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
	HAL062016	A. BUILDING: _____ B. WING _____	R 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on May 11-12, 2026.	D 000		
D 150	10A NCAC 13F .0501 (a & b) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review	D 150	D150-Personal Care Training and Competency (10A NCAC 13F.0501) The Business Office Manager (BOM) Administrator were re-educated regarding the requirement that all staff providing personal care complete the state-approved 80-Personal Care Training withing 6 months of hire. *Staff were immediately scheduled for the next available 80-hour PCA training. Class will be scheduled every 6 months moving forward. *Education included training and documentation, deadlines, and completion. *Admin/designee will review training compliance monthly to ensure all required training is completed within 6 months of hire. Monitoring: The administrator or designee will audit personnel files monthly for 3 months and quarterly thereafter to ensure compliance.	

REVIEWED AND ACKNOWLEDGED 06/16/26 BY NURSE CONSULTANT Sarah B. Nielsen

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D 150	Continued From page 1 by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 6 staff sampled (D, F) who provided personal care services to the residents had completed the state-approved 80-hour personal care training and competency evaluation program. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired as a personal care aide (PCA) on 10/23/25. -The was no documentation of Staff D completing the state-approved 80-hour personal care training and competency evaluation program. Refer to interview with the Business Office Manager (BOM) on 05/12/26 at 9:20am. Refer to interview with the licensed health professional Support (LHPS) nurse 05/12/26 at 9:45am. Refer to interview with the Administrator on 05/12/26 at 12:55pm. 2. Review of Staff F's personnel record revealed: -Staff F was hired as a personal care aide (PCA) on 07/07/25.	D 150	PCA 80-hour class was finished June 24, 2026. Ongoing there will be a class every 6 months. All PCA records were audit June 29, 2026. Charts will be audited monthly for 3 months, then quarterly.	

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D 150	Continued From page 2 -The was no documentation of Staff F completing the state-approved 80-hour personal care training and competency evaluation program. Refer to interview with the Business Office Manager (BOM) on 05/12/26 at 9:20am. Refer to interview with the licensed health professional Support (LHPS) nurse 05/12/26 at 9:45am. Refer to interview with the Administrator on 05/12/26 at 12:55pm. Interview with the BOM on 05/12/26 at 9:20am revealed: -Staff D, and F had not completed the state-approved 80-hour personal care training and competency evaluation program. -Staff should have completed their 80-hour personal care training within six months of hire. -She believed the last 80-hour personal care competency course was held in November of 2024. -The BOM was responsible for sending a list of new hires who needed personal care training to the LHPS nurse in order to get a class set up. -The LHPS nurse was responsible for setting up a class for staff to get their 80-hour personal care training completed. -She did not send the list of staff that needed the 80-hour personal care competency course to the LHPS nurse. Interview with the LHPS Nurse on 05/12/26 at 9:45am revealed: -She taught the 80-hour personal care competency course to the staff members. -She set up the class dates after she received the list of new staff members from the BOM.	D 150		

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D 150	Continued From page 3 -New staff should have completed the 80-hour personal care competency course within six months of hire. -She was not aware that there were staff members that had been working at the facility for more than six months who did not have the personal care training. Interview with the Administrator on 05/12/26 at 12:55pm revealed: -When new staff were hired they should have completed the 80-hour personal care competency course within 6 months. -The BOM and Administrator were responsible for ensuring all staff members had all of their training completed. -She was not sure why staff D and F had not completed the 80-hour personal care competency course. -It was important for staff members to complete the 80-hour PCA competency course so they could provide proper care for the residents in the facility.	D 150		
D 346	10A NCAC 13F .1002(c) Medication Orders 10A NCAC 13F .1002 Medication Orders (c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) oute of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use.	D 346		

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D 346	Continued From page 4 This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to obtain a stated indication for as needed medication used for 3 of 5 sampled residents (#2, #3, #4). Review of the facility's Medication Management Plan: Policies and Procedures dated 2019 revealed: -Medication orders will be verified by staff with a physician or prescribing practitioner when orders are received which are not clear or incomplete. -Medication orders will include reason for use if PRN or as needed. The findings are: 1. Review of Resident #4's current FL-2 dated 04/13/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, intellectual disabilities, obstructive sleep apnea, osteopenia, hypoxemia, and atrial extrasystoles. Review of Resident #4's signed physician's orders dated 04/13/26 revealed: -There was an order for Alprazolam 1mg tablet, take 1/2 every 12 hours as needed (PRN). (It is used to treat anxiety disorders). -The Alprazolam did not have an indication for use. -There was an order for Iprat-Albut 0.5-3(2.5)mg/3ml, inhale 1 vial via nebulizer every 6 hours as needed. (Iprat- Albut is used to treat wheezing, shortness of breath, and chest	D 346	D346-Medication Order (10A NCAC 13F.1002 (c)) All Medication Aides were re-educated on medication order requirements, specifically, that all PRN (as-needed) medication orders must include a documented indication for use. education included physician order review eMAR verification, pharmacy communication, and monthly medication audits. *All residents medication were reviewed to identify PRN medications lacking indications. *Physicians and prescribing PA were contacted to obtain missing indications. *eMARs were updated to reflect complete medication orders. *SCC staff were educated to verify all new orders before approval and pharmacy entry. Monthly audits for verification that all PRN medications contain documented indications for use. Findings will be reviewed by the Admin or designee for 3 months and quarterly thereafter. All Med Techs were re-educated May 13, 2026. Med Tech class held for new med techs July 20, 2026. Med Techs are observed weekly. Any new med techs are observed 3 completed days on cart then weekly.	

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D 346	Continued From page 5 tightness in patients with chronic obstructive pulmonary disease). -The Iprat-Albut did not have an indication for use. Review of Resident #4's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 1mg tablet, take 1/2 every 12 hours as needed. -The Alprazolam did not have an indication for use, but it was documented as administered on 04/13/26, 04/16-17/26, 04/19/26, 04/21/26, and 04/24/26. -There was an entry for Iprat-Albut 0.5-3(2.5)mg/3ml, inhale 1 vial via nebulizer every 6 hours as needed. -The Iprat-Albut did not have an indication for use. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for Alprazolam 1mg tablet, take 1/2 every 12 hours as needed. -The Alprazolam did not have an indication for use, but it was documented as administered on 05/07/26. -There was an entry for Iprat-Albut 0.5-3(2.5)mg/3ml, inhale 1 vial via nebulizer every 6 hours as needed. -The Iprat-Albut did not have an indication for use. Interview with a medication aide (MA) on 05/11/26 at 3:05pm revealed: -She had administered Alprazolam to Resident #4 in the past. -She knew what the Alprazolam was used for because of her basic knowledge. -The use for the medication should be on the	D 346	PRN medications audit June 8th and July 8th. They will be reviewed monthly for 3 months and then quarterly.	

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D 346	Continued From page 6 eMAR. Interview with a second MA on 05/12/26 at 10:03am revealed: -When a resident requested their PRN medications, she checked the eMAR first to determine if the resident could be administered the medication. -She would compare the eMAR to the medication label before she administered a PRN medication. -If the PRN medication was administered, she would check on the resident one hour later to see if the medication was effective. -She administered Alprazolam to Resident #4 because the resident asked for it due to her anxiety. -She was aware the indication for use was not on the eMAR for the Alprazolam and she notified the Special Care Coordinator (SCC), but it was never fixed. -The indication for use for the Alprazolam should be on the eMAR as anxiety. Refer to interview with a medication aide on 05/11/26 at 3:05pm. Refer to interview with the Special Care Coordinator on 05/11/26 at 3:47pm. Refer to second interview with the Special Care Coordinator on 05/12/26 at 7:52am. Refer to interview with the Administrator on 05/12/26 at 1:00pm. 2. Review of Resident #2's current FL-2 dated 08/15/25 revealed diagnoses included Alzheimer dementia, depression, mood disorder, and failure to thrive.	D 346		

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D 346	Continued From page 7 Review of Resident #2's signed physician's orders dated 12/08/25 revealed: -There was an order for Quetiapine Fumarate 50mg tablet, take 1/2 every 6 hours as needed. Please use first and Ativan only if Seroquel is not effective. (Quetiapine Fumarate is the brand name for Seroquel. It is used to treat depression. Ativan is used to treat anxiety). -The Quetiapine Fumarate did not have an indication for use. Review of Resident #2's May 2026 eMAR revealed: -There was an entry for Quetiapine Fumarate 50mg tablet, take 1/2 every 6 hours as needed. Please use first and Ativan only if Seroquel is not effective. -The Quetiapine Fumarate did not have an indication for use. Refer to interview with a medication aide on 05/11/26 at 3:05pm. Refer to interview with the Special Care Coordinator on 05/11/26 at 3:47pm. Refer to second interview with the Special Care Coordinator on 05/12/26 at 7:52am. Refer to interview with the Administrator on 05/12/26 at 1:00pm. 3. Review of Resident #3's current FL-2 dated 11/05/25 revealed diagnoses included end stage renal disease with dialysis, primary hypertension, bipolar disorder one, chronic obstructive pulmonary disease (COPD), anxiety, diabetes mellitus 2, gastroesophageal reflux disorder, chronic systolic, diastolic, congestive heart failure, obesity, anemia, panic disorder, lumbar	D 346		

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D 346	Continued From page 8 strain, hyperlipidemia, and gastrointestinal bleed. Review of Resident #3's signed physician's orders dated 04/13/26 revealed: -There was an order for Pilocarpine HCL 5mg tablet, take 1 three times a day as needed (PRN). (Pilocarpine is used to treat dry mouth, increasing saliva production and improving oral comfort.). -The Pilocarpine did not have an indication for use. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Pilocarpine HCL 5mg tablet, take 1 tablet three times a day as needed. -The Pilocarpine HCL did not have an indication for use. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for Pilocarpine HCL 5mg tablet, take 1 tablet three times a day as needed. -The Pilocarpine HCL did not have an indication for use. Review of Resident #3's May 2026 eMAR revealed: -There was an entry for Pilocarpine HCL 5mg tablet, take 1 tablet three times a day as needed. -The Pilocarpine HCL did not have an indication for use. Refer to interview with a medication aide on 05/11/26 at 3:05pm. Refer to interview with the Special Care Coordinator on 05/11/26 at 3:47pm. Refer to second interview with the Special Care	D 346		

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D 346	Continued From page 9 Coordinator on 05/12/26 at 7:52am. Refer to interview with the Administrator on 05/12/26 at 1:00pm. Interview with a medication aide on 05/11/26 at 3:05pm revealed the use for the medication should be on the eMAR. Interview with the Special Care Coordinator on 05/11/26 at 3:47pm revealed: -There should be an indication for use with PRN medications. -If there was no indication for a PRN, the medication aides would not know what the medication was used for. -If there was no indication for use for a PRN medication, the medication aides could make a mistake and administer the medication for the wrong reason. Second interview with the Special Care Coordinator on 05/12/26 at 7:52am revealed: -The facility conducted medication cart audits monthly, but she had not completed one lately. -She was responsible for reviewing the residents' progress notes and sending any orders to the pharmacy. -The pharmacy would place the orders in the eMAR system, and she would review the orders and approve or decline the orders. -She should have gotten clarification from the primary care provider (PCP) for PRN medication orders that did not have an indication for use. Interview with the Administrator on 05/12/26 at 1:00pm revealed: -The Special Care Coordinator was responsible for following up and approving medication orders, but she was responsible for ensuring that process	D 346	D358-Medication Administration (10A NCAC 13F.1004 (a)) Education Topics Included: 1. Do Not Crush Medication *Staff were educated to consult the Do Not Crush list before crushing medications. *Updated Do Not Crush reference lists were placed in all medication rooms, med carts and a copy was given to each medication aide for reference. 2. Medication Administration Times *Medications must be administered within one hour before or after the scheduled administration time unless otherwise ordered. *Staff were educated regarding medications requiring administration on an empty stomach or before meals, including levothyroxine and glipizide. 3. Following Physician Parameters *Staff were educated to obtain and document required vital signs prior to administering medications with holding parameters 4. Documentation Requirements *Medication aides were re-educated to accurately document administration, refusals, omissions, late administrations, and resident responses on the eMAR.	

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D 346	Continued From page 10 was being done. -The facility completed a medication cart audit monthly but was not checking the medication orders to ensure there were indications for use of PRN medications.	D 346	5. Medication Availability *Staff were educated on timely medication reordering procedures and escalation processes when medications are unavailable to prevent missed dose.	
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 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#6, #7,#8) observed during the medication pass including errors with an extended-release medication which was crushed and administered (#8), failing to administer medications that were scheduled to be administered (#6, #7) and administering medications after the given time of the scheduled time (#6) and for 1 of 5 residents (#4) sampled for record review for a medication used to lower fluid pressure inside the eye (#4). The findings are: Review of the facility's Medication Management Plan: Policies and Procedures dated 2019	D 358	Corrective Measures: *Immediate competency validation completed for all Medication Aides. *Medication pass observation conducted by SCC/LHPS nurse. *Medication cart audit resumed monthly. *Do Not Crush list posted in all medication preparation areas. *Pharmacy communication process reviewed and reinforced. SCC/Administrator will perform weekly medication pass observation and monthly cart audit for 3 months. May 13, 2026 all Med Tech were educated on Do Not Crush medications. Administration time and vitals are monitored weekly for 3 months , then quarterly.	

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D 358	Continued From page 11 revealed: -Medication, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Medications that require crushing will be prepared immediately before administration. -Unless otherwise specified by the prescriber's directions. Medications will be administered within one (1) hour before or one (1) hour after the prescribed or scheduled time unless an emergency situation precludes the administration. -The Medication Administration Record (MAR) will include the following information the resident's name, name of medication and/or treatment to be performed, strength and dosage or quantity of medication, instructions for administering the medication or performing the treatment, date and time of administration, or date and time when treatment was performed, name and initials of the person administering the medication or performing the treatment, if initials are used, a signature equivalent to those initials will appear on the MAR, for PRN (as needed) medications and treatments, the reason for use and results to the resident, utilized special administration/ monitoring techniques as indicated (vital signs, crush medications. check blood sugar, mix with food or liquid). -The employee is to be knowledgeable of the facility's policy on crushing medications and mixing medications in food. -A current list of medications that should not be crushed may be available for staff to use or facility policy should require that no medications be crushed prior to checking with the pharmacist. Observation of the medication rooms and medication carts on assisted living and special care units on 05/12/26 between 10:30am	D 358		

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D 358	Continued From page 12 -10:45am revealed there were no "do not crush lists" available for review by the medication aides (MA). 1. The medication error rate was 25% as evidenced by the observation of 7 errors out of 28 opportunities during the morning medication pass on 05/11/26. a. Review of Resident #8's current FL-2 dated 10/13/25 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia, unspecified hearing loss, deafness, gastroesophageal reflux disease, and chronic lymphocytic leukemia. Review of Resident #8's signed physician order dated 01/06/26 revealed there was an order for potassium CL (KCL) extended release (ER) 20mEq (a medication used to ensure proper function of the heart and treat low blood potassium) take 1 tablet daily. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 6 medications for Resident #8. -These medications included potassium CL ER 20mEq. -The MA took the medication cup with the 6 medications and placed them into a plastic sleeve and used the pill crusher and crushed all the medications in the sleeve. -The MA placed chocolate pudding into a medication cup and poured the crushed medications from the plastic sleeve onto the chocolate pudding and mixed the crushed	D 358		

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D 358	Continued From page 13 medications into the chocolate pudding. -The MA administered the chocolate pudding with the medications mixed in to Resident #8. Review of Resident #8's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for potassium CL (KCL) extended release (ER) 20mEq take 1 tablet daily scheduled at 8:00am. -Potassium CL ER 20mEq was documented as administered at 8:00am on 05/11/26. Observation of Resident #8's medications on hand on 05/11/26 at 9:03am revealed: -There was a bubble card of potassium CL ER 20mEq a label with directions to take 1 tablet every day. -A black handwritten time of 8:00am was documented in the upper left-hand corner of the bubble pack. -There were 28 tablets dispensed on 05/10/26 by the facility's contracted pharmacy. -There were 24 tablets remaining after the MA popped one into the medication cup to administer to Resident #8 at 9:03am. Interview with the MA on 05/11/26 at 10:30am revealed: -She knew medications that had ER in the name should not be crushed. -She was not aware of any list of do not crush medications in the facility. -There was a book on the medication cart that the list might be in it. -She had overlooked the ER on the medication card for Resident #8's KCL ER 20mEq tablet. Interview with the Special Care Coordinator (SCC) on 05/12/26 at 10:45am revealed:	D 358		

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D 358	Continued From page 14 -She had put a do not crush (DNC) list on the bulletin board in each of the medication rooms on the assisted living side as well as the Special Care Unit (SCU). -She was not sure why the DNC list had been removed from the bulletin board. -She was unaware that the pharmacy book on each medication cart did not contain a DNC list. -She was concerned about the MAs crushing medications that were extended-release medications. -The MA should have checked the labels completely and should have known extended-release medications could not be crushed. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Resident #8 had a current order for KCL extended release 20mEq take 1 tablet daily. -Extended-release potassium chloride should not be crushed. -If extended-release potassium chloride was crushed, it could increase the resident's potassium level by releasing all the potassium at once and could affect the heart causing tachycardia (a condition characterized by a fast heart rate exceeding 100 beats per minute and can cause irregular electrical signals in the heart and may cause dizziness which could cause falls and chest pain, and these symptoms can be mild to life-threatening). Telephone Interview with Resident #8's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -KCL ER 20mEq was used to treat low potassium levels. -Extended-release medications should not be	D 358		

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D 358	Continued From page 15 crushed since they were supposed to release the medication over time. Based on observations, interviews, and record reviews it was determined that Resident #8 was not interviewable. b. Review of Resident #7's current FL-2 dated 06/30/25 revealed diagnoses included dementia, schizophrenia, hypertension, and thyroid disease. Review of Resident #7's signed physician order dated 12/18/25 revealed there was an order for levothyroxine 50mcg (used to treat hypothyroidism by replacing thyroid hormones) take 1 tablet daily. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 9:00am, the MA opened a drawer of the medication cart, retrieved, and prepared 10 medications for Resident #8. -These medications included levothyroxine 50mcg. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #7 at 9:15am. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 50mcg (used to treat hypothyroidism by replacing thyroid hormones) take 1 tablet daily scheduled at 6:30am. -Levothyroxine 50mcg was documented as administered on 05/11/26 at 6:30am.	D 358		

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D 358	Continued From page 16 -There was no exception noted on the eMAR to note that the levothyroxine was administered late. Observation of Resident #7's medications on hand on 05/11/26 at 9:09am revealed: -There was a bubble pack of levothyroxine 50mcg with a label with directions to take 1 tablet every day. -A black handwritten time of 6:30am was documented in the upper left-hand corner of the bubble pack. -There were 28 tablets dispensed on 05/11/26 by the facility's contracted pharmacy. -There were 26 tablets remaining after the MA popped one into the medication cup to administer to Resident #7. Interview with the MA on 05/11/26 at 10:30am revealed: -She knew that medications should be administered at least 1 hour before or 1 hour after the scheduled time. -She was helping administer medications for the other MA who was behind in administering medications to residents. Interview with the Special Care Coordinator (SCC) on 05/12/26 at 10:45am revealed: -She was not sure why the MA was running late on administering medications -She was concerned about the MAs administering medications that were scheduled to be given at 6:30am but administering them after 9:00am especially with other medications and after the resident had eaten breakfast. Interview with the Administrator on 05/12/26 at 11:00am revealed: -The right time would be 1 hour before or 1 hour after the scheduled time.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 17 -She expected the MAs to give medications at the scheduled times. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Resident #7 had a current order for levothyroxine 50mcg take 1 tablet daily. -The levothyroxine was scheduled to be administered at 6:30am. -The levothyroxine should be administered on an empty stomach and without other medications to provide better absorption of the levothyroxine and prevent interactions with other medications. Telephone interview with Resident #7's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Levothyroxine was used to treat hypothyroidism by replacing thyroid hormones. -She was concerned that Resident #7 could have increased symptoms of hypothyroidism like feeling tired if he was receiving it late. -She expected the MA to administer the medication on time as ordered. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. c. Review of Resident #7's signed physician order dated 12/18/25 revealed there was an order for metoprolol tartrate 25mg take 1 tablet twice a day and to hold if systolic blood pressure was less than 100. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed:	D 358		

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D 358	Continued From page 18 -At 9:00am, the MA opened a drawer of the medication cart, retrieved, and prepared 10 medications for Resident #7. -These medications included metoprolol tartrate 25mg. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #7. -There was no blood pressure measurement observed for Resident #7 at 9:15am. -There was no exception noted on the eMAR to note that the metoprolol was administered late. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg take 1 tablet twice a day and to hold if systolic blood pressure was less than 100 scheduled at 8:00am and 8:00pm. -Metoprolol tartrate 25mg was documented as refused on 05/11/26 at 8:00am. -The entry on 05/11/26 at 8:00am on the exceptions page of the eMAR revealed that the resident refused. -There was no entry of a blood pressure reading documented on the eMAR. Observation of Resident #7's medications on hand on 05/11/26 at 9:03am revealed: -There was a bubble pack of Metoprolol tartrate 25mg with a label direction - take 1 tablet twice a day *hold for SBP<100* (hold for systolic blood pressure below 100). -There were handwritten times in the upper left corner of 8:00am and 8:00pm. -There were 56 tablets dispensed on 05/10/26 by the facility's contracted pharmacy. -There were 20 tablets remaining after the MA	D 358		

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D 358	Continued From page 19 popped one into the medication cup to administer to Resident #7. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed: -The MA should have checked Resident #7's blood pressure to follow the parameters of holding the medication if the systolic blood pressure (SBP) was below 100. -If the MA did not check the BP, she would not be able to hold the medication if needed. Interview with the Administrator on 05/12/26 at 11:00am revealed: -The SCC was responsible for supervising the MAs. -The MAs reported to the SCC. -She expected the MAs to follow the 6 rights of medication administration and to check blood pressures according to the medication orders. Telephone interview with Resident #7's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Metoprolol was prescribed to treat high blood pressure (BP). -She thought there was an order to check the BP not just the parameters to hold the metoprolol. -She was concerned that the Resident #7's BP may be higher if metoprolol was administered late. -If Resident #7's blood pressure became too high he may have dizziness, increasing his risk for a fall. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. d. Review of Resident #7's signed physician order	D 358		

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D 358	Continued From page 20 dated 12/18/25 revealed there was an order for Enulose 10gm (a laxative used to treat constipation) daily. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 9:00am, the MA opened a drawer of the medication cart, retrieved, and prepared 10 medications for Resident #8. -These medications did not include Enulose 10gm. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #7. -There was no Enulose 10gm administered to Resident #7 during the medication pass. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Enulose 10gm (a laxative used to treat constipation) daily take 15mL daily scheduled at 8:00am. -Enulose 10gm at 8:00am was documented as administered on 05/11/26 at 8:00am. Observation of Resident #7's medications on hand on 05/11/26 at 9:10am revealed there was no Enulose observed on the medication cart. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed: -The MA should have administered all the residents' medications at the time they were scheduled. -If the MA did not administer the medication as ordered, she should have documented a	D 358		

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D 358	Continued From page 21 medication error. Interview with the Administrator on 05/12/26 at 11:00pm revealed she expected the MAs to follow the 6 rights of medication administration and to administer all medications according to the medication orders at the scheduled time. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Resident #7 had a current order for Enulose (used to treat constipation) 10gm/mL take 15 mL daily no dispensed record was given. -The Enulose was scheduled to be administered at 8:00am. -She was concerned that Resident #7 may become constipated if he did not receive his Enulose as ordered. -Chronic constipation could lead to fecal impaction where stool becomes hard and stuck in the rectum. Telephone interview with Resident #7's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Enulose was prescribed to treat constipation. -She was concerned that Resident #7's may become constipated if he did not receive his Enulose as ordered. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. e. Review of Resident #6's current FL-2 dated 12/08/25 revealed: -Diagnoses included Diabetes Mellitus Type 2, dementia, schizoaffective disorder, hypertension, and peripheral vascular disease.	D 358		

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D 358	Continued From page 22 -There was an order for Glipizide 10mg (used to treat diabetes and according to the manufacturer take the regular tablet 30 minutes before your first meal of the day) take 2 tablets twice a day before meals. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 9 medications for Resident #6. -These medications included Glipizide 10mg. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #6 at 9:00am. Review of Resident #6's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Glipizide 10mg take 2 tablets twice a day before meals. -Glipizide 10mg was documented as administered on 05/11/26 at 7:00am. -There was no exception noted on the eMAR to note that the Glipizide 10mg was administered late. Observation of Resident #6's medications on hand on 05/11/26 at 8:58am revealed: -There was a bubble pack of Glipizide 10mg with a label direction - take 2 tablets (20mg) twice daily before meals. -There were handwritten times in the upper left corner of 7:00am and 5:00pm. -There were 112 tablets dispensed on 05/10/26 by the facility's contracted pharmacy. -There were 46 tablets remaining after the MA	D 358		

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D 358	Continued From page 23 popped 2 into the medication cup to administer to Resident #6. Interview with the medication aide (MA) on 05/11/26 at 10:30am revealed: -She knew that medications should be administered at least 1 hour before or 1 hour after the scheduled time. -She was helping administer medications for the other MA who was behind in administering medications to residents. Interview with the Special Care Coordinator (SCC) on 05/12/26 at 10:45am revealed: -She was not sure why the MA was running late on administering medications -She was concerned that the MA administered medications that were scheduled to be administered at 7:00am but administered them after 9:00am especially when they were scheduled to be administered before or with meals. -Breakfast was served between 7:30am-8:00am. Interview with the Administrator on 05/12/26 at 11:00pm revealed: -She expected the MAs to follow the 6 rights of medication administration according to the medication orders. -The right time to administer medications would be 1 hour before or 1 hour after the scheduled time. -She expected the MAs to give medications at the scheduled times. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Resident #6 had a current order for Glipizide 10mg take 2 tablets twice daily before meals.	D 358		

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D 358	Continued From page 24 -The Glipizide was scheduled to be administered at 7:00am. -The Glipizide should be administered on an empty stomach and without other medications to provide better absorption of the Glipizide and prevent interactions with other medications. Telephone Interview with Resident #6's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Glipizide was used to treat diabetes and was better absorbed on an empty stomach. -She expected the MA to administer the medication on time. f. Review of Resident #6's signed physician order dated 12/16/25 revealed: -There was an order for metformin 1000mg (used to manage type 2 diabetes, primarily working to lower blood sugar levels by improving insulin sensitivity and reducing glucose production in the liver) take 1 tablet twice a day with meals. -There was an order for metformin 500mg to be administered in addition to the metformin 1000mg every morning to equal 1500mg take 1 tablet twice a day with meals. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 9 medications for Resident #6. -These medications included metformin 1000mg and metformin 500mg. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #6 at 9:00am.	D 358		

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D 358	Continued From page 25 Review of Resident #6's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metformin 1000mg take 1 tablet twice a day with meals along with metformin 500mg take 1 tablet every morning to = 1500mg and it was scheduled at 7:00am and 5:00pm. -Metformin 1000mg and metformin 500mg were documented as administered on 05/11/26 at 7:00am. -There were no exceptions noted on the eMAR to note that the metformin 1000mg and metformin 500mg was administered late. Observation of Resident #6's medications on hand on 05/11/26 at 8:58am revealed: -There was a bubble pack of metformin 1000mg with a label direction - take 1 tablet twice daily with meals with handwritten times in the upper left corner of 7:00am and 5:00pm. -There were 56 tablets of Metformin 1000mg dispensed on 05/10/26 by the facility's contracted pharmacy with 15 tablets remaining after the MA popped 1 into the medication cup to administer to Resident #6. -There was a bubble pack of metformin 500mg with a label direction - take 1 tablet every morning with 1000mg to equal 1500mg with a handwritten time in the upper left corner of 7:00am. -There were 28 tablets of Metformin 500mg dispensed on 05/10/26 by the facility's contracted pharmacy with 24 tablets remaining after the MA popped 1 into the medication cup to administer to Resident #6. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed: -She was not sure why the MA was running late	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

(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 26 on administering medications -She was concerned that the MA administered medications that were scheduled to be administered at 7:00am but administered them after 9:00am especially when they were scheduled to be administered before or with meals. Interview with the Administrator on 05/12/26 at 11:00pm revealed: -The SCC was responsible for supervising the MAs. -The MAs reported to the SCC. -She expected the MAs to follow the 6 rights of medication administration and to adhere to the 1 hour before - 1 hour after the scheduled times according to the medication orders. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Metformin was prescribed to treat diabetes. -She was concerned that the Resident #6's blood sugar may be higher if metformin was administered late especially since other medications could affect the absorption of the metformin. Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable. g. Review of Resident #6's signed physician order dated 12/18/25 revealed: -There was an order for quetiapine 200mg (used to treat schizophrenia and depression) twice a day. -There was an order for quetiapine 50mg to be taken with 200mg = 250mg twice a day.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 27 Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 9 medications for Resident #6. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #6 at 9:00am. -There was no quetiapine 200mg nor quetiapine 50mg administered. Review of Resident #6's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 200mg (used to treat schizophrenia and depression) twice a day. -There was an entry for quetiapine 50mg to be taken with 200mg = 250mg twice a day. -Quetiapine 200mg twice a day was documented as administered on 05/11/26 at 8:00am. -Quetiapine 50mg twice a day was documented as administered on 05/11/26 at 8:00am.. Observation of Resident #6's medications on hand on 05/11/26 at 8:58am revealed there was no quetiapine 200mg nor quetiapine 50mg on the medication cart. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed: -The MA should have administered all the residents' medications at the time they were scheduled. -If the MA did not administer the medication as ordered, she should have documented a medication error.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 28 -She was concerned that Resident #6 may have behavioral issues from missing doses of his quetiapine. Interview with the Administrator on 05/12/26 at 11:00pm revealed: -She expected the MAs to follow the 6 rights of medication administration and to administer all medications according to the medication orders at the scheduled time. -The resident might exhibit behaviors from missing the quetiapine. Telephone interview with Resident #6's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Quetiapine was prescribed to treat schizoaffective disorder and depression. -She was concerned that Resident #6's may have behavioral issues related to him missing doses of the quetiapine. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed: -Resident #6 had a current order for quetiapine 200mg (used to treat schizophrenia and depression) twice a day to be taken with quetiapine 50mg twice a day for a total of 250mg. -The quetiapine 200mg and 50mg were scheduled to be administered at 8:00am and 8:00pm. -She was concerned that Resident #6 may have behaviors related to his diagnosis of schizoaffective disorder if he did not receive his quetiapine as ordered. Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 29 2. Review of Resident #4's current FL-2 dated 04/13/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, intellectual disabilities, obstructive sleep apnea, osteopenia, hypoxemia, and atrial extrasystoles. Review of Resident #4's signed physician's orders dated 04/13/26 revealed there was an order for Simbrinza 1%-0.2% eye drops, instill 1 drop into each eye three times daily. (Simbrinza is used to lower fluid pressure inside the eye). Review of Resident #4's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Simbrinza 1%-0.2% eye drops, instill 1 drop into each eye three times daily. -The Simbrinza was documented as not administered from 04/13/26 to 04/30/26. -There was an entry on the exceptions page that Simbrinza was waiting for pharmacy. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for Simbrinza 1%-0.2% eye drops, instill 1 drop into each eye three times daily. -The Simbrinza was documented as not administered from 05/01/26 to 05/11/26. -There was an entry on the exceptions page that Simbrinza was waiting for pharmacy. Observation of Resident #4's medications on hand on 05/11/26 at 3:10pm revealed there were no Simbrinza 1%-0.2% eye drops in the medication cart.	D 358		

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D 358	Continued From page 30 Interview with Resident #4 on 05/12/26 at 10:34am revealed she thought she was getting all the eye drops she was supposed to get but was not sure. Interview with a medication aide (MA) on 05/11/26 at 3:05pm revealed: -She could look in the system and see Resident #4's Simbrinza had been reordered and filled. -Resident #4's Simbrinza had been reordered several times. -The facility had not received the Simbrinza for Resident #4 from the pharmacy. Interview with the Special Care Coordinator (SCC) on 05/12/26 at 8:11am revealed: -The facility conducted medication cart audits monthly, but she had not completed one lately. -The MAs should have notified her that Resident #4's Simbrinza had not come in because she would have notified the primary care provider (PCP) to let them know Resident #4 had not received her eye drops as ordered. Telephone interview with the facility's contracted pharmacist on 05/12/26 at 12:42pm revealed: -There was an active order for Simbrinza eye drops, instill 1 drop into each eye three times per day for Resident #4. -The Simbrinza was last dispensed for Resident #4 on 03/05/26. -The Simbrinza was called in to the backup pharmacy, and the facility was notified on 03/06/26 via fax. Interview with the Administrator on 05/12/26 at 1:05pm revealed: -The MAs should have alerted the SCC that Resident #4's Simbrinza was not in the facility after it was ordered and did not come in the next	D 358		

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D 358	Continued From page 31 day. -The SCC should then notify the Administrator if the medication did not come. -The Administrator and the SCC would check the status of the medication with the pharmacy and or the primary care provider (PCP) if necessary. -The pharmacy would send a notification to the facility if the medication was sent to the backup pharmacy, but the facility never received any notifications. Interview with Resident #4's primary care provider (PCP) on 05/12/26 at 12:51pm revealed: -She was not the original prescriber for Resident #4's Simbrinza eye drops order. -The Simbrinza was used for glaucoma or to lower the pressure in the eyes due to glaucoma. -If Resident #4 was not administered the Simbrinza it could cause decreased vision. _____ The facility failed to ensure medications were administered as ordered to 3 of 3 residents (#6, #7, #8) observed during the medication pass. Resident #8's potassium extended-release medication was crushed and administered which could release all the potassium at once which could cause an increased heart rate. Resident #7 had a medication administered late which was used to treat hypothyroidism which could cause the medication not to be absorbed properly and could interact with other medications and a blood pressure (BP) medication that was administered without checking the BP which could cause the resident's BP to become too low and was not administered a medication used to treat constipation which could cause a fecal impaction. Resident #6 had two medications used to treat high blood sugars which were administered late which could cause elevated blood sugars and was not administered a medication used to treat	D 358		

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D 358	Continued From page 32 behaviors which could result in increased behaviors. And medication were not administered as ordered to 1 of 5 sampled residents (#4) who missed 54 doses of a medication used to lower fluid pressure inside the eye which could result in decreased vision. 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 05/11/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367		

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D 367	Continued From page 33 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 (eMARs) were accurate for 2 of 3 residents (#6, #7) observed during the medication pass related to inaccurate documentation of medications used to treat high blood pressure, chronic obstructive pulmonary disease, and constipation (#7) and medications used to treat schizophrenia and depression and 2 medications used to treat diabetes mellitus (#6). The findings are: Review of the facility's Medication Management Plan: Policies and Procedures dated 2019 revealed: -Medication, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -The MAR will include the following information resident's name, name of medication and/or treatment to be performed, strength and dosage or quantity of medication, instructions for administering the medication or performing the treatment, date and time of administration, or date and time when treatment was performed, name and initials of the person administering the medication or performing the treatment. -If initials are used, a signature equivalent to those initials will appear on the MAR.	D 367		

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D 367	Continued From page 34 1. Review of Resident #7's current FL-2 dated 06/30/25 revealed diagnoses included dementia, schizophrenia, hypertension, and thyroid disease. a. Review of Resident #7's current FL-2 dated 06/30/25 revealed there was an order for metoprolol tartrate 25mg (used to treat high blood pressure) take 1 tablet twice a day and to hold if systolic blood pressure was less than 100. Review of Resident #7's signed physician order dated 12/18/25 revealed there was an order for metoprolol tartrate 25mg take 1 tablet twice a day and to hold if systolic blood pressure was less than 100. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 9:00am, the MA opened a drawer of the medication cart, retrieved, and prepared 10 medications for Resident #7. -These medications included metoprolol tartrate 25mg. -The MA took the medication cup with the medications and placed them into a plastic cup. -The MA administered the medications to Resident #7. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg take 1 tablet twice a day scheduled at 8:00am and 8:00pm. -Metoprolol tartrate 25mg was documented as refused on 05/11/26 at 8:00am. -The entry on 05/11/26 at 8:00am on the exceptions page of the eMAR revealed that the	D 367		

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D 367	Continued From page 35 resident refused metoprolol tartrate 25mg. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed the MA should document medications administered and if the resident refused the MA should document accordingly. Interview with the Administrator on 05/12/26 at 11:00am revealed she expected the MAs to document medication administration and refusals on the eMAR correctly. Telephone interview with Resident #7's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Metoprolol was prescribed to treat high blood pressure. -The inaccurate documentation would lead her to believe the resident was refusing his medications when he was taking it which could lead her to making medication changes that were not needed or could be harmful to the resident. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. b. Review of Resident #7's signed physician order dated 12/18/25 revealed there was an order for Trelegy Ellipta 200-62.5 (a dry powder inhaler used for chronic obstructive pulmonary disease (COPD). Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 9:00am, the MA opened a drawer of the medication cart, retrieved, and prepared 10	D 367		

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medications for Resident #7.
-These medications included Trelegy Ellipta 200-62.5.
-The MA administered the medications to Resident #7.
-Resident #7 refused the Trelegy Ellipta when the MA offered the inhaler to him.

Review of Resident #7's May 2026 (eMAR) on 05/11/26 revealed:
-There was an entry for Trelegy Ellipta 200-62.5 one puff every morning scheduled at 8:00am.
-Trelegy Ellipta 200-62.5 was documented as administered on 05/11/26 at 8:00am.

Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed:
-The MA should have documented all the residents' medications that were administered.
-If the resident refused the Trelegy, the MA should have documented the refusal on the eMAR.

Interview with the Administrator on 05/12/26 at 11:00am revealed:
-She expected the MAs to follow the 6 rights of medication administration and to document accordingly.
-The residents had the right to refuse to take medication, but the MA should document it correctly on the eMAR.
-The initials should be circled on the eMAR and then the exceptions page would document the refusal.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/12/26 at 1:17pm revealed:
-Resident #7 had a current order for Trelegy Ellipta 200-62.5 one puff every morning

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D 367	Continued From page 37 scheduled at 8:00am. -The resident had the right to refuse but the MA should document accordingly. Telephone interview with Resident #7's primary care provider (PCP) on 05/12/26 at 12:50pm revealed: -Trelegy was prescribed to treat COPD. -She was concerned that Resident #7's refusals were not documented because she reviewed the eMARs for compliance and for adjusting the medications as needed. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. c. Review of Resident #7's current FL-2 dated 06/30/25 revealed there was an order for Enulose 10gm (a laxative used to treat constipation) daily. Review of Resident #7's signed physician order dated 12/18/25 revealed there was an order for Enulose 10gm (a laxative used to treat constipation) daily. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 9 medications for Resident #7. -These medications did not include Enulose 10gm. -The MA administered the medications to Resident #7. -The MA did not prepare or administer Enulose 10gm during the 8:00am medication pass.	D 367		

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D 367	Continued From page 38 Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Enulose 10gm (a laxative used to treat constipation) daily. take 15mL daily scheduled at 8:00am. -Enulose 10gm was documented as administered on 05/11/26 at 8:00am. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. 2. Review of Resident #6's current FL-2 dated 12/08/25 revealed diagnoses included Diabetes Mellitus Type 2, dementia, schizoaffective disorder, hypertension, and peripheral vascular disease. Review of Resident #6's signed physician order dated 12/18/25 revealed: -There was an order for quetiapine 200mg (used to treat schizophrenia and depression) twice a day. -There was an order for quetiapine 50mg to be taken with 200mg = 250mg twice a day. Review of Resident #6's May 2026 electronic Medication Administration Record (eMAR) on 05/11/26 revealed: -There was an entry for quetiapine 200mg (used to treat schizophrenia and depression) twice a day. -There was an entry for quetiapine 50mg to be taken with 200mg = 250mg twice a day. -Quetiapine 200mg and quetiapine 50mg were documented as administered on 05/11/26 at 8:00am. Observation of a medication aide (MA)	D 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

(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 367	Continued From page 39 administering medications during the 8:00am medication pass on 05/11/26 from 8:58am to 9:15am revealed: -At 8:58am, the MA opened a drawer of the medication cart, retrieved, and prepared 9 medications for Resident #6. -These medications did not include quetiapine 200mg or quetiapine 50mg. -The MA administered the medications to Resident #6 at 9:00am. -The MA did not prepare or administer the quetiapine 200mg or quetiapine 50mg during the 8:00am medication pass. Interview with the Special Care Coordinator (SCC) on 05/11/26 at 3:47pm revealed the MA should only document medications that were administered to the resident as being administered. Interview with the Administrator on 05/12/26 at 11:00am revealed: -She expected the MAs to document medications as administered, late, refused, or not available. -The documentation needed to be accurate. Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.	D 367		