STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092-331	A. BUILDING: _____ B. WING _____	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE CARE HOMES 3	1410 KILDAIRE FARM ROAD CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on June 13 2025.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 2 sampled residents (#1) for a supplement. The findings are:	C 342		

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C 342	Continued From page 1 Review of Resident #1's current FL-2 dated 03/18/25 revealed diagnoses included cerebrovascular disease. Review of Resident #1's current resident register revealed he was admitted to the facility on 03/25/25. Review of a physician order form dated 03/25/25 revealed a discontinue order for Niacinamide 500 milligram tablets. Observation of Resident #2's medications on hand on 06/13/25 at 10:35am revealed: There was a bubble pack containing 23 of 23 Niacinamide 500 milligram tablets(used as a supplement) with a dispense date of 03/24/25. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Niacinamide 500 milligram tablet, take one tablet by mouth once daily before breakfast. -The medication was documented as administered 30 of 30 days. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for Niacinamide 500 milligram tablet, take one tablet by mouth once daily before breakfast. -The medication was documented as administered 31 of 31 days. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/05/25 revealed there was no entry for Niacinamide 500 milligram tablet. Interview with a medication aide (MA) on	C 342		

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C 342	Continued From page 2 06/13/25 at 10:55am revealed: -The Niacinamide 500 milligram tablet was discontinued on 03/25/25. -She stopped administering the Niacinamide 500 milligram tablet to the resident on 03/25/25. -She continued to sign the eMAR as if she was administering the Niacinamide 500 milligram tablet to the resident. -She was rushing and did not realize that she was continuing to sign for a medication that she was not administering. -When she received a discontinue order from the physician she should have sent the order to the pharmacy immediately and removed the medication off of the cart. -She sent all discontinue orders to the pharmacy to get the medication removed from the eMAR. -She was responsible for ensuring medications the eMAR is accurate. -She sent the discontinue order for the Niacinamide 500 milligram tablet around June 1, 2025. -It was important to ensure that the eMARs are accurate and that medications are administered as ordered for the health of the resident. Interview with the Administrator on 06/13/25 at 11:05am revealed: -When the primary care provider wrote a discontinue order the medication aide was supposed to send it to the pharmacy. -She was responsible for following up and checking all physician orders to ensure the eMAR was accurate. -She did not know how she overlooked the discontinue order for Niacinamide 500 milligram tablet. -She expected the medication aide to document accurately which medications she administered on the eMAR.	C 342		

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C 342	Continued From page 3 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/13/25 at 12:00pm revealed: -Resident #1 had an order for Niacinamide 500 milligram tablet. -The Niacinamide 500 milligram tablet was last dispensed on 03/24/25. -The Niacinamide 500 milligram tablet was discontinued on 05/26/25. -The facility sent discontinue orders to the pharmacy. -The facility should have sent discontinue orders to the pharmacy when they received them from the physician. Telephone interview with Resident #1's hospice nurse on 06/13/25 at 12:20pm revealed: -The Niacinamide 500 milligram tablet was discontinued on 03/25/25 to reduce pill burden for Resident #1. -Niacinamide 500 milligram tablet was not a necessary medication. -She expected discontinued medications to be removed from the eMAR and the cart immediately. -She had no concerns because the medication was a supplement. Attempted interview with Resident #1's on 06/13/25 at 11:15am revealed resident was not interviewable.	C 342		
C 362	10A NCAC 13G .1007 (b) Medication Disposition 10A NCAC 13G .1007 Medication Disposition (b) Medications, excluding controlled medications, that are expired, discontinued, prescribed for a deceased resident or	C 362		

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C 362	Continued From page 4 deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a discontinued medication was stored separately from actively used medications until disposed of for 1 of 2 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 03/18/25 revealed diagnoses included cerebrovascular disease. Review of Resident #1's current resident register revealed he was admitted to the facility on 03/25/25. Review of a physician order form dated 03/25/25 revealed a discontinue order for Niacinamide 500 milligram tablets. Observation of Resident #2's medications on hand on 06/13/25 at 10:35am revealed there was a bubble pack containing 23 of 23 Niacinamide 500 milligram tablets(used as a supplement) with a dispense date of 03/24/25. Review of Resident #1's April 2025 eMAR revealed: -There was an entry for Niacinamide 500 milligram tablet, take one tablet by mouth once daily before breakfast. -The medication was documented as administered 30 of 30 days.	C 362		

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C 362	Continued From page 5 Review of Resident #1's May 2025 eMAR revealed: -There was an entry for Niacinamide 500 milligram tablet, take one tablet by mouth once daily before breakfast. -The medication was documented as administered 31 of 31 days. Review of Resident #1's June 2025 eMAR from 06/01/25 to 06/05/25 revealed there was no entry for Niacinamide 500 milligram tablet. Interview with a medication aide (MA) on 06/13/25 at 10:55am revealed: -The Niacinamide 500 milligram tablet was discontinued on 03/25/25. -She stopped administering the Niacinamide 500 milligram tablet to the resident on 03/25/25. -She was rushing and did not realize that she was continuing to sign for a medication that she was not administering. -When she received a discontinue order from the physician she should have taken the medication off of the cart. -She was responsible for ensuring discontinued medications were removed from the cart. -Discontinued medications should be sent back to the pharmacy or destroyed. Interview with the Administrator on 06/13/25 at 11:05am revealed: -When the primary care provider wrote a discontinue order the medication aide was supposed to send it to the pharmacy. -She was responsible for following up and checking all physician orders. -She did not know how she overlooked the discontinue order for Niacinamide 500 milligram tablet. -Discontinued medications should not be left on	C 362		

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C 362	Continued From page 6	C 362		

the cart with the residents active medications.
-She expected the medication aide to remove discontinued medications from the cart and store them separately until they could be sent to the pharmacy or destroyed.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/13/25 at 12:00pm revealed:
-Resident #1 had an order for Niacinamide 500 milligram tablet.
-The Niacinamide 500 milligram tablet was last dispensed on 03/24/25.
-The Niacinamide 500 milligram tablet was discontinued on 05/26/25.
-The facility sent discontinue orders to the pharmacy.
-Discontinued medications should not be on the cart with medications that were being administered.
-The facility should have sent discontinued medications back to the pharmacy or destroy them.

Telephone interview with Resident #1's hospice nurse on 06/13/25 at 12:20pm revealed:
-The Niacinamide 500 milligram tablet was discontinued on 03/25/25 to reduce pill burden for Resident #1.
-Niacinamide 500 milligram tablet was not a necessary medication.
-She expected discontinued medications to be removed from the eMAR and the cart immediately.
-Discontinued medications should not be on the cart with the active medication.
-She had no concerns because the medication was a supplement.
Attempted telephone interview with Resident #1's primary care provider on 06/13/25 at 12:20pm

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C 362	Continued From page 7 was unsuccessful. Attempted interview with Resident #1 on 06/13/25 at 11:15am revealed resident was not interviewable.	C 362		