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
	FCL060157	A. BUILDING: _____ B. WING _____	R 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON FAMILY CARE HOME	13418 HAMILTON ROAD CHARLOTTE, NC 28278

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from June 29, 2026 to June 30, 2026.	C 000	Thank you for the time spent at Hamilton Family Care Home.	
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .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 staff person who administered medications documented on the medication administration records immediately after administration of medications to 1 of 4 residents (#2). The findings are: Review of Resident #2's current FL2 dated 06/5/26 revealed: -Diagnoses included hypertension, chronic kidney disease, protein calorie malnutrition and urinary retention. -Resident #2 had an order for lorazepam 0.5mg (medication to treat anxiety) by mouth daily. -Resident #2's level of care was assisted living.	C 341	10A NCAC 13G .1004 Medication Administration was obtained, and staff was reeducated. Resident #2 medication orders were reviewed immediately and reconciled with the physician's orders to ensure accuracy. Staff were educated to ensure the use of the controlled substance log for Resident #2 and all residents. Narcotics must reflect the amount dispensed, the amount on hand, and be tallied/reconciled with the MAR and the narcotic sheet to ensure accuracy. Staff received immediate education on documentation in the MAR immediately after administration of medication. Pre-charting and late charting are prohibited. An audit of Resident #2 and all residents' controlled substance narcotic records were completed.	8/8/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

8/8/26

Reviewed and acknowledged 8/13/26

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C 341	Continued From page 1 Review of Resident 2's resident register showed an admission date of 12/05/25. Interview with a pharmacist at the facility's contracted pharmacy on 06/29/26 at 4:56pm revealed: -Resident #2 had an order dated 02/04/26 for lorazepam 0.5mg, one tablet daily as needed, 30 tablets were dispensed on 02/04/26 and 30 tablets were dispensed on 03/02/26. -A total of 60 tablets of lorazepam 0.5mg were dispensed for Resident #2 in February 2026 and March 2026. -If Resident #2 was administered more than 60 tablets of lorazepam 0.5mg, the medication did not come from their pharmacy. -The facility did not call to refill Resident #2's lorazepam 0.5mg for April 2026 and May 2026. -They received a refill request for Resident #2's lorazepam 0.5mg, one tablet daily as needed, on 06/29/26 (today). Review of Resident #2's record revealed there was no physician order dated 02/04/26 for lorazepam 0.5mg one tablet daily as needed. Review of the Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed. -There was documentation lorazepam 0.5mg was administered 25 times. Review of Resident #2's February 2026 Controlled Drug Record/ Disposition Form revealed: -Resident #2 had a medication label for lorazepam 0.5mg, quantity of 30, take one tablet	C 341	To ensure documentation is accurate and complete, all medication aides and licensed staff were reeducated on 10A NCAC 13G .1004 regarding immediate documentation of medication administration and using the guidelines for completing medication administration skills. The facility administrator will perform weekly audits of medication administration and the controlled substance log for Resident #2 and all residents, then monthly thereafter, to ensure ongoing compliance. Any discrepancies will be corrected immediately, and additional education will be provided as needed.	8/8/26

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C 341	Continued From page 2	C 341		

by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 24 times in February 2026.

Review of Resident #2's March 2026 eMAR revealed:
- There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 14 times.

Review of Resident #2's March 2026 Controlled Drug Record/ Disposition Form revealed:
-Resident #2 had a medication label for lorazepam 0.5mg, quantity of 30, take one tablet by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 35 times.

Review of Resident #2's April 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 8 times.

Review of Resident #2's record revealed there was no April 2026 Controlled Drug Record/ Disposition Form.

Review of Resident #2's May 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 2 times.

Review of Resident #2's record revealed there was no May 2026 Controlled Drug Record/ Disposition Form.

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C 341	Continued From page 3 Review of Resident #2's June 2026 eMAR revealed: -There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed. -There was no documentation lorazepam 0.5mg was administered. Review of Resident #2's record revealed there was no June 2026 Controlled Drug Record/ Disposition Form. Observation of medications available for administration on 06/29/26 at 3:57pm revealed Resident #2 had no lorazepam 0.5mg tablets, take one tablet by mouth once daily, on hand. Interview with the Administrator on 06/29/26 at 6:00pm revealed: -He documented on the controlled substance record sheet after administering Resident #2's lorazepam and at times, he forgot to document Resident #2's lorazepam on her eMARs. -Although he documented on the eMAR that he administered more than one dose of lorazepam on certain days, he administered Resident #2's lorazepam as ordered. -He did not remember what days he did not immediately document on Resident #2's eMAR after administering her lorazepam in February 2026 and March 2026. -There were no Controlled Drug Record/ Disposition forms for April 2026, May 2026 and June 2026 for Resident #2's lorazepam 0.5mg because he did not call in refills to the pharmacy. -He knew he was supposed to immediately document the eMAR after administering medication but did not. Attempted telephone interview with another	C 341		

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C 341	Continued From page 4 facility nurse on 06/30/26 at 6:05pm was unsuccessful.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the electronic medication records were accurate for 1 of 4 sampled residents (#2) related to orders for a medication used to treat anxiety. The findings are:	C 342	Resident #2 medication orders were reviewed. The EMAR was also reviewed to ensure accuracy, reflecting the physician's orders and compliance with 10A NCAC 13G .1004 Medication Administration rules. Controlled substance documentation was reviewed for accuracy and ongoing compliance. A complete audit of Resident #2's MAR and all residents' MARs were completed to verify that medication orders matched the physician's orders and pharmacy records. Staff were educated by Pharmacist maintaining accurate MAR documentation, including PRN medication administration, time, date, route, strength, dosage, instructions, reason, omissions, and signature/initials. All narcotics sheets were appropriately reviewed to reflect accurate documentation, order entries on the MAR. Staff completed all 10 rights of medications, consisting of right patient, drug, dose, route, time, documentation, reason, refusal, education, and response.	8/8/26

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C 342	Continued From page 5 Review of Resident #2's current FL2 dated 06/05/26 revealed: -Diagnoses included hypertension, chronic kidney disease, protein calorie malnutrition and urinary retention. -Resident #2's was constantly disoriented. Review of Resident 2's Resident Register revealed an admission date of 12/05/25. Interview with a pharmacist at the facility's contracted pharmacy on 06/29/26 at 4:56pm revealed: -Resident #2 had an order dated 02/04/26 for lorazepam (used to treat anxiety) 0.5mg, one tablet daily as needed, 30 tablets were dispensed on 02/04/26 and 30 tablets were dispensed on 03/02/26. -A total of 60 tablets of lorazepam 0.5mg were dispensed for Resident #2 in February 2026 and March 2026. -If Resident #2 was administered more than 60 tablets of lorazepam 0.5mg, the medication did not come from their pharmacy. -The facility did not call to refill Resident #2's lorazepam 0.5mg for April 2026 and May 2026. -They received a refill request for Resident #2's lorazepam 0.5mg, one tablet daily as needed, today (06/29/26). Review of Resident #2's record revealed no physician's order dated 02/04/26 for lorazepam 0.5mg. one tablet daily as needed. Review of Resident #2's current FL2 dated 06/05/26 revealed there was an order for lorazepam 0.5mg, one tablet daily as needed. Observation of medications on hand on 06/29/26 at 3:57pm revealed Resident #2 had no	C 342	Weekly audits will be conducted for four weeks, followed by monthly audits. Audit results will be reviewed, and corrective action will be implemented if any discrepancies are found.	8/8/26

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lorazepam 0.5mg tablets, take one tablet by mouth once daily as needed, was available for administration.

Review of the February 2026 calendar revealed there were 28 days in the month.

Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed with a start date of 02/04/26 and no stop date.
-Lorazepam 0.5mg was administered once daily on 02/08/26, 02/10/26, 02/11/26, 02/12/26 02/13/26, 02/15/26, 02/17/26, 02/22/26, 02/24/26, and 02/26/26.
-Lorazepam 0.5mg was administered 5 times on 02/19/26.
-Lorazepam 0.5mg was administered 2 times on 02/18/26, 02/20/26, 02/23/26, 02/25/26 and 02/27/26.
-There was no documentation lorazepam 0.5mg was administered 02/07/26, 02/09/26, 02/14/26, 02/21/26, and 02/28/26.
-Lorazepam 0.5mg was documented as administrated a total of 25 times in February 2026.

First review of Resident #2's February 2026 Controlled Drug Record/Disposition Form on 06/29/26 revealed:
-Resident #2's name and lorazepam 0.5mg tablet daily as needed, quantity of 30 tablets filled on 02/04/26 was typed on the top left corner of the form.
-There was a box on the form with four columns on it, the columns were titled date, time, number (NO.), and signature.
-There were 14 tablets signed out with a date,

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time, and signature in black ink until on 02/24/26 with 16 lines (tablets) that did not have a date and time but a signature.
-There was no documentation lorazepam 0.5mg was administered to Resident #2 on 02/08/26, from 02/11/26, 02/13/26, 02/18/26 (2nd dose), 02/19/26 (4 additional doses), and 02/20/26 (2nd dose).

Second review of Resident #2's February 2026 Controlled Drug Record/Disposition Form on 06/29/26 revealed:
-The 16 lines (tablets) that were not signed out on the first review had a date and time entered in blue ink from 02/25/26 to 03/10/26.
-There were March 2026 sign-off counts entered on the February 2026 form.
-Lorazepam 0.5mg was administered twice on 02/29/26.
-There was documentation lorazepam 0.5mg was administered twice on 03/01/26, once from 03/02/26 to 03/05/26 and 03/10/26.

Interview with the Administrator on 06/29/26 at 4:20pm revealed:
-He did not fully complete the February 2026 Controlled Drug Record/Disposition Form until the surveyor inquired about why the form was missing sign-off count dates after 02/24/26.
-He left the room and added the missing dates to the 2026 Controlled Drug Record/Disposition Form.
-He forgot to enter the remainder of sign-off dates and his initials on the February 2026 Controlled Drug Record/Disposition Form after administering Resident #2's lorazepam 0.5mg as needed once daily.

Review of Resident #2's February 2026 Receipt/Record/Disposition form compared to the

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number of tablets dispensed from the facility's contracted pharmacy revealed lorazepam 0.5mg was not documented as administered on the February 2026 eMAR on 02/07/26, 02/09/26, 02/14/26, 02/21/26, and 02/28/26.

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-Lorazepam 0.5mg was administered daily on 03/01/26, 03/13/26, 03/15/26, from 03/17/26 to 03/18/26, and from 03/22/26 to 03/28/25.
-Lorazepam 0.5mg was administered twice on 03/16/26 and twice on 03/20/26.
-Lorazepam 0.5mg administration on the March 2026 eMAR did not match the lorazepam 0.5mg administration on the March 2026 Controlled Drug Record/Disposition Form.
-Lorazepam 0.5mg was administered 14 times in March 2026.

Review of Resident #2's March 2026 Controlled Drug Record/Disposition Form revealed:
-Resident #2's name and lorazepam 0.5mg tablet daily as needed, quantity of 30 tablets filled on 02/04/26 was typed on the top left corner of the form.
-Lorazepam 0.5mg was administered twice on 03/21/26, twice on 03/23/26, and 4 times on 03/28/26.
-There were three entry dates after 03/28/26 that were illegible.
-Lorazepam 0.5mg was administered 35 times in March 2026.

Review of Resident #2's March 2026 eMAR and March 2026 Controlled Drug Record/Disposition Form revealed the administration of lorazepam 0.5mg on the March 2026 eMAR and the sign-off

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count on the March 2026 Controlled Drug Record/Disposition Form did not match.

Review of Resident #2's April 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-Lorazepam 0.5mg was administered 04/02/26, from 04/21/26 to 04/24/26, 04/27/26 and from 04/29/26 to 04/30/26.

Review of Resident #2's record revealed there was no Controlled Drug Record/Disposition Form for lorazepam 0.5 for April 2026.
Review of Resident #2's May 2026 eMAR revealed:
-Lorazepam 0.5mg, take one tablet once daily as needed.
-There was documentation lorazepam 0.5mg was administered on 05/01/26 and 05/07/26.

Review of Resident #2's record revealed there was no Controlled Drug Record/Disposition Form for lorazepam 0.5 for May 2026.

Interview with the Administrator on 06/29/26 at 6:00pm revealed:
-He also worked as the facility nurse and was a licensed practical nurse (LPN).
-He was the facility nurse who shared duties with another facility nurse and was responsible for double checking/matching the eMARs, Controlled Drug Record/Disposition Forms, orders and medications available for administration.
-He administered Resident #2's lorazepam 0.5mg as needed for anxiety from February 2026 to May 2026.
-He documented on the Controlled Drug Record/Disposition Form after administering Resident #2's lorazepam and he did not always

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C 342	Continued From page 10 document Resident #2's lorazepam on the eMAR until later in his shift. -Although he documented on the eMAR that he administered more than one dose of lorazepam on certain days, he did not administer more than one dose in a day. -He inadvertently documented inaccurately on Resident #2's eMARs on 02/18/26 (2 doses), 02/19/26 (5 doses), 02/20/26 (2 doses), 02/23/26 (2 doses), 02/25/26 (2 doses), 02/27/26 (2 doses), 03/16/26 (2 doses), and 03/20/26 (2 doses). -He inadvertently documented inaccurate information on Resident #2's Controlled Drug Record/Disposition Forms for February 2026 and March 2026. -Instead of ordering refills of Resident #2's lorazepam, he borrowed another resident's medication then administered 8 doses in April 2026 and two doses in May 2026 to Resident #2, then documented on the eMARs. -He did not have an explanation for not contacting the pharmacy to reorder Resident #2's lorazepam.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION	C 367	Controlled substance inventory was reviewed, and missing medication was investigated. Borrowing medication between residents was discontinued immediately. Staff will notify providers of medications that are not on hand. Controlled medications and all other medications will be ordered five days before depletion.	8/8/26

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C 367	Continued From page 11 Based on observations, record review and interviews the facility failed to maintain a record of controlled substances with documentation of the receipt, administration, disposition of controlled substances for accurate reconciliation for 2 of 4 sampled residents (#2, #4) related to medication used to treat anxiety (#2) and medication used to treat pain (#4). The findings are: Review of the facility's Medication Administration Policies and Procedures dated 04/2006 revealed: -Controlled substances should have a method of accountability. -Discrepancies should be reported and records should be retained for accountability. -Refills of medications should be ordered from the pharmacy, and a delivery receipt of medications should be retained. 1. Review of Resident #4's FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's dementia, heart failure, polyneuropathy (nerve damage), hypertension, and high cholesterol. -Resident #4 was non-ambulatory. -He had an order for morphine sulfate 100/5ml, a schedule II-controlled substance used to treat moderate to severe pain, take 0.5ml every 8 hours as needed for pain. -His level of care was assisted living. Review of Resident #4's record revealed he was admitted to the facility with hospice services on 05/15/26. Review of Resident #4's May 2026, June 2026 and July 2026 electronic medication	C 367	All delivered medication receipts will be placed in a binder and initialed by the receiver. The packing list will be checked to ensure which medications were delivered, and staff will follow up with the pharmacy as needed. Staff will perform controlled substance counts at the end of each shift. Staff completed retraining regarding controlled substance adminstration, handling, storage, destruction and documentation. Monthly controlled substance reconciliation will be completed by the Administrator/RN. Daily count verification will be completed by staff. Weekly audits will be conducted for four weeks, then monthly thereafter.	8/8/26

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administration record (eMAR) revealed:
-There was an entry for morphine sulfate solution 100/5ml, take 0.5ml by mouth or sublingually (under the tongue) every 6 hours as needed for pain or shortness of breath (prefilled syringes).
-There was no documentation morphine sulfate solution was administered.

Observation of Resident #4's medications on hand on 06/30/26 at 1:00pm revealed there was no morphine sulfate solution available for administration.

Interview with a pharmacist at the facility's contracted pharmacy on 06/30/26 at 2:28pm and 5:10pm revealed:
-Resident #4 had an active order for morphine sulfate solution 100/ 5ml, take 0.5ml by mouth or sublingually every 6 hours as needed for pain or shortness of breath (prefilled syringes).
-Resident #4's morphine sulfate solution 100/ 5ml, quantity of fifteen 7.5ml prefilled syringes was last dispensed on 05/15/26 and delivered to the facility's front porch by a delivery service on 05/20/26 at 2:38pm.
-According to the delivery driver's picture confirmation on 05/20/26, Resident #4's morphine was delivered at 2:38pm and no signature was required by the facility or delivery service.

Interview with Resident #4's hospice nurse on 06/30/26 at 3:22pm revealed:
-Resident #4 had an active order for morphine sulfate, take 0.5ml by mouth or sublingually every 6 hours as needed for pain or shortness of breath (pre-filled syringes).
-She did not know Resident #4 did not have any morphine available for administration.

-She ordered 20 pre-filled morphine syringes

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C 367	Continued From page 13 today (06/30/26) when the Administrator reported Resident #4 did not have any morphine available at the facility. -Resident #4's pain was under control and was being managed with a prescribed different pain medication. Interview with the Administrator on 06/30/26 at 6:15pm revealed: -He also worked as the facility nurse and was a licensed practical nurse (LPN). -He was responsible for auditing medications, comparing and matching orders, eMARs and medications available for administration. -He worked alone on 05/20/26 during the time the Resident #4's morphine was reportedly delivered to the facility and could not recall if Resident #4's morphine was delivered on 5/20/26. -If medications were delivered, he would have retrieved medication deliveries from the front porch, reviewed the delivery receipt and package before discarding the receipt. -He did not keep medication delivery receipts or keep a log of medication deliveries after verifying delivery/receipt of all medications. -He did not know Resident #4's morphine was not available in the facility and could not locate the missing morphine or its controlled substance record form. -Resident #4 did not require any as needed morphine since his admission to hospice services on 05/15/26. 2. Review of Resident #2's current FL2 dated 06/5/26 revealed: -Diagnoses included hypertension, chronic kidney disease, protein calorie malnutrition and urinary retention. -Resident #2's was constantly disoriented.	C 367		

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C 367	Continued From page 14 Review of Resident 2's Resident Register revealed an admission date of 12/05/25. Review of the February 2026 calendar revealed there were 28 days in the month. Review of the Resident #2's February 2026 eMAR revealed: -There was an entry for lorazepam 0.5mg, take one tablet, once daily as needed. -There was documentation lorazepam 0.5mg was administered 25 times. -There was documentation lorazepam 0.5mg was administered 5 times on 02/19/26. -There was documentation lorazepam 0.5mg was administered 2 times on 02/18/26, 02/20/26, 03/23/26, 02/25/26 and 02/27/26. -There was documentation lorazepam 0.5mg was administered once daily on 02/08/26, from 02/10/26 to 02/13/26, 02/15/26, 02/17/26, 02/22/26, 02/24/26, and 02/26/26. -There was no documentation lorazepam 0.5mg was administered 02/07/26, 02/09/26, 02/14/26, 02/21/26, and 02/28/26. Review of Resident #2's February 2026 Controlled Substances Record/Disposition Form revealed: -Resident #2's name and lorazepam 0.5mg tablet daily as needed, quantity of 30 tablets filled on 02/04/26 was typed on the top left corner of the form. -There was documentation lorazepam 0.5mg was administered 25 times in February 2026. -There was documentation lorazepam 0.5mg was administered twice on 02/29/26. -There was documentation lorazepam 0.5mg was administered twice on 03/01/26, once from 03/02/26 to 03/05/26 and 03/10/26. -There was no documentation lorazepam 0.5mg	C 367		

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was administered on 02/08/26, from 02/11/26, 02/13/26, 02/18/26 (2nd dose), 02/19/26 (4 additional doses), and 02/20/26 (2nd dose).

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed.
-There was documentation lorazepam 0.5mg was administered 14 times.
-There was documentation lorazepam 0.5mg was administered on 03/01/26, 03/13/26, 03/15/26, from 03/17/26 to 03/18/26, and from 03/22/26 to 03/28/26.
-There was documentation lorazepam 0.5mg was administered twice on 03/16/26 and twice on 03/20/26.

Review of Resident #2's March 2026 controlled substances record form revealed:
-Resident #2's name and lorazepam 0.5mg tablet daily as needed, quantity of 30 tablets filled on 02/04/26 was typed on the top left corner of the form.
-There was documentation lorazepam 0.5mg was administered 29 times.
-There was documentation lorazepam 0.5mg was administered twice on 03/21/26, twice on 03/23/26, and 4 times on 03/28/26.
-There were three entry dates after 03/28/26 that were illegible.

Review of Resident #2's April 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one tablet, once daily as needed.
-There was documentation lorazepam 0.5mg was administered 04/02/26, from 04/21/26 to 04/24/26, 04/27/26 and from 04/29/26 to 04/30/26.

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C 367	Continued From page 16 Review of Resident #2's record revealed there was no controlled substances record form for April 2026. Review of Resident #2's May 2026 eMAR revealed: -There was an entry for lorazepam 0.5mg, take one tablet, once daily as needed. -There was documentation lorazepam 0.5mg was administered on 05/01/26 and 05/07/26. Review of Resident #2's record revealed there was no controlled substances record for May 2026. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for lorazepam 0.5mg, take one tablet by mouth once daily as needed. -There was no documentation lorazepam 0.5mg was administered. Review of Resident #2's record revealed there was no controlled substances record for June 2026. Observation of medications on hand on 06/29/26 at 3:57pm revealed Resident #2 had no lorazepam 0.5mg was available for administration. Interview with a pharmacist at the facility's contracted pharmacy on 06/29/26 at 4:56pm revealed: -Resident #2 had an order dated 02/04/26 for lorazepam (used to treat anxiety) 0.5mg, one tablet daily as needed, 30 tablets were dispensed on 02/04/26, and 30 tablets were dispensed on 03/02/26.	C 367		

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C 367	Continued From page 17 -A total of 60 tablets of lorazepam 0.5mg were dispensed for Resident #2 in February 2026 and March 2026. -If Resident #2 was administered more than 60 tablets of lorazepam 0.5mg, the medication did not come from their pharmacy. -The facility did not call to refill Resident #2's lorazepam 0.5mg for April 2026 and May 2026. -They received a refill request for Resident #2's lorazepam 0.5mg, one tablet daily as needed, today (06/29/26). Interview with the Administrator on 06/29/26 at 6:00pm revealed: -He also worked as the facility nurse and was a LPN. -He and the facility nurse were responsible for double checking and matching the eMARs to the orders and medications available for administration. -He and another facility nurse were responsible for documenting on the eMAR and Controlled Substance Record after each controlled substance was administered and ensuring the controlled substance count was correct. -He administered Resident #2's lorazepam 0.5mg as needed for anxiety from February 2026 to May 2026. -He documented on the controlled substance disposition sheet after administering Resident #2's lorazepam and he did not always document Resident #2's lorazepam on the eMAR until later in his shift. -He forgot to fill in the remainder of the February 2026 Controlled Substance Record from 02/25/26 to 03/10/26. -He inadvertently documented Resident #2's lorazepam administration March 2026 dates (from 03/01/26 to 03/05/26 and 03/10/26) on the February 2026 Controlled Substance Record.	C 367		

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C 367	Continued From page 18 -Although he documented on the eMAR that he administered more than one dose of lorazepam on certain days, he administered one tablet once daily as needed per the order. -He inadvertently documented inaccurately on Resident #2's eMARs on 02/18/26 (2 doses), 02/19/26 (5 doses), 02/20/26 (2 doses), 02/23/26 (2 doses), 02/25/26 (2 doses), 02/27/26 (2 doses), 03/16/26 (2 doses), and 03/20/26 (2 doses). -He inadvertently documented inaccurate information on Resident #2's Controlled Substance Record sheets for February 2026 and March 2026. -Instead of ordering refills of Resident #2's lorazepam, he borrowed another resident's medication then administered 8 doses in April 2026 and two doses in May 2026 to Resident #2, then documented on the eMARs. -Since he did not order refills of Resident #2's lorazepam from the pharmacy for April 2026 and May 2026, there were no controlled substance record forms for April and May. -He did not have an explanation for not contacting the pharmacy to reorder Resident #2's lorazepam. Attempted telephone call with the facility nurse on 06/30/26 at 6:00pm was unsuccessful. Refer to tag 342, 10A NCAC 13F .1004 (j) Medication Administration. _____ The facility failed to document the receipt of 15 oral syringes of morphine sulfate, a strong pain medication, categorized as a Schedule II Controlled substance, which resulted in all 15 of the syringes being unaccounted for with no documentation of administration to a hospice resident (#4). The facility also failed to maintain	C 367		

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C 367	Continued From page 19 an accurate and readily retrievable record of the administration of lorazepam, an anti-anxiety medication, categorized as a Schedule IV Controlled Substance, which resulted in an inaccurate accounting of the narcotic, as well as documentation reflecting the medication was administered more often than prescribed (Resident #2). The Administrator, an LPN, documented the administration of lorazepam for March 2026 in June of 2026. These failures resulted in two residents not having their prescribed medication available for use. These failures were 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 06/30/26 for this violation. _____ THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JULY 30, 2026.	C 367		