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D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual survey on August 4, 2026 through August 5, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the facility was free of hazards related to two large unsecured oxygen tanks stored outside the facility. The findings are: Review of the United States Occupational Health and Safety Administration's (OSHA) regulations on the storage of compressed gas cylinders dated 05/21/12 revealed: -Compressed gas cylinders should be in secured in an upright position at all times. -A steadying device should be used to keep cylinders from being knocked over. -Compressed gas cylinders should not be	D 079		

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intentionally dropped, struck, or permitted to strike each other violently.

Review of the current National Center for Patient Safety (compressed gas) Cylinder Hazard Summary revealed:
-A compressed gas cylinder can be turned into a missile if the cylinder is fractured.
-Escaping gas will propel the cylinder with enough force to penetrate cinder block walls.

Observation of the facility on 08/04/26 at 4:45pm revealed:
-There were two large empty oxygen tanks located outside the employee exit door that were not secured in a steadying device.
-There was a round table with two chairs located in front of the tanks with a cigarette butt filled coffee can in the middle of the table.

Observation of the Administrator on 08/04/26 at 5:01pm revealed:
-She made a telephone call to the local oxygen supply company to make arrangements again to have the empty tanks removed from the facility.
-The representative on the telephone informed her someone would be at the facility by 6:00pm to pick up the oxygen tanks.

Telephone interview with a representative at the local oxygen supply company on 08/05/26 at 11:17am revealed:
-They had received a call from the facility's Administrator on both 07/31/26 and 08/03/26 requesting two oxygen tanks be picked up.
-They planned to pick them up on 08/03/26 but they were short-staffed and did not get around to it that day.

Interview with the Administrator on 08/04/26 at

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D 079	Continued From page 2 4:50pm revealed: -The oxygen tanks were empty and needed to be returned to the local oxygen supply company. -She did not have a steadying device to keep them in and did not know that was a requirement. -She did not know the unsecured oxygen tanks were a hazard if they were knocked over. -The tanks were usually kept in a room that residents did not enter but were moved outside so the oxygen supply company could pick them up. -She called the company on 07/31/26 and 08/03/26 to make arrangements to have them picked up. -She was told they were going to be picked up on 08/03/26 but the supply company did not come. -Staff sat at the table and chairs near the oxygen tanks when they took breaks and smoked cigarettes.	D 079		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by:	D 234		

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Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (#1 and #2) were tested for tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health.

The findings are:

1.Review of Resident #1's current FL2 dated 04/09/26 revealed diagnoses included depression and insomnia.

Review of Resident #1's Resident Register revealed an admission date of 11/14/23.

Review of Resident #1's record revealed:
-There was documentation a TB test was completed for Resident #1 on 11/09/23.
-There was documentation a second TB test was placed on 03/22/24 and was documented as having a negative result on 04/05/26 (read 14 days after placement).
-There was no other documentation another TB test was completed for Resident #1.

According to the Center for Disease Control and Prevention, once a TB skin test has been administered it should be read within two to three days and if not read within two to three days the test should be repeated.

Interview with the Administrator on 08/05/26 at 8:18am revealed:
-She could not locate where a second valid TB test for Resident #1 was completed.
-She did not know why there was a delay in reading Resident #1's TB test placed on 03/22/24, but she knew they had a difficult time getting the nurse to come to the facility.

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D 234	Continued From page 4 2. Review of Resident #2's current FL2 dated 04/09/26 revealed diagnoses included diabetes with complications. weakness, gastroesophageal reflux disease, and insomnia. Review of Resident #2's Resident Register revealed an admission date of 08/17/23. Review of Resident #2's admission tuberculosis (TB) skin tests revealed: -A TB skin test was placed on 08/16/26 on the left forearm. -There was no documentation the TB skin test was read and results documented. Review of Resident #2's record revealed: -There was a TB skin test placed on 03/22/24. -The TB skin test placed on 03/22/24 was documented as having a negative result on 04/05/26 (read 13 days after placement). According to the Center for Disease Control and Prevention, once a TB skin test has been administered it should be read within two to three days and if not read within two to three days the test should be repeated. Review of Resident #2's TB skin test revealed: -A TB skin tests was placed on 07/24/26. -The TB skin test was documented as negative for TB on 07/26/24. Interview with the Administrator on 08/05/26 at 12:21pm revealed: -Resident #2 was admitted from a rehabilitation facility. -Resident #2 would have been required to have TB testing in the rehabilitation facility. -She knew Resident #2 had a TB test prior to admission.	D 234		

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D 234	Continued From page 5 -Then it was their policy to obtain a second TB test within 30 days of admission. -She did not know why there was a delay in reading Resident #2's TB test placed on 03/22/24.	D 234		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to have a matching therapeutic diet menu for 1 of 1 sampled residents (#3) with a physician-ordered therapeutic diet for guidance of food service staff related to a mechanical soft diet. The findings are: Review of Resident #3's current FL2 dated 04/23/26 revealed diagnoses included chronic kidney disease, intellectual and developmental disabilities, and traumatic brain injury. Review of Resident #3's physician's orders dated 06/18/26 revealed a mechanical soft diet.	D 296		

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D 296	Continued From page 6 Review of the list of diet orders posted on the kitchen refrigerator revealed Resident #3 was documented as a mechanical soft diet. Interview with the Activity Director on 08/04/26 at 10:33am revealed: -The cook was scheduled to come to work at 3:00pm so she was scheduled to serve lunch. -For lunch they were serving pizza from a local delivery restaurant. -Resident #3 needed his food chopped because he had a history of choking so she planned to put his pizza in the blender. Observation of the kitchen on 08/04/26 at 4:15pm revealed therapeutic diet menus were not available for guidance. Interview with a cook on 08/04/26 at 4:15pm revealed: -She did not have a menu for a mechanical soft diet. -She used the regular menu as guidance for everyones diet. -Resident #3's food was chopped up fine because he ate fast, stuffed too much food into his mouth at one time and coughed frequently. Interview with Resident #3 on 08/05/26 at 10:30am revealed: -All his food was chopped because he ate too much food with each bite and that made him cough. -He had pizza on 08/04/26 and it was served to him chopped. -He got "choked up" about every three days but never so much that he could not breath. -He was always able to cough up the food he choked on.	D 296		

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D 296	Continued From page 7 Observation of Resident #3's lunch meal on 08/05/26 at 12:26pm revealed: -The meal consisted of a hamburger on a bun, french fries and strawberries and bananas. -All food served to Resident #3's was chopped finely. Interview with the Administrator on 08/04/26 at 10:20am and 4:20pm revealed: -No residents at the facility were ordered a therapeutic diet. -Resident #3 was on a mechanical soft diet but she did not consider that a therapeutic diet. -She thought therapeutic diets were only diets like diabetic and low cholesterol. -The facility used a regular menu and chopped items as necessary for a mechanical soft diet. -The facility used to have therapeutic diet extensions that were written by a dietitian but they no longer had those because she did not think they were needed.	D 296		
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: TYPE B VIOLATION	D 358		

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Based on observations, interviews, and record reviews, the failed to administer medications as ordered for 2 of 4 sampled residents (Resident #1 and #4) related to a medication to treat depression, eye drops to treat eye irritation related to allergies, an antibiotic to prevent infections and a topical antibiotic to prevent skin infections (#1) and an eye drop used to prevent eye itching (#4).

The findings are:

1. Review of Resident #1's current FL2 dated 04/09/26 revealed diagnoses included major depression and insomnia.

a. Review of Resident #1's physician's orders revealed:
-There was an order dated 06/23/26 to discontinue quetiapine 25mg (used to treat depression) at 8:00am and 5:00pm.
-There was an order dated 06/23/26 to start quetiapine 25mg at 5:00pm for 7 days then discontinue.
-There was an order dated 07/10/26 for quetiapine 25mg twice a day.
-There was an order dated 07/21/26 for quetiapine 25mg twice a day to be discontinued.
-There was an order dated 07/21/26 for quetiapine 12.5mg at 8:00am and 5:00pm for 7 days and then discontinue.
-There was an order dated 04/09/26 for quetiapine 400mg at bedtime.

Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered on 06/22/26 at 8:00am and on

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06/21/26 and 06/23/26 through 06/30/26 at 8:00am and 5:00pm.
-There was an entry for quetiapine 25mg for 7 days and then discontinue that was documented as administered on 06/25/26 at 5:00pm and then put on hold from 06/26/26 through 06/30/26.
-There was an entry for quetiapine 400mg at 10:00pm that was not administered on 06/20/26, 06/21/26 or 06/22/26.

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered twice daily on 07/01/26 through 07/04/26, 07/06/26, 07/09/26, 07/13/26, 07/14/26, 07/16/26, 07/17/26, 07/19/26, 07/20/26, 07/23/26 through 07/31/26 and once daily on 07/05/26, 07/07/26, 07/08/26, 07/11/26, 07/15/26, 07/18/26 and 07/22/26.
-There was a second entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered twice daily on 07/11/26 through 07/18/26 and once daily on 07/10/26 and 07/19/26.
-There was an entry for quetiapine 12.5mg at 8:00am and 5:00pm that was documented as administered twice daily on 07/23/26 through 07/29/26 and at 8:00am on 07/30/26.
-There was an entry for quetiapine 400mg at 10:00pm that was not documented as administered on 07/01/26 through 07/04/26 and 07/07/26 through 07/09/26 with reason of "on order from pharmacy" and no documentation of administration on 07/12/26 and 07/27/26.

Review of Resident #1's August 2026 eMAR revealed there was an entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered twice daily on 08/01/26 through

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D 358	Continued From page 10 08/03/26 and on 08/04/26 at 8:00am. Observation of medications on hand on 08/04/26 at 9:17am revealed: -Quetiapine 25mg was not available to administer. -Quetiapine 400mg was available to administer with 3 of 29 tablets left in the bubble pack that was dispensed on 07/10/26. Interview with a medication aide (MA) on 08/05/26 at 12:53pm revealed: -She administered Resident #1's medications the morning of 08/04/26. -She administered quetiapine 25mg to Resident #1 because she thought she still had an order for it at 8:00am. -She did not think she made any mistakes other than not reading the dose on the quetiapine package and administering a 400mg dose instead of a 25mg dose. Telephone interview with a representative from the facility's contracted pharmacy on 08/04/26 at 10:33am revealed: -The pharmacy received an order on 06/24/26 from Resident #1's mental health provider (MHP) to stop the morning dose of quetiapine 25mg and stop the 5:00pm dose 7 days later. -The pharmacy received an order from Resident #1's primary care provider (PCP) on 07/10/26 to start quetiapine 25mg twice daily and they dispensed those 58 tablets on 07/10/26. -The pharmacy received an order from the MHP on 07/22/26 to reduce quetiapine to 12.5mg twice daily for 7 days and then stop and they dispensed those 14 tablets on 07/22/26 -The pharmacy dispensed 50 tablets of quetiapine 25 mg on 05/26/26 and 4 tablets on 07/07/26.	D 358		

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-Considering the multiple order changes they received on Resident #1, the most current order was quetiapine 400mg at 10:00pm originally written by the MHP on 11/24/25 and renewed on 04/09/26 and 07/10/26.
-The pharmacy dispensed 31 tablets of quetiapine 400mg on 05/02/26, 29 tablets on 07/10/26 and 31 tablets on 08/01/26.
-The pharmacy entered new medication orders into the facility's eMAR system.
-New orders they entered were flagged until someone from the facility acknowledged the order by either approving or denying the order.

Telephone interview with Resident #1's MHP on 08/05/26 at 4:49pm revealed:
-Resident #1 was ordered quetiapine for her diagnosis of depression.
-She started a quetiapine dose reduction in June 2026 due to Resident #1 being too drowsy during the day.
-On 06/23/26 she ordered the quetiapine 25mg at 8:00am to be stopped and the 8:00pm dose to continue for 7 more days and then be stopped.
-When she conducted a follow-up appointment with Resident #1 on 07/21/26 she noticed it had not been stopped so she wrote the reduction order again, but this time she wrote for the 8:00am and 5:00pm doses to be reduced to 12.5mg for one week and then stopped.
-She was not informed Resident #1's PCP wrote and order on 07/10/26 to restart the quetiapine 25mg at 8:00am and 5:00pm.
-She was Resident #1's MHP and she was upset another provider ordered a mental health medication after she initiated a dose reduction.
-She did not want Resident #1 to be so drowsy during the day that all she wanted to do was stay in bed.
-She was very concerned that the MA did not

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read the dose and attempted to give Resident #1 400mg of quetiapine during the morning and hoped the MA had not done that previously since quetiapine 25mg was still listed on the eMAR even though it was discontinued and was not available in the cart.
-Taking too much quetiapine during the day will cause Resident #1 to be excessively tired.
-There was a change in the computer system the pharmacy used in June 2026 and she was aware there were many errors in the system since then.

Interview with the Administrator on 08/05/26 at 1:30pm revealed:
-Resident #1's MHP sent all prescription changes as electronic orders to the pharmacy and gave the facility a copy of all medication changes so there should be no question of what the orders were.
-The Administrator's assistant was responsible for monitoring all medication changes and ensuring they were completed.
-The pharmacy entered orders into the eMAR system and the orders had a flag on them in the computer until someone from the facility either approved or denied the order.
-They had a file in the office where they kept all orders until they were confirmed that they were completed.
-She thought there was a communication problem and they needed to develop a written, step-by-step process to verify orders.
-They completed cart and chart audits every three months but it had been several months since they last completed one.
-There was a change in the computer system the pharmacy used in June 2026 and they discovered many errors since that happened.
-The MAs were all trained on proper medication administration and should slow down and read

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the eMAR more carefully.

b. Review of Resident #1's physician's orders dated 04/23/26 revealed ketorolac 0.5% ophthalmic solution (used to treat eye discomfort related to allergies), one drop in each eye twice daily.

Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for ketorolac 0.5% ophthalmic solution,one drop in each eye at 8:00am and 8:00pm.
-There was documentation ketorolac 0.5% ophthalmic solution was administered twice a day from 07/01/26 through 07/06/26, 07/09/26, 07/13/26, 07/23/26 through 07/31/26.
-There was documentation ketorolac 0.5% ophthalmic solution was administered at 8:00am on 07/07/26, 07/12/26, 07/14/26, 07/16/26, 07/17/26 and 07/20/26.
-There was documentation ketorolac 0.5% ophthalmic solution was administered at 8:00pm on 07/08/26, 07/22/26.
-There was documentation ketorolac 0.5% ophthalmic solution was not administered on 07/07/26 at 8:00pm, 07/08/26 at 8:00pm, 07/10/26 at 8:00am through 07/11/26 at 8:00pm, 07/12/26 at 8:00pm, 07/14/26 at 8:00pm, 07/15/26 at 8:00am and 8:00pm, 07/16/26 and 07/17/26 at 8:00pm, 07/18/26 and 07/19/26 at 8:00am and 8:00pm, and on 07/20/26 at 8:00pm due to the medication "on order from the pharmacy".

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for ketorolac 0.5% ophthalmic solution,one drop in each eye at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 8:00am and 8:00pm. -There was documentation ketorolac 0.5% ophthalmic solution was administered twice a day from 08/01/26 through 08/04/26. Observation of medications on hand on 08/04/26 at 9:17am revealed ketorolac 0.5% ophthalmic solution was not available. Interview with Resident #1 on 08/04/26 at 10:01am revealed: -She was asleep when the medication aide (MA) came by to administer medications earlier in the morning. -She did not get the eye drops earlier and had not been receiving them "for a while". -She needed her eye drops and did not know why the facility had a hard time getting refills. Telephone interview with a representative from the facility's contracted pharmacy on 08/04/26 at 3:48pm revealed: -Ketorolac 0.5% ophthalmic solution was dispensed one time on 04/23/26. -The bottle contained approximately a 50 day supply of eye drops. -There was no documentation the pharmacy was ever contacted for a refill. Interview with a medication aide (MA) on 08/05/26 at 11:00am revealed: -Resident #1 was out of ketorolac eye drops and had been "for a while". -She usually marked a medication as not administered and reordered it. -She did not know if Resident #1's ketorolac had been reordered. Telephone interview with a second MA on 08/05/26 at 12:53pm revealed she thought the	D 358		

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over the counter eye drops that were in the medication cart were Resident #1's ketorolac eye drops and those were the ones she administered to Resident #1.

c. Review of Resident #1's physician's orders revealed:
-There was an order dated 04/09/26 for doxycycline (used to treat infections) 100mg daily.
-There was an order dated 06/25/26 for doxycycline 100mg twice daily for 14 days after Resident #1's surgery scheduled on 07/21/26.

Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for doxycycline 100mg twice daily for 14 days; on hold from 06/26/26 until 07/21/26.
-There was documentation doxycycline 100mg twice daily was administered at 8:00am on 06/26/26.

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for doxycycline 100mg twice daily for 14 days; on hold from 06/26/26 until 07/21/26.
-There was no documentation doxycycline 100mg twice daily was administered from 07/22/26 through 07/31/26.
-There was an entry for doxycycline 100mg daily and doxycycline was documented as administered 07/01/26 through 07/20/26 and 07/23/26 through 07/31/26.

Review of Resident #1's August 2026 eMAR revealed:
-There was not an entry for doxycycline 100mg twice daily for 14 days.

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D 358	Continued From page 16 -There was an entry for doxycycline 100mg daily and doxycycline was documented as administered 08/01/26 through 08/04/26. Observation of medications on hand on 08/04/26 at 9:17am revealed doxycycline 100mg twice daily was not available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/04/26 at 3:48pm revealed: -The pharmacy received an order on 06/25/26 for doxycycline 100mg twice daily for 14 days after surgery from Resident #1's orthopaedic sugreon. -The pharmacy dispensed 26 tablets of doxycycline 100mg in a bubble pack on 06/25/26. -The pharmacy entered new orders into the facility's eMAR system. -New orders were flagged until someone from the facility acknowledged the order and then either approved or denied the order. Telephone interview with Resident #1's orthopaedic surgeon's medical assistant from a call placed on 08/05/26 at 12:28pm revealed: -Resident #1 was ordered doxycycline 100mg to be administered twice daily for 14 days after surgery that occured on 07/21/26. -Doxycycline 100mg twice daily was an antibiotic that was ordered routinely after knee surgery to prevent post-operative infections. -Resident #1 was examined by the surgeon on 08/05/26 and was healing well and showed no signs of infection so continuing to receive the doxycycline 100mg daily that was written by her PCP was adequate even though the surgeon ordered it to be twice daily. Interview with the Administrator on 08/05/26 at 1:30pm revealed:	D 358		

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-When Resident #1 was ordered doxycycline by her surgeon in June 2026 the order was entered into the eMAR system but it was put on hold until after the surgery in July 2026.
-Because the doxycycline was on hold it did not show up on the screen when the MAs were administering medications.
-She was responsible for removing the hold on the doxycycline order after Resident #1's surgery and she failed to do it.
-New medication orders were kept in a file in the office and she or her assistant were responsible for ensuring the orders were entered on the eMAR.
-When a new order was entered on the eMAR by the pharmacy it was flagged and she had to either approve or decline the entry.

d. Review of Resident #1's physician's orders dated 06/25/26 revealed mupirocin 2% ointment (used to prevent skin infection) apply a small amount to both nostrils for five nights prior to surgery on 07/21/26.

Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for mupirocin 2% ointment- apply a small amount to both nostrils nightly for five nights prior to surgery.
-The order was suspended from 06/25/26 until 07/22/26.
-There was a stop date of 06/30/26.

Interview with a representative from the facility's contracted pharmacy revealed:
-Resident #1 had an order for mupirocin 2% ointment dated 06/25/26.
-A tube of mupirocin 2% ointment was dispensed to the facility on 06/25/26.

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D 358	Continued From page 18 Interview with the Administrator on 08/05/26 at 9:35am revealed: -Mupirocin 2% ointment was entered on the June eMAR with a note that it was on hold. -She or her assistant should have removed the hold prior to surgery but she was ultimately responsible for removing the hold 5 days prior to surgery. -She found the unopened tube of mupirocin ointment in the office a few moments ago. Observation of Resident #1``s medications on hand on 08/05/26 at 9:35am revealed: -The unopened tube of mupirocin 2% ointment was in a box. -The prescription label on the box documented the tube was dispensed on 06/25/26 with directions to apply small amount to both nostrils for 5 nights before surgery. Interview with Resident #1 on 08/04/26 at 3:41pm revealed she did not receive any mupirocin ointment to her nostrils before surgery. Telephone interview with Resident #1's orthopaedic surgeon's medical assistant from a call placed on 08/05/26 at 12:28pm revealed: -Resident #1 was ordered mupirocin 2% ointment to be administered for 5 days prior to surgery scheduled on 07/21/26. -Mupirocin 2% ointment was a topical antibiotic that was ordered routinely before surgery to prevent post-operative methicillin-resistant staphylococcus aureus (MRSA) infections. -Ideally Resident #1 would have received mupirocin 2% opintment but not having the mupirocin ointment applied did not harm Resident #1 because she was examined by the surgeon on 08/05/26 and was healing well and showed no	D 358		

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signs of infection.

2. Review of Resident #4's current FL2 dated 04/09/26 revealed:
-Diagnoses included traumatic brain injury, epilepsy, glaucoma, hypertension and type 2 diabetes.
-There was an order for epinastine 0.05% (used to prevent itching of the eyes) eye drops instill one drop into each eye twice daily.

Review of Resident #4's primary care provider (PCP) order dated 06/18/26 revealed epinastine 0.05% eye drops instill one drop into each eye twice daily.

Review of Resident #4's June 2026 electronic medication administration record (eMAR) revealed
-There was an entry for epinastine 0.05% eye drops instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm.
-The epinastine 0.05% was documented as administered as ordered from 06/01/26-06/30/26 for 58 out of 60 opportunities.
-On 06/26/26 at 8:00pm, the epinastine 0.05% was not administered due to "on order from the pharmacy."
-On 06/27/26 at 8:00am, the epinastine 0.05% was not administered due to "resident refused."

Review of Resident #4's July 2026 eMAR revealed:
-There was an entry for epinastine 0.05% eye drops instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm.
-The epinastine 0.05% was documented as administered as ordered from 07/01/26-07/31/26 for 61 out of 62 opportunities.
-On 07/01/26 at 8:00pm, the epinastine 0.05%

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was not administered with no documented reason.

Review of Resident #4's August 2026 eMAR from 08/01/26-08/04/26 revealed:
-There was an entry for epinastine 0.05% eye drops instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm.
-The epinastine 0.05% was documented as administered from 08/01/26-08/05/26 at 8:00am as ordered.
-On 08/05/26, the epinastine 0.05% was not administered due to "resident refused."

Observation of Resident #4's medications on hand on 08/05/26 at 9:58am revealed:
-There was one partial bottle of epinastine 0.05% eye drops available on the medication cart for Resident #4.
-The label directions were epinastine 0.05% eye drops instill one drop in both eyes twice daily with a dispense date of 06/30/26.
-There was no open date on the epinastine eye drops.

Interview with the Administrator on 08/05/26 at 10:00am revealed:
-She did not know if Resident #4 brought a supply of epinastine 0.05% eye drops with him from the previous assisted living facility.
-She instructed staff to use eye drops that were open upon admission if they were not expired before opening new eye drops received from the pharmacy.
-The staff failed to document an open date on the current bottle.

Interview with Resident #4 on 08//04/26 at 9:15am revealed:
-He was supposed to receive eye drops in the

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mornings and at 7:00pm.
-The medication aides (MA) were only administering his eye drops once a day at 7:00pm.

Second interview with Resident #4 on 08/05/26 at 11:40am revealed:
-He was supposed to receive the eye drop with the "white cap" at breakfast and at bedtime.
-He had only been receiving the white cap eye drop at bedtime.
-He experienced more itching and irritation in his eyes as a result of not receiving his eye drops in the mornings.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/05/26 at 11:59am revealed they dispensed Resident #4's epinastine 0.05% 1 bottle (a 25-day supply) on 03/27/26 and 06/30/26.

Interview with a MA on 08/05/26 at 10:27am revealed:
-She routinely worked 8:00am-8:00pm.
-She administered the epinastine 0.05% eye drops to Resident #4 at 8:00pm.
-She knew Resident #4 was receiving the epinastine eye drops at 8:00pm because she administered them.

Interview with a second MA on 08/05/26 at 12:55pm revealed:
-She routinely worked 8:00pm-8:00am.
-She administered the epinastine 0.05% eye drops to Resident #4 at 8:00am.
-Resident #4 received his morning eye drops because she administered them.
-Resident #4 brought an additional supply of eye drops with him upon admission.

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Telephone interview with Resident #4's PCP on 08/05/26 at 12:36pm revealed:
-Resident #4 was ordered the epinastine 0.05% eye drops to prevent itchy eyes.
-Resident #4 could experience itchy eyes when he did not receive the eye drops as ordered.
-If itching of the eyes caused Resident #4 to touch his eyes more often with his hands, it could predispose the resident to infection.

Second interview with the Administrator on 08/05/26 at 1:05pm revealed:
-The MAs were supposed to write an open date on the label of eye drops.
-The MAs received medication administration training "every year."
-The facility's contracted pharmacy nurse performed medication cart audits every three months.
-During the medication cart audits, the nurse would look for expired medications and let the facility staff know so they could reorder the medications.

_____

The facility failed to administer medications as ordered to 2 of 4 sampled residents related to quetiapine continuing to be administered after a dose reduction was initiated due to daytime drowsiness, failed to administer an oral antibiotic after surgery and a topical antibiotic before surgery that was ordered to prevent post-surgical infections and failed to administer eyedrops to reduce eye irritation related to allergies (#1) and failed to administer eye drops to prevent itchy eyes (#4). 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 08/04/26 for

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D 358	Continued From page 23 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2026.	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 1 sampled residents (#1) take their medications related to a cup containing 11 medications that were left on the resident's bedside table. The findings are: Review of Resident #1's current FL2 dated 04/09/26 revealed diagnoses included major depression and insomnia. Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/14/23.	D 366		

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D 366	Continued From page 24 Observation of Resident #1's room during initial tour on 08/04/26 at 9:12am revealed: -Resident #1 was asleep in her bed. -On the bedside table was a glass of water and a small, clear medicine cup containing 11 pills. -The 11 pills consisted of a small peach color pill, a large yellow oval pill, a white capsule marked A135, 2 small white oval pills marked with a 10, a small white tablet that was broken, a small round yellow tablet, a small beige tablet marked ZC25, a red capsule, a white oblong tablet that had a deep score in the middle, small white tablet Review of Resident #1's physician's orders revealed: -An order dated 04/09/26 for atorvastatin 10mg daily. -An order dated 04/09/26 for meloxicam 15mg daily. -An order dated 04/09/26 for Quetiapine 400mg at bedtime. -An order dated 04/09/26 for Quetiapine 25mg twice daily that was discontinued on 07/22/26. -An order dated 04/09/26 for buspirone 5mg twice daily. -An order dated 04/09/26 for buspirone 7.5 mg twice daily as needed for anxiety that was discontinued on 05/26/26. -An order dated 04/09/26 for oxycodone 5mg daily. -An order dated 07/22/26 for aspirin, 81mg twice a day for 4 weeks. -An order dated 07/22/26 for doxycycline hyclate 100mg, twice a day for 2 weeks. -An order dated 07/22/26 for celecoxib 100mg, twice a day for 2 weeks. -An order dated 07/30/26 for cephaloxin 500mg three times daily for 10 days.	D 366		

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D 366	Continued From page 25 Observation of medications at bedside on 08/04/26 at 9:45am revealed: -The small peach colored pill was aspirin 81mg. -The large yellow oval pill was quetiapine 400mg. -The white capsule marked A135 was celecoxib 100mg. -The 2 small white oval pills marked 10 were atorvastatin 10mg. -The white broken pill was buspirone 5mg. -The small yellow pill was doxycycline hyclate 100mg. -The small beige tablet marked ZC25 was meloxicam 15mg. -The red capsule was cephalexin 500mg. -The oblong white tablet with a deep score was buspirone 7.5mg. -The small white tablet was oxycodone 5mg. Review of Resident #1's electronic medication administration record (eMAR) for 08/04/26 revealed: -There was not an entry for aspirin 81mg. -There was an entry for quetiapine 400mg with an administration time of 10:00pm that was not documented as administered. -There was an entry for celecoxib 100mg with an administration time of 8:00am that was documented as administered. -There was an entry for atorvastatin 10mg with an administration time of 8:00am that was documented as administered. -There was an entry for buspirone 5mg with an administration time of 8:00am that was documented as administered. -There was an entry for doxycycline hyclate 100mg with an administration time of 8:00am that was documented as administered. -There was an entry for meloxicam 15mg with an administration time of 8:00am that was documented as administered.	D 366		

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D 366	Continued From page 26 -There was an entry for cephalexin 500mg with an administration time of 8:00am that was documented as administered. -There was not an entry for buspirone 7.5mg. -There was an entry for oxycodone 5mg with an administration time of 8:00am that was documented as administered. Interview with the MA on 08/05/26 at 12:53pm revealed: -She administered Resident #1's medications the morning of 08/04/26. -Resident #1 was asleep when she entered her room so she woke her up. -Resident #1 told her she was going to take her medications and had them in her hand but she did not actually watch her take them. -She was trained to watch residents swallow the pills before she documented they were administered. -She read the label for quetiapine but did not read the dose so she must have accidentally put the 10:00pm dose in the cup because she thought she was ordered quetiapine at 8:00am. -She did not remember popping two atorvastatins out of the bubble pack and putting them in the medication cup. -She administered the morning medications that were in the medication cart and did not think she made any mistakes other than not reading the dose on the quetiapine. Interview with the Administrator on 08/04/26 at 9:17am revealed: -The night-shift MA left at 8:00am after administering morning medications. -The MA was not trained to leave medications at bedside and should always watch the resident take them before she documented they were administered.	D 366		

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D 366	Continued From page 27 -The MA took a refresher MA training class a few weeks ago and should have known not to leave them at the bedside.	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, (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 failed to ensure medication administration records were accurate for 1 of 4 sampled residents (Resident #1) related to documentation of 3 medications to treat depression, eye drops to treat eye irritation related to allergies, a medication to prevent post-surgical blood clots, 2 medications to treat	D 367		

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constipation, a medication to treat nerve pain and an inhaler to treat breathing problems.

The findings are:

Review of Resident #1's current FL2 dated 04/09/26 revealed diagnoses included major depression and insomnia.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/14/23.

1. Review of Resident #1's physician's orders revealed:
-There was an order written by her mental health provider (MHP) dated 06/23/26 to discontinue quetiapine 25mg (used to treat depression) at 8:00am and 5:00pm.
-There was an order written by her MHP dated 06/23/26 to start quetiapine 25mg at 5:00pm for 7 days then discontinue.
-There was an order written by her primary care provider (PCP) dated 07/10/26 for quetiapine 25mg twice a day.
-There was an order dated 04/09/26 for quetiapine 400mg daily at 10:00pm.
-There was an order written by her MHP dated 07/21/26 for quetiapine 25mg twice a day to be discontinued.
-There was an order written by her MHP dated 07/21/26 for quetiapine 12.5mg at 8:00am and 5:00pm for 7 days and then discontinue.

Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered at 5:00pm on 07/10/26, at 8:00am

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and 5:00pm on 07/11/26 through 07/18/26 and at 8:00pm on 07/19/26.
-There was a second entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered at 5:00pm on 07/11/26, 07/15/26 and 07/18/26 and at 8:00am on 07/12/26 and at 8:00am and 5:00pm on 07/13/26, 07/14/26, 07/16/26 and 07/17/26.
-There was an entry for quetiapine 400mg at 10:00pm that was not documented as administered on 07/01/26 through 07/04/26 and 07/07/26 through 07/09/26 due to "on order from pharmacy" and documented as administered on 07/05/26 and 07/06/26 and documented as administered on 07/21/26 when she was in the hospital.

Review of Resident #1's August 2026 eMAR revealed there was an entry for quetiapine 25mg at 8:00am and 5:00pm that was documented as administered at 8:00am on 08/04/26.

Observation of medications on hand on 08/04/26 at 9:17am revealed quetiapine 25mg was not available to administer.

Interview with the Administrator on 08/05/26 at 1:30pm revealed:
-She did not know why the quetiapine 25mg was still on the eMAR if it was supposed to be discontinued.
-She did not know why the medication aide (MA) documented administration if the medication was not available.

Telephone interview with a representative from the facility's contracted pharmacy on 08/04/26 at 10:33am revealed:
-They entered new orders into the eMAR system.
-New orders were flagged until someone from the

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facility acknowledged the order and then either approved or denied the order.
-They changed to a new system in June 2026 and the facility should have alerted the pharmacy about errors if they discovered them on the MAR.

2. Review of Resident #1's physician's orders dated 04/23/26 revealed ketorolac 0.5% ophthalmic solution (used to treat eye discomfort related to allergies), one drop in each eye twice daily.

Interview with Resident #1 on 08/04/26 at 10:01am revealed:
-She was asleep when the MA came by to administer medications earlier so she did not get the eye drops and had not been receiving them "for a while".
-She needed her eye drops and did not know why the facility had a hard time getting refills.

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for ketorolac 0.5% ophthalmic solution, one drop in each eye at 8:00am and 8:00pm.
-There was documentation ketorolac 0.5% ophthalmic solution was administered twice a day from 07/01/26 through 07/06/26, 07/09/26, 07/13/26, 07/23/26 through 07/31/26.
-There was documentation ketorolac 0.5% ophthalmic solution was administered at 8:00am on 07/07/26, 07/12/26, 07/14/26, 07/16/26, 07/17/26 and 07/20/26.
-There was documentation ketorolac 0.5% ophthalmic solution was administered at 8:00pm on 07/08/26, 07/22/26.

Review of Resident #1's August 2026 eMAR revealed:

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D 367	Continued From page 31 -There was an entry for ketorolac 0.5% ophthalmic solution,one drop in each eye at 8:00am and 8:00pm. -There was documentation ketorolac 0.5% ophthalmic solution was administered twice a day from 08/01/26 through 08/04/26. Observation of medications on hand on 08/04/26 at 9:17am revealed ketorolac 0.5% ophthalmic solution was not available. Telephone interview with a representative from the facility's contracted pharmacy on 08/04/26 at 3:48pm revealed: -Ketorolac 0.5% ophthalmic solution was dispensed one time on 04/23/26. -The bottle contained approximately a 50 day supply of eye drops and should have been empty by the end of May 2026. -There was no documentation the pharmacy was ever contacted for a refill. Interview with an MA on 08/05/26 at 11:00am revealed: -Resident #1 was out of ketorolac eye drops and had been "for a while". -She documented she administered it because it was the end of her shift and she "was tired and probably distracted". Telephone interview with a second MA on 08/05/26 at 12:53pm revealed she thought the over the counter eye drops were the ketorolac eye drops and those were the ones she administered to Resident #1. Interview with the Administrator on 08/05/26 at 1:30 revealed: -She did not remember administering eye drops to Resident #1 "for a while".	D 367		

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-The MAs should not be using the over-the-counter eye drops as a substitution for ketorolac.
-She did not know why the eye drops were not reordered and why the were documented as administered if they were not available.

3. Review of Resident #1's physician's orders dated 07/22/26 revealed aspirin (used to prevent blood clots after surgery) 81mg twice a day for 4 weeks starting on 07/22/26.

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for aspirin 81mg at 8:00am and 8:00pm.
-There was no documentation aspirin 81mg was administered on 07/24/26 through 07/31/26.

Review of Resident #1's August 2026 eMAR revealed there was not an entry for aspirin 81mg.

Observation of medications on hand on 08/04/26 at 9:17am revealed:
-Two bubble packs with 28 tablets each were dispensed on 06/25/26.
-There were 13 tablets removed from one bubble pack and 1 tablet removed from the second bubble pack.
-The bubble packs were in the medication cart with Resident #1's other medications.

Interview with the Administrator on 08/04/26 at 9:17am revealed:
-Resident #1 started receiving aspirin 81mg after her return from the hospital on 07/22/26.
-She thought the MAs were using both the bubble packs and the facility's house stock of aspirin.
-She did not know why aspirin did not transition to the August eMAR and why the MAs did not

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continue to document on the July 2026 eMAR.

4. Review of Resident #1's physician's orders dated 04/09/26 revealed duloxetine (used to treat depression) 60mg daily.

Review of Resident #1's August 2026 eMAR revealed there was an entry for duloxetine 60mg at 8:00am that was documented as administered on 08/04/26 and 08/05/26.

Observation of Resident #1's medications on hand on 08/04/26 at 9:17am revealed duloxetine was not in Resident #1's medication cup at her bedside or in the medication cart.

Interview with a MA on 08/05/26 at 11:00am revealed:
-Resident #1 was out of duloxetine when she administered medications on 08/05/26.
-She documented she administered it because it was the end of her shift and she "was tired and probably distracted".

Telephone interview with a MA on 08/05/26 at 12:53pm revealed:
-She administered Resident #1's medications the morning of 08/04/26.
-She administered the morning medications that were in the medication cart and did not think she made any mistakes in documentation.

Interview with the Administrator on 08/04/26 at 9:17am revealed duloxetine 60mg was not available and she did not know why the MAs documented they administered it.

5. Review of Resident #1's physician's orders dated 04/09/26 revealed docusate (used to treat constipation) 100mg daily.

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D 367	Continued From page 34 Review of Resident #1's August 2026 eMAR revealed there was an entry for docusate 100mg at 8:00am that was documented as administered. Observation of Resident #1's medications on hand on 08/04/26 at 9:17am revealed docusate was not in Resident #1's medication cup at her bedside but it was available in the medication cart. Interview with the MA on 08/05/26 at 12:53pm revealed: -She administered Resident #1's medications the morning of 08/04/26. -She administered the morning medications that were in the medication cart and did not think she made any mistakes in documentation. Interview with the Administrator on 08/04/26 at 9:17am revealed: -Resident #1 usually refused docusate every day. -She did not know why the MA documented she administered it since it was not in the cup at the bedside. 6. Review of Resident #1's physician's orders dated 06/25/26 revealed gabapentin (used to treat nerve pain) 100mg twice daily. Review of Resident #1's August 2026 eMAR revealed there was an entry for gabapentin 100mg at 8:00am that was documented as administered. Observation of Resident #1's medications on hand on 08/04/26 at 9:17am revealed gabapentin 100mg was not in Resident #1's medication cup at her bedside but it was available in the medication cart.	D 367		

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D 367	Continued From page 35 Interview with the MA on 08/05/26 at 12:53pm revealed: -She administered Resident #1's medications the morning of 08/04/26. -She administered the morning medications that were in the medication cart and did not think she made any mistakes in documentation. Interview with the Administrator on 08/04/26 at 9:17am revealed gabapentin 100mg was available on the medication cart and she did not know why the MA documented she administered it when it was not in the cup that was at the bedside. 7. Review of Resident #1's physician's orders dated 06/25/26 revealed senna (used to treat constipation) 8.6mg daily. Review of Resident #1's August 2026 eMAR revealed there was an entry for senna 8.6mg at 8:00am that was documented as administered. Observation of Resident #1's medications on hand on 08/04/26 at 9:17am revealed senna 8.6mg was not in Resident #1's medication cup at her bedside but it was available in the medication cart. Interview with the MA on 08/05/26 at 12:53pm revealed: -She administered Resident #1's medications the morning of 08/04/26. -She administered the morning medications that were in the medication cart and did not think she made any mistakes in documentation. Interview with the Administrator on 08/04/26 at 9:17am revealed:	D 367		

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-Senna was available and Resident #1 usually refused it every day.
-She did not know why the MA documented she administered it.

8. Review of Resident #1's physician's orders dated 06/25/26 revealed ventolin (used to treat breathing problems) 90mcg twice daily.

Review of Resident #1's August 2026 eMAR revealed there was an entry for ventolin 90mcg at 8:00am that was documented as administered.

Observation of Resident #1's medications on hand on 08/04/26 at 9:17am revealed ventolin 90mcg was available in the medication cart.

Interview with Resident #1 on 08/04/26 at 10:01am revealed she was asleep when the MA came by to administer her morning medications on 08/04/26.

Interview with the MA on 08/05/26 at 12:53pm revealed:
-She administered Resident #1's medications the morning of 08/04/26.
-She administered the ventolin inhaler that were in the medication cart and did not think she made any mistakes in documentation.

Interview with the Administrator on 08/04/26 at 9:17am revealed she did not know why the MA documented she administered the ventolin inhaler if she was asleep when she left the other medications in her room.

9. Review of Resident #1's physician's orders dated 04/09/26 revealed trazodone (used to treat depression) 50mg daily at bedtime.

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D 367	Continued From page 37 Review of Resident #1's August 2026 eMAR revealed: -There was documentation Resident #1 was admitted to the hospital on the morning of 07/21/26 for surgery, -There was an entry for trazodone 50mg at 10:00pm that was documented as administered on 07/21/26. Observation of Resident #1's medications on hand revealed trazodone 50mg was available in the medication cart. Interview with the Administrator on 08/05/26 at 1:30pm revealed: -She did not know why the MAs were making so many documentation error. -She or her assistant conducted cart and chart audits, including eMAR audits every three months. -The last time a eMAR audit was conducted was several months ago.	D 367		