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
	HAL027003	A. BUILDING: _____ B. WING _____	R 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on September 03, 2025 and September 04, 2025.	D 000	Response to cited defeciencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Defeciencies or Corrective Action Report; the Plan of Correction is prepared solely as matter of compliance with State Law.	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify orders for 2 of 5 sampled residents (#2, #5) with orders for finger stick blood sugar checks (#2) and a supplement used to support sleep (#5). The findings are: Review of the facility's undated Medication Orders policy revealed: -Signed copies of medication orders are in the resident's record in an orderly manner and reconcile or match the medication orders on the medication administration records. -Medication orders should be transcribed onto the medication administration record at the time the	D 344	10A NCAC 13F .1002(a) Medication Orders Currituck House will ensure that medication orders are clarified and verified by the prescriber. 09/10/25 The Clinical Nurse Consultant, CNC, RN in-serviced Care Coordinator's(CC) and Med Techs on verification and clarification of orders with the prescriber upon any descrepancies or orders that are not clear. 09/10/25 Currituck House Med Techs will ensure the use of the use of the Order Processing System for follow up to clarify and verify orders with the prescriber. 09/10/25 CNC, RN in-serviced the CC's and Med Techs on the importance of the accuracy of EMAR's and the Order Processing System to ensure appropriate follow up. 09/10/25 CC's will complete weekly med cart audits per facilty schedule to ensure medications ordered by prescriber have been verified and on hand. The med cart audits will be performed by use of Physician Order to EMAR to medication cart. Any descrepancy will be immediately clarified with prescriber. 09/26/25 The CC's will conduct at minimum 2 resident chart audits per week to ensure all orders are processed accurately. 09/26/25 Community Managers (ED and CC's) will review facility reports in daily stand up. Any descrepancies identified with orders will immediately be reported and verified with the prescriber. 09/05/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katrina Chamblee TITLE: Executive Director (X6) DATE: 10/14/25

Reviewed and Acknowledged MW 10/14/25

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order is received.
-Clarification of orders is obtained when necessary.
-Medication orders, including admission orders and computerized physician's order sheets are reviewed for accuracy according to the facility's policies and procedures.

1. Review of Resident #2's current FL2 dated 06/18/25 revealed:
-Diagnoses included type 1 diabetes mellitus with neuropathy, nonrheumatic aortic valve stenosis, atherosclerotic heart disease, and cerebrovascular disease.
-He was intermittently disoriented.

Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/14/25.

Review of Resident #2's signed physician's order sheet dated 06/18/25 revealed:
-There was an order to check fasting finger stick blood sugar (FSBS) three times daily before meals at 7:00am, 11:30am and 4:30pm.
-There was an order to check FSBS four times a day at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an order for insulin aspart U-100, inject 6 units before meals, hold for blood sugar less than 130, at 7:30am, 11:30am and 4:30am.
-There was an order for insulin glargine 100unit/ml, inject 11 units twice daily, give bedtime snack and hold for FSBS less than 110, twice a day at 8:00am and 8:00pm.

Review of a subsequent signed physician's order dated 06/18/25 revealed:
-There was an order to discontinue insulin aspart U-100, 6 units three times per day.
-There was an order to start insulin aspart U-100,

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D 344	Continued From page 2 8 units three times per day with meals, hold if FSBS is less than 100. -There was an order to discontinue insulin glargine 11 units twice daily. -There was an order to start insulin glargine 22 units at bedtime, hold if FSBS is less than 100, and contact primary care provider (PCP). Review of a subsequent signed physician's order dated 08/12/25 revealed: -There was an order to increase the insulin glargine dose to 26 units at bedtime. -There was an order to increase insulin aspart to 9 units before meals three times per day. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed. -There was an entry for fasting FSBS three times daily before meals, scheduled at 7:00am, 11:30am, and 4:30pm. -Resident #2's FSBS was documented as checked at 7:00am on 07/01/25 through 07/31/25, ranging from 132 to 323. -Resident #2's FSBS was documented as checked at 11:30am on 07/01/25 through 07/13/25, ranging from 112 to 300. -Resident #2's FSBS was documented as not checked at 11:30am on 07/14/25, with the exception documented as "resident unavailable". -Resident #2's FSBS was documented as checked at 4:30pm on 07/01/25 through 07/08/25, ranging from 156 to 324. -Resident #2's FSBS was documented as not checked at 4:30pm on 07/09/25, with the exception documented as "resident unavailable". -Resident #2's FSBS was documented as checked at 4:30pm on 07/10/25 through 07/31/25, ranging from 82 to 296. -There was a second entry for FSBS four times	D 344		

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D 344	Continued From page 3 per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 7:30am, 11:30am on 07/01/25 through 07/31/25, there was no documentation of the FSBS reading. -Resident #2's FSBS was documented as checked at 4:30pm on 07/01/25 through 07/08/25, there was no documentation of the FSBS reading. -Resident #2's FSBS was documented as not checked at 4:30pm on 07/09/25, with the exception documented as "resident unavailable". -Resident #2's FSBS was documented as checked at 4:30pm on 07/10/25 through 07/31/25, there was no documentation of the FSBS number. -Resident #2's FSBS was documented as checked at 8:00pm on 07/01/25 through 07/31/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP, scheduled at 8:00pm. -Insulin glargine, 22 units was documented as administered at 8:00pm on 07/01/25 through 07/31/25. Review of Resident #2's August 2025 eMAR revealed: -There was an entry for fasting FSBS three times daily before meals, scheduled at 7:00am, 11:30am, and 4:30pm. -Resident #2's FSBS was documented as checked at 7:00am on 08/01/25 through 08/31/25, ranging from 70 to 284. -Resident #2's FSBS was documented as checked at 11:30am on 08/01/25 through 08/31/25, ranging from 82 to 337. -Resident #2's FSBS was documented as	D 344		

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D 344	Continued From page 4 checked at 4:30pm on 08/01/25 through 08/31/25, ranging from 115 to 337. -There was a second entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 7:30am, 11:30am, 4:30pm and 8:00pm on 08/01/25 through 08/31/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP with an end date of 08/14/25. -Insulin glargine 22 units was documented as administered at 8:00pm on 08/01/25 through 08/13/25. -There was an entry for insulin glargine, inject 26 units at bedtime, hold if FSBS is less than 100 and notify PCP, scheduled at 8:00pm with a start date of 08/14/25. -Insulin glargine 26 units was documented as administered at 8:00pm on 08/14/25 through 08/31/25. Review of Resident #2's September 2025 eMAR revealed: -There was an entry for insulin aspart inject 9 units before meals three times daily, hold if less than 100. -Resident #2's FSBS was documented as checked at 7:30am on 09/01/25 through 09/03/25 ranging from 130 to 234. -Resident #2's FSBS was documented as checked at 11:30am on 09/01/25 and 09/02/25, ranging from 103 to 185. -Resident #2's FSBS was documented as checked at 4:30pm on 09/01/25 and 09/02/25, ranging from 108 to 177. -There was an entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and	D 344		

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D 344	Continued From page 5 8:00pm. -Resident #2's FSBS was documented as checked at 7:30am, 11:30am, 4:30pm and 8:00pm on 09/01/25 and 09/02/25 and at 7:30am on 09/03/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 26 units at bedtime, hold of FSBS is less than 100, scheduled at 8:00pm. -Insulin glargine, 26 units was documented as administered at 8:00pm on 09/01/25 and 09/02/25. Telephone with a pharmacist with the facility's contracted pharmacy provider on 09/04/25 at 2:57pm revealed: -An order was received on 05/14/25 for Resident #2 to have fasting FSBS checks three times a day before meals. -A second order was received on 05/16/25 for FSBS four times per day. Interview with a medication aide (MA) on 09/04/25 at 4:15pm revealed: -She had not noticed that there were two separate orders for FSBS for Resident #2. -Resident #2 received FSBS before meals and at bedtime. -The Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) processed all the orders for the residents. Interview with the RCC on 09/04/25 at 5:12pm revealed: -If there were duplicate orders for the residents, the order should be clarified with the resident's PCP. -Audits of the eMARs were done once a week. -An eMAR audit consisted of printing the resident's signed physician's orders and the	D 344		

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signed orders were compared to the resident's eMAR.
-She thought Resident #2's FSBS order changed when his insulin dose changed.
-She should have noticed Resident #2 had 2 separate orders for FSBS checks and should have clarified the FSBS order with his PCP.

Interview with the Administrator on 09/04/25 at 05:45pm revealed:
-Any time there was a duplicate order or a question about an order the RCC should contact the resident's PCP for clarification.
-The RCC performed weekly eMAR audits for all the residents.
-An eMAR audit consisted of comparing the signed physician's orders to the resident's eMAR to make the orders were accurate and the resident's medications were available.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:36pm revealed:
-She initially ordered FSBS check for Resident #2 three times a day before meals and at bedtime.
-Resident #2 was no longer under care as June 2025 and had an outside provider.

Attempted telephone interview with Resident #2's PCP on 09/04/25 at 4:00pm was unsuccessful.

2. Review of Resident #5's current FL2 dated 02/12/25 revealed diagnoses included seizures, hyperlipidemia, history of stroke, and schizoaffective disorder.

Review of Resident #5's signed physician's order sheet dated 03/05/25 revealed an order for melatonin 3mg, take one tablet at bedtime.

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D 344	Continued From page 7 Review of Resident #5's hospital after visit summary dated 08/22/25 revealed: -Her diagnosis was internal right carotid artery stenosis (narrowing). -Her medication list included "change how you take melatonin 3mg, take one tablet nightly as needed for insomnia" and was initialed by her primary care provider (PCP). Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for melatonin 3mg, take one tablet at bedtime scheduled at 8:00pm. -Melatonin 3mg was documented as administered at 8:00pm on 08/22/25 through 08/31/25. -There was a second entry for melatonin 3mg, take one tablet at bedtime as needed for insomnia. -There was no documentation melatonin 3mg, take one tablet as needed was administered. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for melatonin 3mg, take one tablet at bedtime scheduled at 8:00pm. -Melatonin 3mg was documented as administered at 8:00pm on 09/01/25 and 09/02/25. -There was a second entry for melatonin 3mg, take one tablet at bedtime as needed for insomnia. -There was no documentation melatonin 3mg, take one tablet as needed was administered. Observation of Resident #5's medications on hand on 09/04/25 at 4:14pm revealed: -The was a weekly multidose package of medications that included melatonin 3mg tablets.	D 344	Type text here	

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D 344	Continued From page 8 -The top tab Resident #5's weekly multi-dose medication package listed each medication contained in the multi-dose package and included the physician's order on how to administer each medication including one tablet of melatonin 3mg, take one tablet at bedtime. -The multi-dose medication package had a print date of 08/26/25. -There were 5 days remaining for Resident #5's evening multi-dose package. -There was no separate medication card for melatonin 3mg, take one tablet as needed for insomnia. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 09/04/25 at 2:45pm revealed: -An order for melatonin 3mg, take 1 tablet at bedtime was received for Resident #5 on 11/06/24. -Melatonin 3mg take one tablet at bedtime has dispensed for Resident #5 on 08/22/25 for a quantity of 10 tablets, on 08/27/25 for a quantity of 5 tablets, on 09/01/25 for a quantity of 2 tablets and on 09/03/25 for a quantity of 7 tablets. -An order was received for Resident #5 for melatonin 3mg, take 1 tablet at bedtime as needed on 08/22/25. -Melatonin 3mg, 30 tablets, to take 1 tablet at bedtime as needed was dispensed on 08/23/25 for Resident #5. -There was no discontinue order on file for Resident #5's scheduled melatonin 3mg tablets. Interview with a medication aide (MA) on 09/04/25 at 4:55pm revealed: -When a resident returned from the hospital, all hospital paperwork was given to the Resident Care Coordinator (RCC). -The RCC reviewed the resident's hospital	D 344		

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D 344	Continued From page 9 paperwork for new orders and faxed the orders to the facility's pharmacy. -She had not noticed that Resident #5 had two orders for melatonin. -If she had noticed a duplicate order, she would have brought it to the attention of the RCC. Interview with the RCC on 09/04/25 at 5:12pm revealed: -She was off the day Resident #5 returned from the hospital, so she did not review her hospital visit paperwork. -She knew some of Resident #5's medications had changed after her recent hospitalization. -She was not aware there were two separate orders for Resident #5's melatonin. -She did weekly eMAR audits for the residents, which consisted of printing the residents' physician's order sheets and compared their orders to the eMAR. Interview with the Administrator on 09/04/25 at 5:45pm revealed: -She or the RCC reviewed the residents' paperwork for new orders. -Any time there was a duplicate order or a question about an order the RCC should contact the resident's primary care provider (PCP) for clarification. -The RCC performed weekly eMAR audits for all the residents. -An eMAR audit consisted of comparing the signed physician's orders to the resident's eMAR to make the orders were accurate and the resident's medications were available. Telephone interview with Resident #5's PCP on 09/04/25 at 3:38pm revealed: -Resident #5 had a recent hospitalization for an ischemic stroke.	D 344		

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D 344	Continued From page 10 -Resident #5's behavioral health provider prescribed her melatonin and the facility should have contacted Resident #5's behavioral health provider to clarify the melatonin order. -She would not recommend additional melatonin for Resident #5 to avoid the resident being over sedated. Attempted telephone interview with Resident #5's behavioral health provider on 09/04/25 at 3:57pm was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered to 1 of 6 residents (#6) observed on the morning medication pass and to 3 of 5 sampled residents (#1, #2, #5) pertaining medication used to treat arthritic joint pain, a vitamin supplement, an iron supplement (#6), medications used to treat elevated blood glucose	D 358	10A NCAC 13F .1004(a) Medication Administration Currituck House will ensure that residents receive medications as ordered by the prescribing physician and/or practitioner in accordance to the resident record. CNC, RN in-serviced Med Techs on the importance of Medication Administration to include the 6 Rights of Medication Administration and in accordance of community policy and procedures and the Order Processing System to ensure ordering and follow up of medications. CC's will complete Physician Orders to EMAR to cart audits weekly per facility schedule to ensure availability and accuracy of medication orders. The audits will be reviewed by the ED for compliance. The CC and ED will conduct random med pass observations to ensure Medication Technicians are performing med passes appropriately. Any concerns identified will have follow up and additional training. The CC's will conduct at minimum 2 resident chart audits weekly to ensure all orders have been processed properly to allow for proper medication administration.	09/26/25 09/10/25 09/26/25 09/26/25 09/26/25

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D 358	Continued From page 11 levels (#1, #2), an antibiotic (#2), and medications used to treat high blood pressure, low magnesium levels, depression, anxiety and schizophrenia (#5). The findings are: Review of the facility's undated Medication Administration policy revealed staff uses medication administration records when preparing and administering medications and checks medication labels against the medication administration record. Review of the facility's undated Medication Orders policy revealed medication orders, including admission orders and computerized physician's order sheets are reviewed for accuracy according to the facility's policies and procedures. 1. The medication error rate was 8% as evidenced by 3 errors out of 37 opportunities during the 8:00am medication pass on 09/03/25. a. Review of Resident #6's current FL-2 dated 02/17/25 revealed: -Diagnoses included dementia, muscle weakness, unsteadiness on feet, hypothyroidism, severe protein-calorie malnutrition, hyperlipidemia, hypertension and asthma. -She was intermittently disoriented. Review of Resident #6's signed physician's order sheet dated 02/17/25 revealed an order for diclofenac sodium gel (diclofenac gel is a topical non-steroidal anti-inflammatory medication used to treat arthritic pain) 1%, apply topically to affected area, 2 grams twice daily.	D 358		

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CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 Observation of the 8:00am medication pass on 09/03/25 revealed: -The medication aide (MA) took the medication cart to Resident #6 who was sitting in the hallway. -The MA removed a tube of diclofenac 1% gel from the medication cart. -The MA donned gloves and opened the tube of diclofenac gel and squirted a thumb tip sized amount of diclofenac gel to her gloved fingers and applied to Resident #6's left knee and then repeated the same for her right knee. -The MA did not use the provided dosing card to administer diclofenac gel to Resident #6. Review of Resident #6's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for diclofenac sodium gel 1%, apply 2 grams topically to bilateral knees twice daily, scheduled at 8:00am and 8:00pm. -Diclofenac sodium gel 1% was documented as administered at 8:00am on 09/01/25 through 09/03/25 and at 8:00pm on 09/01/25 and 09/02/25. Observations of Resident #6's medications on hand on 09/03/25 at 10:55am revealed: -There was a manufacturer labeled box with a pharmacy prescription label with Resident #6's name, diclofenac sodium gel 1%, apply topically 2 grams to bilateral knees twice daily that contained a 100-gram tube of diclofenac sodium 1% gel with a dispense date of 07/30/25. -Resident #6's box for diclofenac gel contained a dosing card and instructions for how to measure 2 grams. Telephone interview with a pharmacist from the facility's contracted pharmacy at 2:24pm revealed:	D 358		

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D 358	Continued From page 13 -Diclofenac sodium gel 1% was dispensed for Resident #6 to use 2 grams topically to bilateral knees twice a daily on 05/30/25 and 07/30/25 for a 100-gram tube each time. -Diclofenac sodium gel came with a dosing card to measure 2 grams. Interview with Resident #6 on 09/03/25 at 1:59pm revealed: -Staff always applied the diclofenac gel to her knees. -She felt the diclofenac gel was very helpful for her knee pain. Interview with the MA on 09/03/25 at 10:56am revealed: -She knew she was to use the dosing card supplied with the diclofenac gel for Resident #6. -She was anxious during the morning medication pass and forgot to use the provided dosing card for Resident #6 and guessed at the amount needed of diclofenac gel. Interview with the Resident Care Coordinator (RCC) on 09/03/25 at 2:28pm revealed: -Diclofenac gel came with a dosing card in each box. -The only way to make sure the resident got the ordered diclofenac dose was to use the dosing card. -The MA should have used the dosing card to measure the amount of diclofenac gel for Resident #6 to make sure she received the ordered dose. Interview with the Administrator on 09/03/25 at 2:40pm revealed: -Diclofenac gel should always be administered using the supplied dosing card. -She expected the MAs to administer the	D 358		

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D 358	Continued From page 14 residents' medications as ordered. -By not using the dosing card for diclofenac gel, Resident #6 could have gotten too little or too much medication. Interview with Resident #6's primary care provider (PCP) on 09/03/25 at 3:10pm revealed: -She prescribed diclofenac gel for Resident #6 for osteoarthritis in her knees. -Diclofenac came with a dosing card to measure either 2 grams or 4 grams. -It was important that staff use the dosing card to administer the diclofenac to Resident #6 to ensure she received consistent pain control and symptom relief of her osteoarthritis symptoms. b. Review of Resident #6's subsequent signed physician's order dated 08/27/25 revealed an order for ferrous sulfate (ferrous sulfate is an iron supplement to treat anemia or low levels of iron in the blood) 325mg, take one tablet daily for iron deficient anemia (IDA). Observations of the 8:00am medication pass on 09/03/25 revealed: -The medication aide (MA) pulled a multi-dose package of medication for Resident #6 from the medication cart. -The MA emptied to contents of Resident #6's morning multi dose medication package which contained 4 tablets into a medication cup. -The MA pulled another single medication card from the controlled substance drawer for Resident #6 and placed a single tablet in the medication cup with the other 4 tablets for a total of 5 tablets in the medication cup. -The MA administered the 5 tablets to Resident #6 at 8:11am with a cup of water. -The MA also administered an inhaler and a topical gel to Resident #6.	D 358		

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D 358	Continued From page 15 -Ferrous sulfate 325mg was not included in the medications administered to Resident #6 at 8:11am. Review of Resident #6's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg, take one tablet daily for IDA scheduled at 8:00am. -Ferrous sulfate 325mg was documented as administered at 8:00am on 09/01/25 through 09/03/25. Observation of Resident #6's medications on hand on 09/03/25 at 11:01am revealed there was a bubble card of ferrous sulfate 325mg, take one tablet once daily for IDA, dispensed on 08/27/25 for 13 tablets with 9 tablets remaining. Telephone with a pharmacist from the facility's contracted pharmacy provider on 09/03/25 at 2:24pm revealed: -An order for ferrous sulfate 325mg was received for Resident #6 on 08/27/25, to take one tablet daily for IDA. -Ferrous sulfate 325mg was dispensed for Resident #6 on 08/27/25 for 13 tablets to take on daily for IDA. -Ferrous sulfate 325mg was dispensed for Resident #6 on 09/03/25 for seven tablets to take one daily for IDA. Refer to interview with Resident #6 on 09/03/25 at 1:59pm. Refer to interview with the medication aide (MA) on 09/03/25 at 10:56am. Refer to interview with the Resident Care Coordinator (RCC) on 09/03/25 at 2:21pm.	D 358		

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D 358	Continued From page 16 Refer to interview with the Administrator on 09/03/25 at 2:40pm. Refer to interview with Resident #6's primary care provider (PCP) on 09/03/25 at 3:10pm. c. Review of Resident #6's subsequent signed physician's order dated 08/27/25 revealed an order for vitamin B12(vitamin B12 supplement used to treat low levels of vitamin B12 in the blood) 1000mcg, take one tablet daily for vitamin B12 deficiency. Observations of the 8:00am medication pass on 09/03/25 revealed: -The medication aide (MA) pulled a multi-dose package of medication for Resident #6 from the medication cart. -The MA emptied to contents of Resident #6's morning multi dose medication package which contained 4 tablets into a medication cup. -The MA pulled another single medication card from the controlled substance drawer for Resident #6 and placed a single tablet in the medication cup with the other 4 tablets for a total of 5 tablets in the medication cup. -The MA administered the 5 tablets to Resident #6 at 8:11am with a cup of water. -The MA also administered an inhaler and a topical gel to Resident #6. -Vitamin B12 was not included in the medications administered to Resident #6 at 8:11am. Review of Resident #6's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin B12 1000mcg, take one tablet once daily for vitamin B12 deficiency, scheduled at 8:00am.	D 358		

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D 358	Continued From page 17 -Vitamin B12 1000mcg was documented as administered at 8:00am on 09/01/25 through 09/03/25. Observation of Resident #6's medications on hand on 09/03/25 at 11:01am revealed there was a bubble card of vitamin B12 1000mcg, take one tablet daily for vitamin B12 deficiency dispensed on 08/27/25 for 13 tablets with 9 tablets remaining. Telephone with a pharmacist from the facility's contracted pharmacy provider on 09/03/25 at 2:24pm revealed: -An order for vitamin B12 1000mcg, was received for Resident #6 on 08/27/25, to take one tablet daily for vitamin B12 deficiency. -Vitamin B12 1000mcg was dispensed for Resident #6 on 08/27/25 for 13 tablets to take on daily for vitamin B12 deficiency. -Vitamin B12 1000mcg was dispensed for Resident #6 on 09/03/25 for seven tablets to take one daily for vitamin B12 deficiency. Refer to interview with Resident #6 on 09/03/25 at 1:59pm. Refer to interview with the medication aide (MA) on 09/03/25 at 10:56am. Refer to interview with the Resident Care Coordinator (RCC) on 09/03/25 at 2:21pm. Refer to interview with the Administrator on 09/03/25 at 2:40pm. Refer to interview with Resident #6's primary care provider (PCP) on 09/03/25 at 3:10pm. Interview with Resident #6 on 09/03/25 at 1:59pm	D 358		

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D 358	Continued From page 18 revealed: -Staff brought her medications to her daily. -She was not aware of any missed medications. Interview with the MA on 09/03/25 at 10:56am revealed: -The MAs were to check the resident's medications against the eMAR. -Ferrous sulfate and vitamin B12 were not included in Resident #6's multi-dose medication pack and she should have looked for the individual bubble cards. -She forgot to pull Resident #6's ferrous sulfate and vitamin B12 medication cards to administer. -She was anxious during the morning medication pass and checked Resident #6's ferrous sulfate and vitamin B12 as administered in error. Interview with the RCC on 09/03/25 at 2:24pm revealed: -The MAs were trained to check the residents' medications against their eMAR. -Multi-dose medication packages were received weekly on Saturday, and the cycle started on Tuesday. -If a resident had a new medication order, the pharmacy sent an individual medication card until the newly ordered medication could be added to the weekly multi-dose medication package. -If a medication was not in the resident's multi-dose medication package, the MAs were to look for an individual medication card. -The MA should have reviewed Resident #6's eMAR and looked for her ferrous sulfate and vitamin B12 on the medication cart. -Medications should never be documented as administered if they were not. Interview with the Administrator on 09/03/25 at 2:40pm revealed:	D 358		

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D 358	Continued From page 19 -The MAs were to match a resident's medications to the eMAR three times to verify for accuracy. -Multi-dose medication packages were to be compared to the eMAR to make sure all medications were available for administration. -If an ordered medication was not included in the multi-dose medication package, the MA checked the medication cart for an individual medication card. -If the MA could not locate a resident's medications on the medication cart, then she was to notify the resident's PCP and contact the pharmacy. -She expected all medications to be administered to the residents as ordered. Interview with Resident #6's primary care provider (PCP) on 09/03/25 at 3:10pm revealed: -She prescribed ferrous sulfate for Resident #6 for low iron levels on her recent lab work. -She prescribed vitamin B12 for Resident #6 for low vitamin B12 levels on her recent lab work. -Low iron and vitamin B12 levels could cause weakness and fatigue. -Going without the ferrous sulfate and vitamin B12 supplement would result in continued low levels on lab work and cause the resident to feel weak and tired. 2. Review of the facilities undated diabetic medication and treatment policy revealed: -Residents receiving medication and treatments for diabetic care would be monitored according to physician orders. -Each resident would have their own glucose monitor with the resident's name on the monitor and on the bag that contained the monitor. -All medications, blood sugar monitoring, insulins would be added to a diabetic flowsheet. -The provider should include low and high	D 358		

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D 358	Continued From page 20 parameters for resident blood sugar levels. -The medication aide (MA) would notify the Resident Care Coordinator (RCC) or the Special Care Unit Coordinator (SCC) of any refusals and/or abnormal results per parameters given by the resident provider. -The RCC, SCC, or designee would review any refusals and/or abnormal blood sugar readings and notify the provider and document the notification and any new orders in the resident's chart. Review of Resident #1's current FL-2 dated 06/04/25 revealed: -Diagnoses included type 2 diabetes, hypertension, and unsteadiness on feet. -There was a note at the bottom of the current FL-2 to see attached physician orders signed 06/04/25. Review of Resident #1's physician orders attached to the current FL-2 dated 06/04/25 revealed there was an order for Basaglar Kwik Pen U-100 Insulin pen, 100 unit/mL (3mL), inject 10 units subcutaneously at 8:00pm, hold if finger stick blood sugar (FSBS) is less than 100, call the primary care provider if FSBS is greater than 300 (Basaglar is a long acting insulin). Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS at 8:00pm. -There was an entry for Basaglar Kwik Pen U-100 insulin pen; 100 unit/ml (3ml) subcutaneous at 8:00pm, inject 10 units subcutaneously at bedtime (8:00pm), hold if FSBS is less than 100, call the primary care provider (PCP) if FSBS was greater than 300. -On 07/05/254 at 8:00pm, there was a FSBS	D 358		

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D 358	Continued From page 21 documented for 134, Basaglar was not administered, when 10 units of Basaglar should have been administered. -There was documentation on the exceptions that Basaglar was not administered: due to condition. -There was no documentation of what due to condition meant. -On 07/08/25 at 8:00pm, there was a FSBS documented for 122, Basaglar was not administered, when 10 units of Basaglar should have been administered. -There was documentation on the exceptions that Basaglar was not administered: due to condition. -There was no documentation of what due to condition meant. Interview with Resident #1 on 09/04/25 at 11:45am revealed: -A MA checked her blood sugar each night before bedtime. -She received insulin each night before bedtime. -She could not recall any times that she did not receive her insulin injection at bedtime. Interview with a MA on 09/04/25 at 4:54pm revealed: -The MA that held Resident #1's Basaglar insulin on two occasions, should have administered the resident her insulin because her FSBS was over 100. -The MAs were expected to follow primary care provider (PCP) orders. -If she had a question about an order, she would call the PCP or the RCC if she needed directions about what her next step should be. Interview with the RCC on 09/04/25 at 5:09pm revealed: -There should have been a progress note from the MA that documented she did not administer	D 358		

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D 358	Continued From page 22 Resident #1 her Basaglar insulin instead of medication not administered, due to condition. -The MA needed to document in a progress note what the condition the resident had that caused her to not administer Resident #1 her Basaglar insulin. -She was unable to locate a progress note from the MA on the two dates the Basaglar insulin was held for Resident #1. -A MA was not qualified to decide if a resident should be administered insulin or not, they were supposed to follow the PCP orders. -The MA could have contacted Resident #1's PCP if she had a concern about administering the resident her Basaglar insulin. Interview with the Administrator on 09/04/25 at 5:45pm revealed: -Resident #1 did not refuse her medications. -She was not sure why the MA did not administer Resident #1 her Basaglar insulin when her FSBS was greater than 100. -MAs were expected to follow PCP orders, if there was an issue such as a resident refused the medication the MA should have completed a progress note. -There were no progress notes from the MA that failed to administer Resident #1's Basaglar insulin. -The MA made an error that should not have occurred. Interview with Resident #1's PCP on 09/03/25 at 3:33pm revealed: -When a MA did not administer insulin as ordered, they placed the resident at risk of hyperglycemia which could cause the resident to feel jittery and anxious. -MAs should administer Resident #1 her insulin as ordered so she was able to obtain an accurate	D 358		

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D 358	Continued From page 23 hemoglobin A1C reading (A hemoglobin A1C test is a blood test that reflects an individual's average blood glucose levels over the past three months). -Resident #1 did not have a history of refusing her medications or her insulin injections. -Resident #1 still needed her long acting insulin when her FSBS was 134 and 122. -MA needed to follow her orders on when to administer the resident's insulin to prevent hyperglycemia. Attempted interview with the MA that held Resident #1's insulin on 07/05/25 and 07/08/25 was unsuccessful. 3. Review of Resident #2's current FL2 dated 06/18/25 revealed: -Diagnoses included type 1 diabetes mellitus with neuropathy, nonrheumatic aortic valve stenosis, atherosclerotic heart disease, and cerebrovascular disease. -He was intermittently disoriented. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/14/25. a. Review of Resident #2's signed physician's order sheet dated 06/18/25 revealed: -There was an order to check fasting finger stick blood sugar (FSBS) three times daily before meals at 7:00am, 11:30am and 4:30pm. -There was an order to check FSBS four times a day at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an order for insulin glargine 100unit/ml, inject 11 units twice daily, give bedtime snack and hold for FSBS less than 110, twice a day at 8:00am and 8:00pm. Review of Resident #2's subsequent signed	D 358		

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D 358	Continued From page 24 physician's order dated 06/18/25 revealed: -There was an order to discontinue insulin glargine 11 units twice daily. -There was an order to start insulin glargine 22 units at bedtime, hold if FSBS is less than 100, and contact primary care provider (PCP). Review of a subsequent signed physician's order dated 08/12/25 revealed: -Resident #2's Hemoglobin A1c (a blood test that measures the average blood sugar level over the past 2-3 months) was 8.2. -There was an order to increase the insulin glargine dose to 26 units at bedtime. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed. -There was an entry for fasting FSBS three times daily before meals, scheduled at 7:00am, 11:30am, and 4:30pm. -Resident #2's FSBS was documented as checked at 7:00am on 07/01/25 through 07/31/25, ranging from 132 to 323. -Resident #2's FSBS was documented as checked at 11:30am on 07/01/25 through 07/13/25, ranging from 112 to 300. -Resident #2's FSBS was documented as not checked at 11:30am on 07/14/25, with the exception documented as "resident unavailable". -Resident #2's FSBS was documented as checked at 4:30pm on 07/01/25 through 07/08/25, ranging from 156 to 324. -Resident #2's FSBS was documented as not checked at 4:30pm on 07/09/25, with the exception documented as "resident unavailable". -Resident #2's FSBS was documented as checked at 4:30pm on 07/10/25 through 07/31/25, ranging from 82 to 296. -There was a second entry for FSBS four times	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 8:00pm on 07/01/25 through 07/31/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP, scheduled at 8:00pm. -Insulin glargine, 22units was documented as administered at 8:00pm on 07/01/25 through 07/31/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Review of Resident #2's August 2025 eMAR revealed: -There was an entry for fasting FSBS three times daily before meals, scheduled at 7:00am, 11:30am, and 4:30pm. -Resident #2's FSBS was documented as checked at 7:00am on 08/01/25 through 08/31/25, ranging from 70 to 284. -Resident #2's FSBS was documented as checked at 11:30am on 08/01/25 through 08/31/25, ranging from 82 to 337. -Resident #2's FSBS was documented as checked at 4:30pm on 08/01/25 through 08/31/25, ranging from 115 to 337. -There was a second entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 8:00pm on 08/01/25 through 08/31/25, there was no documentation of the the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP with an end date of	D 358		

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D 358	Continued From page 26 08/14/25. -Insulin glargine 22units was documented as administered at 8:00pm on 08/01/25 through 08/13/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. -There was an entry for insulin glargine, inject 26 units at bedtime, hold if FSBS is less than 100 and notify PCP, scheduled at 8:00pm with a start date of 08/14/25. -Insulin glargine 26 units was documented as administered at 8:00pm on 08/14/25 through 08/31/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Review of Resident #2's September 2025 eMAR revealed: -There was an entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 7:30am on 09/01/25 through 09/03/25 ranging from 130 to 234. -Resident #2's FSBS was documented as checked at 11:30am on 09/01/25 and 09/02/25, ranging from 103 to 185. -Resident #2's FSBS was documented as checked at 4:30pm on 09/01/25 and 09/02/25, ranging from 108 to 177. -Resident #2's FSBS was documented as checked at 8:00pm on 09/01/25 and 09/02/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 26 units at bedtime, hold of FSBS is less than 100, scheduled at 8:00pm. -Insulin glargine, 26 units was documented as	D 358		

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D 358	Continued From page 27 administered at 8:00pm on 09/01/25 and 09/02/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Telephone with a pharmacist with the facility's contracted pharmacy provider on 09/04/25 at 2:57pm revealed: -An order was received on 05/14/25 for Resident #2 to have fasting FSBS checks three times a day before meals. -A second order was received on 05/16/25 for FSBS four times per day. -It was the facility's responsibility to add a space on the resident's eMAR to record the 8:00pm FSBS reading. -An order for insulin glargine to inject 22 units at bedtime, hold for FSBS less than 100 was received for Resident #2 on 06/18/25. -An order to increase insulin glargine to 26 units at bedtime, hold if FSBS is less than 100 was received for Resident #2 on 08/13/25. -2 300ml pens of insulin glargine were dispensed for Resident #2 on 08/13/25 to use 26 units at bedtime, hold for FSBS less than 100. Observations of Resident #2's medications on hand on 09/04/25 at 1:34pm revealed there was a 3ml pen of insulin glargine, labeled with Resident #2's name with an opened date of 09/02/25 handwritten on an attached sticker. Interview with Resident #2 on 09/04/25 at 1:56pm revealed: -Staff administered insulin three or four times per day depending on what his FSBS was. -Staff performed finger pricks for FSBS checks four times per day.	D 358		

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D 358	Continued From page 28 Interview with a medication aide (MA) on 09/04/25 at 4:15pm revealed: -She always recorded Resident #2's FSBSs. -She worked day shift, so she had not noticed there was no space on Resident #2's eMAR to record his 8:00pm FSBS. Interview with a second MA on 09/04/25 at 4:55pm revealed: -When a resident had FSBS checks, the eMAR directed the MA to enter the FSBS reading. -She checked Resident #2's 8:00pm FSBS but had not noticed that there was no space to document his 8:00pm FSBS reading. -She did not record Resident #2's 8:00pm FSBS on his eMAR or anywhere else, she just reviewed the reading with his insulin order. -It had not occurred to her to let the Resident Care Coordinator (RCC) know there was no space to record Resident #2's 8:00pm FSBS reading. Interview with the RCC on 09/04/25 at 5:12pm revealed: -FSBS readings should always be documented on the residents' eMAR to ensure they received the appropriate amount of insulin and to keep track of what their FSBSs were. -No one had notified her that there was no space available on Resident #2's eMAR to record his 8:00pm FSBS reading. -Management was not aware until today that Resident #2's 8:00pm FSBSs were not recorded. -She could add a space to Resident #2's eMAR to record his 8:00pm FSBSs. -She did weekly eMAR audits for all the residents to match the residents' medication orders to their eMARs. -She had not noticed that Resident #2's 8:00pm FSBS readings were not documented.	D 358		

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D 358	Continued From page 29 Interview with the Administrator on 09/04/25 at 5:45pm revealed: -FSBS reading should always be documented on the residents' eMAR to ensure the correct amount of insulin was administered. -She thought the pharmacy was responsible to make sure there was a space to enter all FSBS readings. -The RCC was responsible for weekly eMAR audits -It was an oversight that there was no space on Resident #2's eMAR to enter his 8:00pm FSBS reading. -Without documentation of Resident #2's 8:00pm FSBS reading, there was no way to know if he should have or have not received the insulin glargine. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:36pm revealed: -She previously treated Resident #2. -She ordered FSBSs for Resident #2 three times a day and at bedtime. -It was important to record all the FSBS reading to look for high and low trends and to make the resident received the correct amount of insulin. -If the resident's FSBS was less than 100 and he received insulin, his blood sugar could drop too low causing hypoglycemia which could result in jitteriness, shaking, lethargy, seizures, and unresponsiveness. -It was also important to know what the residents' FSBS readings were to make sure they received adequate control of their blood sugar and if the insulin dosage needed to be adjusted. Attempted telephone interview with Resident #2's PCP on 09/04/25 at 4:00pm was unsuccessful.	D 358		

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D 358	Continued From page 30 b. Review of Resident #2's electronic progress notes dated 07/10/25 revealed: -There was an entry by the Administrator at 10:15am. -Resident #2 was seen at Urgent Care in a neighboring city for wax build up in the ear on 07/09/25. -Resident #2's diagnosis was acute left otitis media (otitis media is an infection behind the eardrum in the middle ear) and amoxicillin (an antibiotic used to treat bacterial infections) 875mg, take one daily with food for 7 days was prescribed and were called to a retail pharmacy. Review of Resident #2's Urgent Care visit summary dated 07/09/25 revealed: -The assessment was acute pain in both ears and impacted cerumen (ear wax) of both ears. -The plan orders were the resident had ear lavage of both ears. -The medications ordered were amoxicillin 875mg-potassium clavulanate 125mg tablets, take one twice a day with food for seven days and sent to a local retail pharmacy. -The Urgent Care visit summary was date and time stamped by the provider on 07/09/25 at 4:23pm. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed there was no entry for amoxicillin 875mg-potassium clavulanate 125mg tablets. Telephone interview with a representative from the local retail pharmacy on 09/04/25 at 10:11am revealed: -A prescription for amoxicillin 875-potassium clavulanate 125mg tablets to take one twice a day for seven days for a quantity of 14 tablets was	D 358		

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D 358	Continued From page 31 received for Resident #2 on 07/09/25. -The amoxicillin 875mg-potassium clavulanate 125mg prescription was never picked up for Resident #2. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 09/04/25 at 2:24pm revealed there was no record on file for amoxicillin-potassium clavulanate prescription for Resident #2. Telephone interview with a second retail pharmacy on 09/04/25 at 4:52pm revealed: -An order was received for Resident #2 on 07/11/25 for amoxicillin 875mg-potassium clavulanate 125mg for 14 tablets to take twice a day for 7 days. -The amoxicillin-potassium clavulanate was picked up by Resident #2 on 07/11/25. Telephone interview with the licensed practical nurse (LPN) at the Urgent Care clinic on 09/04/25 at 4:36pm revealed: -Resident #2 was seen at the Urgent Clinic on 07/09/25 for a diagnosis of otitis media and prescription for amoxicillin 875-potassium clavulanate 125mg, 14 tablets to take one twice a day for 7 days was sent to a local retail pharmacy on 07/09/25. -There was documentation of a call from Resident #2 on 07/10/25 that he wanted the amoxicillin-potassium clavulanate prescription sent to a different retail pharmacy. -Amoxicillin-clavulanate was sent to both retail pharmacies for Resident #2. -She called the facility at 8:10am on 07/11/25 to notify Resident #2 or staff, the amoxicillin-clavulanate prescription had been sent to the second retail pharmacy but she received voice mail, and the voice mail box was full, she	D 358		

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D 358	Continued From page 32 was unable to leave a message, so she sent a letter that the amoxicillin-potassium clavulanate prescription had been sent for Resident #2. Interview with Resident #2 on 09/04/25 at 1:36pm revealed: -He had a terrible earache a month or so ago and was treated with antibiotics. -The earache improved after the antibiotics. Second interview with Resident #2 on 09/04/25 at 4:52pm revealed: -He thought someone from the facility took him to the pharmacy to pick up the antibiotic prescription that was prescribed for his earache. -He could not remember exactly which staff took him, but he was pretty certain the staff went into the pharmacy to pick up the amoxicillin prescription for him because he had difficulty walking. -He kept the amoxicillin prescription and administered it to himself. -He was not told to give the amoxicillin prescription to the medication aide (MA) or staff. Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 4:05pm revealed: -Resident #2 went to Urgent Care in July 2025 for an earache and an antibiotic prescription was sent to a local retail pharmacy for him. -Resident #2 went to Urgent Care because he did not have a PCP at that time. Interview with the Administrator on 09/04/25 at 4:22pm revealed: -Resident #2 was seen at Urgent Care on 07/09/25 for an earache and was prescribed amoxicillin that was sent to a retail pharmacy. -The local retail pharmacy was closed when Resident #2 finished his appointment at the	D 358		

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D 358	Continued From page 33 Urgent Care clinic. -A medication aide (MA) went back to the retail pharmacy the next day to pick up Resident #2's amoxicillin prescription and was told there was no amoxicillin prescription there for Resident #2. -Resident #2 wanted the amoxicillin prescription sent to a retail pharmacy in another town, so the Urgent Care clinic was contacted and requested Resident #2's amoxicillin prescription be sent to the new pharmacy. -The Activities Director (AD) took Resident #2 to the requested retail pharmacy to pick up his amoxicillin prescription and told Resident #2 to give the amoxicillin prescription to the MA when he returned to the facility. Interview with the AD on 09/04/25 at 4:25pm revealed: -She took Resident #2 to a local retail pharmacy in a neighboring town, about one and half months ago to pick up a prescription. -Resident #2 went into the pharmacy and picked up his prescription and held on to his prescription. -She told Resident #2 to give the amoxicillin prescription to the MA when he returned to the facility. -She did not touch Resident #2's amoxicillin prescription because the residents were funny about their belongings. -She had another resident with her, and they made two more stops for food and shopping before returning to the facility. -Once they returned to the facility, she dropped Resident #2 off at the door and parked the facility vehicle. -She assumed Resident #2 gave the amoxicillin prescription to the MA. Second interview with the Administrator on 09/04/25 at 4:29pm revealed:	D 358		

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D 358	Continued From page 34 -The residents knew all outside medications were to be given to a MA or the RCC. -Once the MA received the prescription from the resident, if there was paperwork with the prescription, it was faxed to the facility's contracted pharmacy so it could be profiled and added to the resident's eMAR. -If there was no paperwork with the prescription, the MA contacted the local retail pharmacy to request paperwork to send to the facility's contracted pharmacy to be profiled and added to the eMAR. -Medications could not be administered to the residents if it was not listed on the eMAR. -No resident in the facility self-administered medications. Interview with a MA on 09/04/25 at 4:55pm revealed: -If a resident or resident's family member brought in outside medications, the medications were to be given to staff. -If she received outside medications for a resident, she gave the medication to the RCC to handle getting the medication added to the resident's eMAR. Second interview with the RCC on 09/04/25 at 5:12pm revealed: -Residents and residents' family members were to give all outside prescriptions to a MA or herself. -The facility's contracted pharmacy had to have paperwork on all outside prescriptions to profile the residents and to add to their eMAR so the medication could be administered. -Resident #2 did not have a self-administer order for medications. -A paper medication administration record (MAR) could be started for outside medications for the residents until the new medication could be	D 358		

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D 358	Continued From page 35 added to the resident's eMAR. -The MA on duty should have questioned Resident #2 about the amoxicillin prescription when he returned from the pharmacy. Third interview with the Administrator on 09/04/25 at 5:45pm revealed: -Resident #2 had a history of non-compliance. -Resident #2 knew the procedure for outside medications and that he was to give the amoxicillin prescription to the MA on duty when he returned to the facility from the pharmacy. -She was sure the AD probably dropped Resident #2 off at the door and he went straight to his room. -Resident #2 should have been questioned about his amoxicillin prescription when he returned from the pharmacy so it could be turned over to staff and a paper MAR could have been started for the amoxicillin until it could be added to the eMAR. -There was no way to know if Resident #2 took his amoxicillin as ordered. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:36pm revealed: -She last treated Resident #2 in June 2025, and he was currently under the care of an outside PCP. -Generally speaking, if otitis media was left untreated it could worsen and result in a ruptured ear drum, pain, fever or sepsis. Attempted telephone interview with Resident #2's PCP on 09/04/25 at 4:00pm was unsuccessful. Attempted telephone interview with the provider at the Urgent Care clinic on 09/04/25 at 4:36pm was unsuccessful.	D 358		

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D 358	Continued From page 36 3. Review of Resident #5's current FL2 dated 02/12/25 revealed: -Diagnoses included seizures, hyperlipidemia, history of stroke, and schizoaffective disorder. -She was intermittently disoriented. Review of Resident #5's signed physician's order sheet dated 03/05/25 revealed: -There was an order for amlodipine (amlodipine is used to treat hypertension) 5mg, take one tablet once daily for high blood pressure. -There was an order for magnesium oxide (magnesium oxide is a vitamin supplement) 400mg, take one tablet daily for hypomagnesium. -There was an order for paroxetine (paroxetine is used to treat depression) 40mg, take one tablet once daily. -There was an order for risperidone (risperidone is used to treat schizophrenia) 2mg, take one tablet every evening. -There was an order for trazodone (trazodone is an anti-depressant) 50mg, take one tablet at bedtime for insomnia. Review of Resident #5's hospital after visit summary dated 08/22/25 revealed: -Her diagnosis was internal right carotid artery stenosis (narrowing). -Her medication list included instructions to stop taking these medications, amlodipine 5mg, magnesium oxide 400mg, paroxetine 40mg, risperidone 1mg, and trazodone 50mg and was initialed by her primary care provider (PCP) but the initials were not dated. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 5mg, take one tablet every day for high blood pressure,	D 358		

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D 358	Continued From page 37 scheduled for 8:00am. -Amlodipine 5mg was documented as administered at 8:00am on 08/23/25 through 08/31/25. -There was an entry for magnesium oxide 400mg, take one tablet once daily for hypomagnesium, scheduled at 8:00am. -Magnesium oxide 400mg was documented as administered at 8:00am on 08/23/25 through 08/31/25. -There was an entry for paroxetine 40mg, take one tablet once daily scheduled for 8:00am. -Paroxetine 40mg was documented as administered at 8:00am on 08/23/25 through 08/31/25. -There was an entry for risperidone 2mg, take one tablet every evening, scheduled at 8:00pm. -Risperidone 2mg was documented as administered at 8:00pm on 08/22/25 through 08/31/25. -There was an entry for trazodone 50mg, take one tablet at bedtime for insomnia, scheduled at 8:00pm. -Trazodone 50mg was documented as administered at 8:00pm on 08/22/25 through 08/31/25. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for amlodipine 5mg, take one tablet every day for high blood pressure, scheduled for 8:00am. -Amlodipine 5mg was documented as administered at 8:00am on 09/01/25 through 09/03/25. -There was an entry for magnesium oxide 400mg, take one tablet once daily for hypomagnesium, scheduled at 8:00am. -Magnesium oxide 400mg was documented as administered at 8:00am on 09/01/25 through	D 358		

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D 358	Continued From page 38 09/03/25. -There was an entry for paroxetine 40mg, take one tablet once daily scheduled for 8:00am. -Paroxetine 40mg was documented as administered at 8:00am on 09/01/25 through 09/03/25. -There was an entry for risperidone 2mg, take one tablet every evening, scheduled at 8:00pm. -Risperidone 2mg was documented as administered at 8:00pm on 09/01/25 and 09/02/25. -There was an entry for trazodone 50mg, take one tablet at bedtime for insomnia, scheduled at 8:00pm. -Trazodone 50mg was documented as administered at 8:00pm on 09/01/25 and 09/02/25. Observation of Resident #5's medications on hand on 09/04/25 at 4:14pm revealed: -The was a weekly multidose package of medications that included amlodipine 5mg tablets, magnesium oxide 400mg tablets, paroxetine 40mg tablets, risperidone 2mg tablets, and trazodone 50mg tablets. -The top tab Resident #5's weekly multi-dose medication package listed each medication contained in the multi-dose package and included the physician's order on how to administer each medication including amlodipine 5mg, take once daily for high blood pressure, magnesium oxide 400mg, take one tablet daily for hypomagnesium, paroxetine 40mg, take once daily scheduled for morning and risperidone 2mg, take one tablet every evening, and trazodone 50mg, take one tablet at bedtime for insomnia for bedtime. -The multi-dose medication package had a print date of 08/26/25. -There were 4 days remaining on Resident #5's morning multi-dose package.	D 358		

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D 358	Continued From page 39 -There were 5 days remaining for Resident #5's evening multi-dose package. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/04/25 revealed: -The 08/22/25 hospital after visit summary was received on 08/22/25 for Resident #5 along with new prescriptions and orders for new medication dosages. -She saw the list of discontinued medications on Resident #5's 08/22/25 hospital after visit summary that included amlodipine 5mg, magnesium oxide 400mg, paroxetine 40mg, risperidone 1mg, and trazodone 50mg but these medications had not been discontinued by the pharmacy on Resident #5's eMAR. -The list of discontinued medications for Resident #5 was signed by her PCP. -She was not sure why the discontinued medications on Resident #5's 08/22/25 hospital after visit summary had not been stopped and removed from her eMAR. Interview with a medication aide (MA) on 09/04/25 at 4:55pm revealed: -The Resident Care Coordinator (RCC) processed all the medication and treatment orders for the residents. -The RCC reviewed the hospital after visit and discharge paperwork for the residents when they returned from the hospital. -If a resident returned after hours or on the weekend, the MAs placed the resident's hospital paperwork in a box for the RCC or the Administrator to review. Interview with the RCC on 09/04/25 at 5:12pm revealed: -She reviewed all hospital paperwork for the	D 358		

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D 358	Continued From page 40	D 358		

residents for new orders and order changes.
-If she was not here, the MAs faxed the hospital paperwork to the pharmacy and left it for her to review.
-She approved new orders in the eMAR system and approved discontinued orders in the eMAR system.
-She was off when Resident #5 returned from the hospital and the Special Care Coordinator (SCC) reviewed Resident #5's hospital paperwork, faxed it to the facility's contracted pharmacy and filed the hospital visit information in the resident's record.
-She knew Resident #5 had new medication orders and that some of her medications had changed but she was not aware of the discontinued medications.

Interview with the Administrator on 09/04/25 at 5:45pm revealed:
-She or the Care Managers, (RCC or SCUC) reviewed all hospital discharge paperwork for the residents.
-If a resident returned from the hospital after hours, the MAs faxed the hospital discharge paperwork to the pharmacy and placed it in a box for the RCC to review when she returned.
-The RCC scanned the hospital discharge information and sent it to the facility's contracted pharmacy and to the resident's PCP.
-The resident's hospital after visit summary was kept in a "hot box" or bucket until of the new medications orders, medication dosage changes, or discontinue orders were received and approved in the eMAR system so the hospital after visit summary could be compared to the new orders on the eMAR for completeness.
-The hospital after visit summary was removed from the "hot box" and placed in the resident's record after all of the new orders were reflected

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D 358	Continued From page 41 on the resident's eMAR. -Resident #5's hospital discharge information should not have been filed in the resident's record until all of the new orders were reviewed and approved on the eMAR system. Telephone interview with Resident #5's PCP on 09/04/25 at 3:38pm revealed: -Resident #5 had a recent hospitalization for an ischemic stroke. -She saw Resident #5 recently for a quick visit and had reviewed her hospital after visit summary paperwork. -She knew a lot of Resident #5's medications had been changed and discontinued. -Resident #5 was placed on a new medication for her blood pressure at this last hospital visit and continuing the amlodipine with the new blood pressure medication could cause Resident #5's blood pressure to drop too low leading to dizziness and weakness and put her at risk for falls. -Resident #5's behavioral health provider prescribed paroxetine, risperidone and trazodone, so she could not speak to these medications, but said it was possible since her recent hospitalization, these medications could cause excessive sedation. Attempted telephone interview with Resident #5's behavioral health provider on 09/04/25 at 3:57pm was unsuccessful.	D 358	Type text here	
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	D 367	10A NCAC 13F .1004(j) Medication Administration Currituck House will ensure that residents medication records are accurate. CNC, RN in-serviced Med Techs on the 6 Rights of Medication Adminsitration to include high risk medications and the importance of the accuracy of EMAR's.	09/26/25 09/10/25

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D 367	Continued From page 42 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 1 of 5 sampled residents (#2) related to documentation of fingerstick blood sugars and a medication used to treat bacterial infections (#2). The findings are: Review of the facilities undated diabetic medication and treatment policy revealed: -Residents receiving medication and treatments for diabetic care would be monitored according to physician orders. -All medications, blood sugar monitoring, insulins would be added to a diabetic flowsheet.	D 367	ED and CC's will review facility reports in daily stand up to ensure appropriate orders and accuracy of EMAR's. Any desrepancies identified will be immediately reported for follow up to the prescribing physician. CC's will perform weekly med cart audits per facility schedule by physician order to EMAR to cart. Any descrepancies will be immediately reported for follow up by prescribing physician. CC will conduct at mimimum 2 resident chart audits weekly to ensure accuracy of orders by prescribing physician. Any descrepancies will immediately be verified and clarified with the precribing physician.	09/10/25 09/26/25 09/26/25

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D 367	Continued From page 43 Review of the facility's undated Medication Administration Record (MAR) policy revealed: -The MAR provides instruction to the medication aide (MA) for administering medications. -Electronic medication administration records (eMARs) may be used, and they require staff to document information and administer medication on the computerized MAR. -The eMARs should include the resident's name, room number, medication name, strength of dose or amount of medication to be given , date and time to be given, route to be given, date the order was written, date the order expires (if applicable), resident's allergies, initials of staff administering medication with each administration, refusals or medication not given are indicated by staff person's initials with a circle around them, and medication administration times are indicated on the MAR. Review of the facility's undated Medication Administration policy revealed: -Blood pressures, weights, pulses, blood sugars and other orders for monitoring certain medications are obtained in accordance with the facility's policies and procedures or as ordered by the prescribing practitioner. -Staff uses medication administration records when preparing and administering medications and checks medication labels against medication administration records. -Recording of the administration of medication is promptly following the act of administration by the staff who administers the medications. -Staff that administers the medication observes the resident actually taking the medication. -Medication orders should be transcribed onto the medication administration record at the time the order is received.	D 367		

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D 367	Continued From page 44 1. Review of Resident #2's current FL2 dated 06/18/25 revealed: -Diagnoses included type 1 diabetes mellitus with neuropathy, nonrheumatic aortic valve stenosis, atherosclerotic heart disease, and cerebrovascular disease. -He was intermittently disoriented. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/14/25. a. Review of Resident #2's signed physician's order sheet dated 06/18/25 revealed: -There was an order to check fasting finger stick blood sugar (FSBS) three times daily before meals at 7:00am, 11:30am and 4:30pm. -There was an order to check FSBS four times a day at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an order for insulin glargine 100unit/ml, inject 11 units twice daily, give bedtime snack and hold for FSBS less than 110, twice a day at 8:00am and 8:00pm. Review of a subsequent signed physician's order dated 06/18/25 revealed: -There was an order to discontinue insulin glargine 11 units twice daily. -There was an order to start insulin glargine 22 units at bedtime, hold if FSBS is less than 100, and contact primary care provider (PCP). Review of a subsequent signed physician's order dated 08/12/25 revealed an order to increase the insulin glargine dose to 26 units at bedtime. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed.	D 367	Type text here	

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D 367	Continued From page 45 -There was an entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 8:00pm on 07/01/25 through 07/31/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP, scheduled at 8:00pm. -Insulin glargine, 22units was documented as administered at 8:00pm on 07/01/25 through 07/31/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Review of Resident #2's August 2025 eMAR revealed: -There was an entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 8:00pm on 08/01/25 through 8/31/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 22 units at bedtime, hold if FSBS is less than 100 and contact the PCP with an end date of 08/14/25. -Insulin glargine 22units was documented as administered at 8:00pm on 08/01/25 through 08/13/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. -There was an entry for insulin glargine, inject 26 units at bedtime, hold if FSBS is less than 100 and notify PCP, scheduled at 8:00pm with a start date of 08/14/25.	D 367		

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D 367	Continued From page 46 -Insulin glargine 26 units was documented as administered at 8:00pm on 08/14/25 through 08/31/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Review of Resident #2's September 2025 eMAR revealed: -There was an entry for FSBS four times per day, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -Resident #2's FSBS was documented as checked at 8:00pm on 09/01/25 and 09/02/25, there was no documentation of the FSBS reading. -There was an entry for insulin glargine, inject 26 units at bedtime, hold of FSBS is less than 100, scheduled at 8:00pm. -Insulin glargine, 26 units was documented as administered at 8:00pm on 09/01/25 and 09/02/25. -There was no documentation of the 8:00pm FSBS reading to correlate with the 8:00pm dose of insulin glargine. Telephone with a pharmacist with the facility's contracted pharmacy provider on 09/04/25 at 2:57pm revealed: -An order was received on 05/14/25 for Resident #2 to have fasting FSBS checks three times a day before meals. -A second order was received on 05/16/25 for FSBS four times per day. -It was the facility's responsibility to add a space on the resident's eMAR to record Resident #2's 8:00pm FSBS reading. Interview with Resident #2 on 09/04/25 at 1:56pm revealed:	D 367		

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D 367	Continued From page 47 -Staff administered insulin three or four times per day depending on what his FSBS was. -Staff performed finger pricks for FSBS checks four times per day. Interview with a medication aide (MA) on 09/04/25 at 4:15pm revealed: -She always recorded Resident #2's FSBSs. -She worked day shift, so she had not noticed there was no space on Resident #2's eMAR to record his 8:00pm FSBS. Interview with a second MA on 09/04/25 at 4:55pm revealed: -When a resident had FSBS checks, the eMAR directed the MA to enter the FSBS reading. -She checked Resident #2's 8:00pm FSBS but had not noticed that there was no space to document his 8:00pm FSBS reading. -She did not record Resident #2's 8:00pm FSBS on his eMAR or anywhere else, she just reviewed the reading with his insulin order. -It had not occurred to her to let the Resident Care Coordinator (RCC) know there was no space to record Resident #2's 8:00pm FSBS reading on the eMAR. Interview with the RCC on 09/04/25 at 5:12pm revealed: -FSBS readings should always be documented on the residents' eMAR to ensure they received the appropriate amount of insulin and to keep track of what their FSBSs were. -No one had notified her that there was no space available on Resident #2's eMAR to record his 8:00pm FSBS reading. -Management was not aware until today that Resident #2's 8:00pm FSBSs were not recorded. -She could add a space to Resident #2's eMAR to record his 8:00pm FSBSs.	D 367		

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D 367	Continued From page 48 -She did weekly eMAR audits for all the residents to match the residents' medication orders to their eMARs. -She had not noticed that Resident #2's 8:00pm FSBS readings were not documented. Interview with the Administrator on 09/04/25 at 5:45pm revealed: -FSBS readings should always be documented on the residents' eMAR to ensure the correct amount of insulin was administered. -She thought the pharmacy was responsible to make sure there was a space to enter all FSBS readings. -The RCC was responsible for weekly eMAR audits -It was an oversight that there was no space on Resident #2's eMAR to enter his 8:00pm FSBS reading. -Without documentation of Resident #2's 8:00pm FSBS reading on the eMAR, there was no way to know if he received the appropriate amount of insulin glargine. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:36pm revealed: -She previously treated Resident #2. -She ordered FSBSs for Resident #2 three times a day and at bedtime. -It was important to record all the FSBS reading to look for high and low trends and to make the resident received the correct amount of insulin. Attempted telephone interview with Resident #2's current PCP on 09/04/25 at 4:00pm was unsuccessful. b. Review of Resident #2's electronic progress notes dated 07/10/25 revealed:	D 367		

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D 367	Continued From page 49 -There was an entry by the Administrator at 10:15am. -Resident #2 was seen at Urgent Care in a neighboring city for wax build up in the ear on 07/09/25. -Resident #2's diagnosis was acute left otitis media (otitis media is an infection behind the eardrum in the middle ear) and amoxicillin (an antibiotic used to treat bacterial infections) 875mg, take one daily with food for 7 days was prescribed and were called to a retail pharmacy. Review of Resident #2's Urgent Care visit summary dated 07/09/25 revealed: -The assessment was acute pain in both ears and impacted cerumen (ear wax) of both ears. -The plan orders were the resident had ear lavage of both ears. -The medications ordered were amoxicillin 875mg-potassium clavulanate 125mg tablets, take one twice a day with food for seven days and sent to a local retail pharmacy. -The Urgent Care visit summary was date and time stamped by the provider on 07/09/25 at 4:23pm. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed there was no entry for amoxicillin 875mg-potassium clavulanate 125mg tablets. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 09/04/25 at 2:24pm revealed there was no record on file for amoxicillin-potassium clavulanate prescription for Resident #2 from July 2025. Telephone interview with a retail pharmacy on 09/04/25 at 4:52pm revealed: -An order was received for Resident #2 on	D 367	Type text here	

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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 367	Continued From page 50 07/11/25 for amoxicillin 875mg-potassium clavulanate 125mg for 14 tablets to take twice a day for 7 days. -The amoxicillin-potassium clavulanate was picked up for Resident #2 on 07/11/25. Telephone interview with the licensed practical nurse (LPN) at the Urgent Care clinic on 09/04/25 at 4:36pm revealed: -Resident #2 was seen at the Urgent Clinic on 07/09/25 for a diagnosis of otitis media and prescription for amoxicillin 875-potassium clavulanate 125mg, 14 tablets to take one twice a day for 7 days was sent to a local retail pharmacy on 07/09/25. -There was documentation of a call from Resident #2 on 07/10/25 that he wanted the amoxicillin-potassium clavulanate prescription sent to a different retail pharmacy. -Amoxicillin-clavulanate was sent to both retail pharmacies for Resident #2. Interview with Resident #2 on 09/04/25 at 1:36pm revealed: -He had a terrible earache a month or so ago and was treated with antibiotics. -The earache improved after the antibiotics. Second interview with Resident #2 on 09/04/25 at 4:52pm revealed: -He thought someone from the facility took him to the pharmacy to pick up the antibiotic prescription that was prescribed for his earache. -He could not remember exactly which staff took him, but he was pretty certain the staff went into the pharmacy to pick up the amoxicillin prescription for him because he had difficulty walking. -He kept the amoxicillin prescription and administered it to himself.	D 367		

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D 367	Continued From page 51 -He was not told to give the amoxicillin prescription to the medication aide (MA) or staff. Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 4:05pm revealed: -Resident #2 went to Urgent Care in July 2025 for an earache and an antibiotic prescription was sent to a local retail pharmacy for him. -Resident #2 went to Urgent Care because he did not have a PCP at that time. Interview with the Administrator on 09/04/25 at 4:22pm revealed: -Resident #2 was seen at Urgent Care on 07/09/25 for an earache and was prescribed amoxicillin that was sent to a retail pharmacy. -The local retail pharmacy was closed when Resident #2 finished his appointment at the Urgent Care clinic. -A medication aide (MA) went back to the retail pharmacy the next day to pick up Resident #2's amoxicillin prescription and was told there was no amoxicillin prescription there for Resident #2. -Resident #2 wanted the amoxicillin prescription sent to a retail pharmacy in another town, so the Urgent Care clinic was contacted and requested Resident #2's amoxicillin prescription be sent to the new pharmacy. -The Activities Director (AD) took Resident #2 to the requested retail pharmacy to pick up his amoxicillin prescription and told Resident #2 to give the amoxicillin prescription to the MA when he returned to the facility. Interview with the AD on 09/04/25 at 4:25pm revealed: -She took Resident #2 to a local retail pharmacy in a neighboring town, about one and half months ago to pick up a prescription. -Resident #2 went into the pharmacy and picked	D 367	Type text here	

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D 367	Continued From page 52 up his prescription and held on to his prescription. -She told Resident #2 to give the amoxicillin prescription to the MA when he returned to the facility. -She did not touch Resident #2's amoxicillin prescription because the residents were funny about their belongings. -She had another resident with her, and they made two more stops for food and shopping before returning to the facility. -Once they returned to the facility, she dropped Resident #2 off at the door and parked the facility vehicle. -She just assumed Resident #2 gave the amoxicillin prescription to the MA. Second interview with the Administrator on 09/04/25 at 4:29pm revealed: -The residents knew all outside medications were to be given to a MA or the RCC. -Once the MA received the prescription from the resident, if there was paperwork with the prescription, it was faxed to the facility's contracted pharmacy so it could be profiled and added to the resident's eMAR. -If there was no paperwork with the prescription, the MA contacted the local retail pharmacy to request paperwork to send to the facility's contracted provider to be profiled and added to the resident's eMAR. -Medications could not be administered to the residents if it was not listed on the eMAR. Interview with a MA on 09/04/25 at 4:55pm revealed: -If a resident or resident's family member brought in outside medications, the medications were to be given to staff. -If she received outside medications for a resident, she gave the medication to the RCC to	D 367		

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D 367	Continued From page 53 handle getting the medication added to the resident's eMAR. Second interview with the RCC on 09/04/25 at 5:12pm revealed: -Residents and residents' family members were to give all outside prescriptions to a MA or herself. -The facility's contracted pharmacy had to have paperwork on all outside prescriptions to put on profile for the residents and to add to their eMAR so the medication could be administered. -Resident #2 did not have a self-administer order for medications. -A paper medication administration record (MAR) could be started for outside medications for the residents until the new medication could be added to the resident's eMAR. -The MA on duty should have questioned Resident #2 about the amoxicillin prescription when he returned from the pharmacy. Third interview with the Administrator on 09/04/25 at 5:45pm revealed: -Resident #2 had a history of non-compliance. -Resident #2 knew the procedure for outside medications and that he was to give the amoxicillin prescription to the MA on duty when he returned to the facility from the pharmacy. -She was sure the AD probably dropped Resident #2 off at the door and he went straight to his room. -Resident #2 should have been questioned about his amoxicillin prescription when he returned from the pharmacy so it could be turned over to staff and a paper MAR could have been started for the amoxicillin until it could be added to the eMAR. -Without documentation on the resident's eMAR, there was no way to know if Resident #2 took his amoxicillin as ordered.	D 367	1	

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D 367	Continued From page 54 Attempted telephone interview with Resident #2's PCP on 09/04/25 at 4:00pm was unsuccessful. Attempted telephone interview with the provider at the Urgent Care clinic on 09/04/25 at 4:36pm was unsuccessful.	D 367	Type text here	
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) had physicians' orders to self-administer a medication used to treat bacterial infections. The findings are: Review of the facility's undated Self Administration of Medication policy revealed: -Any perspective or current resident who desires	D 375	10A NCAC 13F .1005 Self-Administration of Medications- Currituck House will ensure that residents who self administer are successfully checked off by the RN and signed by prescribing physician. CNC, RN in-serviced CC's and Med Techs on the importance of residents having and RN evaluate a resident for the self-administration of medications and signed order by the prescribing physician. Med Techs will ensure that all resident medications are properly stored and locked on medication cart. All staff will conduct daily room checks to ensure all rooms are free from medications. Any resident with a self-administration order shall have the medication appropriately stored. Facility managers will conduct daily walk throughs to ensure resident rooms are free from hazards. Any areas of concern will be followed up on immediately.	09/3025 09/30/25 09/30/25 09/30/25 09/30/25

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D 375	Continued From page 55 to self-manage his/her medications must successfully complete the Self-Administration Assessment by the Nurse Consultant or designee. -File the completed Assessment for Medication Self-Management in the resident's chart with the resident's assessment. -Once the resident satisfactorily passed the evaluation, the Resident Care Coordinator (RCC) or designee will ensure there is a Physician's Order in place that indicates the resident is able to store and self-administer his/her medications. Review of the facility's undated Medication Services policy revealed: -Residents will be determined to be one of the following categories. -Independent, the resident can safely self-administer medications or treatments after the community nurse or designee performs a self-administration assessment and the resident is deemed safe to self-administer for which the resident will assessed quarterly or as needed for any changes. -Medication administration requires total assistance with all medications and is completely incapable of self-directing their medication care, this includes licensed nurse administration of injections. -The required level of medication assistance will be documented in the resident's care plan. Review of Resident #2's current FL2 dated 06/18/25 revealed: -Diagnoses included type 1 diabetes mellitus with neuropathy, nonrheumatic aortic valve stenosis, atherosclerotic heart disease, and cerebrovascular disease. -He was intermittently disoriented.	D 375		

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D 375	Continued From page 56 Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/14/25. Review of Resident #2's current care plan dated 06/18/25 revealed: -The resident was oriented. -His memory was adequate. -He was ambulatory with assistive devices. -The resident required limited assistance with eating, bathing and dressing. -There was no level of medication assistance documented. Review of Resident #2's electronic progress notes dated 07/10/25 revealed: -There was an entry by the Administrator at 10:15am. -Resident #2 was seen at Urgent Care in a neighboring city for wax build up in the ear on 07/09/25. -Resident #2's diagnosis was acute left otitis media (otitis media is an infection behind the eardrum in the middle ear) and amoxicillin (an antibiotic used to treat bacterial infections) 875mg, take one daily with food for 7 days was prescribed and were called to a retail pharmacy. Review of Resident #2's Urgent Care clinic visit summary dated 07/09/25 revealed: -The assessment was acute pain in both ears and impacted cerumen (ear wax) of both ears. -The plan orders were the resident had ear lavage of both ears. -The medications ordered were amoxicillin 875mg-potassium clavulanate 125mg tablets, take one twice a day with food for seven days and sent to a local retail pharmacy. -The Urgent Care visit summary was date and time stamped by the provider on 07/09/25 at	D 375		

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D 375	Continued From page 57 4:23pm. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed there was no entry for amoxicillin 875mg-potassium clavulanate 125mg tablets. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 09/04/25 at 2:24pm revealed there was no record on file for amoxicillin-potassium clavulanate prescription for Resident #2. Telephone interview with a retail pharmacy on 09/04/25 at 4:52pm revealed: -An order was received for Resident #2 on 07/11/25 for amoxicillin 875mg-potassium clavulanate 125mg for 14 tablets to take twice a day for 7 days. -The amoxicillin-potassium clavulanate was picked up by Resident #2 on 07/11/25. Telephone interview with the licensed practical nurse (LPN) at the Urgent Care clinic on 09/04/25 at 4:36pm revealed: -Resident #2 was seen at the Urgent Clinic on 07/09/25 for a diagnosis of otitis media and prescription for amoxicillin 875-potassium clavulanate 125mg, 14 tablets to take one twice a day for 7 days was sent to a local retail pharmacy on 07/09/25. -There was documentation of a call from Resident #2 on 07/10/25 that he wanted the amoxicillin-potassium clavulanate prescription sent to a different retail pharmacy. -Amoxicillin-clavulanate was sent to both retail pharmacies for Resident #2. Interview with Resident #2 on 09/04/25 at 1:36pm revealed:	D 375		

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D 375	Continued From page 58 -He had a terrible earache a month or so ago and was treated with antibiotics. -The earache improved after the antibiotics. Second interview with Resident #2 on 09/04/25 at 4:52pm revealed: -He thought someone from the facility took him to the pharmacy to pick up the antibiotic prescription that was prescribed for his earache. -He could not remember exactly which staff took him, but he was pretty certain the staff went into the pharmacy to pick up the amoxicillin prescription for him because he had difficulty walking. -He kept the amoxicillin prescription and administered it to himself. -He was not told to give the amoxicillin prescription to the medication aide (MA) or staff. Interview with the Administrator on 09/04/25 at 4:22pm revealed: -Resident #2 was seen at Urgent Care on 07/09/25 for an earache and was prescribed amoxicillin that was sent to a retail pharmacy. -The local retail pharmacy was closed when Resident #2 finished his appointment at the Urgent Care clinic. -A MA went back to the retail pharmacy the next day to pick up Resident #2's amoxicillin prescription and was told there was no amoxicillin prescription there for Resident #2. -Resident #2 wanted the amoxicillin prescription sent to a retail pharmacy in another town, so the Urgent Care clinic was contacted and requested Resident #2's amoxicillin prescription be sent to the new pharmacy. -The Activities Director (AD) took Resident #2 to the requested retail pharmacy to pick up his amoxicillin prescription and told Resident #2 to give the amoxicillin prescription to the MA when	D 375		

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D 375	Continued From page 59 he returned to the facility. Interview with the AD on 09/04/25 at 4:25pm revealed: -She took Resident #2 to a local retail pharmacy in a neighboring town, about one and half months to pick up a prescription. -Resident #2 went into the pharmacy and picked up his amoxicillin prescription and held on to his prescription. -She told Resident #2 to give the amoxicillin prescription to the MA when he returned to the facility. -She did not touch Resident #2's amoxicillin prescription because the residents were funny about their belongings. -She had another resident with her, and they made two more stops for food and shopping before returning to the facility. -Once they returned to the facility, she dropped Resident #2 off at the door and parked the facility vehicle. -She assumed Resident #2 gave the amoxicillin prescription to the MA. Second interview with the Administrator on 09/04/25 at 4:29pm revealed: -The residents knew all outside medications were to be given to a MA or the Resident Care Coordinator (RCC). -Once the MA received the prescription from the pharmacy, if there was paperwork with the prescription, it was faxed to the facility's contracted pharmacy so it could be profiled and added to the resident's eMAR. -If there was no paperwork with the prescription, the MA contacted the local retail pharmacy to request paperwork to send to the facility's contracted provider to be profiled and added to the eMAR.	D 375		

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D 375	Continued From page 60 -Medications could not be administered to the residents if it was not listed on the eMAR. -Resident #2 did not have a self-administration order. -No resident in the facility self-administered medications. Interview with the RCC on 09/04/25 at 5:12pm revealed: -Residents and residents' family members were to give all outside prescriptions to a MA or herself. -The facility's contracted pharmacy had to have paperwork on all outside prescriptions to profile the residents and to add to their eMAR so the medication could be administered. -A physician's order and a self-administration assessment were required for a resident to self-administer medications. -Resident #2 did not have a self-administer order for medications. -The MA on duty should have questioned Resident #2 about the amoxicillin prescription when he returned from the pharmacy. Third interview with the Administrator on 09/04/25 at 5:45pm revealed: -Resident #2 had a history of non-compliance. -Resident #2 knew the procedure for outside medications and that he was to give the amoxicillin prescription to the MA on duty when he returned to the facility from the pharmacy. -She was sure the AD probably dropped Resident #2 off at the door and he went straight to his room. -Resident #2 should have been questioned about his amoxicillin prescription when he returned from the pharmacy so it could be turned over to staff. -A physician's order and self-administration screening were required for a resident to self-administer medications.	D 375		

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D 375	Continued From page 61 -Resident #2 did not have a self-administration order or a self-administration screening. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:36pm revealed: -She last treated Resident #2 in June 2025, and he was currently under the care of an outside PCP. -She had never issued a self-administration order for Resident #2 while she was treating him. Attempted telephone interview with Resident #2's current PCP on 09/04/25 at 4:00pm was unsuccessful. Attempted telephone interview with Resident #2's behavioral health provider on 09/04/25 at 3:57pm was unsuccessful. Attempted telephone interview with the provider at the Urgent Care clinic on 09/04/25 at 4:36pm	D 375		