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
	HAL065036	A. BUILDING: _____ B. WING _____	R 06/18/2026

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted a follow up survey and complaint investigation on June 16, 2026 through June 18, 2026. The complaints were initiated by New Hanover County Department of Social Services on May 1, 2026, May 7, 2026, May 12, 2026, May 27, 2026, June 2, 2026, and June 8, 2026.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with state law	
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was stocked with a	D 285	10A NCAC 13F .0904(a)(4) Nutrition and Food Community will ensure an adequate 3-day and 5-day supply of food is on hand based on census and menus. Community Executive Director(ED) and Dietary Manager will review menu cycles and census during Daily Stand-Up meetings Dietary Manager will inventory food supply no less than 3 times weekly for the next 30 days then weekly there after to ensure adequate supply. Dietary Manager and ED will review all Food orders and inventory together prior to submission food orders to ensure correct amounts are ordered Community placed an emergency food order during survey process to ensure 3-day and 5-day supply was on hand ED has in-serviced Dietary Manager on the food ordering process and rule are of Nutrition and Food Service	8/1/2026

Reviewed and acknowledged on 07/24/2026 Joyce Johnston

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D 285	Continued From page 1 3-day supply of perishable food and a 5-day supply of nonperishable food based on their census and menu. The findings are: Review of the facility's census for 06/16/26 revealed there were 56 residents in the facility. Observation of the kitchen on 06/16/26 at 10:25am revealed: -There were 6 containers of liquid eggs, with servings per container for 7. -According to the census of 56 and the serving size per container, the facility would use 6 containers during one meal and still needed an additional 4 containers for that meal, needing an additional 24 containers to meet the 3- day supply requirement. -There were 6 containers of milk, with servings per container for 16. -According to the census of 56 and the serving size per container, the facility would use 4 containers during one meal, needing an additional 4 containers to serve for dinner based on the menu, and an additional 16 containers to meet the 3- day supply requirement. -There were 6 cans of sliced beets with serving per can for 24. -According to the census of 56 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 3 cans, needing an additional 9 cans for a 5-day supply. -There were 3 cans of carrots with serving per can for 24. -According to the census of 56 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 0 cans, needing an additional 12 cans for a 5-day supply. -There were 4 cans of black eye peas with	D 285		

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D 285	Continued From page 2 serving per can for 24. -According to the census of 56 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 1 can, needing an additional 11 cans for a 5-day supply. -There were 4 cans of baked beans with serving per can for 24. -According to the census of 56 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 1 can, needing an additional 11 cans for a 5-day supply. -There were 4 cans of greens with serving per can for 22. -According to the census of 56 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 1 can, needing an additional 12 cans for a 5-day supply. Interview with the Dietary Manager (DM) on 06/16/26 at 12:25pm revealed he came in today to do the food order and ensure everything was running smoothly in the kitchen. Second interview with the DM on 06/17/26 at 9:00am revealed he was not aware there needed to be a 3-day supply of perishable food and a 5-day supply of non-perishable food. Interview with the Administrator on 06/17/26 at 9:25am revealed: -She thought there was a 3-day supply of perishable food and a 5-day supply of non-perishable food in the kitchen. -The kitchen staff must have used the 3-day supply of perishable and a 5-day supply of non-perishable. -She expected the kitchen staff to notify her if they used the 3-day supply of perishable food and a 5-day supply of non-perishable food so it could be reordered by the DM.	D 285		

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D 285	Continued From page 3 -There should always be a 3-day supply of perishable food and a 5-day supply of non-perishable food in the kitchen.	D 285		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements In Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure nutritionally adequate meals were served to residents as evidence by residents being served smaller portion sizes of food based on the menu. The findings are: Review of the facility's lunch menu on 06/16/26 revealed 1 baked potato was to be served. Review of the facility's breakfast menu on 06/17/26 revealed ½ cup (4-ounces) of fruit was to be served. Observation of the lunch meal on 06/16/26	D 297	10A NCAC 13F .0904(d)(1) Nutrition and Food Service Community ED and/or Dietary Manager will ensure adequate serving portions sizes are provided based on menus. Executive Director has ensured that standardized serving utensils are ready available to dietary employees Utensils have been labeled by ounce size and portion size guides have been posted in kitchen Dietary staff received retraining on menu compliance and therapeutic diets ED and/or on-site managerment staff are monitoring meal services no less than weekly to ensure adequate serving and correct diets	8/1/26

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D 297	Continued From page 4 between 12:01pm and 12:40pm revealed: -The cook was preparing plates for the memory care residents. -The cook used a knife to cut the baked potato in half and served it on the plates. -The residents in the assisted living unit received a whole baked potato on their plates. Observation of the breakfast meal on 06/17/26 at 7:15am revealed: -The Dietary Manager (DM) used a 3-ounce ladle to serve applesauce to the residents who required a mechanically altered fruit. -The DM was wearing gloves and used his hands to put fruit in a bowl. -The surveyor asked the cook to remove a bowl of fruit and placed the fruit in a 4-ounce ladle. -The fruit was less than 4-ounces in the ladle. Interview with the cook on 06/17/26 at 8:43am revealed: -She reviewed the menu before she cooked. -She gave the residents in memory care ½ baked potato because she thought they were too big and she was trained to do that. Interview with the DM on 06/17/26 at 9:00am revealed: -He reviewed the menu to determine the portion sizes to offer during the meals. -He thought the fruit was to be served at 3-ounces. -He eyeballed the fruit to determine how much to put in the bowl. -He expected staff to use the menu and serve portion sizes based on the menu. -The residents in memory care did not eat as much as the residents in assisted living because he observed the plates when they returned from the dining room.	D 297		

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D 297	Continued From page 5 Interview with the Administrator on 06/17/26 at 9:25am revealed: -She was not aware the kitchen staff were serving residents in memory care less food than assisted living residents. -She expected the kitchen staff to follow the menu and use the correct portion sizes.	D 297		
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 CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Unabated Type B Violation has not been abated. Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 4 of 6 sampled residents (#1, #2, #7. #8) including medications for urinary tract infection (UTI) (#1), medication used to treat a respiratory infection and yeast infection (#8), medication used to treat a fungal infection (#8), medication used to treat elevated blood sugar (#7), and medications used to treat high blood pressure, abnormal movements,	D 358	10A NCAC 13F .1004(a) Medication Administration Community will assure that all medications and treatments are administered as ordered Community Executive Director and Care Coordinators have completed a full medication cart audit Medication aides have been instructed and inserviced on ensuring they review the Eletronic care stream prior to the end of shift Executive and Care Coordinators will review new orders, including but not limited to ABX orders and conduct follow-ups with pharmacy on any outstanding medications ED and/or Care Coordinators will conduct weekly cart audits to ensure all medications are on hand ED and Care Coordinators will review electroic health record dashboard daily and ensure follow-up is completed on any outstanding medications	7/18/26

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D 358	Continued From page 6 mental health disorders, and mood control (#2). The findings are: Review of the facility's medication administration policy dated November 2018 revealed: -Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. -Five Rights; right resident, right drug, right dose, right route, and right time are applied for each medication being administered. -A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration, when the medication is selected, when the dose is removed from the container, and finally just after the dose is prepared and the medication put away. -Check #1, select the medication, the label, container, ad contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 rights. -Check #2, prepare the dose, the dose is removed from the container and verified against the label and the MAR by reviewing the 5 rights. -Check #3, complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 rights when putting the medication away. -The medication administration record (MAR) is always employed during medication administration. -Prior to administration of any medication, the medication dosage schedule on the resident's MAR are compared with the medication label. -If the label and MAR are different and the container has not already been flagged indicating	D 358	Continued from page 6 Community ED and/or Care Coordinators will conduct Medication Pass Observations weekly with differnet medication staff for the next 4 weeks ED and Care Coordinators have been conducting weekly meetings and in-services with medication staff Medication Aides were re-educated and in-serviced on 1) The rights of medication administration 2) Obtaing orders 3) Pharmacy Follow-Ups 4) Documentation Requirements 5) New admission medication reconcilliation Medication Aides will complete skin assessment forms for skin treatments each shift ED and/or Care Coordinators will review skin assessments no less than twice weekly for 30 days and then weekly there after	7/18/26

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D 358	Continued From page 7 a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. -When a medication order is changed, and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of medication is labeled with the current directions. -If a medication with a current or active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (other units) are searched, if possible. -If the medication cannot be located after further investigation, the pharmacy is contacted or the medication may be removed from the emergency drug supply. -Medications are administered in accordance with written orders of the prescriber. 1. Review of Resident #1's FL-2 dated 10/26/25 revealed: -Diagnoses included orthostatic hypotension, dementia, depression, osteoporosis gastroesophageal reflux disease, and hyperlipidemia. -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory. -Resident #1 was incontinent of urine. Review of Resident #1's Resident Register revealed she was admitted to the facility on 09/08/25. Review of Resident #1's urgent care documentation dated 09/07/25 revealed: -Resident #1 was seen on 09/07/25 and treated for a urinary tract infection (UTI).	D 358		

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D 358	Continued From page 8 -Resident #1 was provided an order for Cephalexin 500mg administer one capsule three times daily for seven days (Cephalexin is used to treat bacterial infections). -Resident #1 was to follow up with primary care provider (PCP) that week and go to the emergency department (ED) for any acute worsening of condition. Review of Resident #1's urgent care note dated 09/16/25 revealed a new order for Nitrofurantoin 100mg administer one capsule twice daily for seven days (Nitrofurantoin is specifically used to treat urinary tract infections). The order was provided after the urine culture results were reviewed. Review of Resident #1's physician order sheet dated 09/16/25 at 5:25pm revealed: -The Administrator completed a physician order sheet as a verbal order from the urgent care center. -The verbal order was for Nitrofurantoin 100mg twice daily for 17 days. Review of Resident #1's September 2025 electronic medication record (eMAR) revealed: -There was not an entry for Cephalexin 500mg administer three times daily for seven days. -There was an entry for Nitrofurantoin 100mg administer twice daily for 17 days beginning on 09/17/26 at 9:00pm. -The total number of Nitrofurantoin 100mg documented as administered was 13 capsules. -Nitrofurantoin 100mg was documented as administered from 09/18/25 to 09/23/25 at 9:00am. -Nitrofurantoin 100mg was documented as administered from 09/17/25 to 09/23/25 at 9:00pm.	D 358		

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D 358	Continued From page 9 -Nitrofurantoin 100mg was documented as not administered from 09/24/25 to 09/26/25 at 9:00am. -Nitrofurantoin 100mg was documented as not administered from 09/24/25 to 09/25/25 at 9:00pm. -There was documentation on 09/24/25 at 9:00am that Nitrofurantoin 100mg was not administered because the number of days was incorrect and was supposed to be 7 days. -There was documentation on 09/24/25 at 9:00pm Nitrofurantoin 100mg was not administered because the medication order was complete. -There was documentation on 09/25/25 at 9:00am Nitrofurantoin 100mg was not administered because medication was not available. -There was documentation on 09/25/25 at 9:00pm Nitrofurantoin 100mg was not administered because it was discontinued. Interview with Resident #1's facility contracted pharmacist on 06/17/26 at 2:00pm revealed: -Resident #1's Nitrofurantoin 100mg twice daily for 17 days was added to Resident #1's profile but was not filled on 09/17/25. -Nitrofurantoin 100mg was used to treat a severe UTI. Telephone interview with Resident #1's urgent care office on 06/18/26 at 11:37am revealed: -Resident #1 was seen and treated for UTI on 09/07/25. -Resident #1 was provided with a prescription for Cephalexin 500mg three times daily for 7 days. -Nitrofurantoin 100mg twice daily for 7 days was called into a pharmacy on 09/16/25. Telephone interview with Resident #1's primary	D 358		

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D 358	Continued From page 10 care provider's (PCP) nurse revealed: -Resident #1 was seen by one of the other providers on 09/18/25 in the office for follow-up for UTI. -The provider did not perform a urinalysis because it was reported Resident #1 started on Nitrofurantoin 100mg on 09/16/25. Interview with Resident #1's family member on 06/16/26 10:20am revealed: -She brought a bottle of Cephalexin 500mg to the facility when Resident #1 was admitted on 09/07/25 that she obtained from an urgent care on 09/06/25. -The medication and paperwork from the visit was in a bag. -Resident #1 had become more confused and scared about one week after admission and she asked the Administrator if the UTI could have caused this behavior. -The Administrator did not know anything about Resident #1's UTI or antibiotic and stated if the medication was not on the FL-2 then the facility could not administer. -She had to obtain another order for the Cephalexin 500mg. -She took Resident #1 to her PCP for a follow-up appointment on 09/18/26. -It was 11 days after the diagnosis of a UTI that Resident #1 started on an antibiotic. -The facility gave her the bottle Cephalexin 500mg. Interview with a medication aide (MA) on 06/18/26 at 12:05pm revealed: -She started working at the facility in January 2026. -The MA or the Resident Care Coordinator (RCC) could have called the provider to obtain an order to administer a medication.	D 358		

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D 358	Continued From page 11 Telephone interview with the previous RCC on 06/17/26 at 10:15am revealed: -She did not remember seeing the Cephalexin order for Resident #1. -She was not sure why Resident #1's Cephalexin was not started. -If Resident #1's Cephalexin was in the facility the MA could have called the PCP to obtain an order to administer the medication. Interview with the Administrator on 06/17/26 at 2:30pm revealed: -The previous RCC admitted Resident #1. -She was not sure what paperwork the RCC received on Resident #1 related to the Cephalexin. Second interview with the Administrator on 06/18/26 at 10:57am revealed: -The facility never received an order for the Cephalexin 500mg. -The facility should have called the urgent care to obtain an order to administer Resident #1's Cephalexin 500mg. -She did not know why this did not happen. -The RCC or the MA should have called the urgent care for a verbal order to start the Cephalexin 500mg. -She was concerned that Resident #1's UTI and confusion could have gotten worse. -She was concerned that the staff did not follow up with the provider to obtain an order to administer Resident #1's Cephalexin. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's	D 358		

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D 358	Continued From page 12 PCP on 06/18/26 at 9:42am was unsuccessful. 2. Review of Resident #8's current FL2 dated 01/02/26 revealed: -Diagnoses included type 2 diabetes, dementia, hypertension, coronary artery disease, paranoid schizophrenia, peptic ulcer disease, ventral hernia, and pulmonary embolism. -His level of care was Special Care Unit (SCU). a. Review of Resident #8's primary care provider (PCP) visit note dated 05/19/26 revealed: -Resident #8 was seen today (05/19/26) after noticing a wet productive cough. -Resident #8 was seen today (05/19/26) and reported he did not feel well. -He was noted to be slightly hypoxic (low levels of oxygen) on exam but denied shortness of breath. -Rhonchi (low-pitched rattling lungs sounds) were noted bilaterally on exam. -His oxygen saturation was 88% on room air. -The treatment plan was chest x-ray and doxycycline (an antibiotic used to treat bacterial infections) 100mg, take one tablet twice a day for seven days. Review of a handwritten signed physician's order sheet for Resident #8 dated 05/19/26 revealed: -There was an order for a chest x-ray. -There was an order for doxycycline 100mg tablets, take one tablet twice a day for seven days, Review of Resident 8's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for doxycycline 100mg, take one tablet twice daily for seven days scheduled at 9:00am and 9:00pm with a start date of 05/26/26. -Doxycycline 100mg was documented as	D 358		

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D 358	Continued From page 13 administered at 9:00am from 05/27/26 through 05/30/26. -Doxycycline 100mg was documented as administered at 9:00pm from 05/27/26 through 05/29/26. -Doxycycline 100mg was documented as not administered at 9:00am on 05/31/26 with the exception documented a leave of absence (LOA). -Doxycycline 100mg was documented as not administered at 9:00pm on 05/30/26 and 05/31/26 with the exception documented as LOA. Review of Resident #8's June 2026 eMAR revealed: -There was an entry for doxycycline 100mg, take one tablet twice daily for seven days scheduled at 9:00am and 9:00pm with a start date of 05/26/26. -Doxycycline 100mg was documented as not administered at 9:00am on 06/01/26 with the exception documented as LOA. -Doxycycline 100mg was documented as administered at 9:00am on 06/02/26. -Doxycycline 100mg was documented as administered at 9:00pm on 06/01/26 and 06/02/26. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 06/17/26 at 2:05pm revealed: -An order was received for Resident #8's doxycycline 100mg, take one tablet twice daily for 7 days on 05/26/26 at 6:30pm. -Resident #8's order for doxycycline 100mg, take one twice daily for seven days was dated 05/19/26. -Doxycycline 100mg was dispensed for Resident #8 for 14 tablets to take one tablet twice a day for seven days on 05/27/26. -Doxycycline was used to treat bacterial infections and a delay in starting could cause continued	D 358		

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D 358	Continued From page 14 infection or cause symptoms to escalate. Telephone interview with Resident #8's Responsible Party (RP) on 06/17/26 at 3:59pm revealed: -She picked Resident #8 up most weekends and brought him to her house. -When Resident #8 came to stay with her, staff gave her his medications. -She remembered receiving antibiotics for Resident #8 but was never told why the antibiotics were ordered. Interview with a medication aide (MA) on 06/17/26 at 11:22am revealed when a resident was seen by their PCP, the orders were given to the care managers, either the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) to send to the pharmacy. Interview with the SCC on 06/18/26 at 10:18am revealed: -When the PCP came to the facility to see the residents, she did an exit interview with her so they could go over any new orders or changes for the residents. -The PCP gave her written orders, and she faxed the orders to the facility's contracted pharmacy, made a copy of the order and placed the order in her daily check box. -She checked the orders in her daily check box every day, once the order was entered by the pharmacy and the medications arrived at the facility, she approved the order in the eMAR system. -If a medication did not arrive the following day, she contacted the pharmacy. -She was not working on 05/19/26 when Resident #8's PCP wrote the order for his doxycycline. -She did receive a text message from Resident	D 358		

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D 358	Continued From page 15 #8's PCP on 05/19/26 that she wrote an order for doxycycline and gave it to the Administrator and to call her if she had questions. -She thought the Administrator told her when she returned that she received the order for Resident #8's doxycycline. -She never gave orders to the medication aides (MA) to fax. -She did not know why there was delay in Resident #8 receiving his doxycycline. Interview with the Administrator on 06/18/26 at 11:30am revealed: -When a resident was seen by the PCP, orders were given to either the care managers (RCC, SCC), the MAs, or herself. -Orders were faxed to the pharmacy by either the care managers or the MAs. -After the orders were faxed to the pharmacy, they were placed in a file folder to be followed up. -The file folder containing orders in the copy room was to be checked daily by the care managers. -The pharmacy entered orders into the eMAR system, and the care manager approved the orders in the eMAR system once the medication arrived in the facility. -She thought that Resident #8's PCP gave her the order for his doxycycline, and she gave it to one of the MAs to fax to the pharmacy. -She did not remember if she checked the order file folder the next day for Resident #8's doxycycline. -Resident #8's doxycycline order was faxed on 05/26/26, she thought after Resident #8's PCP notified her that she did not see the doxycycline order on his eMAR and she electronically faxed his doxycycline order to the pharmacy. -She did not know why there was an eight-day delay in receiving and starting Resident #8's doxycycline.	D 358		

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D 358	Continued From page 16 -She did not know why there was no follow-up on Resident #8's doxycycline order. Telephone interview with Resident #8's PCP on 06/18/26 at 12:08pm revealed: -She ordered a chest x-ray and doxycycline for Resident #8 at his 05/19/26 visit for a wet productive cough and his oxygen saturation was a little low at 88% with a normal oxygen saturation being 95% or greater. -Resident #8's chest x-ray was done on 05/19/26 and was clear. -She was not aware or notified that Resident #8's doxycycline was not started until 05/27/26. -She would have expected Resident #8's doxycycline to have started the following day on 05/20/26. -The delay in treating Resident #8's cough and respiratory symptoms could have led to progression of his symptoms. -A delay in starting antibiotics could mean a delay in treating an infection. b. Review of Resident #8's primary care provider (PCP) visit note dated 02/24/26 revealed: -Resident #8 has struggled with an ongoing candidal (a fungal infection caused by an overgrowth of yeast) rash to the groin. -Resident #8's rash appeared improved today but still with malodorous drainage. -Nystatin (an anti-fungal agent) powder 100.000 units/gram was ordered to apply topically to bilateral groin and abdominal folds twice a day for 60 days. Review of a handwritten signed physician's order sheet for Resident #8 dated 02/24/26 revealed an order for Nystatin powder 100,000 units/gram, apply topically to bilateral groin and abdominal folds twice a day for sixty days.	D 358		

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D 358	Continued From page 17 Review of Resident #8's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin powder 100,000 units/gram, apply topically to bilateral groin and abdominal folds twice daily for 60 days scheduled at 9:00am and 9:00pm. -Nystatin powder was documented as administered at 9:00am and 9:00pm from 02/25/26 though 02/28/26. Review of Resident #8's March 2026 eMAR revealed: -There was an entry for Nystatin powder 100,000 units/gram, apply topically to bilateral groin and abdominal folds twice daily for 60 days, scheduled at 9:00am and 9:00pm. -Nystatin powder was documented as administered at 9:00am from 03/01/26 through 03/14/26. -Nystatin powder was documented as not administered at 9:00am on 03/15/25 with the exception documented as "drug not given" (DNG). -Nystatin powder was documented as administered at 9:00am on 03/16/26 and on 03/17/26. -Nystatin powder was documented as not administered at 9:00am on 03/18/26 with the exception documented as "DNG". -Nystatin powder was documented as administered at 9:00am from 03/19/26 through 03/31/26. -Nystatin powder was documented as administered at 9:00pm from 03/01/26 through 03/09/26. -Nystatin powder was documented as not administered at 9:00pm from 03/10/26 through 03/12/26 with the exception documented as	D 358		

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D 358	Continued From page 18 "resident refused"(REF) on each occasion. -Nystatin powder was documented as administered at 9:00pm from 03/13/26 through 03/15/26. -Nystatin powder was documented as not administered at 9:00pm on 03/16/26 and 03/17/26 with the exception documented as "REF". -Nystatin powder was documented as administered at 9:00pm from 03/18/26 through 03/29/26. -Nystatin powder was documented as not administered at 9:00pm on 03/30/26 and on 03/31/26 with the exception documented as "REF" on both occasions. Review of Resident #8's April 2026 eMAR revealed: -There was an entry for Nystatin powder 100,000 units/gram, apply topically to bilateral groin and abdominal folds twice daily for 60 days, scheduled at 9:00am and 9:00pm with a stop date of 04/26/26. -Nystatin powder was documented as administered at 9:00am from 04/01/26 through 04/04/26. -Nystatin powder was documented as not administered at 9:00am on 04/05/26 and on 04/06/26 with the exception documented as "leave of absence" (LOA) on both occasions. -Nystatin powder was documented as administered at 9:00am from 04/07/26 through 04/25/26. -Nystatin powder was documented as administered at 9:00pm from 04/01/26 through 04/03/26. -Nystatin powder was documented as not administered at 9:00pm from 04/04/26 through 04/06/26 with the exception documented as "LOA" on each occasion.	D 358		

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D 358	Continued From page 19 -Nystatin powder was documented as administered at 9:00pm from 04/07/26 through 04/25/26. Telephone interview with the pharmacist from the facility's contracted pharmacy provider on 06/17/26 at 2:05pm revealed: -An order was received for Resident #8 on 02/24/26 for Nystatin powder 100,000 units/gram to apply to bilateral groin and abdominal folds twice daily for 60 days. -Nystatin powder 100,000units/gram was dispensed for Resident #8 on 02/24/26 for 60 grams (4 15-gram bottles) and on 03/23/26 for 60-grams (4 15-gram bottles). Observation of Resident #8's medications on hand in the medication cart on 06/17/26 at 11:22am revealed: -There was a 15-gram bottle of Nystatin powder 100,000 units/gram, labeled with Resident #8's name to apply topically to bilateral groin and abdominal folds twice a day for 60 days, with a dispense date of 02/24/26 with approximately 5% of the powder remaining. -There were no other bottles of Nystatin powder in the medication cart for Resident #8. Observation of Resident #8's medications on hand on 06/17/26 at 2:56pm in the medication room of the SCU revealed: -There were 3 full 15-gram bottles of Nystatin powder in a zip closure type clear plastic bag with prescription labels on the plastic bag and on each 15-gram bottle of Nystatin powder, containing Resident #8's name and directions to apply topically to bilateral groin and abdominal folds twice daily for 60 days with a dispense date of 03/23/26 on each bottle. -There was a fourth full 15-gram bottle of Nystatin	D 358		

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D 358	Continued From page 20 powder with a prescription label containing Resident #8's name and directions to apply topically to bilateral groin and abdominal skin folds twice daily for 60 days with a dispense date of 03/23/26. Refer to interview with a medication aide (MA) on 06/17/26 at 11:22am. Refer to interview with a second MA on 06/17/26 at 3:23pm. Refer to interview with Resident #8 on 06/17/26 at 3:32pm. Refer to interview with the Special Care Coordinator (SCC) on 06/18/26 at 10:06am Refer to interview with the Administrator on 06/18/26 at 11:30am. Refer to interview with Resident #8' s PCP on 06/18/26 at 12:08pm revealed. c. Review of a physician's order for Resident #8 dated 05/30/26 revealed an order for Nystatin (an anti-fungal agent) 100,000 units/gram topical powder, apply 1 application topically three times a day to abdominal folds. Review of Resident #8's June 2026 eMAR revealed: -There was an entry for Nystatin powder 100,000 units/gram, apply topically three times daily to abdominal folds with a start date of 06/02/26, scheduled at 9:00am, 3:00pm and 9:00pm. -Nystatin powder was documented as administered at 9:00am from 06/02/26 through 06/16/26. -Nystatin powder was documented as	D 358		

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D 358	Continued From page 21 administered at 3:00pm from 06/02/26 through 06/10/26. -Nystatin powder was documented as not administered at 3:00pm on 06/11/26 and on 06/12/26 with the exception documented as "REF" on each occasion. -Nystatin powder was documented as administered at 3:00pm on 06/13/26 and on 06/14/26. -Nystatin powder was documented as not administered at 3:00pm on 06/15/26 with the exception documented as "REF". -Nystatin powder was documented as administered at 9:00pm from 06/02/26 through 06/15/26. Telephone interview with the pharmacist from the facility's contracted pharmacy provider on 06/17/26 at 2:05pm revealed: -An order was received for Resident #8 on 05/30/26 for Nystatin powder 100,000units/gram, apply to abdominal folds three times a day. -Nystatin powder 100,000 units/gram was dispensed for Resident #8 on 06/01/26 for one 15-gram bottle. Observation of Resident #8's medications on hand in the medication cart on 06/17/26 at 11:22am revealed: -There was a 15-gram bottle of Nystatin powder 100,000 units/gram, labeled with Resident #8's name to apply topically to bilateral groin and abdominal folds twice a day for 60 days, with a dispense date of 02/24/26 with approximately 5% of the powder remaining. -There were no other bottles of Nystatin powder in the medication cart for Resident #8. Observation of Resident #8's medications on hand on 06/17/26 at 2:56pm in the medication	D 358		

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D 358	Continued From page 22 room of the SCU revealed: -There were 3 full 15-gram bottles of Nystatin powder in a zip closure type clear plastic bag with prescription labels on the plastic bag and on each 15-gram bottle of Nystatin powder, containing Resident #8's name and directions to apply topically to bilateral groin and abdominal folds twice daily for 60 days with a dispense date of 03/23/26 on each bottle. -There was a fourth full 15-gram bottle of Nystatin powder with a prescription label containing Resident #8's name and directions to apply topically to bilateral groin and abdominal skin folds twice daily for 60 days with a dispense date of 03/23/26. -There was a fifth full 15-gram bottle of Nystatin powder with a prescription label containing Resident #8's name and directions to apply topically three times a day to abdominal folds with a dispense date of 06/01/26. Observation of Resident #8 on 06/17/26 at 3:32pm revealed: -The medication aide (MA) escorted Resident #8 to his room. -She cleaned between the abdominal skin folds with a moist clean cloth and dried between the skin folds with a second dry cloth. -There skin between the abdominal folds was pink to light red, there was no odor noted. -The MA applied Nystatin powder Resident #8's abdominal folds. Refer to interview with a MA on 06/17/26 at 11:22am. Refer to interview with a second MA on 06/17/26 at 3:23pm. Refer to interview with Resident #8 on 06/17/26 at	D 358		

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D 358	Continued From page 23 3:32pm. Refer to interview with the Special Care Coordinator (SCC) on 06/18/26 at 10:06am. Refer to interview with the Administrator on 06/18/26 at 11:30am. Refer to interview with Resident #8' s PCP on 06/18/26 at 12:08pm. Interview with a medication aide (MA) on 06/17/26 at 11:22am revealed: -Resident #8 did not refuse or resist care. -When she applied Nystatin powder to Resident #8, she shook some of the powder into a medication cup and took it to his room and applied it to his skin folds. -She did not know why the bottle of Nystatin powder for Resident #8 was dated 02/24/26. -There was no other Nystatin powder available for Resident #8 that she was aware of. Interview with a second MA on 06/17/26 at 3:23pm revealed: -Resident #8 often refused the 3:00pm application of Nystatin powder because he said he received Nystatin powder at night, but she would ask if he wanted the 3:00pm application of Nystatin powder. -Resident #8 agreed to the 3:00pm dose of Nystatin powder. -She was not sure why the bottle of Nystatin powder for Resident #8 on the medication cart was dated 02/24/26. -She did not know why Resident #8 had all the bottles of Nystatin powder remaining from 03/23/26 and 06/01/26 in the medication room. Interview with Resident #8 on 06/17/26 at 3:32pm	D 358		

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D 358	Continued From page 24 revealed: -His shower days were Tuesday, Thursday, and Saturday. -He did not refuse showers or medications. -He thought staff applied his Nystatin powder when he needed it. -His rash was better. Interview with the Special Care Coordinator (SCC) on 06/18/26 at 10:06am revealed: -She did not know why Resident #8 had so much Nystatin powder remaining in the medication room. -She did not know why the bottle of Nystatin powder that was on the medication cart for Resident #8 was dated 02/24/26. -She expected the MAs to administer Resident #8's Nystatin powder as ordered. Interview with the Administrator on 06/18/26 at 11:30am revealed: -Resident #8 may have refused his Nystatin powder at times. -She could not explain why Resident #8 had 5 bottles remaining of Nystatin powder in the medication room. -She expected the MAs to administer the residents' medications as ordered. Telephone interview with Resident #8's PCP on 06/18/26 at 12:08pm revealed: -Resident #8 struggled with ongoing candidal infection of the groin and skin folds. -She ordered Nystatin powder for Resident #8 to treat the skin yeast infection. -Nystatin powder was re-ordered for Resident #8 on 05/30/26 by an on-call provider. -A yeast infection of the skin folds could cause redness, irritation, and itching. -Resident #8 was not resistant to care or his	D 358		

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D 358	Continued From page 25 medications. -She was concerned that Resident #8 was not receiving the Nystatin powder as ordered and that could allow the yeast infection to continue. 3. Review of Resident #7's FL-2 dated 05/14/26 revealed diagnoses included focal seizures, stroke symptoms, diabetes, hypertension, neuropathy, and hypothyroidism. Review of Resident #7's Resident Register revealed he was admitted to the facility on 04/07/26. Review of Resident #7's admission FL-2 dated 03/31/26 revealed there was an order for Mounjaro 15mg once weekly on Mondays (Mounjaro was used to treat high blood sugar). Review of Resident #7's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Mounjaro 15mg administer every week on Monday. -There was documentation on 04/13/26 and 04/20/26 at 9:00am that Mounjaro 15mg was not available. -There was documentation on 04/27/26 at 9:00am that Mounjaro 15mg was administered. Review of Resident #7's blood glucose results for 04/08/26 to 04/26/26 revealed: -Resident #7's documented blood glucose for 04/09/26 to 04/25/26 at 7:00am ranged from 62 to 249. -Resident #7's documented blood glucose for 04/08/26 to 04/25/26 at 12:00pm ranged from 110 to 262. -Resident #7's documented blood glucose for 04/08/26 to 04/25/26 at 5:00pm ranged from 131	D 358		

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D 358	Continued From page 26 to 333. -Resident #7's documented blood glucose for 04/08/26 to 04/25/26 at 9:00am ranged from 131 to 279. Observation of Resident #7's medications on hand on 06/17/26 at 11:00am revealed that there was not any Mounjaro 15mg available. Telephone interview with Resident #7's contracted pharmacist on 06/17/26 at 3:40pm revealed: -Mounjaro 15mg was dispensed on 02/11/26 and delivered on 02/12/26 for a 84-day supply, 12 pens. -Mounjaro 15mg was dispensed on 04/22/26 and delivered to the facility on 04/23/26 for a 84-day supply, 12 pens. -Mounjaro 15mg was dispensed on 06/17/26 and picked up on 06/17/26 for a 84-day supply, 12 pens, facility reported out of the medication, dispensed early medication should have lasted 4 more weeks. Interview with Resident #7 on 06/17/26 at 8:40am revealed: -He saw an endocrinologist for his diabetes. -He received insulin twice daily and more often depending on his blood glucose results and received a weekly shot for his diabetes. -He was not sure if he had missed any does of Mounjaro. -The staff checked his blood glucose with his continuous glucose monitor. Interview with Resident #7 on 06/17/26 at 10:00am revealed: -He brought all his medications with him when he was admitted including 3 boxes of Mounjaro -The facility told him they could not administer his	D 358		

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D 358	Continued From page 27 medications because they were not in blister packs. Telephone interview with a nurse at Resident #7's PCP's office on 06/18/26 at 9:50am revealed: -Resident #7 was first started on Mounjaro on 03/12/24. -Resident #7 started Mounjaro 15mg on 12/15/25. Interview with a medication aide (MA) 06/17/26 at 11:00am revealed Resident #7 did not have any Mounjaro in the facility. Second interview with the MA on 06/18/26 at 12:05pm revealed: -She did not know why Resident #7 did not have Mounjaro on 4/13/26 and 4/20/26. -She had not called the pharmacy to obtain Resident #7's Mounjaro. Telephone interview with the previous RCC on 06/17/26 at 10:15am revealed: -There was not a process for documenting medications that were brought with residents when they were admitted. -She was not working when Resident #7 was admitted, she was off work for three days around that time. -Resident #7's medications were in a backpack and were placed on her desk. -She kept her office locked; the Administrator and maintenance had a key. -The Administrator should have made sure that Resident #7 had his medications before admission. -There was not an inventory of medications completed on Resident #7's admission. -She did not see Mounjaro in Resident #7's bag. -She was told that Resident #7's Mounjaro had already been given.	D 358		

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D 358	Continued From page 28 -She did not know why Resident #7 would have missed the Mounjaro. -The MA should have checked the medications in. -When medications were delivered to the facility by pharmacy a staff member had to sign for them. Interview with the Administrator on 06/17/26 at 2:43pm revealed: -The previous RCC admitted Resident #7. -Resident #7 brought his medications with him from another facility in a duffle bag. -The medications Resident #7 brought with him were used prior to ordering medications from the pharmacy. -She did not know how many doses (pens) of Mounjaro Resident #7 had on admission. -There was not a process for documenting medications that were brought when a resident was admitted the facility. -She knew that Resident #7 had Mounjaro when he was admitted and instructed staff to hold Mounjaro until it was ordered from pharmacy. -She did not open the boxes of Mounjaro. -The RCC or MA should have ordered Resident #7's Mounjaro on admission. -She did not know what happened to Resident #7's Mounjaro. -She called the pharmacy to order the Mounjaro and was told it was too early to order. -She obtained a verbal order from Resident #7's PCP on 04/13/26 to hold Mounjaro until received from pharmacy. -The facility received Resident #7's Mounjaro from the pharmacy on 04/23/26. -She obtained a 90-day supply of Resident #7's Mounjaro that would start on 06/22/26. -She was not sure why Resident #7 was out of his Mounjaro early.	D 358		

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D 358	Continued From page 29 Attempted telephone interview with Resident #7's endocrinologist on 06/17/26 at 10:20am was unsuccessful. Attempted telephone interview with Resident #7's PCP on 06/17/26 at 3:48pm was unsuccessful. 4. Review of Resident #2's current FL-2 dated 04/30/26 revealed: -Diagnoses included schizophrenia, dementia without behavioral disturbance, mood disturbance, and anxiety, anxiety disorder, hypertension, type 2 diabetes mellitus, hypothyroidism, and major depressive disorder. -The resident was semi-ambulatory. -There was no information related to the resident's orientation. -The resident's current level of care was domiciliary. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 11/09/21. a. Review of a physician's order sheet for Resident #2 dated 03/25/26 revealed orders for Carbidopa-Levodopa 25-100mg, take ½ tab three times daily (a medication used to treat abnormal movement). Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Carbidopa-Levodopa 25-100mg, ½ tablet (12.5-50mg) three times daily scheduled for 9:00am, 3:00pm, and 9:00pm. -Carbidopa-Levodopa was documented as not administered on 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" (drug not	D 358		

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D 358	Continued From page 30	D 358		

given) due to medication pending pharmacy.
-Carbidopa-Levodopa was documented as administered on 04/26/26 at 3:00pm and 9:00pm.

Review of Resident #2's electronic progress note dated 04/26/26 revealed:
-At 2:44pm, a medication aide (MA) noted the resident had several medications that were not administered due to pending pharmacy as a physician order sheet or electronic order was needed.
-The MA called the on call provider who sent 4 electronic orders to the backup pharmacy.

Review of Resident #2's primary care provider (PCP) encounter note dated 04/28/26 revealed:
-The resident's gait and station were stiff and unsteady.
-Per the on call provider, the resident was out of some of his medications over the weekend.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 1:19pm revealed:
-The pharmacy received an order on 04/26/26 for Resident #2's Carbidopa/Levodopa 25-100mg take ½ tablet (12.5mg) three times daily and a 9 day supply was dispensed to the facility on 04/26/26.
-The pharmacy dispensed a 4 day supply of Carbidopa/Levodopa to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26.

Second telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 3:11pm revealed:
-Resident #2's Carbidopa/Levodopa was used to treat mental health and Parkinson's and missed medications could increase trimmers and cause

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D 358	Continued From page 31 muscle stiffness. Refer to interview with Resident #2 on 05/01/26 at 2:49pm. Refer to interview with a medication aide (MA) on 06/17/26 at 11:40am. Refer to telephone interview with the previous RCC on 06/17/26 at 10:40am. Refer to telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm. Refer to interview with the Administrator on 06/17/26 at 3:45pm. b. Review of a physician's order sheet for Resident #2 dated 03/25/26 revealed orders for Lamotrigine 150mg, take ½ tab two times daily (a medication used to treat mood control). Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lamotrigine 150mg, 1 two times daily scheduled for 9:00am and 9:00pm. -Lamotrigine was documented as not administered on 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" due to mediation pending pharmacy. -Lamotrigine was documented as administered on 04/26/26 at 9:00pm. Review of Resident #2's electronic progress note dated 04/26/26 revealed: -At 2:44pm, a medication aide (MA) noted the resident had several medications that were not	D 358		

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D 358	Continued From page 32 administered due to pending pharmacy as a physician order sheet or electronic order was needed. -The MA called the on call provider who sent 4 electronic orders to the backup pharmacy. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 1:19pm revealed: -The pharmacy received an order on 04/26/26 for Resident #2's Lamotrigine 150mg twice daily and a 9 day supply was dispensed to the facility on 04/26/26. -The pharmacy dispensed a 4 day supply of Lamotrigine to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. Second telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 3:11pm revealed: -Resident #'2 Lamotrigine was used to treat mood and seizures and missed medications could cause headaches, mood changes, and nausea. -The pharmacy had received Resident #2's hospital discharge summary dated 03/25/26, but she did not see that the facility had sent clarifications with refills dated 03/25/26. -The facility should send any new orders to the pharmacy which would include FL-2's and physician orders. Refer to interview with Resident #2 on 05/01/26 at 2:49pm. Refer to interview with a medication aide (MA) on 06/17/26 at 11:40am. Refer to telephone interview with the previous RCC on 06/17/26 at 10:40am.	D 358		

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D 358	Continued From page 33 Refer to telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm. Refer to interview with the Administrator on 06/17/26 at 3:45pm. c. Review of a physician's order sheet for Resident #2 dated 03/25/26 revealed orders for Lopressor 50mg, one tablet two times daily (a medication used to treat high blood pressure). Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol tartrate (Lopressor) 50mg, 1 twice daily scheduled for 9:00am and 9:00pm. -Metoprolol tartrate was documented as not administered on 04/25/26 and 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" medication pending pharmacy. -Metoprolol tartrate was documented as administered on 04/25/26 and 04/26/26 at 9:00pm. Review of Resident #2's electronic progress note dated 04/26/26 revealed: -At 2:44pm, a medication aide (MA) noted the resident had several medications that were not administered due to pending pharmacy as a physician order sheet or electronic order was needed. -The MA called the on call provider who sent 4 electronic orders to the backup pharmacy. Review of Resident #2's primary care provider (PCP) encounter note dated 04/28/26 revealed: -The resident was seen on 04/28/26 at the request of facility staff. -The resident takes metoprolol tartrate twice	D 358		

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D 358	Continued From page 34 daily. -The resident was not sure if he had received his metoprolol tartrate last night (04/27/26) and was worried about his medications. -The resident's blood pressure and heart rate were slightly elevated on 04/28/26. -The resident's blood pressure was 166/80 and his heart rate was 104 per minute. -Per the on call provider, the resident was out of some of his medications over the weekend. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 1:19pm revealed: -The pharmacy received an order on 04/26/26 for Resident #2's Metoprolol tartrate 50mg one twice daily and a 9 day supply was dispensed to the facility on 04/26/26. -The pharmacy dispensed a 4 day supply of Metoprolol tartrate to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. Second telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 3:11pm revealed: -Resident #2's Metoprolol tartrate was used to treat blood pressure and missed medication could cause increase in blood pressure and heart rate which increased the risk of a stroke. Refer to interview with Resident #2 on 05/01/26 at 2:49pm. Refer to interview with a medication aide (MA) on 06/17/26 at 11:40am. Refer to telephone interview with the previous RCC on 06/17/26 at 10:40am.	D 358		

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D 358	Continued From page 35 Refer to telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm. Refer to interview with the Administrator on 06/17/26 at 3:45pm. d. Review of a physician's order sheet for Resident #2 dated 03/25/26 revealed orders for Quetiapine 300mg, one tablet every night (a medication used to treat schizophrenia) , and Quetiapine 300mg, take ½ tablet (150mg) every morning. Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Quetiapine 300mg, take ½ tablet every morning scheduled and 9:00am and 1 tablet at bedtime scheduled for 9:00pm. -Quetiapine was documented as not administered on 04/25/26 and 04/26/26 at 9:00am as the eMAR was documented with DNG due to medication pending pharmacy. -Quetiapine was documented as administered on 04/25/26 and 04/26/26 at 9:00pm. Review of Resident #2's electronic progress note dated 04/26/26 revealed: -At 2:44pm, a medication aide (MA) noted the resident had several medications that were not administered due to pending pharmacy as a physician order sheet or electronic order was needed. -The MA called the on call provider who sent 4 electronic orders to the backup pharmacy. Review of Resident #2's primary care provider (PCP) encounter note dated 04/28/26 revealed -The resident reported increased symptoms on 04/28/26 with auditory hallucinations.	D 358		

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D 358	Continued From page 36 -Per the on call provider, the resident was out of some of his medications over the weekend. Review of Resident #2's mental health encounter note dated 05/06/26 revealed: -The resident's MAR indicated the resident missed Quetiapine doses on 04/25/26 and 04/26/26. -The provider spoke with lead staff who reported the resident missed 9:00am doses of Quetiapine on 04/25/26 and 04/26/26, and that she was not notified by staff that resident missed doses of medication due to medication not being in the facility. Telephone interview with Resident #2's mental health provider on 06/17/26 at 11:23am revealed: -She spoke with the Administrator on 05/06/26 about Resident #2 missing his Quetiapine as indicated on his eMAR because the medication was not in the building to be administered. -The Administrator indicated that staff did not notify her that Resident #2 had missed his medications on 04/25/26 and 04/26/26. -The facility should ensure medications were ordered and were in the facility timely for administration. -She would expect medications to be available and administered as ordered. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 1:19pm revealed: -The pharmacy received an order on 04/26/26 for Resident #2's Quetiapine 300mg ½ tablet (150mg) every morning and 300mg every night. -Resident #2's Quetiapine was dispensed from a backup pharmacy on 04/27/26 due to a low stock supply. -The pharmacy dispensed a 4 day supply of	D 358		

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D 358	Continued From page 37 Quetiapine to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. -The facility was on a weekly cycle fill for medications, as medications were shipped on Wednesday, received by the facility on Thursday for the medication to be started on Tuesday. -Every 7 days the provider and facility were notified via fax an order was needed for a refill if the resident had less that a 30 day supply. -The pharmacy sent Resident #2's PCP and the facility a refill request on 04/15/26 at 10:12am but did not hear anything back until 04/26/26 when the orders were sent to the pharmacy. Second telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 3:11pm revealed: -Resident #2's Quetiapine was used to treat mental health and missed medication could increase anxiety and cause insomnia. Refer to interview with Resident #2 on 05/01/26 at 2:49pm. Refer to interview with a medication aide (MA) on 06/17/26 at 11:40am. Refer to telephone interview with the previous RCC on 06/17/26 at 10:40am. Refer to telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm. Refer to interview with the Administrator on 06/17/26 at 3:45pm. --- Interview with Resident #2 on 05/01/26 at 2:49pm revealed: -He could not remember the date but about 1	D 358		

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	HAL065036	A. BUILDING: _____ B. WING _____	R 06/18/2026

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D 358	Continued From page 38 week ago he missed getting some of his medications over the weekend. -He did not know the names of the medications he missed but thought he went without some of his medications for 2 days. -His medications kept him from hearing voices and noises in his head and that was why he needed to take them. -One of the MAs told him he was out of medications and that she would have to call the pharmacy. -He had not had any trouble getting his medication since that weekend. Interview with a medication aide (MA) on 06/17/26 at 11:40am revealed: -She was the MA on 04/25/26 and 04/26/26. -She was not able to give Resident #2 some of his medications on 04/25/26 and 04/26/26 as the resident was out of medications. -Resident #2 was out of Carbidopa/Levodopa, Lamotrigine, Metoprolol, and Quetiapine. -She looked on the medication cart and medication room with over flow of medications but Resident #2's medications could not be found in the building. -She sent Resident #2's PCP a text message on 04/25/26 at 7:45am to let her know the resident was out of medications and that medications were not in the building. -On 04/26/26 at 7:00am she called the on call provider for Resident #2 who sent electronic orders to the pharmacy for Carbidopa/Levodopa, Lamotrigine, Metoprolol, and Seroquel. -She did not think to call the on call provider on 04/25/26 because she had sent the PCP a text message on 04/25/26. -Resident #2's PCP responded to her text message on 04/27/26 at 9:59am and said she did not know why the resident did not have	D 358		

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D 358	Continued From page 39 medications as he had refills for those medications and that the resident should not have missed his medications. -The MAs and Resident Care Coordinator (RCC) were responsible for making sure the residents medications were in the facility. -Resident #2 should not have missed his medications. -The facility was responsible for administering residents their medications as ordered. Telephone interview with the previous RCC on 06/17/26 at 10:40am revealed: -Her last day working at the facility was on 05/13/26. -On 04/27/26, the Administrator informed her that Resident #2 had missed medications over the previous weekend as medications were not in the facility. -She could not recall what medications Resident #2 missed. -She did not know for sure but felt like Resident #2's medications were in the facility. -In the past there had been issues where medications were in the facility but the MAs did not go look for the medications in overflow when medications were not on the medication cart. -MAs were responsible for doing cart audits daily, as 3 residents are picked each shift to audit their medications. -The MAs were to compare the MAR with the order and make sure medication was on hand. -Resident #2's medications were on a weekly cycle fill so he should not have missed any of his medications. -The MAs and RCC were responsible for calling to get a medication refill if needed, making sure the medication was ordered, and delivered to the facility.	D 358		

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D 358	Continued From page 40 Telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm revealed: -On 04/26/26, a MA had contacted the on call provider to indicate that Resident #2's had some medications that were not in the facility. -The on call provider sent electronic orders to the pharmacy on 04/26/26 for Metoprolol 50mg one twice daily, Lamotrigine 150mg one twice daily, Carbidopa/Levodopa 25-100mg take ½ tablet (12.5mg) three times daily, Quetiapine 300mg take ½ tablet (150mg) every morning, and Quetiapine 300mg every night. -Resident #2 took Quetiapine and Lamotrigine for mental health and missed medication could increase risk of psychosis, as the resident had a history of suicidal ideation, and put the resident at risk for danger to self. -Resident #2 took Metoprolol to control his blood pressure and missed medications could elevate the resident's flood pressure and heart rate, increasing the resident's risk for heart attack and stroke. -Resident #2 took Carbidopa/Levodopa to help with his abnormal gait, and missed medication would make it hard for the resident to walk and increase his risk for falls. -Resident #2 should not have missed medications, since she had clarified the resident's medications on 03/25/26 and gave written refills, after the resident had returned from the facility from the hospital. -She would expect Resident #2's medication to be in the facility to be administered as ordered. Interview with the Administrator on 06/17/26 at 3:45pm revealed: -Resident #2's PCP clarified Resident #2's medications orders on 03/25/26 which also included medication refills. -She did not know why the pharmacy said they	D 358		

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D 358	Continued From page 41 did not receive a copy of Resident #2's medication clarifications and refills dated the 03/25/26, because she sent a copy via electronic mail (email) to the pharmacy on 03/26/26 at 11:38pm. -She was aware that Resident #2 did not get his Quetiapine the weekend of 04/25/26 because the medication was not in the building. -She was not aware Resident #2 missed his Carbidopa/Levodopa, Lamotrigine, and Metoprolol tartrate the same weekend he missed his Quetiapine. -The MA should have informed her that Resident #2 missed his medications. -The MAs were responsible for conducting weekly medication cart audits, where the MAs looked to see if a medication count was low and needed to be refilled, medications were on the cart, checking the medication order to the medication on hand. -The medication cart audits should be documented, but she did not have a medication cart audit for Resident #2 around the time of 04/25/26. -She could not give a date, but since 04/25/26, she implemented that once the MA completed a medication cart audit, they were to give the paperwork to the RCC. -The MAs and/or the RCC could have contacted Resident #2's PCP to get a refill and send to the pharmacy. -Resident #2's medications were on a weekly cycle fill, as medications were delivered to the facility on Thursday for medications to start on Tuesday. -There was no reason Resident #2 should have missed his medications. The facility failed to administer medications as ordered to four sampled residents (#1, #2, #7, #8)	D 358		

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D 358	Continued From page 42 including an antibiotic that was not administered resulting in a delay in treatment of a urinary tract infection (#1), an antibiotic to treat a respiratory infection was delayed for 7 days, a medication to treat a yeast infection (#8), and a medication for high blood sugar (#7). One resident (#2) missed three doses of two mental health medications, and one dose of a medication for high blood pressure, and a medication for abnormal body movements (#2) due to medications not being available for administration. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/26.	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	D 367	10A NCAC 13F .1004(j) Medication Administration Community will ensure that medication administration records (MAR) are accurate and include required information ED and/or CCs will conduct weekly cart audits that include but are not limited to review of the MAR. ED and/or CCs will review no less than five resident MARs weekly for the next 4 weeks to ensure accuracy. Any discrepancy found will be reviewed with pharmacy and clarified with physician Medicaiton Staff, ED and CCs have been in-service on reviewing of medication administration records for accuracy	

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D 367	Continued From page 43 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 medication administration records were accurate for 1 of 6 sampled residents (#2) to including medications used to treat mental health disorders, mood control, abnormal movement, and high blood pressure. Review of the facility's revised Medication Administration policy dated November 2018 revealed: -Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. -If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication may be removed from the emergency drug supply. -Documentation (including electronic) includes the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. Review of Resident #2's current FL-2 dated 04/30/26 revealed diagnoses included schizophrenia, dementia without behavioral disturbance, mood disturbance, and anxiety,	D 367		

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D 367	Continued From page 44 anxiety disorder, hypertension, type 2 diabetes mellitus, hypothyroidism, and major depressive disorder. Review of a physician's order sheet for Resident #2 dated 03/25/26 revealed orders for Carbidopa-Levodopa 25-100mg, take ½ tab three times daily (a medication used to treat abnormal movement), Lamotrigine 150mg, take ½ tab two times daily (a medication used to treat mood control), Lopressor 50mg, one tablet two times daily (a medication used to treat high blood pressure), Quetiapine 300mg, one tablet every night (a medication used to treat schizophrenia) , and Seroquel 300mg, take ½ tablet (150mg) every morning. Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Carbidopa-Levodopa 25-100mg, ½ tablet (12.5-50mg) three times daily scheduled for 9:00am, 3:00pm, and 9:00pm. -Carbidopa-Levodopa was documented as not administered on 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" (drug not given) due to medication pending pharmacy. -Carbidopa-Levodopa was documented as administered on 04/26/26 at 3:00pm and 9:00pm. -There was an entry for Lamotrigine 150mg, 1 two times daily scheduled for 9:00am and 9:00pm. -Lamotrigine was documented as not administered on 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" due to mediation pending pharmacy. -Lamotrigine was documented as administered on 04/26/26 at 9:00pm. -There was an entry for Metoprolol tartrate (Lopressor) 50mg, 1 twice daily scheduled for	D 367		

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D 367	Continued From page 45 9:00am and 9:00pm. -Metoprolol tartrate was documented as not administered on 04/25/26 and 04/26/26 at 9:00am, as the eMAR was documented with a "DNG" medication pending pharmacy. -Metoprolol tartrate was documented as administered on 04/25/26 and 04/26/26 at 9:00pm. -There was an entry for Quetiapine 300mg, take ½ tablet every morning scheduled and 9:00am and 1 tablet at bedtime scheduled for 9:00pm. -Quetiapine was documented as not administered on 04/25/26 and 04/26/26 at 9:00am as the eMAR was documented with DNG due to medication pending pharmacy. -Quetiapine was documented as administered on 04/25/26 and 04/26/26 at 9:00pm. Review of Resident #2's electronic progress note dated 04/26/26 revealed: -At 2:44pm, a medication aide (MA) noted the resident had several medications that were not administered due to pending pharmacy as a physician order sheet or electronic order was needed. -The MA called the on call provider who sent 4 electronic orders to the backup pharmacy. Review of Resident #2's primary care provider (PCP) encounter note dated 04/28/26 revealed: -The resident was seen on 04/28/26 at the request of facility staff. -The resident took metoprolol tartrate twice daily. -The resident was not sure if he had received his metoprolol tartrate last night (04/27/26) and was worried about his medications. -Per the on call provider, the resident was out of some of his medications over the weekend. Review of Resident #2's mental health encounter	D 367		

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D 367	Continued From page 46 note dated 05/06/26 revealed: -The resident's MAR indicated the resident missed Quetiapine doses on 04/25/26 and 04/26/26. -The provider spoke with lead staff who reported the resident missed 9:00am doses of Quetiapine on 04/25/26 and 04/26/26, and that she was not notified by staff that resident missed doses of medication due to medication not being in the facility. Interview with Resident #2 on 05/01/26 at 2:49pm revealed: -He could not remember the date but about 1 week ago he missed getting some of his medications over the weekend. -He did not know the names of the medications he missed but thought he went without some of his medications for 2 days. -His medications kept him from hearing voices and noises in his head and that was why he needed to take them. -One of the MAs told him he was out of medications and that she would have to call the pharmacy. -He had not had any trouble getting his medication since that weekend. Interview with a medication aide (MA) on 06/17/26 at 11:40am revealed: -She was the MA on 04/25/26 and 04/26/26. -She was not able to administer Resident #2 some of his medications on 04/25/26 and 04/26/26 as the resident was out of medications. -Resident #2 was out of Carbidopa/Levodopa, Lamotrigine, Metoprolol, and Quetiapine. -She looked on the medication cart and medication room with over flow of medications but medications could not be found in the facility. -She sent Resident #2's PCP a text message on	D 367		

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D 367	Continued From page 47 04/25/26 at 7:45am to let her know the resident was out of medications and that medications were not in the facility. Telephone interview with the previous Resident Care Coordinator (RCC) on 06/17/26 at 10:40am revealed: -Her last day working at the facility was on 05/13/26. -On 04/27/26, the Administrator informed her that Resident #2 had missed medications over the previous weekend as medications were not in the building. -She could not recall what medications Resident #2 missed. -The MAs and RCC were responsible for calling to get a medication refill if needed, making sure the medication was ordered, and delivered to the facility. Telephone interview with Resident #2's PCP on 06/17/26 at 12:57pm revealed: -On 04/26/26, a MA had contacted the on call provider to indicate that Resident #2's had some medications that were not in the building. -The on call provider sent electronic orders to the pharmacy on 04/26/26 for Metoprolol 50mg one twice daily, Lamotrigine 150mg one twice daily, Carbidopa/Levodopa 25-100mg take ½ tablet (12.5mg) three times daily, Quetiapine 300mg take ½ tablet (150mg) every morning, and Quetiapine 300mg every night. Telephone interview with Resident #2's mental health provider on 06/17/26 at 11:23am revealed she spoke with the Administrator on 05/06/26 about Resident #2 missing his Quetiapine as indicated on his eMAR because the medication was not in the building to be administered.	D 367		

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D 367	Continued From page 48 Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/17/26 at 1:19pm revealed: -The pharmacy received an order on 04/26/26 for Resident #2's Carbidopa/Levodopa 25-100mg take ½ tablet (12.5mg) three times daily and a 9 day supply was dispensed to the facility on 04/26/26. -The pharmacy dispensed a 4 day supply of Carbidopa/Levodopa to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. -The pharmacy received an order on 04/26/26 for Resident #2's Lamotrigine 150mg twice daily and a 9 day supply was dispensed to the facility on 04/26/26. -The pharmacy dispensed a 4 day supply of Lamotrigine to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. -The pharmacy received an order on 04/26/26 for Resident #2's Metoprolol tartrate 50mg one twice daily and a 9 day supply was dispensed to the facility on 04/26/26. -The pharmacy dispensed a 4 day supply of Metoprolol tartrate to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. -The pharmacy received an order on 04/26/26 for Resident #2's Quetiapine 300mg ½ tablet (150mg) every morning and 300mg every night. -The Quetiapine was dispensed from a backup pharmacy on 04/27/26 due to a low stock supply. -The pharmacy dispensed a 4 day supply of Quetiapine to the facility on 04/15/26, which was to start on 04/21/26 and last until 04/24/26. -The facility was on a weekly cycle fill from medications, as medications were shipped on Wednesday, received by the facility on Thursday for the medication to be started on Tuesday. -Every 7 days the provider and facility were	D 367		

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D 367	Continued From page 49 notified via fax a prescription was needed for a refill if the resident had less that a 30 day supply. -The pharmacy sent Resident #2's PCP and the facility a refill request on 04/15/26 at 10:12am but did not hear anything back until 04/26/26 when the e-scripts were sent to the pharmacy. Interview with the Administrator on 06/17/26 at 3:45pm revealed: -Resident #2's PCP clarified Resident #2's medications orders on 03/25/26 which also included refills. -She does not know why the pharmacy said they did not receive a copy of Resident #2's medication clarifications and refills dated the 03/25/26, because she sent a copy to the pharmacy by electronic mail (email) 03/26/26 at 11:38pm. -She was aware that Resident #2 did not get his Quetiapine the weekend of 04/25/26 because the medication was not in the building. -She was not aware Resident #2 missed his Carbidopa/Levodopa, Lamotrigine, and Metoprolol tartrate the same weekend he missed his Quetiapine. -The MA who documented Resident #2's medications were administered at 9:00pm on 04/25/26 and 04/26/26 when the medications were pending pharmacy was no longer employed at the facility. -She did not know why the MA would document a medication was given if the medication was not in the building to be administered. -If the medication was not in the building and not available to be administered she would have expected the MA to document the medication was not administered.	D 367		