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
	hal026065	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT HOPE MILLS	7051 ROCKFISH ROAD FAYETTEVILLE, NC 28306

(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 an annual survey from 05/19/26 to 05/21/26.	D 000	D000 Response to cited deficiencies 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 Deficiencies or Corrective Action Report; the plan of correction is prepared solely as a matter of compliance with state law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure follow-up on a referral for 1 of 7 residents related to a test for urinary tract infection (UTI) (#4). The findings are: Review of Resident #4's FL-2 dated 12/02/25 revealed diagnoses included metabolic encephalopathy, rheumatoid arthritis, type II diabetes, hypertension, depression, and age-related osteoporosis. Review of a lab requisition order form dated 03/19/26 revealed: -There was an order for urinalysis (UA) with micro culture and sensitivity (C&S) (UA with micro C&S are laboratory tests for UTI). -The prescriber listed was Resident #4's PCP. Review of an email dated 05/20/26 revealed: -The email signature showed communication was sent from Resident #4's PCP staff. -Resident #4 had a UA with micro C&S ordered on 03/19/26 and as of 04/03/26 the lab had not been collected and was cancelled.	D 273	D 273 Health Care Director or designee will process all orders as soon as received from issuing provider. Order processing to include making or changing appointments for the need of the resident or collection of specimens and any ordering of diagnostic testing. Executive Director in-serviced nursing staff regarding expectation for timely order processing and timely follow up of labs. Healthcare Director or designee will re-train clinical staff regarding lab orders and collecting specimens timely. Healthcare Director or designee will train newly hired staff regarding the expectations of new lab orders and collecting specimens timely, upon hire and as needed. Healthcare Director or designee will audit orders daily to ensure compliance. Completion date: 6/17/2026.	

Reviewed and Acknowledged 07/06/26
Teresa A Hoyle

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D 273	Continued From page 1 Interview with the primary care provider (PCP) for Resident #4 on 05/21/26 at 8:33am revealed: -Resident #4's UA with micro and C&S was never performed. -The purpose of the test was to make sure there was no infection and the second reason would be if the nephrologist requested that the test be done. -If there was an infection and they wanted to make sure it was cleared they would also order the test. -If it was ordered she would reassess the patient and if the resident was not symptomatic they may not have to run the test. -If the resident was symptomatic she could just be treated. -Since there was a cancellation of the order on 04/03/26 it was not needed or the patient had no symptoms. -The facility should ensure they can perform the test the same day or next day after it is ordered. -She received notification that it was not done on 04/03/26. -The company she worked for followed up on labs and orders that were not done and asked if it was still needed. Interview with the Administrator on 05/21/26 at 5:32pm revealed: -The health care director was responsible for oversight of the med aides for collection of the urine sample. -If an order was given for a UA the expectation was for the order to be worked simultaneously between the medication aides (MAs) and healthcare director to make sure that the sample is collected. -They did not know when a resident might have to go to the restroom but they had to work collectively to make sure it was done.	D 273		

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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 interviews and record reviews the facility failed to clarify medication orders for 1 of 7 sampled residents related to a hospital discharge and pharmacy request (#3). The findings are: Review of Resident #3's FL-2 dated 04/15/26 revealed: -Diagnoses included metabolic encephalopathy, rheumatoid arthritis, type II diabetes, hypertension, depression, and age-related osteoporosis. -There was an order for Cetirizine 10mg take one tab at bedtime (Cetirizine is medication used to treat allergy symptoms). -There was an order for Culturelle to take one capsule every day (Culturelle is a probiotic supplement).	D 344	D344 Healthcare Director will review all medication orders of each resident for accuracy and any clarifications of medications and administration times shall immediately be performed by contacting the prescribing physician as well as the pharmacy. Any and all updates to the orders shall be reflected correctly on the MAR for the Medication Aides to follow. Executive Director in-serviced nursing staff regarding expectation for timely medication processing for residents. Healthcare Director or designee will reconcile medications immediately upon receiving orders. Completion date: 6/17/2026.	

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D 344	Continued From page 3 -There was an order for Delsym 20mg/5ml suspension take 10mls=60mg every 12 hours as needed, without specification of indication for use (Delsym is medication for temporary cough relief). -There was an order for Magnesium Oxide 400mg take one tab every day (Magnesium Oxide is indicated for treating constipation and preventing or treating magnesium deficiency). -There was an order for Melatonin 3mg take one tablet at bedtime (Melatonin is medication used to aide sleep). -There was an order for Tolterodine Tartrate 2mg take one tablet two times a day (Tolterodine Tartrate is medication which can be used to treat urinary frequency, urinary urgency, and urinary urge incontinence). Review of Resident #3's Resident Register revealed she was admitted to the facility on 09/16/22. Review of Resident #3's Hospital Discharge Summary dated 04/22/26 revealed: -The expected medication list at discharge included Metformin 500mg tablet take one tablet two times a day with meals (Metformin is medication which can be used to help control blood sugar and treat type 2 diabetes). -The expected medication list at discharge included Januvia 100mg take one tablet one time each day (Januvia is medication which can be given to help with blood glucose control in people with type 2 diabetes). -The expected medication list at discharge included Atorvastatin 40 mg take one tablet one time each day (Atorvastatin is medication which can be used to treat hyperlipidemia and dyslipidemia). -The expected medication list at discharge	D 344		

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D 344	Continued From page 4 included Lisinopril 2.5 mg take one tablet once a day (Lisinopril is medication which can be used to treat hypertension, heart failure, and myocardial infarction). -The expected medication list at discharge included Combivent Respimat 20-100 mcg/act inhaler inhale one puff four times a day if needed for wheezing or shortness of breath (Combivent Respimat is medication which can be used to treat certain symptoms in patients with COPD). Review of Resident #3's FL-2/Discharge Summary Verification Form dated 04/23/26 revealed: -The form was created by the facility's contracted pharmacy. -The word "faxed" was located at the top left-hand corner of the document. -The document had a bar code in the lower left-hand corner (the presence of a bar code means that a fax was processed end-to-end). -There were original document numbers on the pages, and it was received on 04/23/26 at 3:47pm. -The resident was either a new admission or had returned from hospitalization with a discharge summary. -The orders on the document required clarification per state regulations. -There was a request for the provider to clarify Cetirizine 10mg take one tablet at night. -There was a request for the provider to clarify Culturelle take one capsule daily. -There was a request for the provider to clarify Delsym 30/5 Take 10ML Q12H PRN. -There was a request for the provider to clarify Magnesium 400mg take one tablet daily. -There was a request for the provider to clarify Melatonin take one tablet at night. -There was a request for the provider to clarify	D 344		

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D 344	Continued From page 5 Metformin 500mg take one tablet twice a day. -There was a request for the provider to clarify Januvia 100mg take one tablet daily. -There was a request for the provider to clarify Tolterodine Tartrate 2mg take one tablet twice a day. -There was a request for the provider to clarify Atorvastatin 40mg take one tablet daily. -There was a request for the provider to clarify Lisinopril 2.5mg take one tablet daily. -There was a request for the provider to clarify Combivent 20-100mcg 1 puff four times a day as needed. -There was a space for the provider's signature and date. -The document was not signed by the Resident #3's PCP. Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Cetirizine 10mg tablet take one tablet at bedtime for allergies. -There was an entry for Culturelle take one capsule every day for supplement. -There was an entry for Delsym 30mg/5ml suspension take 10ml every 12 hours as needed for cough. -There was an entry for Magnesium Oxide 400 mg tablet take one every day. -There was an entry for Melatonin 3mg take one tablet at bedtime. -There was no entry for Metformin. -There was no entry for Januvia. -There was an entry for Tolterodine Tartrate 2mg take one tablet two times a day. -There was no entry for Atorvastatin. -There was no entry for Lisinopril. -There was no entry for Combivent Respimat.	D 344		

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D 344	Continued From page 6 Review of Resident #3's May 2026 eMAR revealed: -There was an entry for Cetirizine 10mg tablet take one tablet at bedtime for allergies. -There was an entry for Culturelle take one capsule every day for supplement. -There was an entry for Delsym 30mg/5ml suspension take 10ml every 12 hours as needed for cough. -There was an entry for Magnesium Oxide 400 mg tablet take one every day. -There was an entry for Melatonin 3mg take one tablet at bedtime. -There was no entry for Metformin. -There was no entry for Januvia. -There was an entry for Tolterodine Tartrate 2mg take one tablet two times a day. -There was no entry for Atorvastatin. -There was no entry for Lisinopril. -There was no entry for Combivent Respimat. Interview with a pharmacist from the facility's contracted pharmacy on 05/21/26 at 9:15am revealed: -She did see a discharge summary with Januvia but there was no signature from the doctor on the discharge summary. -The pharmacy faxed an FL-2 discharge summary clarification document, and it discussed the discrepancies in medications so that a provider could sign off. -The Januvia was on the faxed document, and there were quite a few things different between the DC summary and the profile. -She did not see that they had received the document back. -They had faxed the clarification request on 04/23/26. -Metformin was on the same document for clarification request.	D 344		

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D 344	Continued From page 7 -There was a question for the provider to continue or discontinue the medication. -Atorvastatin was on the same document and was not clarified. -Risaquad and Culturelle were kind of duplicate therapy because they were both probiotics. -There was a request for clarification of the Risaquad and Culturelle on the same clarification form. -Combivent was on the same document for clarification. -Lisinopril 2.5 mg take one tablet every day was on the same faxed clarification document that had not been received. Telephone Interview with a staff member at Resident #3's outside pharmacy on 05/21/26 at 4:06pm revealed the pharmacy had no records for Resident #3's Januvia, Metformin, Atorvastatin, Risaquad, Combivent, Tolterodine Tartrate or Delsym. Interview with Resident #3 on 05/21/26 at 4:35pm -She used the outside pharmacy because the medicine was basically free. -Sometimes she used a second outside pharmacy if she needed something right away. Interview with a medication aide (MA) on 05/21/26 at 1:40pm revealed: -When residents came back from the hospital, they checked their bodies for marks and bruises from IVs, and they ask residents if they need anything. -Then look at the paperwork and see if there are medication changes. -If there was anything in the paperwork that she was not sure about, she would contact the lead MA. -When there were changes to the medications	D 344		

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D 344	Continued From page 8	D 344		

then she had to fax it to the pharmacy.
-If she had to speak with the doctor then she would speak with the lead MA.
-She was out of work at the time Resident #3 came back and just returned to work this month.
-To administer medication, she went to the name of resident on eMAR, identified the medication, got the medication from the cart, compared the name, dosage, time, and resident.
-She only gave PRN medications when requested and noted the symptoms for which the medication was requested.

Interview with a second MA on 05/21/26 at 2:32pm revealed:
-When residents came back from the hospital, they got the discharge summary and faxed that to the pharmacy.
-If there were any new orders they would wait for the pharmacy to send the medication to them or they could get it from the back-up pharmacy.
-If they needed clarification of an order the med techs could contact the provider or the health care director and she would contact the provider.
-To give a medication they pull it up on the mar, take medication from drawer, check directions against what's in the eMAR, place the medication in the cup and check the eMAR again.
-The directions should be checked three times.
-Faxes of new orders could be taken by MA's off of the fax machine.
-She had never seen a pharmacy clarification sheet faxed from the pharmacy about clarification of medications.

Interview with Administrator on 05/21/26 at 3:00pm revealed:
-Resident #3 used an outside pharmacy and medication got sent to the family.
-The family brought medication to the facility.

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D 344	Continued From page 9 -They sent it to the facility's contracted pharmacy for repackaging. -Resident #3 had a new primary care provider (PCP). -It was the residents' right to use their own PCP and the pharmacy. Second Interview with the Administrator on 05/21/26 at 5:32pm revealed: -To receive a resident coming back from the hospital, if they came via transportation, they would take any paperwork that was given including orders and discharge paperwork, review the documentation, and send them to the appropriate place to be processed. -Medications went to the pharmacy, referrals were faxed to the providers. -When residents did not use the preferred pharmacy then family was going to partner with them to get things sent to pharmacy or to get things filled. -Resident #3 had a bill with the facility's contracted pharmacy, so Resident #3 wanted to use a different pharmacy. -She was never able to find the document that pharmacy said they faxed on 04/23/26. -The health care director was responsible for clarifying orders. -MA's could fax paperwork and take information from the resident, patient or transport. -The MA's reported to the healthcare director. -She assumed that the health care director audited the MARs and may visit the resident in the hospital. -For some residents, depending on the physician, they would audit the MARs. -The in-house physician had access via a triage line and a portal for information. -The health care director watched the MARs, meds on hand, and the paperwork.	D 344		

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D 344	Continued From page 10 -Oversight of the health care director was done by her. -Supervising the health care director meant that they had meetings to discuss problems whether reported by family, staff, vendors or the healthcare director. -They also have team meetings to discuss any changes in the community or changes in condition. -If the MA's discover discrepancies they should bring it to the health care director's attention. -The pharmacy and health care director maintain the accuracy of the eMAR entries. -With Resident #3 there were new medicines that may have been started at the hospital. -She would have loved to have seen the clarification form from the pharmacy. -Resident #3 got her medications from another location. Attempted telephone interview with the Guardian for Resident #3 on 05/21/26 at 4:42pm was unsuccessful. Attempted Telephone interview with Resident #3's second outside pharmacy on 05/21/26 at 4:30pm 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	D 358		

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D 358	Continued From page 11 and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 2 of 7 sampled residents related to medications for pain, blood clot prevention, and blood pressure (#4) and related to a diuretic, blood clot prevention, pain, dementia, a supplement, and gout (#3). The findings are: 1. Review of Resident #4's FL-2 dated 12/02/25 revealed diagnoses included metabolic encephalopathy, rheumatoid arthritis, type II diabetes, hypertension, depression, and age-related osteoporosis. a. Review of Resident #4's FL-2 dated 12/02/25 revealed there was an order for tramadol 50mg tablet take one two times a day (tramadol is a controlled substance medication used to treat pain). Review of Resident #4's physician order sheet dated 11/17/25 revealed there was an order for tramadol 50mg tablet take one tablet twice a day as needed for pain. Review of Resident #4's primary care provider (PCP) order dated 01/28/26 revealed there was an order to discontinue tramadol. Review of Resident #4's PCP order dated 02/15/26 revealed there was an order to discontinue as needed (PRN) tramadol and to keep the scheduled prescription. Review of Resident #4's PCP order dated	D 358	D358 Healthcare Director will review all medication orders of each resident for accuracy and any clarifications of medications and administration times shall immediately reconciled to the Medication Administration Record with all information reflected in order to be followed by each Medication Aide administering medications to the residents. Any and all updates to the orders shall be reflected correctly on the MAR for the Medication Aides to follow. Executive Director in-serviced nursing staff regarding expectation for timely medication processing for residents. Healthcare Director or designee will reconcile medications immediately upon receiving orders. Completion date: 6/17/2026.	

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D 358	Continued From page 12 05/19/26 revealed: -There was an order for tramadol 50mg one tablet twice a day for pain. -There was a note that the prescription for tramadol was re-sent to the pharmacy. Review of Resident #4's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for tramadol 50mg take one tablet two times a day. -Tramadol 50mg was documented as administered twice daily on the scheduled eMAR entry on 04/27/26 and 04/28/26. -There was an entry for tramadol take one tablet twice daily as needed for pain. -There were no doses documented as administered under the PRN eMAR entry. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for tramadol 50mg take one tablet two times a day. -Tramadol was documented as administered twice daily on 05/01/26 to 05/15/26 and on 05/18/26. -There was no entry for tramadol PRN. Observation of medications on hand on 05/20/26 at 3:45pm revealed: -Resident #4 had 58 remaining tramadol 50mg tablets of 60 dispensed on 05/19/26. -Resident #4's tramadol 50mg tablets on hand were labeled with directions to take one tablet twice a day PRN for pain. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/21/26 at 9:15am revealed: -The current order was for tramadol 50mg take	D 358		

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D 358	Continued From page 13 one two times a day and hold for sedation. -There was not an active PRN order. -This medication was repackaged by the pharmacy. Interview with Resident #4 on 05/19/26 at 10:15am revealed: -Her tramadol prescription was written wrong and she was now out of medication. -They were fixing the problem now. -The problem was always with tramadol; she was getting two instead of one a day. -She was told it was a mistake and that the problem was with the drug store, and they told her they were trying to fix it. -She had scoliosis and a place in her back that could not be repaired because it was very fragile and there was risk of paralysis with surgery. -She has neuropathy in her legs and difficulty walking. -The doctor who saw her for her back prescribed her pain medicine. -It seemed like she had trouble with that medicine before but never had to go this long without it. -Pain was currently burning in her legs and she was told to take acetaminophen by her PCP this morning (acetaminophen is medication which can be used to treat pain or fever). -She rated the pain 10/10 currently; it disrupted her sleep and gave her nightmares. Interview with Resident #4 on 05/21/26 at 1:35pm revealed: -She had worked out her medicines. -There was a problem with the drug store, and she wanted to move on. -After the surveyor spoke with the resident on 05/19/26 people had come to talk with her and now her medications were fixed. -She did not want to talk about it further and it	D 358		

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D 358	Continued From page 14 was all right now. Interview with a medication aide (MA) on 05/21/26 at 1:40pm revealed: -To administer medication, she went to the name of resident on eMAR, identified the medication, got the medication from the cart, compared the name, dosage, time, and resident. -She only gave PRN medications when requested and noted the symptoms for which the medication was requested. -She never saw a label that did not match the eMAR. -If a label did not match the eMAR entry then she would go to the lead and notify them that it was not the same. -She would mark the medication as not given, the eMAR would ask why, and she would document. Interview with a second MA on 05/21/26 at 2:32pm revealed: -To give a medication they pulled it up on the eMAR, took the medication from the drawer, checked directions against what was in the eMAR, placed the medication in the cup and checked the eMAR again. -The directions should be checked three times. -If the eMAR and the medication package directions did not match, they would not give the medication and let the health care director know that they needed clarification of the medication -They could also look to see if there was an order. -If the package did not match the eMAR entry, they could place a sticker on the package to say that the directions had changed. -That would be checked against an order. -MAs could do that independently. -She put the sticker on there right as soon as it happens to people know that the order has been	D 358		

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D 358	Continued From page 15 changed. -If she saw a PRN label on bottle, but the eMAR entry said the medicine was scheduled, she would go look to see if there was an order that said that it was scheduled to see if the doctor had changed it. Interview with the Administrator on 05/21/26 at 5:32pm revealed: -The MAs reported to the healthcare director. -She assumed that the health care director audited the eMARs and may visit the resident in the hospital. -For some residents, depending on the PCP, they would audit the eMARs. -The in-house PCP had access via a triage line and a portal for information. -The health care director watched the eMARs, medications on hand, and the paperwork. -Oversight of the health care director was done by her. -Supervising the health care director meant that they had meetings to discuss problems whether reported by family, staff, vendors or the healthcare director. -They also have team meetings to discuss any changes in the community or changes in condition. -She also did random checks on quality assurance things like incident reports, licensed health professional support (LHPS) and she would spot check randomly once a week for different things. -She could not say how Resident #4's tramadol should be administered. -If they could not say how it should be administered, then a clarification was needed from the PCP or whoever wrote the order. -The responsibility for eMAR accuracy fell to the health care director and the pharmacy to make	D 358		

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D 358	Continued From page 16 sure the entries were updated and following the eMAR was up to the MAs. -If the MAs discovered discrepancies they should bring it to the health care director's attention. -The pharmacy and health care director maintained the accuracy of the eMAR entries. Interview with Resident #4's PCP on 05/21/26 at 8:33am revealed -The eMAR should be accurate for the tramadol to see how much she was getting and to make sure that there was no misuse of the dispensing. -She was told that there was a script with a certain amount of tramadol missing, but she could not remember if it was for Resident #4; that was handled by the administration. -She wanted to lessen controlled substances, so tramadol was changed to PRN. -Her goals were to lessen the controlled substances long-term, if not to discontinue them, which would be great. -The resident was followed by wound care, cardiology and dermatology and she did not think they would prescribe tramadol. -She had to discontinue Resident #4's tramadol because of the missing tramadol and then restart it. -She reviewed her controlled substance website and could not see a different provider ordering tramadol for the resident in reviewing since October. -The resident has complained to her of pain at her last visit on 05/06/26. -The pain she was having was generalized osteoarthritis types of pain. -They talked about continuing tramadol PRN and how to monitor symptoms. -The pain she complained of was mild at the visit on 05/06/26.	D 358		

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D 358	Continued From page 17 Attempted telephone interview with the retail pharmacy which dispensed Resident #4's tramadol was unsuccessful on 05/21/26 at 4:30pm b. Review of pre-procedure instructions for Resident #4's interventional radiology provider dated 03/06/26 revealed: -Resident #4 was to take a Plavix load for one dose of 300mg on 03/06/26 (Plavix is an antiplatelet medication used to prevent blood clots). -Resident #4 was to start Plavix 75mg daily starting 03/07/26. Review of a facility outside physician appointment order form dated 03/26/26 revealed: -Resident #4 had undergone endovascular revascularization of bilateral common iliac arteries. -Resident #4 was to take Aspirin and Plavix for one month and take Aspirin thereafter. -The form was signed by Resident #4's interventional radiology provider. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for Plavix 75mg take one tablet every day. -Plavix 75mg was documented as administered daily from 05/01/26 to 05/20/26. Observation of medications on hand on 05/20/26 at 3:45pm revealed Resident #4 had 12 remaining of 30 Plavix 75mg tablets in a package dated 04/09/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/21/26 at 9:15am revealed:	D 358		

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D 358	Continued From page 18 -Resident #4's order for Plavix 75 mg daily one tablet was not active. -Resident #4's Plavix order dated 03/26/26 was to continue for one month and then just continue aspirin thereafter and Plavix would have fallen off on 04/27/26 (aspirin is medication which can be used to treat pain, fever, and to lower the risk of blood clotting). -The order dated 03/26/26 was written by Resident #4's interventional radiology provider. -Plavix was a repack medication for Resident #4. -They received 30 tablets on 04/09/26 from an outside pharmacy. -Plavix was sent back out on 04/09/26 for 30 tablets to last 30 days. -It was also dispensed from the pharmacy prior to repackage on 03/27/26 for a quantity of 30. -On 03/06/26 the pharmacy sent a quantity of 27 tablets. Interview with the primary care provider (PCP) for Resident #4 on 05/21/26 at 8:33am revealed: -She could not explain the Plavix variations. -The medication was for post-stroke or post-heart attack to decrease clogging of the arteries. -She did not have record of any modifications of the order, and the medicine should be active. -If the resident needed the medicine and did not receive it there could be a slow buildup of plaque in the arteries. -Plaque in the arteries could lead to clogging of the arteries which could cause heart attack and stroke. -Plavix was for the platelets but it was the same concept of clogging the vessels. c. Review of Resident #4's FL-2 dated 12/02/25 revealed there was an order for lisinopril 40mg tablet take one tablet every day (lisinopril is medication that can be used for hypertension,	D 358		

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D 358	Continued From page 19 heart failure, kidney protection, and heart attack management). Review of Resident #4's April 2026 eMAR revealed: -There was an entry for Lisinopril 40mg take one tablet every day. -Lisinopril was documented as not administered on 04/21/26 and on 04/22/26. Observation of Resident #4's medications on hand on 05/20/26 at 3:45pm revealed there were 12 remaining Lisinopril 40mg tablets of 30 dispensed in a package dated 05/03/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/21/26 at 9:15am revealed: -Resident #4's Lisinopril orders were for 40mg tablet take one tablet every day. -Resident #4 was getting this medication in batch so deliveries were made 03/30/26 to start 04/03/26, then another delivery was sent on 04/29/26 to start 05/03/26, both of those were quantities of 30. -If administered as ordered those dispensed should last 30 days. Interview with the primary care provider (PCP) for Resident #4 on 05/21/26 at 8:33am revealed: -Lisinopril was given for blood pressure. -Resident #4 needed the medication. -It could also be used for kidney protection. -If Resident #4 missed two days of medication her blood pressure could elevate. 2. Review of Resident #3's FL-2 dated 04/15/26 revealed: -Diagnoses included metabolic encephalopathy, diabetes mellitus type II, esal resistance, and	D 358		

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D 358	Continued From page 20 urinary tract infection. -The FL-2 was signed by Resident #3's previous primary care provider (PCP). a. Review of Resident #3's FL-2 dated 04/15/26 revealed there was an order for Eliquis 5mg tablet take one tablet two times a day (Eliquis is medication that can be given to prevent or treat blood clots). Review of a physician order for Resident #3 dated 03/17/26 revealed: -There was an order for Eliquis 5mg tablet take one tablet two times a day. -The order was signed by Resident #3's Cardiology provider. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg take one tablet two times a day, scheduled at 8:00am and 8:00pm with an indication that the pharmacy repackaged the medicine. -Eliquis 5mg was not documented as administered at 8:00am on 03/17/26 to 03/21/26. -Eliquis 5mg was not documented as administered at 8:00pm on 03/17/26 to 03/20/26. Observation of Resident #3's medications on hand on 05/20/26 at 10:28am revealed: -There were two cards of Eliquis 5mg tablets on hand which had been repackaged by the facility's contracted pharmacy. -One card contained 21 Eliquis 5mg tablets and the other contained 18 Eliquis 5mg tablets. -The labels indicated that 60 Eliquis 5mg tablets had been repackaged and were dated 05/03/26. -The instructions were for Resident #3 to take one tablet two times a day to prevent blood clots.	D 358		

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D 358	Continued From page 21 Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/21/26 at 9:15am revealed: -Eliquis 5mg tablet take one tablet two times a day was active. -The order was received 03/20/26 and dispensed on the same date. -It shows it was written on 03/17/26 but they did not receive it until 03/19/26 and was dispensed on 03/20/26 for a quantity of 28 on the 20th, that was for 14 days. -They dispensed it next on 03/30/26 for them to start on 04/03/26 for a quantity of 60, for 30 days. Telephone interview with a staff member from Resident #3's outside pharmacy on 05/21/26 at 4:06pm revealed: -Resident #3's Eliquis was dispensed for a 3-month supply. -Resident #3's Eliquis was dispensed on 02/23/26 for a quantity of 180 tablets. -Resident #3 was to take one twice a day and this was a 90-day supply. Refer to interview with the Administrator on 05/21/26 at 5:32pm. b. Review of Resident #3's FL-2 dated 04/15/26 revealed there was an order for Acetaminophen ER 650mg tablet take two tablets two times a day (acetaminophen is medication that can be given to treat fever or pain). Review of a physician order sheet dated 02/26/26 revealed: -There was an order for Acetaminophen 1300mg two times a day. -The sheet was signed by Resident #3's previous primary care provider (PCP).	D 358		

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D 358	Continued From page 22 Review of a PCP order dated 03/05/26 revealed: -Resident #3 was to discontinue acetaminophen 325mg tablets. -Resident #3 was to start acetaminophen 500mg one tablet twice a day. -The order was signed by Resident #3's previous PCP. Review of a PCP order dated 03/17/26 revealed: -Resident #3 was to discontinue Tylenol 500mg. -The order was signed by Resident #3's previous PCP. Review of a physician order sheet dated 04/07/26 revealed: -There was an order for acetaminophen 650mg tablets with direction to take two tablets two times a day. -The order was signed by Resident #3's previous PCP. Review of a physician order sheet dated 04/14/26 revealed: -There was an order to take acetaminophen extended release 650mg to take two tablets two times a day. -The order was signed by Resident #3's previous PCP. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen 500mg with direction to take one tablet two times a day scheduled at 8:00am and 8:00pm. -Acetaminophen 500mg was documented as administered at 8:00am on 03/10/26 to 03/16/26. -Acetaminophen 500mg was documented as administered at 8:00pm on 03/10/26 to 03/17/26.	D 358		

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D 358	Continued From page 23 -There was an entry for acetaminophen 650mg with direction to take two tablets two times a day for knee pain scheduled at 8:00am and 8:00pm. -Acetaminophen 650mg was documented as administered at 8:00am on 03/01/26 to 03/04/26, on 03/06/26 to 03/09/26, on 03/12/26, and on 03/14/26 to 03/31/26. -Acetaminophen 650mg was documented as administered at 8:00pm on 03/01/26 to 03/11/26, on 03/13/26 to 03/15/26, and on 03/17/26 to 03/31/26. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for acetaminophen 500mg with direction to take one tablet two times a day scheduled at 8:00am and 8:00pm. -Acetaminophen 500mg was documented as administered at 8:00am 04/01/26 to 04/11/26 and on 04/14/26 to 04/18/26, on 04/23/26, and 04/25/26 to 04/30/26. -Acetaminophen 500mg was documented as administered at 8:00pm on 04/01/26 to 04/10/26, on 04/14/26 to 04/18/26, on 04/22/26 to 04/30/26. -There was no entry for Acetaminophen 650mg. Telephone interview with Resident #3's outside pharmacy on 05/21/26 at 4:06pm revealed the pharmacy did not have record of Resident #3's acetaminophen. Review of email communication between the facility's contracted pharmacy provider and Resident #3's guardian dated 03/06/26 revealed: -At 5:30pm the pharmacy attached a copy of Resident #3's eMAR for Resident #3's guardian to share with the PCP. -At 5:42pm Resident #3's guardian reported she had purchased and dropped off all non-prescription medicines to the facility on	D 358		

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D 358	Continued From page 24 03/06/26. Interview with the previous PCP for Resident #3 on 05/20/26 at 10:45am revealed: -Resident #3 switched to another primary care provider for chronic management of her conditions. -She only saw her now for urgent care needs and illnesses. -She had not been contacted about the resident running out of medications. -She did not know what dose Resident #3 was on for acetaminophen but would recommend speaking with the PCP. -The order may be changed if she had less pain, because to have a different dose there had to be an order. -She thought maybe Resident #3's PCP would have ordered that. -The hospital may have made a change. -The hospital notes went to the healthcare director, and the healthcare director faxed a medication list to the pharmacy. -If she happened to be in the facility then she would write orders and that would get faxed to the pharmacy, that way the medication aides (MAs) did not have to wait for something from the pharmacy. -When the pharmacy read the discharge paperwork then they made changes to the eMAR. Attempted interview with Resident #3's guardian on 05/21/26 at 4:42pm was unsuccessful. Refer to interview with the Administrator on 05/21/26 at 5:32pm. c. Review of Resident #3's FL-2 dated 04/15/26 revealed there was an order for memantine HCL 5mg tablet take one tablet two times a day	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 (memantine is medication that can be used to treat dementia) Review of a physician order sheet dated 02/26/26 revealed: -There was an order for Resident #3's memantine HCL 5mg tablet take one tablet two times a day. -The sheet was signed by Resident #3's previous primary care provider (PCP). Review of a physician order sheet dated 04/07/26 revealed: -There was an order for Resident #3's memantine HCL 5mg tablet take one tablet two times a day. -The order was signed by Resident #3's previous PCP. Review of a physician order sheet dated 04/14/26 revealed: -There was an order for Resident #3's memantine HCL 5mg tablet take one tablet two times a day. -The order was signed by Resident #3's previous PCP. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for memantine HCL 5mg tablet take one tablet two times a day. -Memantine was documented as not administered by exception on 03/05/26 at 8:00am with reason that Resident #3 was unable to take the medication and 03/06/26 at 8:00pm with reason that the medication needed to be refilled. Observation of Resident #3's medications on hand on 05/20/26 at 10:28am revealed there was a card of Resident #3's Memantine with 1 dose remaining of 60 doses in a card that had been repackaged dated 04/04/26.	D 358		

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	hal026065	A. BUILDING: _____ B. WING _____	05/21/2026

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D 358	Continued From page 26 Telephone interview with outside pharmacy staff on 05/20/26 at 4:06pm revealed there was an order for Memantine 5mg once daily, and a 90-day supply was dispensed on 05/07/26. Interview with Administrator on 05/21/26 at 3:00pm revealed: -Resident #3 used an outside pharmacy and medication got sent to the family. -The family brought medication to the facility. -They sent it to the facility's contracted pharmacy for repackaging. -Resident #3 had a new PCP. -It was the residents' right to use their own PCP and the pharmacy. Interview with the previous PCP for Resident #3 on 05/20/26 at 10:45am revealed: -Resident #3 switched to another primary care provider for chronic management of her conditions. -She only saw her now for urgent care needs and illnesses. -She had not been contacted about the resident running out of medications. Refer to interview with the Administrator on 05/21/26 at 5:32pm. d. Review of Resident #3's FL-2 dated 04/15/26 revealed there was an order for Vitamin D3 2000 IU take one tablet every day (Vitamin D3 is a supplement that can be given to treat a deficiency of Vitamin D). Review of a physician order sheet dated 02/26/26 revealed: -There was an order for Resident #3's Vitamin D3 2000 IU take one tablet every day.	D 358		

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D 358	Continued From page 27 -The sheet was signed by Resident #3's previous primary care provider (PCP). Review of a physician order sheet dated 04/07/26 revealed: -There was an order for Resident #3's Vitamin D3 2000 IU take one tablet every day. -The sheet was signed by Resident #3's previous PCP. Review of a physician order sheet dated 04/14/26 revealed: -There was an order for Resident #3's Vitamin D3 2000 IU take one tablet every day. -The sheet was signed by Resident #3's previous PCP. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 2000 IU take one tablet every day. -Vitamin D3 was documented as not administered on 03/05/26 with reason that the patient was unable to take the medication and on 03/07/26 to 03/13/26 with reason that the patient was unable to take the medication. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for Vitamin D3 2000 IU take one tablet every day. -Vitamin D3 was documented as not administered on 04/03/26, on 04/25/26, and on 04/28/26 to 04/30/26. Review of Resident #3's May 2026 eMAR revealed: -There was an entry for Vitamin D3 2000 IU take one tablet every day.	D 358		

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D 358	Continued From page 28 -Vitamin D3 was documented as not administered on 05/01/26, on 05/06/26, on 05/08/26, on 05/15/26, on 05/17/26 and 05/18/26. Observation of Resident #3's medications on hand on 05/20/26 at 10:28am revealed: -There was a card of Resident #3's Vitamin D3 2000 IU on hand with 12 doses remaining of 13 dated 05/19/26. -The medication was dispensed by the facility's contracted pharmacy. Telephone interview with a pharmacy staff from Resident #3's outside pharmacy on 05/21/26 at 4:06pm revealed the pharmacy did not have record of Resident #3's vitamin D3. Interview with Administrator on 05/21/26 at 3:00pm revealed: -Resident #3 used an outside pharmacy and medication got sent to the family. -The family brought medication to the facility. -They sent it to the facility's contracted pharmacy for repackaging. -Resident #3 had a new PCP. -It was the residents' right to use their own PCP and the pharmacy. Interview with the previous PCP for Resident #3 on 05/20/26 at 10:45am revealed: -Resident #3 switched to another PCP for chronic management of her conditions. -She only saw her now for urgent care needs and illnesses. -She had not been contacted about the resident running out of medications. Refer to interview with the Administrator on 05/21/26 at 5:32pm.	D 358		

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D 358	Continued From page 29 Interview with the Administrator on 05/21/26 at 5:32pm revealed: -To receive a resident coming back from the hospital, if they came via transportation, they would take any paperwork that was given including orders and discharge paperwork, review the documentation, and send them to the appropriate place to be processed. -Medications went to the pharmacy, referrals were faxed to the providers. -When residents did not use the preferred pharmacy then family was going to partner with them to get things sent to pharmacy or to get things filled. -Resident #3 had a bill with the facility's contracted pharmacy, so Resident #3 wanted to use a different pharmacy. -MAs could fax paperwork and take information from the resident, patient or transport. -The MAs reported to the healthcare director. -She assumed that the health care director audited the eMARs and may visit the resident in the hospital. -For some residents, depending on the PCP, they would audit the eMARs. -The in-house PCP had access via a triage line and a portal for information. -The health care director watched the eMARs, medications on hand, and the paperwork. -Oversight of the health care director was done by her. -Supervising the health care director meant that they had meetings to discuss problems whether reported by family, staff, vendors or the healthcare director. -They also have team meetings to discuss any changes in the community or changes in condition. -She also did random checks on quality	D 358		

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D 358	Continued From page 30 assurance things like incident reports, licensed health professional support (LHPS) and she would spot check randomly once a week for different things. -If the MAs discovered discrepancies they should bring it to the health care director's attention. -The pharmacy and health care director maintained the accuracy of the eMAR entries. -With Resident #3 there were new medicines that may have been started at the hospital. -She would have loved to have seen the clarification form from the pharmacy. -Resident #3 got her medications from another location.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	D 367	D 367 Healthcare Director will review EMAR for missed orders and any documentation of medications and administration times shall immediately be reconciled to the EMAR by each Medication Aide administering medications to the residents. Any and all updates to the orders shall be reflected correctly on the EMAR for the Medication Aides to follow. Healthcare Director in-serviced Med Aides regarding expectations for timely medication documentation for residents. Healthcare Director or designee will train newly hired Med Aides regarding proper documentation upon hire and as needed to ensure compliance. Healthcare Director or designee will audit EMAR's weekly to ensure compliance. Completion date: 6/17/2026.	

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D 367	Continued From page 31 administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accurately record medication in the electronic medication administration record (eMAR) for 1 of 7 sampled residents related to a controlled substance medication for anxiety. The findings are: Review of Resident #4's FL-2 dated 12/02/25 revealed: -Diagnoses included metabolic encephalopathy, rheumatoid arthritis, type II diabetes, hypertension, depression, and age-related osteoporosis. -There was an order for Lorazepam 0.5mg tablet take one tablet every morning (Lorazepam is a controlled substance medication which can be used to treat anxiety). Review of a medication order dated 01/22/26 revealed: -There was an order for Lorazepam 0.5mg tablet take one tablet daily. -There was an order to discontinue Lorazepam PRN (as needed) for anxiety. Review of a medication order dated 05/06/26 revealed there was an order to discontinue scheduled Lorazepam for Resident #4 with note that Resident #4 was on PRN only. Review of a medication order dated 05/19/26 revealed there was an order for Resident #4's	D 367		

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D 367	Continued From page 32 Lorazepam 0.5mg one tablet daily PRN for anxiety. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet take one tablet every morning scheduled at 9:00am -There was not an entry for PRN Lorazepam. -Scheduled Lorazepam at 9:00am was documented as administered on 05/09/26 to 05/11/26, 05/14/26, 05/15/26, and 05/20/26. Review of Resident #4's controlled substance log dated 05/07/26 revealed: -The log was for Lorazepam 0.5mg take one tablet every day as needed. -Doses were administered on 05/10/26, 05/11/26, 05/14/26, 05/15/26, and 05/21/26. -There were 10 tablets remaining of 15 dispensed. -The log was dated 05/07/26, but it was not clear when the medication was dispensed. Observation of medications on hand on 05/20/26 at 3:45pm revealed: -Resident #4 had a bottle of Lorazepam 0.5mg tablets labeled with direction to take one tablet daily PRN. -The bottle was labeled for a quantity of 15 dispensed on 05/05/26 -There were 11 remaining of 15 dispensed. Interview with the primary care provider (PCP) for Resident #4 on 05/21/26 at 8:33am revealed documentation on the MAR needed to be accurate to reflect what the patient was and was not receiving. Interview with the Administrator on 05/21/26 at	D 367		

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D 367	Continued From page 33 5:32pm revealed: -Responsibility for eMAR accuracy fell to the health care director and the pharmacy to make sure the entries were updated and following the eMAR was up to the medication aides (MAs). -If the MAs discovered discrepancies they were to bring it to the health care director's attention. -The pharmacy and health care director maintained the accuracy of the eMAR entries.	D 367		