Received via email on 07/11/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032019	A. BUILDING: _____ B. WING _____	R 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 05/28/25 to 05/30/25.	D 000	The following is the Plan of Correction for Brookdale Chapel Hill regarding the Statement of Deficiencies dated 5/30/2025 This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide an environment free from hazards related to unsecured oxygen cylinders in residents' rooms. The findings are: According to guidance from the National Fire Protective Association (NFPA), compressed oxygen (O2) cylinders must be secured in a rack or stand to prevent tipping over. Observation of resident room D5 on 05/28/25 at various times from 9:00am to 3:30pm revealed there were two medium oxygen cylinders	D 079	Associate Executive Director and/ or designee will engage a Durable Medical Equipment Company to verify all oxygen tanks are secured on a rack or stand to help prevent tipping over. To assist with ongoing compliance, the Associate Executive Director or designee will audit oxygen tank storage weekly for or one month and once a month for six (6) months.	7/1/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Associate Executive Director | 7/11/25

Reviewed and acknowledged. PD 07/18/25

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D 079	Continued From page 1 unsecured on the floor beside the resident's O2 concentrator. Observation of resident room D5 on 05/29/25 at various times from 8:48am to 2:27pm revealed there were two medium oxygen cylinders unsecured on the floor beside the resident's O2 concentrator. Observation of resident room C8 on 05/28/25 at various times from 9:08am to 3:38pm revealed there were four small portable oxygen cylinders unsecured on the floor behind the bedroom door. Observation of resident room C8 on 05/29/25 at various times from 8:52am to 2:35pm revealed there were four small portable oxygen cylinders unsecured on the floor behind the bedroom door. Observation of resident room B2 on 05/28/25 at various times from 9:28am to 3:45pm revealed there were six medium portable oxygen cylinders unsecured on the floor beside the bedroom door. Observation of resident room B2 on 05/29/25 at various times from 8:50am to 2:43pm revealed there were four medium portable oxygen cylinders unsecured on the floor behind the bedroom door. Interview with the delivery person from the Durable Medical Equipment (DME) company on 05/29/25 at 11:42am revealed: -He delivered O2 cylinders weekly to residents in the facility. -He took the O2 cylinders to the residents' rooms and placed them behind the bedroom door or in the resident's closet where they could not be knocked over. -The DME company did not have enough racks to	D 079		

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D 079	Continued From page 2 store the O2 cylinders in. -No one had requested a rack for the O2 cylinders to be placed in. Telephone interview with a representative from the DME company on 05/29/25 at 11:52am revealed: -The O2 cylinders should be stored upright and, in a rack to prevent the tank from tipping over. -The DME company supplied the racks for the O2 cylinders in the facility. -The O2 could leak from the regulator if the O2 cylinders were not stored properly. -The O2 cylinders could explode if it fell over. -No one had contacted him to request racks to secure the O2 cylinders. Interview with a MA on 05/30/25 at 11:44am revealed: -He knew O2 cylinders were to be secured. -He knew there were O2 cylinders in the facility that were not secured. -He had notified hospice, who had ordered the O2 cylinders for the facility, and asked for some racks to set the O2 cylinders in. -He would speak to the hospice nurse weekly about needing racks for the O2 cylinders when they came to the facility. Interview with the RCC on 05/29/25 at 11:23am revealed: -Resident's O2 cylinders were stored in residents' bedrooms. -The O2 cylinder should be stored in a rack so the cylinder would be standing straight up. -The facility did not have any racks for the O2 cylinder to be stored in. -She tried to position the O2 cylinder in such a way that they would not fall over; she placed them in a corner or behind the bedroom door.	D 079		

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D 079	Continued From page 3 Interview with the HWD on 05/29/25 at 12:56am revealed: -The O2 cylinder were kept in residents' rooms and should be kept in a rack or in a closet. -She was aware there were O2 cylinder in the facility that were no in racks. -The contracted hospice agency had ordered O2 from the DME company. -She had notified the hospice agency on several occasions, most recently last week, that racks for O2 cylinder were needed. -She did not contact the DME company who delivered the O2 cylinders because they were contracted with the hospice agency. -If an O2 cylinder fell over it could explode or fall on a resident's foot and cause an injury. -The O2 cylinder needed to be in the correct storage to prevent the O2 cylinder from falling over. Interview with the Maintenance Director on 05/29/25 at 2:27pm revealed: -He knew O2 cylinder were to be stored in racks to prevent the O2 cylinder from falling. -He did not know there were O2 cylinder in the facility that were not stored in the racks. -He had racks available to store the O2 cylinder in. -No one had told him that racks for the O2 cylinder were needed. -The contracted DME company was responsible for providing the racks to store the O2 cylinders. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -She did know that O2 cylinder were to be secured in a rack. -She did know there were unsecured O2 cylinders in residents' rooms.	D 079		

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D 079	Continued From page 4 -No one had asked her about racks to secure O2 cylinder.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and C), who administered medications had successfully completed the 5-hour medication aide (MA) training course (Staff B), and the 5 and 10, or 15-hour medication training course (Staff C) or had employment verification as a MA in the previous 24 months before administering medications. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 04/21/25 as a MA. -There was no documentation Staff B completed the 5-hour MA training course before administering medications.	D 125	Associate Executive Director (AED), Health and Wellness Director (HWD) or designee will audit associate records to verify policy training compliance. Staff with identified missing documentation were reviewed and missing records were obtained. To assist with ongoing compliance the HWD/AED and/or designee will verify all direct care staff have completed required training. To assist with compliance AED/HWD or/and designee will audit staff records monthly for six (6) months.	7/1/25

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D 125	Continued From page 5 -There was no employment verification Staff B had worked as a MA in the previous 24 months. Review of a resident's May 2025 electronic medication administration record (eMAR) from 05/08/25 to 05/27/25 revealed there was documentation Staff B administered medications on 12 days from 05/08/25 to 05/27/25. Interview with Staff B on 05/30/25 at 4:33pm revealed: -She worked five days a week on second shift and administered medications to the residents. -She moved from another state, and she paid to take a medication aide course on-line. -She had been certified in the previous state for 18 years. -No one asked her about a 5 and 10, or 15-hour MA training certification when she was hired. -She was told by the Business Office Coordinator (BOC) that she only needed to pass the MA state exam, which she did. -She was not informed that she needed to do anything other than pass the MA state exam. -She was not told she needed to take the MA training course through the facility when she was hired. -She was told today, 05/30/25, that she needed to take the MA training course that was offered at the facility. Interview with the BOC on 05/30/25 at 8:30am revealed: -She verified Staff B had passed the MA state exam. -She did not verify if Staff B had taken the 5-hour MA training course prior to being hired. -Staff B should have been scheduled to take the 5-hour MA training course in April 2025. -She did not know why Staff B did not take the	D 125		

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D 125	Continued From page 6 MA training course in April 2025. Telephone interview with the Assistant Director of Clinical Services on 05/30/25 at 2:02pm revealed: -She could not recall Staff B attending a 5-hour MA training course. -If Staff B attended a MA training course, she would have completed a 5 and 10, or 15-hour certificate of completion and given the certificate of completion to the BOC or the Health Wellness Director (HWD). Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 3:06pm revealed: -She was responsible for preparing the MA schedule. -Staff B was scheduled as the MA for second shift. -She did not have anything to do with the MA training course. Interview with the HWD on 05/30/25 at 4:05pm revealed: -She did not know Staff B did not have a certification for completing the 5 and 10, or 15-hour medication training course before administering medications. -The BOC was responsible for ensuring Staff B had completed the 5 and 10, or 15-hour MA training course. -If she had known, she would have scheduled Staff B for the 5 and 10, or 15-hour MA training course. Refer to the interview with the BOC on 05/30/25 at 8:30am. Refer to the telephone interview with the Assistant Director of Clinical Services on 05/30/25 at 2:02pm.	D 125		

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D 125	Continued From page 7 Refer to the interview with the HWD on 05/30/25 at 4:05pm. Refer to the interview with the Administrator on 05/30/25 at 11:17am and 5:13pm. 2. Review of Staff C's personnel record revealed: -Staff C was hired on 02/13/25 as a MA. -There was no documentation Staff C completed the 5 and 10, or 15-hour MA training course. -There was no employment verification Staff C had worked as a MA in the previous 24 months. Review of a residents' March 2025, April 2025 and May 2025 from 05/01/25 to 05/27/25 electronic medication administration records (eMAR) revealed there was documentation Staff C administered medications on 36 days from 03/01/25 to 05/27/25. Interview with Staff C on 05/30/25 at 11:24am revealed: -She worked second shift and administered medications to the residents. -She had taken the 15-hour medication aide training course about 20 years ago. -She was given a certificate of completion for the 15-hour class. -She did not know where her MA training certificate of completion was. -The Business Office Coordinator (BOC) checked the registry and confirmed she passed the MA state exam. -She was told by the BOC she would be scheduled for the MA training course offered by the facility. -She had been employed since February 2025 and had not been scheduled to attend the MA training course.	D 125		

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D 125	Continued From page 8 -She was checked off on the medication cart by a registered nurse (RN). -The RN watched her pass medications to a couple of residents, asked her questions, and gave her a few scenarios to see how she would handle things. -She may have watched some videos but she was not certain. Interview with the BOC on 05/30/25 at 8:30am revealed: -She verified that Staff C had passed the MA test. -She did not verify that Staff C had taken the 5 and 10, or 15-hour MA training course prior to being hired. -She did not know why Staff C had not taken a MA training course since she was employed in February 2025. Telephone interview with the Assistant Director of Clinical Services on 05/30/25 at 2:02pm revealed: -She could not recall Staff C attending a MA training course. -If Staff C attended a MA training course, she would have completed a 5 and 10, or 15-hour certificate of completion. Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 3:06pm revealed: -She was responsible for preparing the MA schedule. -Staff B was scheduled as the MA for second shift. Interview with the Health Wellness Director (HWD) on 05/30/25 at 4:05pm revealed: -She did not know Staff C did not have a certification for completing the 5 and 10, or 15-hour medication training course before administering medications.	D 125		

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D 125	Continued From page 9 -If she had known, she would have scheduled Staff C for the 5 and 10, or 15-hour MA training course. Refer to the interview with the BOC on 05/30/25 at 8:30am. Refer to the telephone interview with the Assistant Director of Clinical Services on 05/30/25 at 2:02pm. Refer to the interview with the HWD on 05/30/25 at 4:05pm. Refer to the interview with the Administrator on 05/30/25 at 11:17am and 5:13pm. Interview with the BOC on 05/30/25 at 8:30am revealed: -She was responsible for hiring the MAs. -MA training courses were offered monthly by the Assistant Director of Clinical Services. -Sometimes MA training courses were held at the facility and some months at the sister facility. -She gave the list of names of MAs who needed to take the MA training course to the HWD. -The HWD was responsible for scheduling new hires to take the MA training course. Telephone interview with the Assistant Director of Clinical Services on 05/30/25 at 2:02pm revealed: -She held the MA training course at least monthly and bi-monthly if needed. -The HWD would schedule the MA for the MA training course. -She rotated from facility to facility to hold the MA training course; a MA from any facility could come to the monthly MA training course. -The MA training course was a 15-hour course over 2 days.	D 125		

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D 125	Continued From page 10 -After the MA had successfully passed the 15-hour course, she would issue a certificate to the MA and give the HWD and the BOC a copy of the certificate. -She had educated associates at each facility of the criteria and what the state expected during the survey. Interview with the HWD on 05/30/25 at 4:05pm revealed: -The BOC was responsible for ensuring the MAs had a certificate for completing the 5 and 10, or 15-hour medication aide training course. -The MA should bring the certificate of completion and give the BOC a copy for their personnel files. -If the MAs did not have proof of completion of the MA training course, then the MA should go through the facility's 5 and 10, or 15-hour MA training course. -The 5 and 10, or 15-hour MA training course was held monthly. -The BOC was responsible for letting her know if the MAs needed to be scheduled for the MA training course. -She was responsible for scheduling the MA to take the MA training course. Interview with the Administrator on 05/30/25 at 11:17am and 5:13pm revealed: -The MAs had their 5-hour class. -The facility considered the 5-hour class to be the orientation and training the MA received on the medication cart prior to the MA administering medications. -The BOC verified the MA had passed the state approved test. -The BOC did a reference check on the MAs, but did not verify the 5 and 10, or 15-hour MA training had been completed. -She did not know the orientation and training of	D 125		

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D 125	Continued From page 11 the medication cart was not considered the 5-hour class that allowed the MA to start administering medications. -She did not know about MA employment verification form and how to verify the MA had worked as a MA with in the previous 24 months. -The BOC was responsible for ensuring the 5 and 10, or 15-hour MA training course was completed, and the MAs had a certificate of the completed course. -The MAs should be enrolled in the 5 and 10, or 15-hour MA training course offered by the facility if the MAs do not have proof that the MA training course was completed. -The BOC should let the HWD know when a MA needs to take the MA training course. -The HWD was responsible for scheduling the MA for the MA training course. The facility failed to ensure two staff, who worked as medication aides and administered medications to residents completed the 5 and 10, or 15-hour medication aide training course or employment verification form before administering medications resulting in a risk for medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on May 30, 2025, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2025.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 12 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (A, B, and C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 05/07/20 as a MA. -There was no documentation the HCPR review was completed upon hire. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -She did not know Staff A's HCPR was not available in the personnel record for review. -She did not know if Staff A's HCPR was checked; if the HCPR was checked she did not know where the HCPR was. Attempted interview with Staff A on 05/30/25 at 5:45pm was unsuccessful. Attempted interview with the Business Office Coordinator (BOC) on 05/30/25 at 5:47pm was unsuccessful. Refer to the interview with the Administrator on 05/30/25 at 5:13pm.	D 137	Associate Executive Director, Health and Wellness Director and/ or designee will audit associate records to verify employment verification for staff (HCPR). Staff with identified missing documentations were reviewed and obtained. To assist with compliance AED/HWD or/and designee will audit staff records monthly for six (6) months.	7/1/25

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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 137	Continued From page 13 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/21/25 as a MA. -There was no documentation the HCPR review was completed upon hire. Interview with Staff B on 05/30/25 at 6:05pm revealed: -She had worked at the facility for 1 month, since April 2025. -She did know what the HCPR was; it had to be checked for all employees. -She did not know if the facility checked the HCPR. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -She did not know Staff B's HCPR was not available in the personnel record for review. -She did not know if Staff B's HCPR was checked; if the HCPR was checked she did not know where the HCPR was. Attempted interview with the Business Office Coordinator (BOC) on 05/30/25 at 5:47pm was unsuccessful. Refer to the interview with the Administrator on 05/30/25 at 5:13pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 02/13/25 as a MA. -There was no documentation the HCPR review was completed upon hire. Telephone interview with Staff C on 05/30/25 at 11:24am revealed: -She had worked at the facility for 4 months. -She did not know what a HCPR was. -She did not know if the facility checked the	D 137		

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D 137	Continued From page 14 HCPR. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -She did not know Staff B's HCPR was not available in the personnel record for review. -She did not know if Staff B's HCPR was checked; if the HCPR was checked she did not know where the HCPR was. Attempted interview with the Business Office Coordinator (BOC) on 05/30/25 at 5:47pm was unsuccessful. Refer to the interview with the Administrator on 05/30/25 at 5:13pm. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The BOC was responsible for checking the HCPR for new hires. -The HCPR should be printed and placed in the staff members personnel folder. -The BOC should audit new personnel records at 30/60/90 days to ensure the personnel folder was complete for a new hire.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 273	HWD and/or designee will verify referrals and follow up for the residents to meet the acute healthcare needs. Residents with identified missing documentation were reviewed and records were obtained. To assist with ongoing compliance the HWD/AED and/or designee will audit resident records and verify physician notification for residents. To assist with compliance AED/HWD or/and designee will resident records monthly for six months.	7/1/25

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D 273	Continued From page 15 reviews, the facility failed to ensure referral and follow-up to meet the acute healthcare needs for 1 of 5 sampled residents related to a resident who became aggressive toward residents and staff, and the Mental Health Provider (MHP) was not notified (#5). The findings are: Review of Resident #5's current FL-2 dated 01/07/25 revealed: -Diagnoses included memory deficit. -She wandered and was verbally abusive. -She was ambulatory. Review of Resident #5's care plan dated 08/11/24 revealed: -She ambulated with supervision. -She took antipsychotic medications. -She had memory deficit related to nontraumatic intracranial hemorrhage. -The care plan was last reviewed on 02/12/25 with no changes. Observation of Resident #5 on 05/28/25 at 1:35pm revealed: -The exit door alarm was alarming for the D hall. -Resident #5 was being redirected by the staff to leave the exit door. -Resident #5 went from the hallway into a male resident's room. -Staff went into the resident's room and brought Resident #5 back into the hallway as they were telling her it was not her room. -The medication aide (MA) said he was going to give Resident #5 an as needed (PRN) medication because she was wandering today. Review of Resident #5's electronic progress notes from March 2025 revealed:	D 273		

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D 273	Continued From page 16 -There was documentation Resident #5 had behaviors 7 out of 30 days. -Resident #5's behaviors were wandering in other residents' rooms, going through other residents' personal belongings, getting onto other residents' beds, resident to resident altercations, resident to staff altercations, shouting and yelling, agitation, combativeness, and exit seeking. Review of Resident #5's record revealed: -There was no documentation that the MHP was notified when the behaviors occurred. -There were no after-visit summaries available for review. Review of Resident #5's electronic progress notes from April 2025 revealed: -There was documentation Resident #5 had behaviors 4 out of 30 days. -Resident #5 was agitated and exit seeking. Review of Resident #5's record revealed there was no documentation that the MHP was notified when the behaviors occurred. Review of Resident #5's MHP after-visit summary dated 04/02/25 revealed: -Resident #5 was seen for PRN medication review. -Resident #5 was currently on trazodone 25mg at bedtime and 25mg every 12 hours as needed for anxiety. -Resident #5 experienced occasional bouts of anxiety and agitation which were effectively managed with the current medication regimen. -The staff reported that the PRN trazodone was beneficial when used. -The staff would continue to monitor Resident #5's anxiety levels and assess her response to the trazodone.	D 273	Type text here	

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D 273	Continued From page 17 -There were no changes to Resident #5's current medication regimen. -The staff were to watch for changes in anxiety or agitation and document use of PRN trazodone. -Staff were to contact the care team if Resident #5 had changes in memory disturbances. Review of Resident #5's MHP's after-visit summary dated 04/16/25 revealed: -Resident #5 remained confused and forgetful; she was often observed wandering around the facility. -There were no current behavioral concerns reported by the staff. -Resident #5 would continue the current medication regimen and monitor her cognitive and behavioral status. -Resident #5's generalized anxiety disorder appeared to be well managed with her current order of trazodone 25 mg at night and every 12 hours as needed. -The infrequent use of PRN trazodone, only once in the past 14 days, suggested that Resident #5's anxiety was controlled. -The staff were to watch for changes in anxiety or agitation and document use of PRN trazodone. -Staff were to contact the care team if Resident #5's had changes in memory disturbances. Review of Resident #5's MHP's after-visit summary dated 04/30/25 revealed: -Resident #5 was seen for PRN psychotropic medication review. -Resident #5 exhibited disorientation, confusion and forgetfulness, but no behavioral concerns were noted or reported. -Resident #5 was currently prescribed trazodone nightly and PRN for anxiety management, which was used twice in the past 14 days. -Staff reported that trazodone PRN was effective	D 273		

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managing Resident #5's anxiety.
-Resident #5 was to continue trazodone as prescribed, given its efficacy in managing her anxiety symptoms.

Review of Resident #5's electronic progress notes from May 2025 from 05/01/25 to 05/23/25 revealed:
-There was documentation Resident #5 had behaviors 6 out of 23 days.
-Resident #5's behaviors were agitation, combativeness, exit seeking, resident to resident altercation, and aggression toward staff.
-On 05/20/25 at 10:36am, Resident #5's Primary Care Provider (PCP) was in the facility and was notified that Resident #5 assaulted 2 other residents in the facility.
-The facility staff were worried that Resident #5's behaviors were increasingly becoming worse.
-The PCP ordered a urine sample to rule out a urinary tract infection.
-The MHP was to follow up with Resident #5 as soon as possible and staff were to redirect and reorient Resident #5.

Review of Resident #5's record revealed there was no documentation that the MHP was notified when the behaviors occurred.

Review of Resident #5's incident report dated 05/17/25 revealed:
-The location of the incident was resident room at 6:15pm.
-The nature of the incident was alleged aggressive behavior, abuse, neglect or exploitation.
-The incident was an unwitnessed, physical resident to resident encounter.
-No apparent injury occurred.

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D 273	Continued From page 19 Review of Resident #5's incident reports revealed there were no additional incidents reports available for review. Review of Resident #5's record revealed there were no MHP's after-visit summaries available for review for May 2025. Interview with Resident #5's power of attorney (POA) on 05/30/25 at 2:00pm revealed: -Resident #5 was cognitively declining, was more confused and was showing more behaviors. -Her care plan had been changed the week before to show the decline and the increased behaviors. -If there were any incidents with Resident #5, she wanted to be contacted. -The different staff had different ways they redirected Resident #5. -Resident #5 did better when the staff interacted and engaged more with Resident #5. -Resident #5 would get confused and go into other residents' rooms and want them to leave because she thought it was her room. Interview with a personal care aide (PCA) on 05/30/25 at 2:52pm revealed: -She worked on 05/17/25, the day of the altercation between Resident #5 and the male resident. -She heard a commotion and when she rounded the corner toward the male resident's room, she saw Resident #5 grab the male resident's wrist. -She separated Resident #5 and the male resident; another PCA walked with Resident #5 to her room. -She noticed a scratch on the male resident's right wrist. -The male resident stated that Resident #5 was trying to get into his room.	D 273		

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D 273	Continued From page 20 -She reported the incident to the MA. -Resident #5 and a female resident argued a lot, because Resident #5 kept going in the female resident's room and she did not want Resident #5 in her room. -She had found Resident #5 in a room on B hall and a room on D hall. -One day Resident #5 was upset and wanted to leave the facility. -Resident #5 opened the living room door and hit a female resident with the door, causing a bruise on the female resident's nose. Interview with a MA on 05/30/25 at 2:34pm revealed: -On 05/19/25, Resident #5 and a male resident had an argument; he did not know what the argument was about. -He separated Resident #5 and the male resident, and redirected Resident #5. -The male resident told him that Resident #5 entered his room on 05/17/25, there was an altercation and Resident #5 had hit him. -He spoke with two PCAs who confirmed the incident on 05/17/25. -He did not work on 05/17/25, the day of the incident. -He created the incident/accident report for 05/17/25 on 05/19/25 and documented in the electronic progress notes as instructed by the Health Wellness Director (HWD). -He did not know why the incident report was not completed when the incident occurred. -On 05/23/25, Resident #5 was yelling at other residents and when the staff attempted to redirect Resident #5, she started shoving the staff. -Resident #5 was eventually taken to her room and her family member was called. -Resident #5's family was helpful in calming her down.	D 273		

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D 273	Continued From page 21 -He did not complete and incident report; he did not know he was supposed to. -He had not called the MHP for any behaviors or outburst related to Resident #5. -He did not know who to call. -No one had instructed him to call Resident #5's MHP and report the incidents/accidents. -He would mention Resident #5's behaviors to the MHP when she visited the facility every 14 days. Interview with a PCA on 05/30/25 at 2:42pm revealed: -She had found Resident #5 in the male resident room on several different occasions. -Resident #5 would either be lying on the bed or going through the resident's personal items. -If the male resident was in his room when Resident #5 entered, the male resident would try to make Resident #5 leave. -Management was aware of Resident #5 wandering into the residents' room. -Staff were told by management to redirect Resident #5, take her outside to walk, or take her to her room so she could nap. -Resident #5 walked through the halls a lot. -Resident #5 would be upset and trying to leave the facility. -The staff would try to re-direct Resident #5; sometimes it worked. -If she could not re-direct Resident #5, she would get the MA to assist. -Resident #5 was always entering residents' rooms. -She had found Resident #5 in 3 different residents' rooms, 2 rooms on A hall and 1 room on C hall. Interview with a MA on 05/29/25 at 3:45pm revealed: -Resident #5 wandered the hallways and went	D 273		

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D 273	Continued From page 22	D 273		

into other residents' rooms.
-Some of the residents did not like her in their rooms.
-One resident had yelled at Resident #5 for being in his room.
-Resident #5 could be redirected out of other residents' rooms.

Interview with a second MA on 05/30/25 at 10:45am revealed:
-Resident #5 wandered the halls, went into other residents' rooms and was exit seeking.
-He could redirect Resident #5 and had to redirect her a lot.
-He also administered her PRN medications as an intervention when she was having behaviors and redirection did not work.
-He would walk the hallways with her or call family for her to talk to.
-She would wander into other resident rooms and get them upset.
-Resident #5's behaviors had increased recently.

Telephone interview with Resident #5's PCP on 05/30/25 at 8:53am revealed:
-Resident #5 had behaviors and increased episodes of hitting other residents and staff.
-Staff had attempted to redirect Resident #5 but she was hard to redirect.
-Resident #5 spent most of her time walking in the facility.
-Resident #5's behaviors had increased due to her dementia.

Telephone interview with the MHP on 05/20/25 at 12:07pm revealed:
-She visited the facility every 14 days to review the psychotropic medications.
-The Staff verbally told her on Wednesday, 05/28/25, when she visited the facility that

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D 273	Continued From page 23 Resident #5 had an incident with another resident on 05/17/25. -She was not told much details about the altercation other than Resident #5 pushed another resident. -She was not aware of any other altercations with residents or staff. -She had not been notified of any other behaviors Resident #5 was having. -She would like to be notified when Resident #5 exhibited behaviors. -She needed to know about Resident #5's behaviors so she could manage Resident #5's medications. -She could have adjusted Resident #5's medications to help control her behaviors. Interview with the RCC on 05/30/25 at 2:30pm revealed: -Resident #5 ambulated in the hallway frequently. -Resident #5 entered bedrooms, touched other resident's belongings and got on their bed. -On 05/17/25, Resident #5 was in a resident's room going through his belongings. -The resident got upset and tried to get Resident #5 to leave his room. -Resident #5 pushed the resident and he fell to the ground and had a skin tear on his arm. -There was another time where Resident #5 went into the same resident's room and he was fussing about her being in his room. -Resident #5 had been in the male resident's room prior to the 05/17/25 incident, and the male resident asked staff to get Resident #5 out of his room. -The staff often went into other resident rooms to get Resident #5 out. -Resident #5 went into other residents' rooms and messed with their belongings; some residents did not mind, and some residents did not like it.	D 273		

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D 273	Continued From page 24 -One resident told her they did not like Resident #5 coming into their room and touching their things. -Resident #5 had pushed a door on a third resident but did not cause an injury. -Resident #5 wandered, went into other residents' rooms, was exit seeking and became easily agitated. -The MHP should have been notified when the incidents or the residents and staff altercations, and the outburst of yelling and screaming occurred. -The MHP was not told about incidents until she visited the facility, and by the time the MHP came to the facility it was too late. -Something could have been done sooner if the MHP was notified. -The MHP should have been notified the day of the incidents, altercations, and outburst to care for Resident #5 appropriately. -Resident #5 could cause harm to herself or others during the incidents, altercations, and outburst; more than a skin tear or scratch. -The MHP could not manage the care of Resident #5 if she was not aware of what was going on. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The MHP should be notified if Resident #5 had a drastic change, such as a resident-to-resident altercation or being sent to the Emergency Department (ED). -Otherwise, the MHP could be notified weekly when she visited the facility. -She did not know the MHP was not aware of resident to resident/staff altercations. -The MHP could not properly treat or adjust medications for Resident #5 if she was not being notified of incidents, altercations, and outburst.	D 273		

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D 273	Continued From page 25 The facility failed to ensure physician notification for a resident (#5) whose mental health provider was not notified of incidents of aggressive behaviors toward other residents and staff, including yelling, wandering in other residents' rooms, lying on other residents' beds, and going through other residents' personal belongings. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/25, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of orders for 1 of 5 sampled residents (#4) related blood pressure checks. The findings are:	D 276	HWD or designee will verify residents records for treatments and/or order from the physician and their implementation. Residents with identified missing documentation were reviewed and records were obtained. HWC and/or designee will audit resident records for order implementation. To assist with ongoing compliance HWD and/or designee will audit resident records once a month for six months. HWD and/or designee will verify referrals and follow up for residents. Residents with identified missing documentation were reviewed and records were obtained. To assist with ongoing compliance the HWD/AED and/or designee will audit resident records and verify physician notification for residents. To assist with compliance AED/HWD or/and designee will review resident records monthly for six months.	7/1/25

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D 276	Continued From page 26 Review of Resident #4's current FL-2 dated 08/06/24 revealed: -Diagnoses included vascular dementia, anxiety, hyperlipidemia and hypertension. -There was an order for lisinopril 10mg once daily hold for systolic blood pressure (SBP) less than 110. -There was an order for metoprolol 50mg once daily hold for SBP less than 110. Review of Resident #4's signed physician's orders dated 02/04/25 revealed: -There was an order for lisinopril 10mg once daily hold for SBP less than 110. -There was an order for metoprolol 50mg once daily hold for SBP less than 110. Review of Resident #4's electronic medication administration record (eMAR) for March 2025 revealed: -There was an entry for lisinopril 10mg once daily hold for SBP less than 110 scheduled at 9:00am. -Lisinopril 10mg was documented as administered once daily from 03/01/25 to 03/31/25. -There were no blood pressure results documented on the lisinopril entry on the eMAR. -There was an entry for metoprolol 50mg once daily hold for SBP less than 110 scheduled at 9:00am. -Metoprolol 50mg was documented as administered once daily from 03/01/25 to 03/31/25. -There were no blood pressure results documented on the metoprolol entry on the eMAR. -There was an entry for blood pressure checks on the 3rd of every month. -On 03/03/25, Resident #4's SBP blood pressure result was documented as 134.	D 276		

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D 276	Continued From page 27 Review of Resident #4's eMAR for April 2025 revealed: -There was an entry for lisinopril 10mg once daily hold for SBP less than 110 scheduled at 9:00am. -Lisinopril 10mg was documented as administered once daily from 04/01/24 to 04/30/25. -There were no blood pressure results documented on the lisinopril entry on the eMAR. -There was an entry for metoprolol 50mg once daily hold for SBP less than 110 scheduled at 9:00am. -Metoprolol 50mg was documented as administered once daily from 04/01/24 to 04/30/25. -There were no blood pressure results documented on the metoprolol entry on the eMAR. -There was an entry for blood pressure checks on the 3rd of every month. -On 04/03/25, Resident #4's SBP blood pressure result was documented as 154. Review of Resident #4's eMAR for May 2025 from 05/01/25 to 05/28/25 revealed: -There was an entry for lisinopril 10mg once daily hold for SBP less than 110 scheduled at 9:00am. -Lisinopril 10mg was documented as administered once daily from 05/01/25 to 05/28/25. -There were no blood pressure results documented on the lisinopril entry on the eMAR. -There was an entry for metoprolol 50mg once daily hold for SBP less than 110 scheduled at 9:00am. -Metoprolol 50mg was documented as administered once daily from 05/01/25 to 05/28/25. -There were no blood pressure results	D 276		

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D 276	Continued From page 28	D 276		

documented on the metoprolol entry on the eMAR.
-There was an entry for blood pressure checks on the 3rd of every month; Resident #4's SBP was not documented on the May 2025 eMAR.

Telephone interview with Resident #4's primary care provider (PCP) on 05/30/25 at 8:53am revealed:
-Resident #4 had order for blood pressure parameters for her lisinopril and her metoprolol were blood pressure medications and affected her heart rate.
-The parameters were to prevent her from taking a medication and lowering blood pressure even more.
-Resident #4's blood pressure should be taken prior to administering her blood pressure medications.
-If she already had low blood pressure and was administered her blood pressure medications, she would be at increased risk for dizziness and risk of falling; the effect would last for about 30 minutes to an hour.
-Resident #4 could not communicate if she felt dizzy or felt bad.
-She expected the facility to follow the order for the parameters on the lisinopril and the metoprolol.

Interview with a medication aide (MA) on 05/29/25 at 3:45pm revealed:
-She followed blood pressure check parameters for medications and held them according to the parameters on the eMAR.
-She documented blood pressure checks on the eMAR when she took them.
-Resident #4 did not have daily blood pressure checks; it did not come up on the eMAR.
-If the blood pressure checks had come up on the

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D 276	Continued From page 29 screen on the eMAR for Resident #2 she would have taken them. -She had not seen the order on the eMAR for Resident #2's metoprolol or lisinopril with blood pressure parameters. Interview with a second MA on 05/30/25 at 10:10am revealed: -Resident #4 did not have daily blood pressures because it did not "pop-up" on the eMAR while he was administering her medications. -He knew Resident had medications with parameters for blood pressures because he saw them on the medication entries on the eMAR. -He did not take Resident #4's blood pressures before administering her lisinopril or her metoprolol because it did not pop-up on the eMAR. -He only monitored her and did blood pressure checks as needed. -He watched Resident #4 to see if she was dizzy or complaints of not feeling well. -She could complain of dizziness or not feeling well but she never had. -He realized he should have taken Resident #4's blood pressure before administering her lisinopril or her metoprolol because it was on the eMAR entry, even if it did not have a place to document. -He had not reported it to the HWD because he did not realize it. Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 11:45am revealed: -She administered medications from the medication carts three times a week. -Resident #4 did not have daily blood pressure checks on the eMAR. -She checked Resident #4's blood pressures because her blood pressure medications had parameters on the eMAR, but she did not	D 276		

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D 276	Continued From page 30 document them because there was nowhere to document them on the eMAR. -Resident #4's blood pressures were usually normal and her lisinopril and metoprolol medications did not have to be held. -The blood pressure results should have been documented on the eMAR so everyone could see them including her PCP. -She did not address there being nowhere to document blood pressure checks because she would get busy and forget until the next time she administered medications.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' right to privacy and to be free from physical abuse and harm for 1 of 5 sampled residents (#6) who had another resident go into his room, look through his belongings, and push him down. The findings are: Review of Resident #6's current FL-2 dated 08/06/24 revealed: -Diagnoses included dementia, major depressive disorder, and atrial fibrillation. -He was intermittently disoriented and semi	D 338	7/1/25 AED and HWD will verify residents are able to lock the door for privacy purposes. The ED or designee have re-educated residents and reminded on locking his door. The HWD or designee will retrained direct care associates on reminding the resident of locking their doors. Direct care staff were re-educated by the HWD or designee on redirecting residents with wandering behaviors. To assist with compliance the AED/ HWC or designee will review training records for all direct care associates once a month for six months.	

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D 338	Continued From page 31 ambulatory. Review of Resident #6's progress notes from 03/25/25 to 05/20/25 revealed: -On 03/25/25, Resident #6 grabbed another resident's arm because she was in his room, and she would not leave his room; the staff separated the two residents. -On 03/27/25, Resident #6 got into an altercation with another resident because the other resident was in his room. -On 05/20/25, there was a late entry by Resident #6's primary care provider (PCP) for a fall and an assault; no date was given for the assault. -Resident #6 fell backwards because another resident pushed him down. -Per Resident #6, there were no injuries and no complaint of pain. -The plan was to keep Resident #6 away from the resident who assaulted him. -Resident #6 was to be monitored closely. -On 05/27/25, Resident #6 was not sleeping well because another resident was yelling out; Resident #6 was reminded to keep his door closed. Review of Resident #6's incident report dated 05/17/25 revealed: -The location of the incident was in Resident #6's room at 6:15pm. -The nature of the incident was alleged aggressive behavior, abuse, neglect or exploitation. -The incident was an unwitnessed, physical resident to resident encounter. -No apparent injury occurred. Review of Resident #6's physician's after visit report dated 05/20/25 revealed: -He was seen as a follow-up to a fall and assault.	D 338		

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D 338	Continued From page 32 -He fell backwards because another resident pushed him down. -No injuries were reported, and he denied any pain. -He was a poor historian due to cognitive impairment. Telephone interview with Resident #6's primary care provider (PCP) on 05/30/25 at 9:45am revealed: -She saw Resident #6 after he was pushed to the ground by another resident. -She could not recall if he had any injuries; she could not see her notes. Telephone interview with Resident #6's power of attorney (POA) on 05/29/25 at 2:45pm revealed: -She was reading Resident #6's progress notes on 05/19/25 and read where Resident #6 had been assaulted by another resident on 05/17/25 which resulted in Resident #6 being pushed and falling. -The facility never notified her of the incident. -There was a certain female resident who frequently went into Resident #6's room. -Resident #6 told her he did not want the female resident in his room. -On 05/17/25, Resident #6 did not want the same resident to enter his room, and he tried to close the door so she could not come in. -The resident pushed Resident #6 to the floor as he tried to close the floor. Interview with a personal care aide (PCA) on 05/30/25 at 2:42pm revealed: -She found another resident in Resident #6's room on several different occasions. -The other resident would lay on Resident #6's bed or go through the Resident #6's personal items.	D 338		

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D 338	Continued From page 33 -If Resident #6 was in his room when the other resident entered, Resident #6 would try to make her leave. -Management was aware that the other resident wandered into the other residents' rooms. Interview with a second PCA on 05/30/25 at 2:52pm revealed: -She worked on 05/17/25, the day of the altercation between Resident #6 and the other resident. -She heard a commotion and when she rounded the corner toward Resident #6's room, she saw the other resident grab Resident #6's wrist. -She separated Resident #6 and the other resident; another PCA walked with the other resident to her room. -She noticed a scratch on Resident #6's right wrist. - Resident #6 stated that Resident #5 was trying to get into his room. -She reported the incident to the medication aide (MA). Interview with a MA on 05/29/25 at 3:45pm revealed: -Resident #6 had yelled at the other resident for being in his room. -The other resident wandered the hallways and went into other residents' rooms and some of the residents did not like her in their room. -The other resident could be redirected out of Resident #6 and other residents' rooms. Interview with a second MA on 05/30/25 at 10:10am revealed: -The other resident walked around a lot and went into other resident's rooms. -It would trigger Resident #6 when the other resident went in his room and got him upset.	D 338		

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D 338	Continued From page 34 -Resident #6 complained about the other resident being in his room and her behaviors. -Resident #6 wanted staff to remove the other resident from his room when she went into his room. -He had only heard of the incident on 05/17/25 from other staff because he did not work that day. Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 2:30pm revealed: -A resident was in Resident #6's room on 05/17/25 going through Resident #6's belongings. -Resident #6 got upset and tried to get Resident #5 to leave his room. -The resident pushed Resident #6 and he fell to the ground. -Resident #6 had a skin tear on his arm. -She bandaged Resident #6's arm and then left for the day. -There was another time where the other resident went into Resident #6's room and Resident #6 was fussing about her being in his room. -The staff had to go into Resident #6 room and get the other resident out. -The resident went into other residents' rooms and messed with their belongings; some residents did not mind, and some residents did not like it. Interview with the Health and Wellness Coordinator (HWD) on 05/30/25 at 5:05pm revealed: -She was not aware of any residents wandering into Resident #6's room prior to the incident on 05/17/25. -On 05/17/25, a resident who had a history of going into other residents' rooms wandered into Resident #6's room and he fell to the floor when she pushed the door open and the door hit him causing him to fall.	D 338		

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D 338	Continued From page 35 -She did not know about a skin tear to his arm. Interview with the Administrator on 05/30/25 at 6:30pm revealed: -Resident #6 did not like the other resident going into his room. -On 05/17/25, the other resident was attempting to get into Resident #6's room and he was trying to stop her when he was knocked to the ground. -She heard there was a small skin tear to his arm. -The resident had gone into Resident #6's room before. -The facility staff was aware Resident #6 did not want that resident in his room. -He had told the staff he did not like her in his room. -Staff would redirect her to keep her out of Resident #6's room. -Sometimes it would take a couple of times to redirect the other resident away from a Resident #6's room. -Some of the residents could have a key and lock their rooms but Resident #6 could not use a key to lock his room because his roommate was not alert and oriented enough to lock the door. Based on observations, interviews and record reviews Resident #6 was not interviewable. The facility failed to ensure the resident's right to privacy and the right to be free from physical abuse from a resident who was known to wander into the resident's room against his wishes and who scratched and pushed him to the floor when he attempted to keep the resident out of his room (#6). This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in	D 338		

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D 338	Continued From page 36 accordance with G.S. 131D-34 on 06/02/25, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2025.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 sampled residents (#1, #2, and #3,) including a cholesterol medication, a sleep aide, two medications for constipation, and a supplement (#1); a medication for pain, a medication to reduce fluid retention, a vitamin supplement, and a medication for anxiety (#2); and a blood pressure (BP) medication, a medication for anxiety, a sleep aide, and a supplement (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 10/22/24 revealed diagnoses included dementia,	D 358	The Health and Wellness Director and/ or Executive Director or designee will audit associate records to verify compliance. The initial audit was completed 6/2/2025. Med Cart audit was completed on 6/26/25 by the HWD or designee. HWD and/or designee will audit Residents records and Physician order summaries to validate order accuracy. Residents with identified missing documentation were reviewed and records were obtained. HWD and/or designee will review and audit documentation. To assist with ongoing compliance, the HWD and/or designee will review Residents records monthly for three months.	7/1/25

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D 358	Continued From page 37 anxiety, malnutrition, paroxysmal atrial fibrillation and gastroesophageal reflux disease (GERD). a. Review of Resident #2's physician's order dated 12/27/24 revealed there was an order for oxycodone (used to treat pain) 5mg every twelve hours as needed (PRN) for pain. Review of Resident #2's physician's order dated 04/17/25 revealed: -There was an order for oxycodone 5mg twice daily. -There was no order to discontinue the oxycodone 5mg every 12 hours PRN for pain. Review of Resident #2's electronic medication administration record (eMAR) for March 2025 revealed: -There was one entry for oxycodone 5mg one tablet every 12 hours as needed for pain; take one tablet twice a day for pain. -There were no scheduled administration times. -Oxycodone was documented as administered PRN four opportunities from 03/01/25 to 03/31/25. -There were no other entries for oxycodone on the eMAR. Review of Resident #2's eMAR for April 2025 revealed: -There was one entry for oxycodone 5mg one tablet every 12 hours as needed for pain; take one tablet twice a day for pain. -There were no scheduled administration times. -Oxycodone was documented as administered PRN four opportunities from 04/01/25 to 04/30/25. -There were no other entries for oxycodone on the eMAR.	D 358		

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D 358	Continued From page 38 Review of Resident #2's eMAR for May 2025 from 05/01/25 to 05/28/25 revealed: -There was one entry for oxycodone 5mg one tablet every 12 hours as needed for pain; take one tablet twice a day for pain. -There were no scheduled administration times. -Oxycodone was documented as administered PRN eight opportunities from 05/01/25 to 05/28/25. -There were no other entries for oxycodone on the eMAR. Observation of Resident #2's medication on hand on 05/28/25 at 3:57pm revealed: -There were 60 tablets of oxycodone 5mg administer one tablet twice daily dispensed in two bubble packs on 05/23/25; 30 tablets were dispensed in each bubble pack. -There were 30 of 30 tablets of oxycodone 5mg available for administration in one bubble package. -There were 27 of 30 oxycodone 5mg tablets available for administration in the second bubble package. -There were no other bubble packs of oxycodone 5mg on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 10:10am revealed: -Resident #2 had a current order dated 04/17/25, for oxycodone 5mg scheduled twice daily. -On 04/17/25 60 tablets of oxycodone 5mg were dispensed in two cards; thirty tablets were dispensed in each card. -On 05/23/25, 60 tablets of oxycodone 5mg were dispensed in two cards; thirty tablets were dispensed in each card. -Resident #2 did not have a current order for oxycodone 5mg PRN; it was discontinued	D 358		

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D 358	Continued From page 39 04/17/25 and changed to scheduled twice daily. -Oxycodone was ordered to relieve pain; if oxycodone was not administered as ordered Resident #2 could have lack of relief from her pain. Telephone interview with Resident #2's power of attorney (POA) on 05/29/25 at 2:40pm revealed Resident #2 could verbally communicate when she was in pain. Telephone interviews with Resident #2's hospice nurse on 05/30/25 at 1:58pm and 3:20pm revealed: -Resident #2 had a pressure ulcer below her coccyx bone that was healing. -Resident #2 did not have a PRN order for oxycodone 5mg every 12 hours as needed for pain. -Resident #2's oxycodone order had been changed to scheduled administration to better manage her pain. -She expected Resident #2's medication to be administered ordered. Interview with a medication aide (MA) on 05/29/25 at 3:45pm revealed: -Resident #2 had a PRN order for oxycodone but it was scheduled now. -The scheduled oxycodone should have had a separate entry on the eMAR. -She had noticed Resident #2's orders for the PRN and scheduled oxycodone were on the same entry. -She could not find a separate entry for the scheduled oxycodone on the eMAR, so she documented administration only on the controlled substance count sheet (CSCS). -She told the MA on the next shift and the Health and Wellness Director (HWD) about the	D 358		

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oxycodone entry; she could not recall when.
-She administered Resident #2's oxycodone twice daily because it was on the label on the bubble pack.

Interview with a second MA on 05/30/25 at 10:10am revealed:
-He administered Resident #2's oxycodone as a PRN because that was the way it was entered on the eMAR.
-He compared the label on the bubble pack to the eMAR and the CSCS before he administered the oxycodone.
-He had not noticed the entry on the eMAR for oxycodone until today; it had a PRN order and a scheduled order on the same entry.
-Resident #2 could tell you if she had pain; he also monitored her to see if she moaned or cried out "pain".
-The way the entry was written on the eMAR was open to interpretation.
-He had only administered oxycodone to Resident #2 as a PRN and not twice daily as scheduled.
-He had missed that the label on the bubble pack and the eMAR did not match.

Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 2:30pm revealed:
-Resident #2's oxycodone order on the eMAR was confusing.
-She was not sure which order was correct.
-She administered oxycodone as a PRN because there were no scheduled times on the eMAR.
-She was supposed to compare the label on the oxycodone bubble pack to the eMAR.
-She had not administered Resident #2's oxycodone as scheduled, only as a PRN.
-She did not realize the order on the label on the bubble pack of oxycodone and the CSCS were for scheduled oxycodone.

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D 358	Continued From page 41 -Resident #2 had not been in any pain that she was aware of. Interview with the HWD on 05/30/25 at 4:15pm revealed: -The MAs should come to her immediately with concerns with eMAR entries. -Resident #2's oxycodone order was updated and the previous RCC put the scheduled dose on the entry for the PRN in the eMAR. -The entry was an error and the oxycodone not being administered twice daily as ordered was an error. -She was concerned Resident #2 was in pain from her pressure ulcer and they were not managing it. -Resident #2 could not tell staff if she was in pain but staff could see if she was showing symptoms of pain if she grimaced or cried out in pain. -She had compared the eMAR report to the CSCS, but she had not caught the error until today when a MA brought it to her attention. Interview with the Administrator on 05/30/25 at 5:55pm revealed: -The MAs should have questioned the twice daily PRN and every twelve hours on the same entry for Resident #2's oxycodone. -Her concern for Resident #2 was she was nonverbal and she could not say if she was in pain. -If Resident #2's oxycodone was not being administered twice a day as ordered the facility might not be managing her pain. Based on observations, interviews and record reviews Resident #2 was not interviewable. b. Review of Resident #2's current FL-2 dated 10/22/24 revealed there was an order for	D 358		

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D 358	Continued From page 42 furosemide (used to treat fluid retention) 20mg once daily. Review of Resident #2's physician's orders dated 05/06/25 revealed there was an order to discontinue furosemide 20mg once daily and to start furosemide 20mg once daily PRN for edema (swelling in the body's tissues). Review of Resident #2's eMAR for May 2025 from 05/01/25 to 05/28/25 revealed: -There was an entry for furosemide 20mg once daily scheduled at 8:30am. -Resident #2's furosemide 20mg was documented as administered daily at 8:30am for 28 of 28 opportunities from 05/01/25 to 05/28/25. -There was no entry for furosemide 20mg PRN for edema on the eMAR. Observation of Resident #2's medication on hand on 05/28/25 at 3:57pm revealed: -There were 28 tablets of furosemide 20mg with label instruction to take once daily dispensed on 05/15/25. -There were 14 tablets of furosemide available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 10:10am revealed: -Resident #2 had a current order for furosemide 20mg once daily dated 08/07/24. -Resident #2 did not have an order for furosemide 20mg PRN. -Resident #2's furosemide was on a monthly cycle fill. -Twenty-eight tablets of furosemide were dispensed on 04/17/25 and 05/15/25. -Furosemide was used to treat edema by pulling additional fluid out of the body.	D 358		

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D 358	Continued From page 43 Telephone interview with Resident #2's hospice nurse on 05/30/25 at 1:58pm revealed: -Resident #2's scheduled furosemide 20mg was discontinued on 05/06/25 and changed to PRN for edema. -Resident #2 was mostly bedbound and in a reclining position so she did not have swelling. -The furosemide was PRN for the times she would sit up and have some swelling. Interview with a MA on 05/30/25 at 10:10am revealed: -Resident #2's furosemide was scheduled and not PRN. -Resident #2's furosemide dose was 20mg once daily. -He did not know why there were tablets of furosemide missing from Resident #2's bubble pack. Interview with the RCC on 05/30/25 at 2:30pm revealed: -She was not aware Resident #2's furosemide order had changed to PRN. -She did not do anything with medication orders, the HWD sent them to the pharmacy. -The facility staff had been administering Resident #2's furosemide wrong. Interview with the HWD on 05/30/25 at 4:15pm revealed: -She was not aware the hospice physician had discontinued Resident #2's scheduled order for furosemide and started a new order for PRN. -She had not seen the order in Resident #2's record. -It should have been changed the day it was written, or the next day. -The orders were simply missed.	D 358		

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D 358	Continued From page 44 -She was concerned they were removing fluids off Resident #2 when she did not need fluids removed. Interview with the Administrator on 05/30/25 at 5:55pm revealed Resident #2's furosemide order should have been changed on the eMAR and sent to the pharmacy as soon as the primary care provider (PCP) wrote the new order. Based on observations, interviews and record reviews Resident #2 was not interviewable. c. Review of Resident #2's physician's order dated 02/21/25 revealed an order for Vitamin A (used to support soft tissue and skin health) 700mcg twice daily. Review of Resident #2's eMAR for March 2025 revealed: -There was an entry for Vitamin A 700mcg twice daily scheduled at 8:00am and 8:00pm. -Vitamin A 700mcg was documented as administered 62 of 62 opportunities from 03/01/25 to 03/31/25. -There were no other entries for Vitamin A on the eMAR. Review of Resident #2's eMAR for April 2025 revealed: -There was an entry for Vitamin A 700mcg twice daily scheduled at 8:00am and 8:00pm. -Vitamin A 700mcg was documented as administered 59 of 60 opportunities from 04/01/25 to 04/30/25. -There were no other entries for Vitamin A on the eMAR. Review of Resident #2's eMAR for May 2025 from 05/01/25 to 05/28/25 revealed:	D 358		

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D 358	Continued From page 45 -There was an entry for Vitamin A 700mcg twice daily scheduled at 8:30am and 8:00pm. -Vitamin A 700mcg was documented as administered 54 of 55 opportunities from 05/01/25 to 05/28/25. -There were no other entries for Vitamin A on the eMAR. Observation of Resident #2's medication on hand on 05/30/25 at 10:10am revealed: -There was an over the counter (OTC) bottle of Vitamin A 2400mcg with the resident's first name written on the label; there were originally 100 liquid capsules in the bottle. -There were 30 capsules of Vitamin A available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 10:10am revealed: -Resident #2 had an order for Vitamin A 700mcg dated 02/21/25 but they could not supply the dose from the pharmacy; they informed the facility they could not supply the Vitamin A on 02/22/25. -Resident #2's Vitamin A was never dispensed from the pharmacy. Telephone interview with Resident #2 POA on 05/30/25 at 8:30am revealed: -Someone from the facility asked him to provide Resident #2's Vitamin A. -He was told the dosage of Vitamin A to purchase but he could not recall what the dosage was. -He purchased an OTC bottle of Vitamin A and gave it to the facility about two months ago. -He thought there were 100 capsules in the OTC bottle of Vitamin A he purchased. Telephone interview with Resident #2's hospice nurse on 05/30/25 at 3:20am revealed:	D 358		

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D 358	Continued From page 46 -There was an order from the hospice physician for Vitamin A 700mcg twice daily for wound care. -Resident #2 had a pressure ulcer on her coccyx. -The order was not for Vitamin A 2400mcg. -The facility had not contacted her about the dosage. -Toxicity from too much Vitamin A was rare but could happen over a long period of time. -She expected Resident #2's medication to be administered as the order was written. Interview with a MA on 05/29/25 at 3:45pm revealed: -She saw Resident #2's Vitamin A order on the eMAR but she did not find the medication on the cart. -The Vitamin A was a new order, and the medication was on order from the pharmacy. -The other MAs reported at shift change Resident #2's Vitamin A was not on the cart and on order. -She did not tell the HWD about the Vitamin A because it was on order. Interview with a second MA on 05/30/25 at 10:10am revealed: -He administered Resident #2's Vitamin A in the mornings. -He was not aware the dosage on the label did not match the eMAR. -He thought he had checked the dosage on the label on the bottle to the eMAR before he administered the Vitamin A. -If he had caught the dosages were different he would have not administered the Vitamin A and would have notified the HWD. -He did not know how to explain how he missed the incorrect dosage on the bottle; he was overwhelmed and went too fast while administering medications.	D 358		

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D 358	Continued From page 47 Interview with the RCC on 05/30/25 at 2:30pm revealed: -She administered Resident #2's medications three times a week in the mornings. -She compared the label on the bottle of Vitamin A to the eMAR. -The POA had brought a new bottle; she did not recall when. -She had not realized the dose on the Vitamin A bottle did not match the eMAR; none of the staff had caught it. -She should have paid attention and caught the different dosages. -She would have removed the bottle from the medication cart if it had been caught. -It should have been caught during a cart audit. -She had administered the incorrect dosage of Vitamin A to Resident #2. Interview with the HWD on 05/30/25 at 4:15pm revealed: -The pharmacy had let her know Resident #2's Vitamin A was not covered when the order was written. -She reached out to Resident #2's POA to purchase an OTC Vitamin A. -The POA brought in a different dose; the dosage of the OTC bottle of Vitamin A should have been checked before it was placed on the medication cart. -The MAs should have checked the dosage on the label of the OTC bottle before they administered it. -The MAs should have questioned the dosage and notified her; they should have not administered the wrong dosage of Vitamin A. -None of the MAs came to her about the wrong dose of Vitamin A. -The Vitamin A was ordered with other	D 358		

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D 358	Continued From page 48 supplements to help Resident #2's wound heal. Interview with the Administrator on 05/30/25 at 5:55pm revealed: -The MAs were not reading the orders on the eMAR and comparing them to the order on the medication. -The MAs or the HWD should have discovered the incorrect dose on Resident #2's Vitamin A bottle while they were administering her medications. -The MAs were giving Resident #2 too much Vitamin A and it should have been caught in the two months they had the OTC bottle. Based on observations, interviews and record reviews Resident #2 was not interviewable. d. Review of Resident #2's current FL-2 dated 10/22/24 revealed there was an order for quetiapine (used to treat anxiety) 25mg twice daily. Review of Resident #2's physician's order dated 01/03/25 revealed quetiapine 25mg was changed to once daily. Review of Resident #2's physician's order dated 01/31/25 revealed a discontinue order for quetiapine 25mg once daily. Review of Resident #2's physician's order dated 05/06/25 revealed an order to discontinue quetiapine 25mg and start quetiapine 50mg. Review of Resident #2's physician's order dated 05/07/25 revealed an order to discontinue quetiapine 50mg and start quetiapine 25mg at bedtime.	D 358		

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D 358	Continued From page 49 Review of Resident #2's eMAR for March 2025 and April 2025 revealed: -There were no entries for quetiapine. -There was no documentation quietapine was administered. Review of Resident #2's May 2025 eMAR from 05/01/25 to 05/28/25 revealed: -There was an entry was for quetiapine 25mg once daily at bedtime for insomnia scheduled at 8:00pm; the entry began on 05/08/25. -There was documentation quetiapine 25mg was administered 20 of 20 opportunities from 05/08/25 to 05/27/25. -The second entry was for quetiapine 50mg once daily at bedtime for insomnia scheduled at 8:00pm; the entry began on 05/08/25. -There was no documentation of administration on the entry for quetiapine 50mg. Observation of Resident #2's medication on hand on 05/28/25 at 3:57pm revealed: -There were 28 tablets of quetiapine 25mg once daily at bedtime for agitation dispensed on 05/12/25. -There were 9 tablets available for administration. -There was a handwritten bracket on the bubble pack between pill number 25 and 26; 50mg was written beside the bracket. Based on the dispense date of 05/12/25 and the documentation on the May 2025 eMAR from 05/13/25 to 05/27/25, 15 tablets of quetiapine were administered and observation of the medication on hand revealed 19 tablets were administered from 05/13/25 to 05/27/25. Resident #2 was administered 50mg of quetiapine on four days. Telephone interview with a pharmacist from the	D 358		

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D 358	Continued From page 50 facility's contracted pharmacy on 05/29/25 at 10:10am revealed: -Resident #2 had an order dated 05/07/25 for quetiapine 25mg once daily. -On 05/09/25, six tablets of quetiapine 25mg were dispensed until the next cycle fill. -On 05/12/25, 28 tablets of quetiapine 25mg were dispensed; the bubble pack was delivered to the facility at 5:00am on 05/13/25. -Quetiapine was an antipsychotic medication but could be ordered for anxiety or sleep. Telephone interview with Resident #2's POA on 05/29/25 at 2:40pm revealed: -Resident #2 got agitated at times as part of her dementia. -Resident #2 had trouble sleeping at night. -Resident #2 was ordered a medication for her insomnia. -Resident #2 was sleeping better at night since taking the medication. Telephone interview with Resident #2's hospice nurse on 05/30/25 at 3:20am revealed: -Resident #2 had an order for quetiapine 25mg once daily for insomnia and agitation. -Higher dosages of quetiapine would cause Resident #2 to sleep more and be groggier. -Her concern was Resident #2 would engage less and eat less if she was administered more quetiapine. -The facility had not reached out to her to request an increase in the dosage or to give an extra dose. -She expected Resident #2's medication to be administered as ordered. Interview with a MA on 05/30/25 at 5:35pm revealed: -Quetiapine was on Resident #2's eMAR two	D 358		

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D 358	Continued From page 51 times one for 25mg and one entry for 50mg. -There was a box on the eMAR beside the two entries; she clicked on the box to acknowledge there were two entries. -She matched the order on the quetiapine bubble pack to the eMAR before she administered Resident #2 her medication. -The order on the bubble pack was for quetiapine 25mg once daily so that was the entry she documented administration on. -She noticed someone had written 50mg and a bracket on the bubble pack of quetiapine 25mg tablets. -She did not know where the four missing tablets of quetiapine were. Interview with the RCC on 05/30/25 at 2:30pm revealed: -She did not know why Resident #2 had missing quetiapine tablets. -Resident #2 did not have a PRN order for her quetiapine; she should have only been administered her quetiapine when it was scheduled to be administered. -A tablet could have been dropped and replaced; dropped medications were not documented anywhere. -There should not have been extra tablets missing from the bubble pack. Interview with the HWD on 05/30/25 at 4:15pm revealed: -Resident #2 had an order from hospice for quetiapine 50mg once daily on 05/06/25. -She spoke to hospice about the dosage and hospice changed the dosage to quetiapine 25mg once daily the very next day, 05/07/25. -She spoke to the hospice nurse about the dosage change because she did not want Resident #2 to have that much and be too sleepy	D 358		

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D 358	Continued From page 52 during the day. -There were two entries on the eMAR for quetiapine because staff did not remove the entry for quetiapine 50mg. -Staff should have administered quetiapine 25mg as ordered. -She did not know why there were extra tablets missing and she did not know why staff had written 50mg on the bubble pack. -Staff were not comparing the medication order on the label for the quetiapine to the order in the eMAR. -She had not observed or had any reports of Resident #2 being sleepy or hard to wake up. Interview with the Administrator on 05/30/25 at 5:55pm revealed: -The orders in the eMAR should be correct and the MA, the RCC or the HWD should have caught the double orders. -Four missing tablets of quetiapine could mean Resident #2 was over medicated and given 50mg of quetiapine instead of the 25mg. -The MAs needed to slow down and compare the order on the medication card to the eMAR. -She expected the MAs to administer medications as ordered by the PCP. Based on observations, interviews and record reviews Resident #2 was not interviewable. Refer to the interview with a MA on 05/28/25 at 2:32pm. Refer to the interview with a second MA on 05/30/25 at 11:44am. Refer to the interview with the HWD on 05/29/25 at 12:56pm.	D 358		

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D 358	Continued From page 53 Refer to the interview with the Administrator on 05/30/25 at 5:13pm. 2. Review of Resident #3's current FL-2 dated 09/17/24 revealed diagnoses included aortic valve stenosis, hypertension, anxiety, severe dementia, and chronic obstructive pulmonary disease (COPD). a. Review of Resident #3's hospital discharge summary dated 02/18/25 revealed there was an order for hydroxyzine 25mg (used to treat anxiety) at bedtime. Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed: -There was no entry for hydroxyzine 25mg at bedtime. -There was no documentation hydroxyzine 25mg was administered at bedtime from 03/01/25 to 03/31/25. Review of Resident #3's April 2025 eMAR revealed: -There was no entry for hydroxyzine 25mg at bedtime. -There was no documentation hydroxyzine 25mg was administered at bedtime from 04/01/25 to 04/30/25. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was no entry for hydroxyzine 25mg at bedtime. -There was no documentation hydroxyzine 25mg was administered at bedtime from 05/01/25 to 05/27/25. Observation of Resident #3's medication on hand	D 358		

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D 358	Continued From page 54 on 05/28/25 at 2:29pm revealed there were no hydroxyzine 25mg tablets available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed the pharmacy did not receive an order for hydroxyzine 25mg at bedtime for Resident #3. Interview with a medication aide (MA) on 05/30/25 at 4:33pm revealed: -She had not seen an order for hydroxyzine 25mg at bedtime for Resident #3. -Resident #3 had an order for lorazepam (used to treat anxiety) that started in May 2025. -She had administered lorazepam to Resident #3 when she would get anxious. Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/30/25 at 9:27am revealed -Resident #3 could have increased anxiety since she did not receive hydroxyzine as ordered. -She expected hydroxyzine 25mg at bedtime to be administered as ordered. b. Review of Resident #3's hospital discharge summary dated 02/18/25 revealed there was an order for melatonin 3mg (used as a sleep aide) at bedtime. Review of Resident #3's March 2025 eMAR revealed: -There was no entry for melatonin 3mg at bedtime. -There was no documentation melatonin 3mg was administered at bedtime from 03/01/25 to 03/31/25.	D 358		

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D 358	Continued From page 55 Review of Resident #3's April 2025 eMAR revealed: -There was no entry for melatonin 3mg at bedtime. -There was no documentation melatonin 3mg was administered at bedtime from 04/01/25 to 04/30/25. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was no entry for melatonin 3mg at bedtime. -There was no documentation melatonin 3mg was administered at bedtime from 05/01/25 to 05/27/25. Observation of Resident #3's medication on hand on 05/28/25 at 2:29pm revealed there were no melatonin 3mg tablets available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed the pharmacy did not receive an order for melatonin 3mg at bedtime for Resident #3. Interview with a MA on 05/30/25 at 4:33pm revealed: -Resident #3 did not have an entry in the eMAR for melatonin 3mg at bedtime. -She only administered the medications that were entered into the eMAR. -She did not know Resident #3 had an order for melatonin 3mg on her hospital discharge summary that had not been entered into the eMAR. Interview with another MA on 05/30/25 at 10:17am revealed Resident #3 slept well most	D 358		

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D 358	Continued From page 56 nights. Telephone interview with Resident #3's PCP on 05/30/25 at 9:27am revealed: -Resident #3 could have issues sleeping at night if she was not administered the medication as ordered. -She expected melatonin 3mg a bedtime to be administered to as ordered. c. Review of Resident #3's hospital discharge summary dated 02/18/25 revealed there was an order for metoprolol tartrate 25mg (used to treat BP) daily. Review of Resident #3's March 2025 eMAR revealed: -There was no entry for metoprolol tartrate 25mg daily. -There was no documentation metoprolol tartrate 25mg was administered daily from 03/01/25 to 03/31/25. -There was an entry to check vital signs monthly. -There was documentation of a BP reading of 136/63 on 03/02/25. Review of Resident #3's April 2025 eMAR revealed: -There was no entry for metoprolol tartrate 25mg daily. -There was no documentation metoprolol tartrate 25mg was administered daily from 04/01/25 to 04/30/25. -There was an entry to check vital signs monthly. -There was documentation of a BP reading of 143/78 on 04/02/25. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was no entry for metoprolol tartrate 25mg	D 358		

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D 358	Continued From page 57 daily. -There was no documentation metoprolol tartrate was administered daily from 05/01/25 to 05/27/25. -There was an entry to check vital signs monthly. -There was documentation of a BP reading of 138/72 on 05/02/25. Observation of Resident #3's medication on hand on 05/28/25 at 2:29pm revealed there were no metoprolol tartrate 25mg tablets available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed the pharmacy did not receive an order for metoprolol tartrate 25mg daily for Resident #3. Observation of Resident #3's BP reading on 05/30/25 at 1:18pm revealed a BP reading of 144/60. Interview with a MA on 05/30/25 at 11:44am revealed: -He did not know Resident #3 was ordered a BP medication daily. -Resident #3's BP was never elevated. -If the medication was not listed on the eMAR he did not know to look for the medication in the medication cart. Telephone interview with Resident #3's PCP on 05/30/25 at 9:27am revealed: -Resident #3 could have an increase in her BP since the medication was not implemented and administered as ordered. -She expected metoprolol tartrate 25mg to be administered as ordered.	D 358		

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D 358	Continued From page 58 d. Review of Resident #3's hospital discharge summary dated 02/18/25 revealed there was an order for a multivitamin (a supplement) daily. Review of Resident #3's March 2025 eMAR revealed: -There was no entry for a multivitamin daily. -There was no documentation a multivitamin was administered daily from 03/01/25 to 03/31/25. Review of Resident #3's April 2025 eMAR revealed: -There was no entry for a multivitamin daily. -There was no documentation a multivitamin was administered daily from 04/01/25 to 04/30/25. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was no entry for a multivitamin daily. -There was no documentation a multivitamin was administered daily from 05/01/25 to 05/27/25. Observation of Resident #3's medication on hand on 05/28/25 at 2:29pm revealed there were no multivitamin tablets available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed: -The pharmacy did not receive an order for a multivitamin daily for Resident #3. -The pharmacy did not receive a discharge summary with new medication orders for Resident #3 dated 02/18/25. Interview with a MA on 05/30/25 at 11:44am revealed: -He did not know Resident #3 was ordered a multivitamin daily. -All new orders should be entered on the eMAR	D 358		

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D 358	Continued From page 59 and faxed to the pharmacy. -If the medication was not on the eMAR he would not know to administer the medication or to look for the medication in the medication cart. Telephone interview with Resident #3's PCP on 05/30/25 at 9:27am revealed she expected the facility to implement all orders on the hospital discharge summary when the resident returned from the hospital. Interview with the Health Wellness Director (HWD) on 05/29/25 at 12:56pm revealed: -She did not review Resident #3's hospital discharge summary dated 02/18/25. -The hospital discharge summary was initialed by the previous HWC which indicated that the previous HWC reviewed the hospital discharge summary. -The previous HWC did not follow through with the new medication orders written on 02/18/25. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to the interview with a MA on 05/28/25 at 2:32pm. Refer to the interview with a second MA on 05/30/25 at 11:44am. Refer to the interview with the HWD on 05/29/25 at 12:56pm. Refer to the interview with the Administrator on 05/30/25 at 5:13pm. 3. Review of Resident #1's current FL-2 dated 12/10/24 revealed diagnoses included	D 358		

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D 358	Continued From page 60 Alzheimer's disease, hyperlipidemia, hypertension, and osteoporosis. a. Review of Resident #1's hospital discharge summary dated 03/03/25 revealed there was an order for atorvastatin 10mg (use to lower cholesterol) daily. Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin 20mg was administered daily from 03/04/25 to 03/31/25. -There were exceptions documented from 03/01/25 to 03/03/25; the exception was the resident was in the hospital. -There was no entry for atorvastatin 10mg daily. Review of Resident #1's April 2025 eMAR revealed: -There was an entry for atorvastatin 20mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin 20mg was administered daily from 04/01/25 to 04/30/25. -There was no entry for atorvastatin 10mg daily. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was an entry for atorvastatin 20mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin 20mg was administered daily from 05/01/25 to 05/27/25. -There was no entry for atorvastatin 10mg daily. Observation of Resident #1's medication on hand	D 358		

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D 358	Continued From page 61 on 05/28/25 at 2:26pm revealed: -There was a punch card containing 16 of 28 atorvastatin 20mg tablets dispensed on 05/15/25 available for administration. -There was atorvastatin 10mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed: -The pharmacy had an order for atorvastatin 20mg daily dated 02/19/25 for Resident #1. -The pharmacy dispensed 28 atorvastatin 20mg tablets, a 28-day supply, on 03/20/25, 04/17/25, and 05/15/25. -The pharmacy did not have an order for atorvastatin 10mg daily. Interview with a medication aide (MA) on 05/30/25 at 11:44am revealed he administered atorvastatin 20mg to Resident #1 because that was the medication on the medication cart and it matched what was on the eMAR. Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/30/25 at 9:27am revealed: -She did not know why atorvastatin was decreased from 20mg to 10mg on the hospital discharge summary. -She expected the facility to follow all orders on the hospital discharge summary until she saw Resident #1. b. Review of Resident #1's hospital discharge summary dated 03/03/25 revealed there was an order for melatonin 3mg (used as a sleep aide) give 2 tablets (6mg) at bedtime. Review of Resident #1's March 2025 eMAR from	D 358		

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D 358	Continued From page 62 03/04/25 to 03/31/25 revealed: -There was an entry for melatonin 3mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation melatonin 3mg was administered 27 of 30 opportunities from 03/04/25 to 03/31/25. -There were exceptions documented; the exceptions were the resident was in the hospital, the medication was not available for administration, and one was blank. -There was no entry for melatonin 3mg give 2 tablets at bedtime. Review of Resident #1's April 2025 eMAR revealed: -There was an entry for melatonin 3mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation melatonin 3mg was administered from 04/01/25 to 04/30/25. -There was no entry for melatonin 3mg give 2 tablets at bedtime. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was an entry for melatonin 3mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation melatonin 3mg was administered from 05/01/25 to 05/27/25. -There was no entry for melatonin 3mg give 2 tablets at bedtime. Observation of Resident #1's medication on hand on 05/28/25 at 2:26pm revealed: -There was a punch card containing 16 of 28 melatonin 3mg tablets one tablet at bedtime dispensed on 05/15/25 available for administration.	D 358		

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D 358	Continued From page 63 -There was no punch card of melatonin 3mg give 2 tablets at bedtime available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed: -The pharmacy had an order for melatonin 3mg tablets, take one every night dated 12/23/24 for Resident #1. -The pharmacy dispensed 28 melatonin 3mg every night, a 28-day supply, on 03/20/25, 04/17/25, and 05/15/25. -The pharmacy did not have an order for melatonin 3mg two tablets at night. Interview with a MA on 05/30/25 at 4:33pm revealed: -Resident #1's eMAR read melatonin 3mg at bedtime. -Resident #1 had melatonin 3mg in the medication cart. -She administered melatonin 3mg to Resident #1. -She did not administer 2 tablets of melatonin 3mg to Resident #1. -There was not an entry in the eMAR to administer 2 tablets of melatonin to Resident #1. Interview with a second MA on 05/30/25 at 10:17am revealed Resident #1 did not have problems sleeping if night. Telephone interview Resident #1's PCP on 05/30/25 at 9:27am revealed she had not received any reports that Resident #1 was having problems sleeping. c. Review of Resident #1's hospital discharge summary dated 03/03/25 revealed there was an order for polyethylene glycol (used to treat constipation) one packet in 4 to 8 ounces (oz) of	D 358		

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D 358	Continued From page 64 fluid daily. Review of Resident #1's March 2025 eMAR from 03/03/25 to 03/31/25 revealed: -There was no entry for polyethylene glycol one packet in 4 to 8 oz of fluid daily scheduled for administration. -There was no documentation polyethylene glycol was administered daily from 03/03/25 to 03/31/25. Review of Resident #1's April 2025 eMAR revealed: -There was no entry for polyethylene glycol one packet in 4 to 8 oz of fluid daily scheduled for administration. -There was no documentation polyethylene glycol was administered daily from 04/01/25 to 04/30/25. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was no entry for polyethylene glycol one packet in 4 to 8 oz of fluid daily scheduled for administration. -There was no documentation polyethylene glycol was administered daily from 05/01/25 to 05/27/25. Observation of Resident #1's medication on hand on 05/28/25 at 2:25pm revealed there was no polyethylene glycol packets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed: -The pharmacy did not receive an order for polyethylene glycol one packet in 4 to 8 oz of fluid daily for Resident #1.	D 358		

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D 358	Continued From page 65 -The pharmacy had not dispensed polyethylene glycol packets for daily administration for Resident #1. Interview with a MA on 05/30/25 at 11:44am revealed: -He did not know Resident #1 was ordered polyethylene glycol one packet in 4 to 8 oz of fluid daily. -All new orders should be entered on the eMAR and faxed to the pharmacy. Telephone interview with Resident #1's PCP on 05/30/25 at 9:27am revealed: -She had not received any reports that Resident #1 was having problems with constipation. -She expected the facility to follow all orders on the hospital discharge summary until she saw Resident #1. d. Review of Resident #1's hospital discharge summary dated 03/03/25 revealed there was an order for sennosides-docusate 8.6-50mg (used to treat constipation) two tablets twice daily. Review of Resident #1's March 2025 eMAR from 03/03/25 to 03/31/25 revealed: -There was no entry for sennosides-docusate 8.6-50mg two tablets twice daily scheduled for administration. -There was no documentation sennosides-docusate was administered twice daily from 03/03/25 to 03/31/25. Review of Resident #1's April 2025 eMAR revealed: -There was no entry for sennosides-docusate 8.6-50mg two tablets twice daily scheduled for administration. -There was no documentation	D 358		

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D 358	Continued From page 66 sennosides-docusate was administered twice daily from 04/01/25 to 04/30/25. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/28/25 revealed: -There was no entry for sennosides-docusate 8.6-50mg two tablets twice daily scheduled for administration. -There was no documentation sennosides-docusate was administered twice daily from 05/01/25 to 05/28/25. Observation of Resident #1's medication on hand on 05/28/25 at 2:25pm revealed there was no sennosides-docusate 8.6-50mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed: -The pharmacy did not receive an order for sennosides-docusate 8.6-50mg two tablets twice daily for Resident #1. -The pharmacy had not dispensed sennosides-docusate 8.6-50mg tablets for administration for Resident #1. Interview with a MA on 05/30/25 at 11:44am revealed: -He did not know Resident #1 was ordered sennosides-docusate 8.6-50mg two tablets twice daily. -All new orders should be entered on the eMAR and faxed to the pharmacy. Telephone interview Resident #1's PCP on 05/30/25 at 9:27am revealed she had not received any reports that Resident #1 was having problems with constipation.	D 358		

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D 358	Continued From page 67 e. Review of Resident #1's hospital discharge summary dated 03/03/25 revealed there was an order for magnesium oxide 400mg (used as a supplement) daily. Review of Resident #1's March 2025 eMAR from 03/04/25 to 03/31/25 revealed: -There was no entry for magnesium oxide 400mg daily scheduled for administration. -There was no documentation magnesium oxide twice daily was administered from 03/04/25 to 03/31/25. Review of Resident #1's April 2025 eMAR revealed: -There was no entry for magnesium oxide 400mg daily scheduled for administration. -There was no documentation magnesium oxide twice daily was administered from 04/01/25 to 04/30/25. Review of Resident #1's May 2025 eMAR from 05/01/25 to 05/28/25 revealed: -There was no entry for magnesium oxide 400mg daily scheduled for administration. -There was no documentation magnesium oxide twice daily was administered from 05/01/25 to 05/28/25. Observation of Resident #1's medication on hand on 05/28/25 at 2:25pm revealed there were no magnesium oxide 400mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed: -The pharmacy did not receive an order for magnesium oxide 400mg daily for Resident #1. -The pharmacy had not dispensed magnesium	D 358		

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D 358	Continued From page 68 oxide 400mg tablets for administration for Resident #1. Interview with a MA on 05/29/25 at 3:43pm revealed she did not recall reviewing Resident #1's hospital discharge summary. Interview with a second MA on 05/30/25 at 11:44am revealed: -He did not know Resident #1 was ordered magnesium oxide 400mg daily. -All new orders should be entered on the eMAR and faxed to the pharmacy. Telephone interview with Resident #1's PCP on 05/30/25 at 9:27am revealed: -Resident #1 was probably started on magnesium oxide 400mg because of her lab values, but she could not recall what the lab values were. -She expected magnesium oxide 400mg to be administered as ordered. Telephone interview with a representative from the facility's contracted pharmacy on 05/28/25 at 4:45pm revealed the pharmacy did not receive a discharge summary with medication orders dated 03/04/25. Interview with a MA on 05/29/25 at 3:43pm revealed she did not recall reviewing Resident #1's hospital discharge summary. Interview with the Health and Wellness Director (HWD) on 05/29/25 at 12:56pm revealed she did not review Resident #1's hospital discharge summary dated 03/04/25. Attempted telephone interview with Resident #1's family member on 05/29/25 at 2:57pm was unsuccessful.	D 358		

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D 358	Continued From page 69 Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Interview with a MA on 05/29/25 at 3:43pm revealed: -She reviewed the hospital discharge summary, made a copy of the orders and faxed the orders to the pharmacy. -She did not enter medication orders into the eMAR; the HWD and the 1st shift MA entered orders into the eMAR. -She placed the hospital discharge summary in the PCP's folder for review. Interview with a second MA on 05/30/25 at 11:44am revealed: -When a resident returned from the hospital the hospital discharge summary should be given to the HWD. -If the HWD was not in the facility, the MA should review the hospital discharge summary for new orders. -If there were new orders the HWD should be contacted so she could add the new orders to the electronic system. -He would send a picture of the orders to the HWD so she could enter the new orders into the eMAR. -He had worked at the facility less than 2 months and did not feel comfortable entering orders into the eMAR. Interview with a third MA on 05/30/25 at 4:33pm revealed: -When she received a hospital discharge summary, she would notify the HWD and follow the HWD's directions. -She did not enter new orders into the eMAR; she	D 358		

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D 358	Continued From page 70 had not been taught how to enter new orders into the eMAR. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed: -The facility should have faxed the discharge summary to the pharmacy. -If the pharmacy had received the discharge summary, it would have been reviewed for new medication orders. -The new medications orders would have been profiled and the medication would have been dispensed. -The pharmacy personnel did not enter new orders into the facility's eMAR; they only profiled the medication for dispensing. -The facility staff entered all orders into the facility's computer system. Telephone interview with the PCP on 05/30/25 at 9:27am revealed: -The facility should review the hospital discharge summary and implement all orders that were written on the hospital discharge summary. -The new orders should be faxed to the pharmacy so the pharmacy could dispense the medications to the faciliy. -She expected all orders from the hospital discharge summary to be initiated when the resident returned to the facility. -The hospital discharge summary should be placed in her folder for review. -When reviewing the hospital discharge summary she would adjust medications as needed. -Sometimes she did not receive a hospital discharge summary. Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 11:23am revealed:	D 358		

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D 358	Continued From page 71 -The discharge summary was reviewed by the RCC or the MA and then given to the HWD. -If the HWD was not in the facility, the hospital discharge summary would be placed under the HWD's office door for review. -If there were new orders to be entered into the computer, the HWD would be notified to enter the new orders. -If the new orders for medications were not started after discharging from the hospital, the resident could have reoccurring issues that the medications were ordered to manage. Interview with the HWD on 05/29/25 at 12:56pm revealed: -The MA was responsible for reviewing the hospital discharge summary, entering any new orders into the eMAR, and faxing the new orders to the pharmacy. -The MA should attach a new order tracking form to the new orders, give the hospital discharge summary to her, place the hospital discharge summary under her office door if she was not in the facility, or place the hospital discharge summary in the PCP's folder for review. -The RCC or HWD would track the new orders to verify accuracy of the new order placed in the eMAR, and ensure medication was delivered from the pharmacy. -It appeared the MA did not review the hospital discharge orders. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The RCC and the HWD were responsible for reviewing the hospital discharge summary. -The HWD or the RCC should notify the PCP if there were new orders. -The new orders should be faxed to the pharmacy so the medications could be dispensed for	D 358		

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D 358	Continued From page 72 administration. -The RCC and the HWD were responsible for auditing new orders with the eMAR to ensure all orders were entered onto the eMAR. -The RCC and the HWD were responsible for auditing the medication cart to ensure all medication were available for administration. Refer to the interview with a MA on 05/28/25 at 2:32pm. Refer to the interview with a second MA on 05/30/25 at 11:44am. Refer to the interview with the HWD on 05/29/25 at 12:56pm. Refer to the interview with the Administrator on 05/30/25 at 5:13pm. _____ Interview with a MA on 05/28/25 at 2:32pm revealed: -The medication cart audits were done weekly by the HWD. -The HWD printed the eMAR and ensured all medications were on the medication cart. -If a medication was missing from the medication cart, the medication would be ordered from the pharmacy. -Medications were re-ordered from the pharmacy by clicking re-order on the computer or calling the pharmacy. -New medication orders were entered into the eMAR by the HWD or the RCC. -When he entered an order into the eMAR the HWD would check the entry for accuracy. Interview with a second MA on 05/30/25 at 11:44am revealed: -The medication cart audits were done by the	D 358	H	

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D 358	Continued From page 73 HWD. -The chart audits were done by the RCC and the HWD. Interview with the HWD on 05/29/25 at 12:56pm revealed: -The MAs should pull the medication from the medication cart and compare the medication to the entry on the eMAR. -If the medication from the medication cart was the same as what was entered on the eMAR, then the MA should prepare the medication for administration. -If the medication from the medication cart was not the same as the entry on the eMAR, the MA should call the pharmacy for clarification. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -She expected medications to be administered as ordered. -If there was a question regarding the order the PCP should be notified. -She was concerned that new medication were not administered as ordered and the residents were not being provided the medications the PCPs intended for them to have. The facility failed to ensure medications were administered as ordered for a resident who was ordered a pain medication twice daily for pain related to a pressure ulcer and was only administered the medication PRN resulting in increased risk for uncontrolled pain, a medication for edema that continued to be administered daily after it was changed to PRN, a vitamin for healing wounds that was administered at over three times the ordered dosage and a medication for anxiety and insomnia that was administered incorrectly because it was on the eMAR at two different	D 358		

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D 358	Continued From page 74 dosages (#2); a resident who was ordered a medication for anxiety resulting in an increased risk of episodes of anxiety, medication for blood pressure resulting in a increased risk of high blood pressure (#3); a sleep aid resulting in insomnia and stool softeners resulting in a risk for constipation (#1 and #3). The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 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,	D 367	HWD and/or designee will verify Residents Medication Administration Record for compliance. Residents with identified missing documentions were reviewed and records were obtained.The AED, HWD and/or designee will review additional documentation. To assist with ongoing compliance, HWD and/or designee, will review Medication Administration Record, once a month for three months.	7/1/25

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D 367	Continued From page 75 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 3 of 5 sampled residents (#2, #3, and #5) including a medications for pain (#2); a medication for dementia (#3); and an anti-anxiety medication (#5). 1. Review of Resident #2's current FL-2 dated 10/22/24 revealed: -Diagnoses included dementia, anxiety, malnutrition, paroxysmal atrial fibrillation and gastroesophageal reflux disease (GERD). -Review of Resident #2's current FL-2 dated 10/22/24 revealed an order for oxycodone (used to treat pain) 5mg every six hours as needed for pain (PRN). Review of Resident #2's physician's order dated 12/27/25 revealed there was an order for oxycodone 5mg every twelve hours as needed for pain. Review of Resident #2's physician's order dated 04/17/25 revealed there was an order for oxycodone 5mg twice daily. Review of Resident #2's electronic medication administration record (eMAR) for March 2025 revealed: -There was one entry for oxycodone 5mg one	D 367		

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tablet every 12 hours as needed for pain; take one tablet twice a day for pain.
-There were no scheduled administration times.
-Oxycodone was documented as administered PRN four opportunities from 03/01/25 to 03/31/25.
-There were no other entries for oxycodone on the eMAR.

Review of Resident #2's eMAR for April 2025 revealed:
-There was one entry for oxycodone 5mg one tablet every 12 hours as needed for pain; take one tablet twice a day for pain.
-There were no scheduled administration times.
-Oxycodone was documented as administered PRN four opportunities from 04/01/25 to 04/30/25.
-There were no other entries for oxycodone on the eMAR.

Review of Resident #2's eMAR for May 2025 from 05/01/25 to 05/28/25 revealed:
-There was one entry for oxycodone 5mg one tablet every 12 hours as needed for pain; take one tablet twice a day for pain.
-There were no scheduled administration times.
-Oxycodone was documented as administered PRN eight opportunities from 05/01/25 to 05/28/25.
-There were no other entries for oxycodone on the eMAR.

Review of Resident #2's controlled substance count sheets (CSCS) for oxycodone revealed:
-There was a CSCS dated from 04/30/25 to 05/19/25 for oxycodone 5mg twice daily.
-Eighteen of eighteen tablets of oxycodone had been administered.
-There was a CSCS dated 05/24/25 for

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D 367	Continued From page 77 oxycodone 5mg twice daily; 4 of 30 tablets had been administered. -There was a CSCS dated 05/24/25 for oxycodone 5mg twice daily; there were 30 of 30 tablets available for administration. Observation of Resident #2's medication on hand on 05/28/25 at 3:57pm revealed: -There were 60 tablets of oxycodone 5mg administer one tablet twice daily dispensed in two bubble packs on 05/23/25; 30 tablets were dispensed in each bubble pack. -There were 30 of 30 tablets of oxycodone 5mg available for administration in one bubble package. -There were 27 of 30 oxycodone 5mg tablets available for administration in the second bubble package. -There were no other bubble packs of oxycodone 5mg on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 10:10am revealed: -Resident #2 had a current order for oxycodone 5mg scheduled twice daily; the order was dated 04/17/25. -On 04/17/25 60 tablets of oxycodone 5mg were dispensed in two cards; thirty tablets were dispensed in each card. -On 05/23/25, 60 tablets of oxycodone 5mg were dispensed in two cards; thirty tablets were dispensed in each card. -Resident #2 did not have a current order for oxycodone 5mg PRN; it was discontinued and changed to the scheduled twice daily. Interview with a medication aide (MA) on 05/29/25 at 3:45pm revealed: -She documented controlled PRN medications on	D 367		

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D 367	Continued From page 78 the eMAR and the CSCS when she administered medications. -She documented the administration on the eMAR first and then on the CSCS. -Resident #2's oxycodone order had changed from PRN to scheduled; she could not find an entry on the eMAR for the scheduled administration, so she documented the administration on the CSCS, so the count was correct. -She did not notify anyone about the entry for oxycodone on the eMAR. Interview with a second MA on 05/30/25 at 10:45am revealed: -Resident #2 only had an order for PRN oxycodone; he had not administered Resident #2 a scheduled oxycodone. -He documented on the eMAR entry first then the CSCS when he administered Resident #2's PRN oxycodone. -He only looked at the count on the CSCS; he did not look at the previous dates of administration. -Resident #2's oxycodone counts always matched on the medication card and the CSCS. Interview with the Resident Care Coordinator (RCC) on 05/30/25 at 2:30pm revealed: -She documented on the eMAR and then the CSCS when administering controlled medications. -The administrations for controls were supposed to be documented on both the eMAR and the CSCS. -Resident #2's oxycodone order on the eMAR was confusing. -She was not sure which order was correct. -She made sure the counts of the oxycodone CSCS matched the medication card.	D 367		

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	HAL032019	A. BUILDING: _____ B. WING _____	R 05/30/2025

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D 367	Continued From page 79 Interview with the Health and Wellness Director (HWD) on 05/30/25 at 4:15pm revealed: -The MAs should come to her immediately with concerns with eMAR entries. -Resident #2's oxycodone order was updated and the previous RCC put the scheduled dose on the same entry for the PRN in the eMAR. -The entry was an error and the oxycodone not being administered twice daily as ordered was an error. -The eMAR was supposed to be compared to the CSCS and matched. -The CSCS count always matched the tablet count in the medication card, so she never questioned anything. -She had not caught the error until today when a MA brought it to her attention. Interview with the Administrator on 05/30/25 at 5:55pm revealed: -The MAs should have questioned the twice daily PRN and every twelve hours on the same entry for Resident #2's oxycodone on the eMAR. -The documentation of administration on the eMAR should always match the CSCS. -The MAs should have informed the HWD they were confused about where to document administration of Resident #2's oxycodone due to an eMAR entry. Based on observations, interviews and record reviews Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 09/17/24 revealed diagnosis included severe dementia. Review of Resident #3's hospital discharge	D 367		

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D 367	Continued From page 80 summary dated 02/18/25 revealed an order for donepezil 5mg (used to treat memory loss and mental changes) at bedtime. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was an entry for donepezil 5mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation that donepezil was administered at bedtime from 05/01/25 to 05/27/25. Observation of medication on hand 05/29/25 at 2:15pm revealed there was no donepezil available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 05/29/25 at 10:48am revealed: -Resident #3 had an order for donepezil 5mg at bedtime dated 12/22/24. -The pharmacy dispensed 28 donepezil 5mg tablets on 05/08/25 to start the cycle fill administration on 05/15/25. -The facility returned the 28 donepezil 5mg to the pharmacy and the medication was checked in on 05/19/25. -The pharmacy did not have an order to discontinue donepezil 5mg for Resident #3. -She did not know why donepezil 5mg was returned to the pharmacy. Review of the drugs returned to pharmacy form revealed: -On 05/16/25, the Health and Wellness Director (HWD) prepared 28 donepezil 5mg tablets to be returned to the pharmacy. -On 05/17/25, the packaged medication was picked up from a representative from the facility's contracted pharmacy to return the medication to	D 367		

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D 367	Continued From page 81 the pharmacy. Interview with a medication aide (MA) on 05/29/25 at 3:43pm revealed: -Resident #3 had donezepil 5mg on the medication cart to be administered. -She did not know where it came from, but she knew the donezepil was on the medication cart. -She had not removed any medications from the medication cart, including donezepil, to be sent back to the pharmacy. Interview with a second MA on 05/30/24 at 4:33pm revealed: -She documented donepezil as administered on the eMAR. -She thought she administered donepezil as ordered each night. -She documented donepezil as administered because she thought she administered the medication. -She did not know the medication was not on the medication cart. Telephone interview with a third shift MA on 05/30/25 at 10:17am revealed: -The cycle filled punch cards were for 28 days. -She removed all punch cards accept the as needed (PRN) punch cards the night before the new cycle began. -She placed all the new cycle punch cards in the medication cart so they would be available to start the new cycle. -The pharmacy documented the new cycle start date on each punch card. -The new cycle start date for May 2025 was on 05/15/25. -The punch cards from the previous cycle were removed and placed in the medication room. -If there were medications remaining from the	D 367		

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D 367	Continued From page 82 previous cycle, the medication would be returned to the pharmacy. -She did not know why Resident #3's donepezil that was to start on 05/15/25, was sent back to the pharmacy. -She placed the donepezil on the medication cart for the new cycle date on 05/15/25. -She did not know who removed donepezil from the medication cart. -She signed the drugs returned to pharmacy form because she gave the packed container of medications to the driver from the pharmacy to deliver the medications back to the pharmacy. -She did not pack the medications, including donepezil, to be returned to the pharmacy; the initials on the drugs returned to the pharmacy form was the person who packaged the medications for return. Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 4:00pm revealed: -The MA removed all punch cards from the medication cart and placed the new cycle punch cards on the medication cart to start the new cycle. -This exchange of punch cards took place on third shift the night before the cycle started the following morning. -Any medication remaining in the punch cards that were removed from the medication cart were returned to the pharmacy. Interview with the HWD on 05/29/25 at 12:56pm revealed: -She did not know why Resident #3's donepezil was not on the medication cart. -Resident #3's donepezil had not been discontinued. -The MA should let her know when a medication was not on the medications cart for	D 367		

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D 367	Continued From page 83 administration. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The MAs needed to notify their supervisor if a medication was not on the medication cart. -The MAs needed to ensure all medications were administered as ordered. -She expected the MAs to administer medications as ordered. Based on observation, interviews, and records reviews it was determined that Resident #3 was not interviewable. 3. Review of Resident #5's current FL-2 dated 01/07/25 revealed there was a diagnosis of memory deficit. a. Review of Resident #5's current FL-2 dated 01/07/25 revealed there was an order for trazodone 25mg (used to treat depression) at bedtime. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for trazodone 25mg give ½ tablet at bedtime with a scheduled administration time 8:00pm -There was documentation trazodone 25mg ½ tablet was administered a bedtime from 03/01/25 to 03/31/25. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for trazodone 25mg give ½ tablet at bedtime with a scheduled administration time 8:00pm -There was documentation trazodone 25mg ½ tablet was administered a bedtime from 04/01/25	D 367		

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D 367	Continued From page 84 to 04/14/25 and 04/16/25 to 04/30/25. -There was one exception; the exception was the resident refused the medication. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was an entry for trazodone 25mg give ½ tablet at bedtime with a scheduled administration time 8:00pm -There was documentation trazodone 25mg ½ tablet was administered a bedtime from 05/01/25 to 05/11/25 and 05/13/25 to 05/27/25. -There was one exception; the exception was the resident refused the medication. Telephone interview with the representative from the facility's contracted pharmacy on 05/30/25 at 11:06am revealed: -The pharmacy had an order for trazodone 25mg at bedtime dated 01/07/25. -The pharmacy dispensed 30 one-half tablets of trazodone 50mg on 03/20/25, 04/17/25 and 05/15/25. -Trazodone did not come in 25mg tablets. -The pharmacy prepped trazodone 50mg, cut them in half and packaged trazodone 50mg ½ tablets for administration, which is 25mg. -The pharmacy did not have an order for trazodone 25mg give ½ tablet at bedtime. Interview with a medication aide (MA) on 05/30/25 at 11:44am revealed: -The trazodone order read to give one-half of a 25mg tablet. -He had not noticed how the order was entered into the eMAR. -He knew Resident #3 received one-half of a 50mg because that was what the pharmacy sent. -Some one rushed to enter the order into the computer system and got the entry wrong.	D 367		

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D 367	Continued From page 85 Interview with the Health and Wellness Director (HWD) on 05/30/25 at 4:05pm revealed: -The order for trazodone 25mg at bedtime appeared to be entered into the eMAR incorrectly. -She did not know who entered the order into the eMAR. -The order was written in January 2025; the previous MAs and Resident Care Coordinator (RCC) who could have entered the order into the eMAR were no longer employed. -No one had questioned the entry of trazodone 25mg give ½ tablet that was entered on Resident #5's eMAR. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The entries on the eMAR should match the directions on the punch cards. -If they were not the same, the MA should question someone in management or notify the pharmacy. Based on observation, interviews, and records reviews it was determined that Resident #5 was not interviewable. b. Review of Resident #5's current FL-2 dated 01/07/25 revealed there was an order for trazodone 25mg (used to treat depression)every 12 hours as needed for agitation/anxiety/aggression. Review of Resident #3's March 2025 eMAR from 03/27/25 to 03/31/25 revealed: -There was an entry for trazodone 25mg every 12 hours a needed for agitation/anxiety/aggression. -There was documentation trazodone 25mg was administered once from 03/27/25 to 03/31/25.	D 367		

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D 367	Continued From page 86 Review of Resident #3's April 2025 eMAR revealed: -There was an entry for trazodone 25mg every 12 hours a needed for agitation/anxiety/aggression. -There was documentation trazodone 25mg was administered three times from 04/01/25 to 04/30/25. Review of Resident #3's May 2025 eMAR from 05/01/25 to 05/27/25 revealed: -There was an entry for trazodone 25mg every 12 hours a needed for agitation/anxiety/aggression. -There was documentation trazodone 25mg was administered 5 times from 05/01/25 to 05/27/25. Observation of medications on hand on 05/29/25 at 4:05pm revealed there was a punch card of 13 of 30 one-half tablets of trazodone 50mg dispensed on 03/27/25 available for administration. Telephone interview with the representative from the facility's contracted pharmacy on 05/30/25 at 11:06am revealed: -The pharmacy had an order for trazodone 25mg every 12 hours as needed for agitation/anxiety/aggression. -The pharmacy dispensed 30 one-half tablets of trazodone 50mg on 03/27/25. Based on observation, record reviews, and interviews, it was determent there were 13 of 30 trazodone 50mg ½ tablets remaining that were dispensed on 03/27/25, with 9 of the 30 tablets documented as being administered, leaving 8 tablets unaccounted for. Telephone interview with a MA on 05/30/25 at 11:24am revealed: -She had administered PRN trazodone to	D 367		

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D 367	Continued From page 87 Resident #5. -PRN medications were to be documented in the electronic notes and on the eMAR. -She may have forgotten to document the PRN trazodone at times because she would get busy. Interview with the RCC on 05/30/25 at 3:06pm revealed: -All PRN medications should be documented on the eMAR when the medication was administered. -Resident #5 could be administered a PRN medication to early if the previous MA did not document on the eMAR that a PRN was given. -When the Primary Care Provider (PCP) reviewed the eMAR, the PCP would think Resident #5 did not need the trazodone PRN for agitation/anxiety/aggression very often. Interview with the HWD on 05/30/25 at 4:05pm revealed: -All PRN medications that were administered should be documented on the eMAR. -If the MHP reviewed the eMAR, the Mental Health Provider (MHP) would think the medication was controlling the agitation/anxiety/aggression when the medication is not controlling these. -If there was no documentation of a PRN medication in 90 days the PRN medication was automatically discontinued. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The MAs should document the PRNs on the eMAR when the PRN medication was administered. -If the PRN medications were not documented on the eMAR when administered, the MHP would not know how to adjust medications to treat the	D 367		

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D 367	Continued From page 88 resident. Based on observation, interviews, and records reviews it was determined that Resident #5 was not interviewable.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 5 sampled residents (#1) who had a fall and required an Emergency Department (ED) visit two days after the fall for evaluation of back pain, resulting in a lumbar compression fracture. The findings are: Review of the facility's incident report policy dated October 2022 revealed: -Incidents or accidents requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aide should be	D 451	AED or HWD or designee will communicate with the county regarding any accident or incident resulting in death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, medical treatment other than first aid. AED and HWD and/or designee will retrain all direct care staff on reporting policies. To assist with ongoing compliance, AED/HWD and/or designee will review all reportable events once monthly.	7/1/25

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D 451	Continued From page 89 reported to the DSS. -The completed incident/accident report should be submitted to the county DSS by mail, fax, electronic mail, or in person within 48 hours of the initial discovery or knowledge of the accident or incident. Review of Resident #1's current FL-2 dated 12/10/24 revealed: -Diagnoses included Alzheimer's disease, osteoporosis, chronic dizziness, and diabetes mellitus type 2. -She was ambulatory. Review of Resident #1's incident/accident report dated 01/17/25 revealed: -She had an unwitnessed fall. -There was no injury to Resident #1. Review of Resident #1's progress note revealed: -On 01/1725, she was in her room looking through her closet and fell backwards onto her lower back and buttocks. -She stated her back was sore after the fall. -She did not want to be transferred to the ED for evaluation. -On 01/19/25, she was having a hard time moving. -She stated her back hurt, and she did not want to move. -She was transported to the ED by the Emergency Medical Services (EMS). -On 01/20/25, she returned to the facility and complained of pain in her back related to lumbar compression fractures. Review of Resident #1's ED discharge summary dated 01/19/25 revealed: -She was seen in the ED related to back pain. -She was diagnosed with a closed compression	D 451		

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D 451	Continued From page 90 fracture of the lumbar vertebra. -Pain medication was ordered to help control Resident #1's pain. Review of Resident #1's Primary Care Provider's (PCP) after-visit summary dated 01/21/25 revealed: -Resident fell on 01/17/25 and was seen in the ED on 01/19/25 for back pain. -She had a lumbar compression fracture. Telephone interview with Resident #1's family member on 05/29/25 at 3:01pm revealed: -Resident #1 had fallen several times earlier this year, 2025, but she had not fallen recently. -Resident #1 had chronic back pain but he did not recall any fractured vertebra until the fall in January 2025. Interview with a medication aide (MA) on 05/30/25 at 11:44am revealed: -The MAs were responsible for completing the incident/accident reports when needed. -The Health Wellness Director (HWD) reviewed the incident/accident report. -The MAs do not send the reportable incident/accident reports to the Adult Home Specialist (AHS). -He did not know who was responsible for sending the reportable incident/accidents reports to the AHS. Telephone interview with the AHS on 05/29/25 at 9:03am revealed: -She was not notified of Resident #1's fall on 01/17/25, requiring an ED visit on 01/19/25 resulting in a lumbar vertebrae fracture. -She expected to be notified when a resident had a fall and was sent to the ED. -The facility should email the incident/accident	D 451		

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BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

(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 451	Continued From page 91 report to her within 48 hours. Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 11:23am revealed: -The incident/accident report was an electronic form completed by the MA. -The incident/accident report was reviewed by the HWD and the Administrator. -She did not send incident/accident reports to the AHS. -The HWD was responsible for sending reportable incident/accident reports to the AHS. Interview with the HWD on 05/29/25 at 12:56am revealed: -The incident/accident reports were initiated by the MAs. -She reviewed the incident/accident reports and would send a copy of the report to the AHS if needed. -The fall on 01/17/25 was not a reportable incident/accident because Resident #1 was not injured and was not sent to the ED. -Resident #1 was sent to the ED on 01/19/25 because of lower back pain and she would not get out of bed. -She did not report Resident #1 going to the ED on 01/19/25 because of back pain because it was not a reportable incident/accident. -She knew Resident #1 was noted to have a lumbar vertebra fracture when she went to the ED on 01/19/25, but she did not report it to the AHS. Interview with the Administrator on 05/30/25 at 5:13pm revealed: -The HWD was responsible for notifying the AHS of reportable incident/accident reports. -She expected the HWD to notify the AHS of all reportable incidents/accidents.	D 451		