STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092-237	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF APEX	7501 JENKS ROAD APEX, NC 27523

(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 initial survey on 07/01/26 and 07/02/26.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#2) for a medication used to treat shortness of breath and wheezing. The findings are: Review of Resident #2's current FL-2 dated 03/19/26 revealed diagnoses included dementia, mixed hyperlipidemia, osteoarthritis of multiple joints, tremors, diverticulitis, abdominal aortic atherosclerosis and calculus of the gallbladder without cholecystitis.	D 344		

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D 344	Continued From page 1 Review of Resident #2's primary care provider's (PCP) visit notes with physician's orders dated 06/23/26 revealed there was an order to start Albuterol 2.5mg/3mL, inhale via nebulizer every 4 hours as needed for wheezing/shortness of breath. Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Albuterol Nebulizer 0.083%, give 1 vial via nebulizer every 4 hours as needed for wheezing/shortness of breath, scheduled to be administered PRN (as needed). (A 3mL vial that is 0.083% albuterol equals 2.5mg.) -There was an entry for Albuterol Nebulizer 0.083%, give 1 vial via nebulizer every 4 hours for wheezing/shortness of breath, scheduled to be administered PRN. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for Albuterol Nebulizer 0.083%, give 1 vial via nebulizer every 4 hours as needed for wheezing/shortness of breath. -There was an entry for Albuterol Nebulizer 0.083%, give 1 vial via nebulizer every 4 hours for wheezing/shortness of breath, scheduled to be administered PRN. Observation of Resident #2's medications on hand on 07/02/26 at 4:00pm revealed: -There was a supply of Albuterol Nebulizer 0.083% with a label instructions to give 1 vial via nebulizer every 4 hours for shortness of breath. -There was no supply of Albuterol Nebulizer 0.083% with instructions to give 1 vial via nebulizer every 4 hours as needed for wheezing/shortness of breath.	D 344		

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D 344	Continued From page 2 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/02/26 at 5:00pm revealed: -The pharmacy received an electronic prescription for Resident #2 on 06/23/26 from Resident #2's PCP for Albuterol Nebulizer 0.083%, inhale 3mL using nebulizer every 4 hours for shortness of breath. -The pharmacy received a typed prescription on the PCP's letter head that was faxed on 06/23/26 for Resident #2 for Albuterol Nebulizer 0.083%, inhale 3mL using nebulizer every 4 hours as needed for shortness of breath. Interview with a medication aide (MA) on 07/02/26 at 4:05pm revealed: -In the eMAR system, Resident #2 had 2 PRN orders for Albuterol. -She never administered the Albuterol to Resident #2 scheduled because it was to be administered as needed according to the eMAR. -If she had noticed that the label on the Albuterol did not say PRN, she would have added a PRN sticker. -The Resident Care Director (RCD) put the orders in the eMAR system. -The RCD was responsible for clarifying orders. Interview with the RCD on 07/02/26 at 4:17pm and 5:34pm revealed: -She reviewed PCP orders and pharmacy orders. -The PCP orders and pharmacy orders were not supposed to be different and were never different. -She overlooked the 2 Albuterol orders for Resident #2. -She should have clarified the orders with the PCP. Telephone interview with Resident #2's family	D 344		

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D 344	Continued From page 3 members on 07/02/26 at 4:30pm revealed: -Resident #2 was to be administered Albuterol as needed only. -Resident #2 did not need the Albuterol. Interview with the Administrator on 07/02/26 at 5:25pm revealed: -He was not aware of the 2 orders for Albuterol for Resident #2. -He did not know anything about Resident #2's medication. Interview with the Vice President of Operations (VPO) on 07/02/26 at 5:30pm revealed: -She was not aware of the 2 orders for Albuterol for Resident #2. -She did quality assurance for the facility every 2 weeks but had not made it to Resident #2's orders. -When a discrepancy in medication orders was found, the PCP was called for clarification. Attempted telephone interview with Resident #2's PCP on 07/02/26 at 4:53pm was unsuccessful. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable.	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	D 358		

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D 358	Continued From page 4 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#3, #4) observed during the medication pass including errors with inhalers for chronic obstructive pulmonary disease (#3, #4) and a calcium with vitamin D supplement for osteoporosis (#3); and for 1 of 3 residents (#3) sampled for record review including errors with a blood thinner. The findings are: 1. The medication error rate was 11% as evidenced by 3 errors out of 27 opportunities during the 8:00am and 9:00am medication passes on 07/02/26. a. Review of Resident #3's current FL-2 dated 04/22/26 revealed: -Diagnoses included chronic obstructive pulmonary disease, cerebral infarction (stroke), history of transient ischemia attacks (mini-stroke), essential hypertension, age-related osteoporosis, vitamin deficiency, osteoarthritis, pain, hyperlipidemia, glaucoma, and dysphagia. -There was an order for Trelegy Ellipta 200/62.5/25mcg inhaler use 1 puff (1 inhalation) once a day. (Trelegy Ellipta is a dry powder inhaler used for chronic obstructive pulmonary disease. According to the manufacturer, the dose counter on the inhaler will show the total number of doses. It counts down by one each time the cover is opened and a dose is taken. The cover of the inhaler should be fully opened and a clicking sound heard when a dose is ready to be	D 358		

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inhaled. This is shown by a decrease in the number on the counter. If the counter did not count down as the click was heard, the inhaler would not deliver the medication.)

Review of Resident #3's physician's order sheet dated 04/29/26 revealed an order for Trelegy Ellipta 200/62.5/25mcg inhaler, inhale contents of 1 click (1 dose) by mouth every day, rinse mouth after use.

Observation of the 9:00am medication pass on 07/02/26 revealed:
-The medication aide (MA) took Resident #3's Trelegy Ellipta 200/62.5/25mcg inhaler from a foil pouch and the dose counter on the inhaler was on 6.
-The MA handed the Trelegy Ellipta inhaler to Resident #3 at 9:58am, without opening the cover to prepare the dose.
-Resident #3 opened the cover of the Trelegy Ellipta inhaler far enough to expose the mouthpiece but the cover was not fully opened and no click was heard.
-Resident #3 put her mouth around the mouthpiece and inhaled once and handed the inhaler back to the MA.
-Resident #3 rinsed her mouth with water.
-The dose counter on the Trelegy Ellipta inhaler remained on 6, therefore, no dosage was released and inhaled.
-Resident #3 did not receive Trelegy Ellipta as ordered.

Review of Resident #3's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/02/26 revealed:
-There was an entry for Trelegy Ellipta 200/62.5/25mcg inhale contents of 1 click (1 dose) every day, rinse mouth after use.

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-Trelegy Ellipta was scheduled for administration at 9:00am.
-Trelegy Ellipta was documented as administered daily from 07/01/26 - 07/02/26.

Observation of Resident #3's medications on hand on 07/02/26 at 12:32pm revealed:
-There was a Trelegy Ellipta 200/62.5/25mcg inhaler dispensed on 06/01/26.
-The instructions were to inhale contents of 1 click (1 dose) by mouth every day, rinse mouth after use.
-The dose counter was on 6.

Interview with Resident #3 on 07/02/26 at 1:00pm revealed:
-The MAs usually opened the Trelegy Ellipta inhaler and "clicked" it for her.
-She did not know if there was a click sound when she opened the inhaler that morning.
-She used the Trelegy Ellipta inhaler for breathing problems.
-She usually had shortness of breath when she moved around but not usually when resting.

Interview with the MA on 07/02/26 at 12:47pm revealed:
-She usually opened the cover to Resident #3's Trelegy Ellipta inhaler before she handed it to the resident.
-She did not notice there was no clicking sound when the resident opened the cover to the Trelegy Ellipta that morning or that the dose counter did not decrease.
-She was not aware of Resident #3 having any current issues with shortness of breath.

Interview with the Resident Care Director (RCD) on 07/02/26 at 1:11pm revealed:
-The MAs were supposed to open the cover on

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the Trelegy Ellipta inhaler until they heard it click to ensure the medication was prepared for inhalation.
-Resident #3 was always short of breath and that was no worse than normal.

Interview with the Administrator on 07/02/26 at 1:39pm revealed:
-The MAs should double check the instructions on the eMARs and the medication labels and administer medications as ordered.
-If a MA had any questions about how to administer medications, the MA should ask their supervisor.

Attempted telephone interviews with Resident #3's primary care provider (PCP) on 07/02/26 at 4:03pm and 4:53pm were unsuccessful.

b. Review of Resident #3's current FL-2 dated 04/22/26 revealed an order for Calcium with Vitamin D 600mg/400units 2 tablets daily. (Calcium with Vitamin D is a supplement used to help prevent osteoporosis.)

Observation of the 9:00am medication pass on 07/02/26 revealed:
-The medication aide (MA) prepared and administered one Calcium with Vitamin D 600mg/400units tablet to Resident #3 at 8:22am.
-Resident #3 was administered one tablet instead of 2 tablets as ordered.

Review of Resident #3's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/02/26 revealed:
-There was an entry for Calcium with Vitamin D 600/400 tablet take 2 tablets every day for supplement scheduled for 9:00am.
-Calcium with Vitamin D 600/400 tablet was

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D 358	Continued From page 8 documented as administered from 07/01/26 - 07/02/26. Observation of Resident #3's medications on hand on 07/02/26 at 12:24pm revealed: -There was a supply of Calcium with Vitamin D 600/400 tablets dispensed on 05/21/26 with instructions to take 2 tablets every day for supplement. -There were 2 of 56 tablets remaining. Interview with Resident #3 on 07/02/26 at 1:00pm revealed: -She was not sure if she took Calcium and Vitamin D. -She had a broken hip earlier in the year but she was not sure if she was taking a supplement for her bones. Interview with the MA on 07/02/26 at 12:47pm revealed: -She usually administered only one Calcium with Vitamin D tablet to Resident #3. -She had not noticed the instructions on the eMAR and the medication label were to take 2 tablets daily. Interview with the Resident Care Director (RCD) on 07/02/26 at 1:11pm revealed: -The MAs should pay attention to and read the directions on the eMARs and medication labels. -Resident #3 should have received two Calcium with Vitamin D tablets. Interview with the Administrator on 07/02/26 at 1:39pm revealed: -The MAs should double check the instructions on the eMARs and the medication labels and administer medications as ordered. -If a MA had any questions about how to	D 358		

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administer medications, the MA should ask their supervisor.

Attempted telephone interviews with Resident #3's primary care provider (PCP) on 07/02/26 at 4:03pm and 4:53pm were unsuccessful.

c. Review of Resident #2's current FL-2 dated 03/19/26 revealed:
-Diagnoses included dementia, mixed hyperlipidemia, osteoarthritis, tremor, diverticulosis, abdominal aortic atherosclerosis, gallbladder stones, and hard of hearing.
-There was an order for Anoro Ellipta 62.5-25mcg inhaler, inhale 1 puff daily. (Anoro Ellipta is a dry powder inhaler used for chronic obstructive pulmonary disease. According to the manufacturer, the dose counter on the inhaler will show the total number of doses. It counts down by one each time the cover is opened and a dose is taken. After the last dose is inhaled, the counter displays "0" and the inhaler is empty.)

Review of Resident #2's physician's order sheet dated 06/16/26 revealed an order for Anoro Ellipta 62.5-25mcg inhaler, inhale 1 inhalation once daily (discard inhaler 6 weeks after opening or when the counter reads "0").

Observation of the 9:00am medication pass on 07/02/26 revealed:
-The medication aide (MA) took Resident #2's Anoro Ellipta 62.5/25mcg inhaler from a foil pouch and the dose counter on the inhaler was on 0.
-The MA was unable to locate another Anoro Ellipta inhaler for Resident #2.
-Anoro Ellipta inhaler was not administered to Resident #2.

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Review of Resident #2's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/02/26 revealed:
-There was an entry for Anoro Ellipta 62.5/25mcg inhale 1 inhalation once daily (discard inhaler 6 weeks after opening or when the counter reads "0"), scheduled at 9:00am.
-Anoro Ellipta was documented as administered on 07/01/26 and unavailable on 07/02/26.

Observation of Resident #2's medications on hand on 07/02/26 at 10:24am revealed:
-There was an Anoro Ellipta 62.5/25mcg inhaler (30-day supply) dispensed on 06/03/26.
-The opened date was documented as 06/04/26.
-The instructions were to inhale 1 inhalation once daily (discard inhaler 6 weeks after opening or when the counter reads "0").
-The dose counter was on 0.

Interview with the MA on 07/02/26 at 10:19am revealed:
-The MAs were responsible for reordering inhalers when there were 5 doses left on the counter.
-She did not see Resident #2's Anoro Ellipta as being reordered on the reorder list on the clipboard.
-She would reorder Resident #2's Anoro Ellipta inhaler today and it would come in the pharmacy tote tonight.
-Resident #2 would miss the Anoro Ellipta dosage today.
-She was not sure why there were no doses left in the Anoro Ellipta inhaler opened on 06/04/26 since there should have been a 30-day supply.

Interviews with the Resident Care Director (RCD) on 07/02/26 at 10:18am and 1:19pm revealed:
-The MAs should reorder inhalers when there

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were 5 doses left on the counter.
-She did not think Resident #2's Anoro Ellipta inhaler was reordered when it should have been reordered.
-Resident #2 had some shortness of breath at times but not worse than normal.

Interview with the Administrator on 07/02/26 at 1:41pm revealed:
-The RCD and the MAs were responsible for reordering medications.
-Resident #2 should have Anoro Ellipta available for administration.

Attempted telephone interviews with Resident #2's primary care provider (PCP) on 07/02/26 at 4:03pm and 4:53pm were unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

2. Review of Resident #3's current FL-2 dated 04/22/26 revealed diagnoses included chronic obstructive pulmonary disease, cerebral infarction (stroke), history of transient ischemia attacks (mini-stroke), essential hypertension, age-related osteoporosis, vitamin deficiency, osteoarthritis, pain, hyperlipidemia, glaucoma, and dysphagia.

Review of Resident #3's physician's order dated 05/21/26 revealed an order for Warfarin 7.5mg 1 tablet once daily. (Warfarin is a blood thinner used to prevent blood clots.)

Review of Resident #3's lab results dated 05/21/26 revealed:
-The resident's International Normalized Ratio (INR) was 1.4 (below therapeutic range) on 05/21/26. (INR is a lab value used to monitor

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D 358	Continued From page 12 Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations. INR levels below therapeutic range increase the risk of blood clots. INR levels above therapeutic range increase the risk of bleeding.) Review of Resident #3's physician's order dated 05/22/26 at 8:01am revealed: -There was an order to recheck the resident's INR today (05/22/26). -There was an order to continue Warfarin 7.5mg once daily. -There was an order to recheck the resident's INR on 05/26/26. Review of Resident #3's lab results dated 05/22/26 revealed the resident's INR was 1.2 (below therapeutic range). Review of Resident #3's physician's order dated 05/22/26 at 12:46pm revealed: -There was an order to discontinue Warfarin 7.5mg once daily. -There was an order to start Warfarin 15mg once daily for 2 days then decrease to Warfarin 10mg once daily. Review of Resident #3's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Warfarin 7.5mg 1 tablet every day scheduled at 6:00pm. -Warfarin 7.5mg was documented as administered from 05/21/26 - 05/25/26. -There was a second entry for Warfarin 10mg take 1 ½ tablets (15mg) every day for 2 days scheduled at 9:00pm. -Warfarin 15mg was documented as administered on 05/23/26 and 05/24/26.	D 358		

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CALYX LIVING OF APEX	7501 JENKS ROAD APEX, NC 27523

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D 358	Continued From page 13 -There was a third entry for Warfarin 10mg 1 tablet every day scheduled at 9:00pm. -Warfarin 10mg was documented as administered daily from 05/25/26 - 05/31/26. -There was 22.5mg of Warfarin documented as administered on 05/23/26 and 05/24/26 instead of 15mg as ordered. -There was 17.5mg of Warfarin documented as administered on 05/25/26 instead of 10mg as ordered. Review of Resident #3's lab results dated 05/26/26 revealed the resident's INR was 3.4 (above therapeutic range). Review of Resident #3's primary care provider (PCP) visit note dated 05/26/26 revealed: -The resident recently had a supratherapeutic (above therapeutic range) INR related to a facility medication administration error in which prior Warfarin dosing was not discontinued resulting in receipt of overlapping doses for approximately 2 days over the holiday weekend. -The resident's goal INR was a therapeutic range of 2.0 - 3.0. -The resident's INR was 3.4 on 05/26/26 and improved to 2.6 on 05/29/26 after resumption of corrected dosing. -The resident remained clinically stable without major bleeding. -The resident remained at elevated bleeding risk due to anticoagulation and fall history. Review of Resident #3's physician's order dated 05/26/26 revealed: -There was an order to continue Warfarin 10mg once daily. -There was an order to recheck the INR on 05/29/26.	D 358		

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D 358	Continued From page 14 Review of Resident #3's lab results dated 05/29/26 and 06/02/26 revealed: -The resident's INR was 2.6 (within therapeutic range) on 05/29/26. -The resident's INR was 2.3 (within therapeutic range) on 06/02/26. Review of Resident #3's physician's order dated 06/02/26 revealed: -There was an order to continue Warfarin 10mg once daily. -There was an order to recheck the INR on 06/05/26. Review of Resident #3's lab results dated 06/05/26 revealed the resident's INR was 1.6 (below therapeutic range). Review of Resident #3's physician's order dated 06/05/26 revealed: -There was an order to discontinue Warfarin 10mg once daily. -There was an order to start Warfarin 10mg take 1 ½ (15mg) once daily. -There was an order to recheck the INR on 06/09/26. Review of Resident #3's lab results dated 06/09/26 revealed the resident's INR was 2.4 (within therapeutic range). Review of Resident #3's physician's order dated 06/17/26 revealed and order to discontinue Warfarin 15mg daily and start Warfarin 10mg once daily. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for Warfarin 10mg 1 tablet every day scheduled at 6:00pm.	D 358		

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-Warfarin 10mg was documented as not being administered on 06/25/26 due to the medication being unavailable.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/02/26 at 5:00pm revealed:
-Warfarin was not a cycle fill medication so the facility had to reorder it when needed.
-The pharmacy dispensed 7 Warfarin 10mg tablets on 06/17/26 for Resident #3.
-The pharmacy received a refill request for Resident #3's Warfarin on 06/24/26 after the 2:00pm cutoff time.
-The pharmacy dispensed 7 Warfarin 10mg tablets on 06/24/26.
-The supply dispensed on 06/24/26 was delivered on 06/25/26 at 11:51pm because it was ordered after the 2:00pm cutoff time on 06/24/26.
-The facility could have notified the pharmacy to get the Warfarin filled at the backup pharmacy on 06/24/26 if the resident was out of the medication.
-There was no documentation of the facility notifying the pharmacy that Resident #3 was out of Warfarin or that it needed to be sent by the backup pharmacy on 06/24/26.

Interview with Resident #3 on 07/02/26 at 1:00pm revealed:
-She took Warfarin every day but the dose changed sometimes.
-She was not sure if she had missed any doses of Warfarin.
-She denied any current symptoms of unusual bleeding or bruising.

Interview with a medication aide (MA) on 07/02/26 at 4:23pm revealed:
-If Resident #3's Warfarin "popped up" on the eMAR for both dosages to be administered in

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May 2026, she administered both dosages as documented on the eMAR.
-Resident #3's Warfarin was not in the medication cart on 06/25/26 when she documented it as unavailable on that day.
-The MAs were responsible for ordering medications when the supply got to the blue strip on the bubble card.
-She did not recall contacting the pharmacy about Resident #3's Warfarin.
-If medication was not available, the MAs were supposed to notify the Resident Care Director (RCD).

Interview with the RCD on 07/02/26 at 5:20pm revealed:
-The pharmacy usually entered orders into the eMAR system and she was responsible for approving the orders in the eMAR system.
-She remembered approving Warfarin order changes in the May 2026 eMAR system for Resident #3.
-She was new and still learning the eMAR system in May 2026, so she did not realize she needed to discontinue the previous Warfarin order from the eMAR system.
-There had been no issues with Resident #3 having problems with bleeding.

Interview with the Administrator on 07/02/26 at 1:41pm revealed:
-The RCD and the MAs were responsible for reordering medications.
-Medications should be available in the facility for administration.

Interview with the Vice President of Operations (VPO) on 07/02/26 at 3:30pm revealed:
-The facility's RCD was new in May 2026 and when the RCD approved the electronic order for

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D 358	Continued From page 17 the Warfarin dose change, the RCD put in the wrong start date so the new order overlapped with the previous order on the eMAR. -The Warfarin error in May 2026 was discovered during the facility's quality assurance review on 05/26/26 and the primary care provider (PCP) was notified. -She was not aware Resident #3 missed a dose of Warfarin on 06/25/26. -A new card of Warfarin had not come in from the pharmacy at that time, but it should have been in the facility and available for administration, Attempted telephone interviews with Resident #3's primary care provider (PCP) on 07/02/26 at 4:03pm and 4:53pm were unsuccessful.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 2 sampled residents (#4) take their medications that were left on the resident's nightstand in their room in	D 366		

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D 366	Continued From page 18 the special care unit (SCU). The findings are: Review of Resident #4's current FL-2 dated 03/18/26 revealed: -Diagnoses included dementia, essential hypertension, mixed hyperlipidemia, and peripheral arterial disease. -The resident was documented as constantly disoriented. Review of Resident #4's current assessment and care plan dated 04/01/26 revealed: -Resident #4 was admitted to the special care unit (SCU) related to a diagnosis of dementia for safety. -The resident ambulated independently. -The resident was always disoriented, had significant memory loss, and must be directed. Review of Resident #4's physician's order dated 06/02/26 revealed an order to continue Tramadol 50mg 1 tablet twice a day. (Tramadol is a controlled substance used for moderate to severe pain.) Review of Resident #4's physician's order dated 06/23/26 revealed an order for Cranberry Concentrate 500mg capsule take 1 capsule twice a day. (Cranberry Concentrate is a supplement used for prevention of urinary tract infections.) Observation of Resident #4's room during the 8:00am medication pass on 07/02/26 revealed: -At 7:52am, Resident #4 was sitting on her bed when the medication aide (MA) entered the resident's room to administer the resident's medication scheduled for 8:00am. -There was a small clear plastic medication cup	D 366		

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D 366	Continued From page 19 on top of the nightstand beside Resident #4's bed. -There was a small amount of applesauce in the bottom of the medication cup and two pills. -One pill was a dark red softgel capsule and the other pill was a white oblong tablet. -Resident #4's roommate was not in the room. Review of Resident #4's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Cranberry 500mg softgel take 1 capsule twice a day scheduled at 9:00am and 9:00pm. -Cranberry 500mg was documented as administered at 9:00am and 9:00pm on 07/01/26. -There was an entry for Tramadol 50mg 1 tablet twice a day scheduled at 9:00am and 9:00pm. -Tramadol was documented as administered at 9:00am and 9:00pm on 07/01/26. Interview with the MA on 07/02/06 at 7:52am revealed: -There was not supposed to be any medications left in any resident's room. -The MAs were supposed to observe all residents take their medications. -She did not know how long the medications had been in Resident #4's room. -She usually put Resident #4's medications whole in applesauce to help with swallowing. -She last worked on Tuesday, 06/30/26, and she did not recall seeing the medications in the resident's room at that time. -She did not leave medications in residents' rooms. -The pills in the cup were Resident #4's Tramadol (the white tablet) and Cranberry capsule (the dark red softgel). -She had not prepared and administered those	D 366		

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two medications for Resident #4 yet that morning because they were not due until 9:00am.

Observation of Resident #4's medications on hand on 07/02/26 at 7:58am revealed:
-There was a supply of Tramadol 50mg tablets dispensed on 06/12/26 with instructions to take 1 tablet twice daily.
-The Tramadol 50mg tablets in the bubble card matched the white oblong tablet in the clear plastic medication cup found in Resident #4's room.
-There was a supply of Cranberry 500mg softgels dispensed on 06/23/26 with instructions to take 1 capsule twice a day.
-The Cranberry 500mg softgel matched the dark red softgel capsule in the clear plastic medication cup found in Resident #4's room.

Interview with a second MA on 07/02/26 at 4:23pm revealed:
-She administered medications to Resident #4 during the 9:00pm medication pass yesterday, 07/01/26.
-Resident #4 was in the dining room last night when she administered the resident's medications.
-Resident #4 would not remember to take medication if it was left in her room.
-She had observed medications left in residents' rooms at times in the past (could not recall when) and she had reported it to the Resident Care Coordinator (RCC) and the Resident Care Director (RCD).

Interview with the MA Supervisor on 07/02/26 at 8:00am revealed:
-The MAs had been trained to observe residents take their medications and not leave any medications at bedside.

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D 366	Continued From page 21 -Resident #4 would not be able to remember to take medications on her own due to dementia. Interview with the RCC on 07/02/26 at 9:22am revealed: -The MAs were not supposed to leave any medications at bedside, and the MAs were supposed to make sure they watched the residents take their medications. -The MAs were supposed to dispose of all medication cups at the medication cart. -She had not found any medications unattended in any residents' rooms. -If medications were found unattended, they were supposed to notify the RCD. -She did not know who left the medications at Resident #4's bedside unattended. -The nightshift MA on duty last night was training new staff (could not recall who) but she was not sure if that was when the medications were left in the room. -Resident #4's Tramadol and Cranberry capsules were scheduled at 9:00am and 9:00pm. Interview with the Administrator on 07/02/26 at 8:10am revealed: -The MAs should verify and make sure medications were administered and the residents actually swallowed their medications. -The MAs should not be leaving any medications at bedside for any residents. -He was concerned that other residents could wander into Resident #4's room and take the medications which could cause a severe allergic reaction, up to and including death. -He was also concerned if Resident #4 did not receive her pain medication, it could cause her to have more pain. Interview with the Vice President of Operations	D 366		

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D 366	Continued From page 22 (VPO) on 07/02/26 at 9:00am revealed: -The MAs should observe residents take their medications. -She thought the medications left in Resident #4's room may have been the 9:00pm doses from last night, 07/01/26 because the MA had a trainee last night. -She was concerned because of safety and Resident #4 needed her pain medication to maintain pain control. Attempted telephone interviews with Resident #4's primary care provider (PCP) on 07/02/26 at 4:03pm and 4:53pm were unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367		

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D 367	Continued From page 23 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were complete and accurate for 1 of 3 sampled residents (#1) related to medications for hypothyroidism and sleep disorder. The findings are: Review of Resident #1's current FL-2 dated 05/07/26 revealed diagnoses included Adenocarcinoma of colon, metastasis of liver, malignant neoplasm metastatic to both lungs, biliary obstruction, severe protein-calorie malnutrition, debility, other chronic pain and insomnia. Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/16/26. a. Review of Resident #1's current FL-2 dated 05/07/26 revealed there was an order for Levothyroxine 50mcg take one tablet every day. (Levothyroxine is used to treat hypothyroidism.) Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed:	D 367		

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D 367	Continued From page 24 -There was an entry for Levothyroxine 50mcg, take one tablet every day scheduled to be administered at 9:00am from 05/12/26 through 05/16/26, at 8:00am from 05/17/26 through 05/20/26 and at 6:00am from 05/21/26 through 05/31/26. -There was documentation of administration daily from 05/12/26 through 05/31/26. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Levothyroxine 50mcg, take one tablet every day scheduled to be administered at 6:00am. -There was documentation of administration on 06/01/26, 06/02/26, 06/04/26, 06/06/26 through 06/13/26, and 06/15/26 through 06/30/26. -There was no documentation of administration on 06/03/26, 06/05/26 and 06/14/26. Observation of Resident #1's medications on hand on 07/01/26 at 4:00pm revealed: -There was a bubble pack labeled Levothyroxine 50mcg take one tablet every day. -There were 11 tablets remaining out of 28 that were dispensed on 06/18/26. Interview with Resident #1 on 07/02/26 at 11:07am revealed: -She took Levothyroxine at 6:00am daily. -She was having trouble sleeping, at one point in June 2026, so staff let her sleep and gave her the Levothyroxine later because she asked them to. -She received the Levothyroxine consistently. -She had not missed any doses of Levothyroxine Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 7:37am revealed she was not aware of the blank spaces for Resident #1's Levothyroxine on the eMAR.	D 367		

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D 367	Continued From page 25 Interview with the Resident Care Director on 07/02/26 at 8:04am and 9:25am revealed: -Blank spaces on the eMAR for Resident #1's Levothyroxine meant the medication was not scanned and not administered and would show up in the eMAR system as red on the dates of the blank spaces. -She talked to the staff regarding the missed medications and was advised Resident #1 said 6:00am was too early for the Levothyroxine so she would refuse the medication and said she would take them later but did not. Refer to interview with the RCC on 07/02/26 at 7:37am. Refer to interview with the RCD on 07/02/26 at 8:04am and 9:05am. Refer to interview with the Administrator on 07/02/26 at 12:00pm. Refer to interview with the PCP on 07/02/26 at 9:35am. b. Review of Resident #1's current FL-2 dated 05/07/26 revealed there was an order for Melatonin 3mg take three to equal 9mg every evening. (Melatonin is used to treat sleep disorders.) Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Melatonin 3mg, take 3 tablets to equal 9mg every evening scheduled to be administered at 8:00pm 05/12/26 through 05/20/26 and 10:00pm 05/21/26 through 05/31/26.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092-237	A. BUILDING: _____ B. WING _____	07/02/2026

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D 367	Continued From page 26 -There was documentation of administration daily from 05/12/26 through 05/27/26 and from 05/29/26 through 05/31/26. -There was no documentation of administration on 05/28/26. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Melatonin 3mg, take 3 tablets to equal 9mg every evening scheduled to be administered at 10:00pm. -There was documentation of administration on 06/01/26, 06/03/26, 06/04/26, 06/06/26 through 06/30/26. -There was no documentation of administration on 06/02/26 and 06/05/26. Observation of Resident #1's medications on hand on 07/01/26 at 4:00pm revealed: -There was a bubble pack labeled Melatonin 3mg, take 3 tablets to equal 9mg every evening. -There were 45 tablets remaining out of 84 that were dispensed on 06/18/26. Interview with Resident #1 on 07/02/26 at 11:07am revealed: -She asked that the Melatonin administration time be moved to a time later than 9:00pm because she would fall asleep within 30 minutes and only slept one to two hours. -She received her Melatonin consistently. -She had not missed any doses of Melatonin. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 7:37am revealed: -She was not aware of the blank spaces for Resident #1's Melatonin on the eMAR. -Resident #1 took Melatonin every night. -She was unsure why there were blank spaces on the eMAR.	D 367		

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D 367	Continued From page 27 Interview with the Resident Care Director (RCD) on 07/02/26 at 8:04am and 9:25am revealed: -Blank spaces on the eMAR for Resident #1's Melatonin meant the medication was not scanned and not administered and would show up in the eMAR system as red on the dates of the blank spaces. -She talked to the staff regarding the missed medications and was advised Resident #1 said 9:00pm was too early for the Melatonin so she would refuse the medication and said she would take them later but did not. Refer to interview with the RCC on 07/02/26 at 7:37am. Refer to interview with the RCD on 07/02/26 at 8:04am and 9:05am. Refer to interview with the Administrator on 07/02/26 at 12:00pm. Refer to interview with the PCP on 07/02/26 at 9:35am. _____ Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 7:37am revealed: -The electronic medication administration (eMAR) system showed the status of the medications by using 3 colors, once the medication aide (MA) signed into the eMAR system. -Green meant the medication was finished for that hour or that day, depending on the time of day the MA was working. -White identified an upcoming medication and yellow identified medications that were due. -Once in the eMAR system, the MA completed 3 checks with the first check including comparing the medication pack to the eMAR to confirm the	D 367		

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resident, the medication and the dose.
-The second check included scanning the medication which prompted the eMAR system to notify the MA whether the medication was the correct medication for that time frame or not.
-If the medication was not the correct medication for the time frame, the eMAR system would not allow the medication to be scanned.
-After the correct medication was scanned into the eMAR system, the third check was to repeat the 1st step and administer the medication to the resident.
-Medication administration was not saved on the computer until after the resident took the medication, in the event the resident refused the medication and an exception needed to be documented.
-If a medication was refused, the medication was discarded, an exception was documented in the eMAR system, and a progress note was completed as to why the medication was not administered.
-The eMAR should not have blank spaces.
-The importance of accurate eMAR documentation was to keep track of where the medications were going and whether the residents were taking the medications.
-Staff were expected to accurately document on the eMAR in a timely manner with care to ensure medications were properly administered.
-Audits of all the residents' eMARs were recently done June 2026 by the RCC and Resident Care Director (RCD).
-The blank spaces on the eMAR for Resident #1 were not noticed during the eMAR audit.
-The blank space on the eMAR could have been because of a late medication, a missed medication, or a refusal of a medication; but there still should have been something in the box.

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D 367	Continued From page 29 Interview with the RCD on 07/02/26 at 8:04am and 9:25am revealed: -When administering medications, MAs had to scan the medications. -If the medication matched a medication on the eMAR that was due at that time, the computer automatically clicked "yes". -MAs then reviewed the eMAR instructions and compared the medication to the eMAR to confirm the correct resident, dose, time and route. -After administering the medication, the MA saved the information to the eMAR. -Information was not saved to the eMAR until after medication administration because if a medication was not administered for some reason, the documentation would be incorrect. -The eMAR should not have blank spaces. -Blank spaces on the eMAR meant a medication was missed or not administered. -Medications had to be scanned; MAs could not just click a button on the eMAR to say a medication had been administered. -A red notification on the eMAR meant a medication was not administered and was late. -She received a report every morning on missed medications, so she was aware the medications were missed. -The MA advised she forgot to click the refusal button on the eMAR. -She recently started writing progress notes regarding missed medications; she started after 06/14/26. Interview with the Administrator on 07/02/26 at 12:00pm revealed: -He was not familiar with the eMAR documentation and process but expected the eMAR to be complete and accurate. -The importance of the eMAR was to ensure that residents received the correct medications at the	D 367		

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D 367	Continued From page 30 correct time. -He was not aware of any blank spaces on the eMAR. -There should not be any blank spaces on the eMAR. Telephone contact with the facility's contracted primary care provider (PCP) on 07/02/26 at 9:35am revealed: -She had no concerns of Resident #1 missing any medications. -Resident #1 knew how to take her medications and would tell her if she did not receive it. -The missed documentation of Melatonin administration was not a concern because the medication was a sleep aid and an over-the-counter medication. -Levothyroxine was prescribed for hypothyroidism. -Documentation on the eMAR was the only way to know if the medication was administered. -She last saw Resident #1 on Tuesday, 6/31/26 and had no concerns; they discussed the timing of her medications.	D 367		