's electronic medication administration record (eMAR) for April 2025 revealed:
-There was an electronic entry for lactulose 10GM/15ml, 15 ml to be administered twice daily and scheduled for 8:00am and 8:00pm with special instructions that a prescription was needed.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/01/25 at 8:00am because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/08/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/09/25 at 8:00am because it was on hold and not administered at 8:00pm because Resident #4 was not available.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/10/25 at 8:00am because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/11/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/19/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/20/25 at 8:00am and 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/23/25 at 8:00am because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/25/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml,

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15 ml was not administered on 04/26/25 at 8:00am and 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/27/25 at 8:00am and 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/28/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/29/25 at 8:00am and 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 04/30/25 at 8:00am because it was on hold.
-Lactulose 10GM/15ml, 15 ml was not administered 18 times out of 60 scheduled doses.

Review of Resident #4's eMAR for May 2025 revealed:
-There was an electronic entry for lactulose 10GM/15ml, 15 ml to be administered twice daily and scheduled for 8:00am and 8:00pm with special instructions that a prescription was needed with an end date of 05/09/25.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/03/25 at 8:00am because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/07/25 and 05/08/25 at 8:00am and 8:00pm because it was on hold.
-There was a second electronic entry for lactulose 10GM/15ml, 15 ml to be administered twice daily and scheduled for 8:00am and 8:00pm beginning at 8:00pm on 05/09/25 and an end date of 05/16/25.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/09/25 and 05/10/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml,

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15 ml was not administered on 05/12/25 and 05/13/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/15/25 at 8:00pm because it was on hold.
-There was a third electronic entry for lactulose 10GM/15ml, 15 ml to be administered twice daily and scheduled for 8:00am and 8:00pm to begin at 8:00pm on 05/16/25.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/16/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/18/25, 05/19/25 and 05/20/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/23/25 at 8:00am and 8:00pm "due to condition".
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/26/25 at 8:00pm because it was on hold.
-There was documentation lactulose 10GM/15ml, 15 ml was not administered on 05/29/25 at 8:00am because it was on hold.
-Lactulose 10GM/15ml, 15 ml was not administered 18 times out of 60 scheduled doses for May 2025.

Review of Resident #4's record revealed there was no ammonia level ordered and no ammonia level available.

Review of Resident #4's physicians order dated 04/01/25 revealed:
-There was an order to hold lactulose 10Gm/15ml on 04/01/25 through 04/30/25 at 8:00am and 8:00pm.
-There was an order to continue to hold lactulose 10Gm/15ml on 05/01/25 through 05/31/25.

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D 358	Continued From page 21 -The order was signed by the PCP on 06/04/25. Observation of Resident #4's medications on hand for administration on 06/05/25 at 9:51am revealed there was a bottle of lactulose 10Gm/15ml labeled to administer 15ml twice daily for ammonia level with a dispense date of 05/21/25. Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed: -They received an order on 03/30/25 for lactulose 10GM/15ml, 15 ml but it was not signed by a provider. -They reached out to the facility on 03/30/25 and again on 04/10/25 they needed a signed order but did not receive an order until 05/13/25. -They first dispensed a 15 day supply of lactulose on 05/13/25. -Resident #4 was last dispensed a 15 day supply of lactulose on 05/21/25. Interview with a medication aide (MA) on 06/05/25 at 10:00am revealed: -She did not administer lactulose to Resident #4 on 05/23/25 because he was lethargic. -Resident #4 would not wake up to take his lactulose. -She did not know what the signs and symptoms of increased ammonia levels were. Interview with the Director for Resident #4's hospice provider on 06/05/25 at 1:16pm revealed: -The hospice nurse documented lethargy in her note dated 05/22/25 but they expected hospice patients to experience decline. -Hospice did not prescribe a lot of blood test and did not have an ammonia level on record for Resident #4.	D 358		

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Interview with Resident #4's primary care provider (PCP) on 06/04/25 at 3:58pm revealed:
-Resident #4 was ordered lactulose to prevent high ammonia levels in the blood.
-Increased ammonia levels caused confusions, lethargy, breathing problems and could lead to encephalopathy (brain dysfunction).
-She was not aware Resident #4 had missed 18 doses of lactulose in April and May and planned to order an ammonia level to be drawn.

Refer to interview with a MA on 06/05/25 at 3:13pm.

Refer to interview with a second MA on 06/05/25 at 3:20pm.

Refer to interview with the RCC on 06/05/25 at 10:45am.

Refer to second interview with the RCC on 06/05/25 at 4:00pm

Refer to interview with the Administrator on 06/05/25 at 4:13pm.

4. Review of Resident #1's current FL-2 dated 04/23/25 revealed diagnoses included dementia and hypertension.

a. Review of Resident #1's physician order sheet dated 04/23/25 revealed there was an order for Risperidone 0.25mg, take ½ tablet (0.125mg) twice a day at 9:00am and 4:00pm (Risperidone is used to treat schizophrenia and bipolar disorder).

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/05/25 at

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1:47pm revealed:
-The pharmacy dispensed 7 tablets of Risperidone for Resident #1 on 04/23/25.
-The pharmacy dispensed 7 tablets of Risperidone for Resident #1 on 04/30/25.
-The pharmacy dispensed 7 tabletss of Risperidone for Resident #1 on 05/07/25.
-The pharmacy dispensed 7 tablets of Risperidone for Resident #1 on 05/19/25.
-The 7 tablets of Risperidone for Resident #1 that were dispensed on 05/19/25 would begin 05/20/25 and last until 05/27/25.
-The pharmacy sent a request for a new prescription of Risperidone to the resident's primary care provider (PCP) and to the facility on 05/21/25 and 06/04/25.
-As of 06/05/25 at 1:50pm the pharmacy had not received a prescription from the resident's PCP or the facility.

Review of Resident #1's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Risperidone 0.25mg, take ½ tablet (0.125mg) twice a day at 9:00am and 4:00pm.
-Risperidone 0.25mg (0.125mg) was not documented as administered at 8:00am on 05/27/25, Risperidone 0.25mg was documented with a medication aide's (MAs) initials with parentheses around the initials on 05/27/25 at 8:00am.
-There was an entry on the eMAR exceptions that Risperidone 0.25mg (0.125mg) was not administered; on hold on 05/27/25 at 8:00am.
-Risperidone 0.25mg (0.125mg) was not documented as administered at 8:00am and 4:00pm on 05/29/25, Risperidone 0.25mg was documented with a MAs initials with parentheses around the initials on 05/29/25 at 8:00am and

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D 358	Continued From page 24 8:00pm. -There was an entry on the eMAR exceptions that Risperidone 0.25mg (0.125mg) was not administered; on hold on 05/29/25 at 8:00am and 4:00pm. -Risperidone 0.25mg (0.125mg) was not documented as administered at 8:00am and 4:00pm on 05/30/25, Risperidone 0.25mg was documented with a MAs initials with parentheses around the initials on 05/30/25 at 8:00am and 4:00pm. -There was an entry on the eMAR exceptions that Risperidone 0.25mg (0.125mg) was not administered; on hold on 05/30/25 at 8:00am and 4:00pm. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Risperidone 0.25mg, take ½ tablet (0.125mg) twice a day at 9:00am and 4:00pm. -Risperidone 0.25mg (0.125mg) was not documented as administered at 8:00am and 4:00pm on 06/02/25, Risperidone 0.25mg (0.125mg) was documented with a MAs initials with parentheses around the initials on 06/01/25 at 8:00am and 4:00pm. -There was an entry on the eMAR exceptions that Risperidone 0.25mg (0.125mg) was not administered; on hold on 06/02/25 at 8:00am and 4:00pm. -Risperidone 0.25mg (0.125mg) was not documented as administered at 8:00am on 06/04/25, Risperidone 0.25mg (0.125mg) was documented with a MAs initials with parentheses around the initials on 06/04/25 at 8:00am. -There was an entry on the eMAR exceptions that Risperidone 0.25mg (0.125mg) was not administered; on hold on 06/04/25 at 8:00am.	D 358		

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Observation of Resident #1's medications on hand on 06/05/25 at 1:05pm revealed there were no Risperidone 0.25mg (0.125mg) available for Resident #1.

Interview with Resident #1's PCP on 06/04/25 at 3:58pm revealed:
-Resident #1 received Risperidone to help with agitation, anxiety and insomnia.
-She was not aware that Resident #1 had missed several doses of Risperidone.
-Resident #1 was at risk of increased episodes of anxiety and agitation which decreased the resident's quality of life.
-She expected the MAs or Resident Care Coordinator (RCC) to notify her when a residents medication was not administered as ordered.
-She had not provided any hold orders for the resident's Risperidone.

Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable.

Refer to interview with a MA on 06/05/25 at 3:13pm.

Refer to interview with a second MA on 06/05/25 at 3:20pm.

Refer to interview with the RCC on 06/05/25 at 4:00pm.

Refer to interview with the Administrator on 06/05/25 at 4:13pm.

b. Review of Resident #1's physician order sheet dated 04/23/25 revealed there was an order for Lorazepam Intensol, 2mg/ml, give 0.5ml (1mg) once a day at 8:00am (Lorazepam is used to treat

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anxiety and agitation).

Review of Resident #1's physician order sheet dated 05/30/25 revealed there was an order for Lorazepam Intensol, 2mg/1ml, give 0.5ml (1mg) twice a day.

Review of Resident #1's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam Intensol 2mg/ml, give 0.5ml (1mg) once a day at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/14/25, Lorazepam Intensol was documented with a medication aides (MAs) initials with parentheses around the initials on 05/14/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/14/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/16/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/16/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/16/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/17/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/17/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/17/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/18/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on

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05/18/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not documented as administered; on hold on 05/18/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/19/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/19/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/19/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/20/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/20/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/20/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/21/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/21/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/21/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/22/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/22/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/22/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/23/25, lorazepam Intensol was documented with a MAs initials with parentheses around the initials on

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05/23/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/23/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/24/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/24/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/24/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/25/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/25/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/25/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/26/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/26/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not documented as administered; on hold on 05/26/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/27/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on 05/27/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/27/25 at 8:00am.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 05/28/25, Lorazepam Intensol was documented with a MAs initials with parentheses around the initials on

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05/28/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/28/25 at 8:00am.
-Lorazepam Intensol concentrate 0.5ml (1mg) was not administered 14 times from 05/14/25 to 05/28/25.
-There was an entry for Lorazepam Intensol 2mg/ml, give 0.5ml (1mg) twice a day at 8:00am and 8:00pm.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00pm on 05/30/25, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 05/30/25 at 8:00pm.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/30/25 at 8:00pm.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00pm on 05/31/25, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 05/31/25 at 8:00pm.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 05/31/25 at 8:00pm.

Review of Resident #1's June 2025 eMAR revealed:
-There was an entry for Lorazepam Intensol 2mg/ml, give 0.5ml (1mg) twice a day at 8:00am and 8:00pm.
-Lorazepam Intensol 0.5ml was not documented administered at 8:00pm on 06/01/25 at 8:00pm, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 06/01/25 at 8:00pm.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 06/01/25 at 8:00pm.

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-Lorazepam Intensol 0.5ml was not documented as not administered at 8:00pm on 06/02/25, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 06/02/25 at 8:00pm.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 06/02/25 at 8:00pm.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00pm on 06/03/25, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 06/03/25 at 8:00pm.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 06/03/25 at 8:00pm.
-Lorazepam Intensol 0.5ml was not documented as administered at 8:00am on 06/04/25, Lorazepam Intensol was documented with a MA initials with parentheses around the initials on 06/04/25 at 8:00am.
-There was an entry on the eMAR exceptions that Lorazepam Intensol was not administered; on hold on 06/04/25 at 8:00am.

Observation of Resident #1's medications on hand on 06/05/25 at 1:05pm revealed there were 23 syringes each containing 0.5ml of Lorazepam Intensol.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/05/25 at 1:47pm revealed:
-The pharmacy dispensed 15mls of Lorazepam Intensol which was a total of 30 syringes for 0.5mg doses for 30 days on 04/11/25.
-The pharmacy dispensed 15mls of Lorazepam Intensol which was a total of 30 syringes for 0.5mg doses for 30 days on 05/27/25.
-The pharmacy received an order to discontinue

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the 0.5mg dose of Lorazepam Intensol on 05/30/25.
-The pharmacy received a new order for 15mls of Lorazepam Intensol for 0.5mg dose twice a day on 05/30/25.

Interview with a personal care aide (PCA) on 06/05/25 at 3:17pm revealed Resident #1 had a history of being irritable, cursing, and argumentative and was hard to redirect.

Interview with a medication aide (MA) on 06/05/25 at 3:13pm revealed:
-She was not sure why she documented on the eMAR that she did not administer Resident #1 her Lorazepam.
-She had not notified the resident's Primary Care Provider (PCP) to request a hold order when the Lorazepam was not available for Resident #1.
-The resident would curse frequently and was irritable.
-The resident was very hard to redirect, and she gave the resident time to calm down.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 4:00pm revealed:
-She was not aware that the MAs had not administered Resident #1 her Lorazepam for so many days in May.
-There were no hold orders from the PCP for the resident's Lorazepam.
-Resident #1 needed her Lorazepam to help decrease her anxiety and agitation.

Interview with Resident #1's PCP on 06/04/25 at 3:58pm revealed:
-Resident #1 received Lorazepam to help decrease her agitation and anxiety.
-She was not aware that Resident #1 had missed several doses of her Lorazepam.

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-Resident #1 was at risk of increased anxiety, agitation, and refusal of care.
-Resident #1 was not easily redirected when she became anxious or agitated.
-When she did not receive her Lorazepam it decreased her quality of life due to increased behaviors.
-MAs should have notified her or the RCC that Resident #1 did not receive her Lorazepam.
-She had not provided any hold orders for the resident's Risperidone or Lorazepam.

Interview with the Administrator on 06/05/25 at 4:13pm revealed the MAs should have notified the RCC or Resident #1's PCP if her Lorazepam was not available to administer.

Attempted telephone interview with Resident #1's mental health provider (MHP) on 6/5/2025 at 3:06pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable.

Refer to interview with a MA on 06/05/25 at 3:13pm.

Refer to interview with a second MA on 06/05/25 at 3:20pm.

Refer to interview with the RCC on 06/05/25 at 10:45am.

Refer to second interview with the RCC on 06/05/25 at 4:00pm

Refer to interview with the Administrator on 06/05/25 at 4:13pm.

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D 358	Continued From page 33 Interview with a medication aide (MA) on 06/05/25 at 3:13pm revealed: -When a medication was not available to administer she clicked an option on the electronic medication administration record (eMAR) system that the medication was not administered; it was on hold. -The MAs were not allowed to document on the eMAR if a medication was not available to administer. -When a medication was not available for a resident she sent a message to the pharmacy, the resident's primary care provider (PCP), and the Resident Care Coordinator (RCC). -Resident #1 was frequently agitated. Interview with a second MA on 06/05/25 at 3:20pm revealed: -When a MA documented that a medication was not administered and it was on hold, it meant that the medication was not available to administer. -When a medication was not available to administer she notified the RCC and the RCC notified the PCP. -There were times that she would send the PCP a message that the resident was out of her medication. -She followed the eMAR and if a medication was not available to administer, she did not administer the medication. Interview with the RCC on 06/05/25 at 10:45am revealed: -MAs documented "on hold" on the eMAR when a medication was not available for administration. -MAs would let her know if a medication was not available and she would inform that PCP. -She would have the PCP sign an order to hold the medication when she was at the facility.	D 358		

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-She pulled a compliance report each morning and wrote hold orders for the PCP to sign when she came back to the facility or would email them to her.
-MAs were responsible for weekly cart audits which included comparing orders to the medications on hand for each resident and provided it to the RCC by Wednesdays.
-Medications were dispensed weekly with the new packages to begin each Tuesday.
-There was no process in place to review medications that arrived for administration but some MAs would take the time to ensure all medications were delivered.
-The PCP determined if a medication was put on hold.
-The RCC obtained a hold order from PCP by keeping it in a folder for review or emailing it to the PCP when she came on Wednesdays.
-Everything needed to be documented to ensure there was a record of new orders or a hold order.
-The MHP reviewed eMARs and if she had any concerns she brought them to her attention.
-If there was an order in progress note, RCC scaned progress note to pharmacy.
-If an order needed clarification she was responsible for contacting the PCP.
-The RCC expected MAs to notify her if a medication was not available for a resident.
-MAs should document that a medication was not available in the facility progress notes.
-MAs were expected to administer medications as ordered.

Second interview with the RCC on 06/05/25 at 4:00pm revealed the MAs were expected to notify her if a resident was out of a medication.

Interview with the Administrator on 06/05/25 at 4:13pm revealed:

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D 358	Continued From page 35 -MAs were expected to sign off on the eMAR the correct way. -When a medication was not available to administer, MAs should document that the medication was not available to administer because it was not in the facility. -Providers sent orders to pharmacy and are not normally emailed. -Providers, including the PCP and MHP, had access to logs and resident eMARs so they would know what was ordered was administered. -If medications were not available at the facility, the MAs should document that the medication was not available to administer in a facility progress note. -MAs signed for medications when they were delivered to the facility. -The RCC should compare the medications delivered with the packaging slip. -The MAs completed weekly cart audits to compare medications on hand, with the eMAR and physician orders. -If a MA had a question about a medication they should reach out to the RCC or Administrator. -MAs should follow orders as prescribed by the PCP or MHP to ensure medications were administered as ordered. -When medications were not administered as ordered, it could cause harm to the resident. _____ The facility failed to administer medications as ordered to treat anxiety and mood swing for a resident who experienced increased agitation which decreased her quality of life (#1), medications use to treat anxiety and mood swings for a resident that experienced mood changes and sleep disturbance (#3) as well as a medication to treat gastroesophageal reflux disease that also disrupted her sleep,caused vomiting and put her at increased risk for	D 358		

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D 358	Continued From page 36 esophageal erosion (#3) and medications used to prevent ammonia levels from rising in a resident with a history of encephalopathy (#4). This failure resulted in substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/05/25 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 5, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 2 of 3 residents observed during the medication pass related to a medication used to prevenet fluid accumulation in the body (#6) and a medication used to treat vitamin D deficiency (#5,#6).

The findings are:

Review of the facility's undated medication administration policy revealed medications that were not given were indicated by the staff person's initials for the medication with a circle around them.

1. Review of Resident #5's current FL-2 dated 01/08/25 revealed diagnoses included dementia and hypertension.
-There was an order for vitamin D2 1,250 mcg to be administered weekly.

a. . Review of Resident #5's current FL-2 dated 01/08/25 revealed there was an order for vitamin D2 1,250 mcg to be administered weekly.

Observation of the 8:00am medication administration pass on 06/04/25 revealed vitamin D2 1,250 mcg was administered to Resident #5.

Review of Resident #5's electronic medication administration record (eMAR) for June 2025 revealed:
-There was an electronic entry for vitamin D2 1,250 mcg to be administered one weekly for vitamin D deficiency and scheduled for 8:00am.

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D 367	Continued From page 38 -There was documentation vitamin D2 1,250 mcg was administered each day from 06/01/25 to 06/04/25. Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed: -Medications were dispensed weekly in multidose packs for Resident #5. -Vitamin D2 was only dispensed in the dose pack to be administered on Wednesday mornings at 8:00am. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. b. Review of Resident #6's current FL-2 dated 10/30/24 revealed there was an order for spironolactone 25mg to be administered daily at 8:00am. Review of Resident Resident #6's physician's order dated 06/04/25 revealed there was a clarification for spironolactone 25mg, 1/2 tablet was to be administered daily times 7 days 01/24/25. Observation of the 8:00am medication pass on 06/04/25 revealed: -The medication aide pulled a multidose pack of medications that contained 5 and 1/2 tablets for Resident #6. -Each medication was listed on the multidose pack which included 1 tablet of spironolactone 25mg. -The top tab of the weekly dose packets listed each medication contained in the multidose packs and the physician's order on how to administer each medication including	D 367		

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spironolactone 25mg, 1/2 tablet (12.5mg) to be administered each day.
-She compared each medication in the multidose pack to the electronic medication administration record (eMAR) on the the computer, emptied all the medications into a medication cup and handed the medication cup to Resident #6 at 8:50am for him to take when she stopped because the discrepancy between the order on the pack and what was in the pack was brought to her attention.
-The spironolactone whole tablet was not scored and was removed from the medication cup and was not administered.

Review of Resident #6's electronic medication administration record (eMAR) for June 2025 revealed:
-There was an electronic entry for Spironolactone 25 mg, 1/2 tablet (12.5mg) to be administer each day and scheduled for 8:00am.
-There was documentation spironolactone 25 mg, 1/2 tablet (12.5mg) was administered each day on 06/01/25 to 06/03/25.
-There was documentation spironolactone 25mg, 1/2 tablet (12.5mg) was not administered on 06/04/25 because of the wrong dosage.
-There was no entry for spironolactone 25 mg to be administered each day.

Interview with the medication aide (MA) on 06/04/25 at 12:56pm revealed:
-She had not noticed the discrepancy in what was ordered and what was dispensed.
-She did not see that 1 whole tablet of spironolactone 25mg was dispensed instead of spironolactone 25mg, 1/2 tablet that was entered on the and eMAR and documented as administered.
-She administered a whole tablet of

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D 367	Continued From page 40 spironolactone as long as she could remember. Interview with Resident #6's primary care provider (PCP) on 06/04/25 at 3:58pm revealed: -She expected Resident #6 to receive Spironolactone 25mg each day. -Resident #6 had some decreased blood pressure readings in January 2025 and she was not sure if it was the medication or due to infection. -She wrote an order to hold his spironolactone 25mg for 1 week and to start Spironolactone 25mg 1/2 tablet each day. -She thought the order said to administer spironolactone 25mg 1/2 tablet each day for 7 days then resume spironolactone 25mg each day. Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed: -The pharmacy entered orders onto the eMAR and the facility was responsible for approving the order for administration. -She was made aware spironolactone 25 mg was dispensed instead of a 1/2 tablet on 06/04/25. -Multidose medication packages were dispensed each week by automation and sometimes technical errors occurred. -Spironolactone 25mg whole tablets had been dispensed each week since 02/05/25. Interview with the Resident Care Coordinator on 06/05/25 at 10:45am revealed: -MAs were responsible for weekly cart audits which included comparing orders to the medications on hand for each resident and provided to RCC by Wednesdays. -Medications were dispensed weekly with the new packages to begin each Tuesday.	D 367		

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D 367	Continued From page 41 -There was not process in place to review medications that arrived for administration but some MAs would take the time to ensure all medications were delivered. Interview with the Administrator on 06/05/25 at 4:13pm revealed the pharmacy entered orders onto the eMAR. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Refer to telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm. Refer to interview with the facility's contracted primary care provider (PCP) on 06/04/25 at 3:58pm Refer to interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am. Refer to interview with the Administrator on 06/05/25 at 4:13pm 2. Review of Resident #6's current FL-2 dated 10/30/24 revealed: -Diagnoses included dementia, chronic kidney disease, hypertension, type 2 diabetes and history of a pulmonary embolus. -There was an order for vitamin D2 1,250 mcg to be administered one weekly for vitamin D deficiency. Observation of the 8:00am medication pass on 06/04/25 revealed: -Vitamin D was not administered to Resident #6. -The medication aide stated vitamin D was	D 367		

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ordered weekly but was not in the multidose package and she would document that the medication was not administered.

Review of Resident #6's electronic medication administration record (eMAR) for June 2025 revealed:
-There was an electronic entry for vitamin D2 1,250 mcg to be administered one weekly for vitamin D deficiency and scheduled for 8:00am.
-There was documentation vitamin D2 1,250 mcg was administered each day from 06/01/25 to 06/04/25.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed:
-Medications were dispensed weekly in multidose packs for Resident #6.
-Vitamin D2 was only dispensed in the dose pack to be administered on Tuesday mornings at 8:00am.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Refer to telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm.

Refer to interview with the facility's contracted primary care provider (PCP) on 06/04/25 at 3:58pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am.

Refer to interview with the Administrator on 06/05/25 at 4:13pm.

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D 367	Continued From page 43 Telephone interview with the pharmacist for the facility's contracted pharmacy on 06/05/25 at 2:03pm revealed medications that were ordered to be administered weekly should only pop up for administration by the medication aide on the day it was due to be administered but was entered incorrectly by the pharmacy. Interview with the facility's contracted primary care provider (PCP) on 06/04/25 at 3:58pm revealed the the eMAR needed to be accurate so there was no question about what medication had been administered and when it was administered. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 10:45am revealed: -MAs were responsible for weekly cart audits which included comparing orders to the medications on hand for each resident and provided to RCC by Wednesdays. -Medications were dispensed weekly with the new packages to begin each Tuesday. -There was not process in place to review medications that arrived for administration but some MAs would take the time to ensure all medications were delivered. -The RCC was responsible for approving orders on the eMAR for administration. -She was not aware the weekly Vitamin D medications popped up for administration every day for Resident #5 and Resident #6. -MAs were responsible for comparing the medication in the multidose pack to the eMAR at the time of administration to ensure what was ordered, administered and documented as administered was correct. -It was important for eMAR to be accurate because if pharmacy messes up then the facility messes up.	D 367		

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D 367	Continued From page 44 Interview with the Administrator on 06/05/25 at 4:13pm revealed: -She was not aware the weekly Vitamin D medications popped up for administration every day for Resident #5 and Resident #6. -MAs were responsible for reading the eMAR and comparing the medication to be administered to the eMAR prior to administration and notify the RCC if there was a discrepancy. -It was important for the eMAR to accurately reflect what was administered to ensure it documented the medication was administered as ordered by the provider.	D 367		