This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13 F .0802(a)(c) Resident Care Plan

Resident records will be reviewed to verify care plans are in the charts.

Care plans will be completed on move in, at thirty days, every six months, annually and with a change in condition.

Care plans found to be non-compliant will be updated by the assessor and signed by a physician within 15 days.

The DHW/Designee will monitor for compliance using a resident tracker and electronically generated schedule on a weekly basis. The resident tracker will be updated as care plans are completed.

The ED/Designee will monitor monthly for compliance.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .0902 (b) Health Care (Referral and Follow Up)

Staff will be re- educated in use of the Order Management System for physician orders, follow up visits, hospital visits, discharges and other resident related paperwork by the DHW/designee.

A new order tracking form will be attached to new orders and completed throughout the process.

The DHW/Designee will review the new orders/new order tracking form before filing in the resident's record to verify orders for referrals are completed , labs are ordered and collected and other orders as written by the provider are implemented.

Ginger Jones, ED 08/21/26

The DHW/Designee will monitor the Order Management System on a daily and as needed basis. The Executive Director/Designee will monitor random orders weekly for completion and follow up for three months.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .0902(c)Health Care (Documentation and Implementation)

Staff will be re-educated in the Order Management System and new order tracking form for physician orders, after visit notes, hospital discharge summaries and other health care related resident paperwork by the DHW/designee.

The DHW/Designee will review provider paperwork for new orders to verify implementation of orders and documentation of follow up in the resident record before filing in the resident record.

The ED/Designee will monitor new orders weekly for thirty days and randomly thereafter for compliance.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .0904 (a)(1) Nutrition and Food Service (Temperatures)

Dietary staff will receive retraining in food safety guidelines including but not limited to temperature requirements by area director of culinary/designee.

The Director of Culinary Services (DCS)/designee will check the temperatures of food to determine that the food is within the required temperatures prior to serving food twice a week and maintained on a log.

The DCS/designee will review the plating of food prior to service to verify the appropriate placement of hot and/or cold foods at each meal.

The ED/Designee will perform random food temperature checks on a weekly basis and will visually inspect the plating of food at random meals and maintained a log.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .0904(d)(1) Nutrition and Food Service (portion sizes)

Dietary staff/all management staff will receive retraining on the portion sizes required for each diet order to include but not limited to the correct sizes of spoons, spoodles, ladles

Jurgen James, ED 08/21/26

and beverage containers. This training will be conducted by the area director of culinary or designee.

The DCS/Designee will observe plating of food for the correct portion sizes at each meal for verification. For clarification purposes, designee may include the supervising cook on each shift.

The ED/designee will review the portions sizes on resident plates at each meal for accuracy. For clarification purposes, designee may include the MOD (manager on duty) or Med tech on the shift.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .1002(a) Medication Orders (clarification)

Clinical staff responsible for transcription and acceptance of medication orders will be re-educated in the clarification of medication orders.

New orders, after visit summaries, discharge orders, provider notes will be reviewed by the DHW/Designee on a daily basis and noted on the new order tracking form.

Medication orders needing clarification will not be implemented until clarification is obtained.

DHW/designee will contact the provider for clarification of medication orders prior to acceptance in ECP (electronic medication administration system) and prior to administration of the medication.

The DHW/Designee will maintain new order tracking forms for a period of thirty days.

The ED/Designee will monitor the new order tracking forms randomly for accuracy.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .1004(a) Medication Administration (med pass)

Medication Technicians will be re-educated on the six rights of Medication Administration by the DHW/Designee.

Stenger Jones, ED 08/21/26

The DHW/designee will conduct med pass observations on all med techs over a two week period until all med techs have been observed. DHW/designee will conduct random med pass observations on med tech ongoing.

Med Observation sheets will be reviewed by the DHW as received.

The ED will review Med observation sheets monthly.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .1004(n) Medication Administration (infection control)

Medication Technicians will be re-educated on infection control for medication administration by the DHW/Designee.

The DHW/designee will conduct med pass observations on all med techs over a two week period until all med techs have been observed. DHW/designee will conduct random med pass observations on med tech ongoing.

Med Observation sheets will be reviewed by the DHW as received.

The ED will review Med observation sheets monthly.

The date of correction for this standard deficiency is August 28, 2026.

10A NCAC 13F .1006(b) Medication Storage (SCU cream at bedside)

Medication technicians will be re-educated in the proper storage of medications by the DHW/designee.

Care Managers/All staff will be re-educated in reporting of medications noted at bedside or left unattended to the Medication Technicians.

The DHW/designee will monitor storage on a weekly basis for the correct storage. This will include Medication Carts, Medication Storage Areas and Medication Refrigerators.

The MCD(Memory Care Director)/designee will monitor memory care resident rooms for medications left at bedside.

The ED/Designee will monitor randomly by observation of the Medication Cart, Medication Room and SCU rooms.

The date of correction for this standard deficiency is August 28, 2026.

Ginger James, ED 08/21/26

10A NCAC 13F .1212 Reporting of Accidents and Incidents

Incidents and Accidents that require reporting will be sent to the county monitor in the required time frame based on the state regulation.

The DHW/Designee will review incident/accident reports for completion and accuracy.

The ED/Designee will review incidents and accidents at standup to verify compliance with this regulation.

The ED/DHW/Designee will send the report to the county as required.

The date of correction for this standard deficiency is August 28, 2026.

Ginger Jones, ED 08/21/24

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D 000	Initial Comments The Adult Care Licensure Section and the Craven County Department of Social Services conducted an annual survey and complaint investigation on July 07, 2026 through July 09, 2026. The complaint investigation was initiated by the Craven County Department of Social Services on March 11, 2026.	D 000		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of	D 259		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Virginia Jones, ED 8/21/26

Reviewed and Acknowledged MW 9-14-26

Division of Health Service Regulation

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D 259	Continued From page 1 this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the resident care plan was signed by the resident's physician or physician extender for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL-2 dated 07/07/26 revealed diagnoses included hyperlipidemia, hypertension, asthma, osteoporosis and a history of falls. Review of Resident #4's Resident Register revealed she was admitted to the facility on 06/30/24.	D 259		

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D 259	Continued From page 2 Review of Resident #4's record on 07/07/26 revealed: -The annual care plan was completed on 03/04/26. -There was no signature for the resident's physician or physician extender. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 3:42pm and 07/09/26 at 8:38am revealed: -He was responsible for ensuring the residents' care plans were signed by the physician or the physician extender. -He completed the care plans, signed them, and had the resident or family member sign them then he would ensure the physician or physician extender signed them. -He did not know why Resident #4's care plan was not signed by the physician or physician extender. -The care plan for Resident #4 should have been signed. Interview with the Administrator on 07/08/26 at 4:07pm revealed: -The HWD was responsible for completing the care plans and having them signed. -The HWD would drive to the provider's office and have care plans signed.	D 259		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 273		

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D 273	Continued From page 3 reviews, the facility failed to meet the acute health care needs for 1 of 6 sampled residents (#6) related to failure to obtain discontinue medication orders for nine days after five medications were placed on hold. The findings are: Review of Resident #6's current FL2 dated 12/02/25 revealed diagnoses included mixed Alzheimer's Disease, vascular dementia, obstructive sleep apnea, hypertension, gait disturbance, expressive aphasia, anxiety disorder, overactive bladder, and irritable bowel syndrome. Review of Resident #6's previous FL2 dated 05/13/25 revealed diagnoses included obstructive sleep apnea, mixed Alzheimer's Disease, vascular dementia, hypertension, gait disturbance, anxiety disorder, overactive bladder, expressive aphasia, and irritable bowel syndrome. Review of a signed physician order sheet for Resident #6 dated 10/30/25 revealed: -There was an order for meloxicam (a non-steroidal anti-inflammatory used to treat symptoms of arthritis such as inflammation, swelling and joint pain) 7.5mg , twice a day. -The order for meloxicam 7.5mg, was signed by the facility's contracted primary care provider (PCP) on 10/30/25. Review of a second signed physician order sheet for Resident #6 dated 10/30/25 revealed: -There was an order for trazodone (trazodone is used to treat major depressive disorder and can be used to treat insomnia) 50mg, take one tablet twice a day.	D 273		

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D 273	Continued From page 4 -There was an order for hydroxyzine (hydroxyzine is an antihistamine that can be used to treat anxiety, allergic skin reactions and can be used as a sleep aid) 50mg, take one tablet twice a day. -The hydroxyzine 50mg order and the trazodone 50mg orders were signed by the facility's contracted primary care provider (PCP) on 10/30/25. Review of Resident #6's signed physician order dated 07/18/25 revealed an order for gabapentin (gabapentin is used to treat seizure disorders and nerve pain) 300mg, take two capsules two times a day. Review of Resident #6's signed physician's order sheet dated 07/08/25 revealed an order for memantine (memantine is used to treat moderate to severe dementia associated with Alzheimer's Disease) 10mg, take one capsule every morning. Review of Resident #6's handwritten November 2025 medication administration record (MAR) revealed: -There was an entry for meloxicam 15mg, take a half tablet twice daily, scheduled at 9:00am and 9:00pm. -There was documentation on the MAR that meloxicam 15mg was on hold per spouse on 11/11/25. -There was an entry for hydroxyzine 50mg, take 1 tablet twice daily scheduled at 9:00am and 9:00pm. -There was documentation on the MAR that hydroxyzine 50mg was on hold per spouse on 11/11/25. -There was an entry for trazodone 50mg, take 1 tablet twice daily scheduled at 9:00am and 9:00pm. -There was documentation of the MAR that	D 273		

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D 273	Continued From page 5 trazodone 50mg was on hold per spouse on 11/11/25. -There was an entry for gabapentin 600mg, take 2 capsules twice day, scheduled at 9:00am and 9:00pm. -There was documentation on the MAR that gabapentin 600mg was on hold per the spouse on 11/11/25. -There was an entry for memantine 10mg. take 1 capsule every morning, scheduled at 8:0am. -There was documentation on the MAR that memantine 10mg was on hold per spouse on 11/11/25. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included meloxicam 15mg, hydroxyzine 50mg, trazodone 50mg, gabapentin 600mg, and memantine 10mg. -The physician order sheet did not have a provider signature. Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received from Resident #6 outside primary care provider (PCP) on 11/20/25 to discontinue meloxicam 15mg, take a half tablet twice a day and 25 half tablets were returned to the pharmacy from the facility on 11/26/25. -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue trazodone 50mg,one twice daily and 25 tablets of trazodone 50mg were returned to the pharmacy on 11/26/25.	D 273		

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D 273	Continued From page 6 -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue hydroxyzine 50mg, one twice daily and 25 tablets of hydroxyzine 50mg were returned to the pharmacy from the facility on 11/26/25. -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue gabapentin 600mg, take 2 capsules twice daily and 52 capsules of gabapentin 300mg were returned to the pharmacy from the facility on 11/26/25. -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue memantine 10mg, take 1 capsule every morning and 10 capsules of memantine 10mg were returned to the pharmacy from the facility on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged from the hospital on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge. -He did request hydroxyzine and trazodone to be discontinued because of their sedating effect. -He did not request meloxicam to be discontinued. -Resident #6 had been on gabapentin for over 20 years for spinal stenosis and he did not request gabapentin to be discontinued. -Resident #6 had been on memantine for 4 to 5 years and he did not request memantine to be discontinued. Interview with the Health and Wellness Director	D 273		

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D 273	Continued From page 7 (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and felt some of the medications caused Resident #6 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the medications he wanted discontinued and which included meloxicam, trazodone, hydroxyzine, gabapentin, and memantine. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications to be discontinued and notified her that he placed the medications on hold, and she advised him that she would come and review the discontinued request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included meloxicam, trazodone, hydroxyzine, gabapentin, and memantine but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included meloxicam, trazodone, hydroxyzine, gabapentin, and memantine that was dated 11/20/25. -He did what Resident #6's RP asked him to do regarding the medications being placed on hold.	D 273		

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D 273	Continued From page 8 Interview with the Administrator on 07/09/26 at 1:44pm revealed: -She was not sure why Resident #6's handwritten MAR showed medications were held as of 11/11/25 but a discontinue order was not received for Resident #6 until 11/20/25. -She was sure the HWD had contacted the facility's contracted PCP and expected there to be documentation of the contact and conversation about medications being held and discontinued for Resident #6. Review of an email received from the Administrator on 07/13/26 at 2:18pm revealed: -Resident #6's Responsible Party (RP) stated that, as his wife's healthcare power of attorney, he wanted to hold her medication, as her healthcare power of attorney, he should be permitted to make this decision on her behalf. -I have attached North Carolina General Statute § 32A-15, "General Purpose of This Article," under Article 3 regarding healthcare powers of attorney. Please include this supporting documentation with our survey information for review. Attempted telephone interview with the facility's contracted pharmacy provider on 07/09/26 at 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26 at 10:52am was unsuccessful.	D 273		

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D 276	Continued From page 9	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#1) with an order for weekly weights. The findings are: Review of Resident #1's current FL-2 dated 04/30/26 revealed diagnoses included cognitive decline, insomnia, and gait disorder. Review of Resident #1's physician order dated 06/15/26 revealed an order to weigh every 2 weeks x 4. Review of Resident #1's monthly vitals for June and July 2026 revealed: -There was no entry for weights in June. -There was one entry for weights in July. Interview with the Resident Care Coordinator (RCC) on 07/08/26 at 1:34pm revealed: -If a resident had an order for weights, it should have been placed in the electronic medication	D 276		

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D 276	Continued From page 10 administration (eMAR) or the treatment administration record (TAR). -She was not aware Resident #1 had an order to weigh him every 2 weeks x 4. -The staff that received the order should have placed the order on the facility's tracking form. -The order should have been placed on the eMAR. -She confirmed on 07/08/26 with the pharmacy that the order was received because there was an order for Boost, a nutritional supplement, on the same order and it was placed on the eMAR. -She did not know why the order for the weights was not placed in the eMAR system. -She and the Health and Wellness Director (HWD) were responsible for ensuring the order was implemented. Interview with the HWD on 07/08/26 at 3:42pm revealed: -He did not know anything about an order for weights for Resident #1. -He and the RCC were responsible for tracking orders using the facility's tracking order form. -When an order was received, it was sent to pharmacy, the facility obtained confirmation and utilized the tracker form. -Once the tracker form was completed it meant an order was on the eMAR and it was signed off on. -If it was a medication order it meant the medication was in the cart or for weights it meant the weights were being done. -If the order for Resident #1's weight was sent to the pharmacy it should have been placed in the eMAR system. Interview with the Administrator on 07/08/26 at 3:17pm revealed: -The HWD was responsible for ensuring orders	D 276		

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D 276	Continued From page 11 were implemented. -The medication aides (MA) should have implemented the weights for Resident #1 by entering the order in the eMAR or TAR. -The order for the weights would then pop up if the order was entered correctly. Attempted interview with Resident #1's Primary Care Physician (PCP) on 07/08/26 at 3:10pm was unsuccessful.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents' food was free from contamination as evidence by the server serving food that was to be maintained below 41 degrees Fahrenheit in a	D 282		

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D 282	Continued From page 12 bowl with hot food. The findings are: Review of the facility's lunch menu on 07/07/26 revealed 1 chicken salad sandwich was to be served. Review of the facility's recipe for chicken salad on 07/07/26 revealed: -Scoop chicken salad into bread using 1 number 12 scoop per sandwich. (A number 12 scoop consisted of 2.67 ounces to 3 ounces or 1/3 cup). -Hold the chicken salad for service at 41 degrees or lower. Observation of the lunch meal in the memory care unit on 07/07/26 between 11:54am and 12:37pm revealed: -There were 2 residents who were served hot mixed vegetables and chicken salad in a bowl. -The chicken salad was on top and next to the hot mixed vegetables. Interview with the server on 07/08/26 at 9:08am revealed: -The 2 residents who were served their food in a bowl were residents with a mechanical soft diet. (A mechanical soft diet consisted of soft texture foods). -She normally served chicken salad and vegetables in a bowl because she thought they could not receive bread. -She was trained by the previous management to serve chicken salad and vegetables that way. Interview with the Dietary Manager on 07/08/26 at 9:26am revealed: -Hot food and cold food prepared with mayonnaise should not have been served	D 282		

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D 282	Continued From page 13 together in the same bowl. -The chicken salad should have been served in a bowl separate from the vegetables. Interview with the Administrator on 07/08/26 at 10:22am revealed: -There should have been a bowl for each side. -The meal should have been served separately and should not have been together.	D 282		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the lunch meal was nutritionally adequate when served to residents as evidenced by residents being served smaller portion sizes of food based on the menu. The findings are: Review of the facility's lunch menu on 07/07/26 revealed 1 chicken salad sandwich was to be	D 297		

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D 297	Continued From page 14 served. Review of the facility's recipe for chicken salad on 07/07/26 revealed scoop chicken salad into 2 slices of bread using 1 number 12 scoop per sandwich. (A number 12 scoop consisted of 2.67 ounces to 3 ounces or 1/3 cup). Observation of the lunch meal in the memory care unit on 07/07/26 between 11:54am and 12:37pm revealed the residents received ½ chicken salad sandwich. Interview with the server on 07/07/26 at 2:14pm revealed: -She did not have enough bread to serve 2 slices for the chicken salad sandwiches. -She served most of the women in the assisted living unit ½ chicken salad sandwich because they did not eat a full sandwich. -She served all the residents in memory care ½ chicken salad sandwich. Interview with the Dietary Manager on 07/08/26 at 9:20am revealed: -A sandwich consisted of 2 slices of bread. -He was not aware the residents in memory care were served ½ chicken salad sandwich. -Staff were not expected to cut back portion sizes for the residents, full sandwiches should have been served. Interview with the Administrator on 07/08/26 at 10:22am revealed: -All residents should be treated the same way and served the same amount of food. -She was not aware the kitchen staff were serving residents less food than other residents; if she knew she would have sent the food back to the kitchen.	D 297		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to clarify medication orders for 1 of 6 sampled residents (#6) related to medication used to manage behavioral issues. The findings are: Review of Resident #6's current FL2 dated 12/02/25 revealed diagnoses included mixed Alzheimer's Disease, vascular dementia, obstructive sleep apnea, hypertension, gait disturbance, expressive aphasia, anxiety disorder, overactive bladder, and irritable bowel syndrome. Review of Resident #6's previous FL2 dated 05/13/25 revealed diagnoses included obstructive sleep apnea, mixed Alzheimer's Disease, vascular dementia, hypertension, gait	D 344		

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D 344	Continued From page 16 disturbance, anxiety disorder, overactive bladder, expressive aphasia, and irritable bowel syndrome. Review of Resident #6's behavioral health provider note dated 07/08/25 revealed: -The resident was admitted on 05/30/25 with a history of Alzheimer's Disease and anxiety. -Staff reported the resident was yelling, screaming and crying day and night. -Requesting initial assessment due to psychotropic usage and psychiatric history. -The resident had a history of mixed Alzheimer's and vascular dementia, anxiety, and gait disturbance, and was seen today for evaluation of frequent yelling and screaming. -She resides in an assisted living facility and exhibited frequent yelling and screaming behaviors, which were disruptive to the facility. -These behaviors were reportedly worse when she was being moved or touched. -She was unable to stand or pivot and is often found rolling in bed and screaming. -Under Plan, initiate risperidone 0.5mg daily and Ativan, Benadryl, Haldol (ABH) gel (ABH gel is a compounded topical medication combining Ativan, Benadryl, and Haldol, used to treat nausea, and agitation) as needed to mitigate disruptive vocalizations, and mood disturbance contingent on Power of Attorney's (POA) consent. -Under Plan of Care, amended 07/10/25 following POA phone call, medication change as follows, start risperidone 0.25mg, one daily for behaviors #30 with 3 refills, start ABH gel 1mg/12.5mg/1mg/ml, apply 1ml topically daily as needed for extreme agitation, #30 with 3 refills, staff to monitor for side effects and contact provider for further instructions, rationale, management of dementia related behaviors.	D 344		

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D 344	Continued From page 17 Review of Resident #6's provider order from the facility's contracted behavioral health provider dated 07/10/25 revealed: -There was an order for risperidone 0.25mg one daily for behaviors, -There was an order for ABH gel 1mg/12.5mg/1mg/ml, apply 1 ml topically daily as needed for extreme agitation. -Staff to monitor for side effects and contact provider for further instructions. Review of Resident #6's hospital after visit summary (AVS) dated 07/18/25 revealed: -The resident was admitted on 07/17/25 and discharged on 07/18/25. -The diagnosis was listed as acute brain disorder. -Under the section titled "your medications have changed", stop taking risperidone 0.25mg was documented. Review of Resident #6's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for risperidone 0.25mg, take one tablet every day for behaviors scheduled at 8:00am. -Risperidone 0.25mg was documented as administered at 8:00am on 07/11/25 through 07/17/25. -Risperidone 0.25mg was documented as administered at 8:00pm on 07/18/25 through 07/31/25. Review of Resident #6's scanned Order for Facility from the facility's contracted behavioral health provider dated 07/18/25 revealed: -Under history, Resident #6's POA requested risperidone to be discontinued, as he feels that it is contributing to increased sedation. -Plan, discontinue risperidone 0.5mg.	D 344		

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D 344	Continued From page 18 -Rationale, POA request. Review of a correspondence from Resident #6's preferred extended care pharmacy dated 07/29/25 revealed: -The correspondence was addressed to Resident #6's outside primary care provider (PCP). -Resident #6's Responsible Party reported that she is very sedated and recently been seen at the local hospital for altered mental status and loss of consciousness. -He asked that we review her medication list for anything that could possibly be discontinued to help with pill burden and sedation. -Her hospital After Visit Summary stated for her to stop Ativan and risperidone, but the facility requires a written order to initiate the change. -Also, several other medications could potentially be discontinued. -Under recommendations, discontinue risperidone as per hospital visit was listed and "yes" was written by the recommendation to discontinue risperidone and the correspondence was signed by Resident #6's outside PCP and dated 08/01/25. Telephone interview with a pharmacist from Resident #6's extended care pharmacy on 07/08/26 at 3:57pm revealed: -An order was received for Resident #6 for risperidone 0.25mg, take one tablet daily on 07/10/25. -Risperidone 0.25mg, take one tablet daily was dispensed for Resident #6 on 07/10/25 for 25 tablets for a 25-day supply. -Resident #6's RP contacted the pharmacy on 07/29/25 with concerns about medications making her too sedated. -The facility had a hospital AVS to discontinue risperidone but could not use the AVS as an	D 344		

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D 344	Continued From page 19 order. -The pharmacy reached out to Resident #6's outside PCP on 07/29/25 to recommend that risperidone be discontinued. -The pharmacy received the signed request to discontinue Resident #6's risperidone 0.25mg back from her PCP on 08/01/25 and the signed request was forwarded to the facility's contracted pharmacy provider on 08/01/25. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 07/08/26 at 3:39pm revealed: -An order for risperidone 0.25mg was received for Resident #6 on 07/10/25, to take one tablet daily. -The risperidone 0.25mg order to take one tablet every day was put on profile for Resident #6 since she received her medications from another pharmacy. -If medications were to be taken once daily, the administration time defaulted to 8:00am unless the order stated otherwise. -The facility had the ability to change the administration time of medications. -An email was received from Resident #6's outside extended care pharmacy on 08/01/25 that Resident #6's outside PCP had discontinued her risperidone 0.25mg. Interview with a medication aide (MA) on 07/08/26 at 4:08pm revealed: -When a resident was sent to the hospital, a green folder was sent with them that contained their medical information. -When a resident returned from the hospital, the green folder was given to the MA on duty when the resident returned. -All hospital paperwork was in the green folder and the MA reviewed the green folder for orders. -If there were orders, an order tracking sheet was	D 344		

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D 344	Continued From page 20 completed, and the order was faxed to the pharmacy and then the order was given to the Health and Wellness Director (HWD). -There was also a tracking sheet for discontinued medications. Interview with the Resident Care Coordinator (RCC) on 07/08/26 at 4:36pm revealed: -When a resident returned from the hospital, the MA on duty reviewed the green folder for any orders. -The orders were copied, a copy was placed in the resident's record, and a copy was faxed to the pharmacy and documented on the pharmacy tracking sheet. -The MA should notify her or the HWD of any new orders and was to report to the next shift if there was a pending order. Interview with the RCC on 07/09/26 at 11:35am revealed: -Resident #6's RP was very involved with Resident #6's medications. -He frequently requested medications be changed or discontinued or requested medication administration times be changed. -The care managers and a few senior MAs could change medication administration times in the system. -She knew several of Resident #6's medications had been discontinued at the request of her RP, but she could not remember exactly what medications were changed since so much time had passed. Interview with the HWD on 07/09/26 at 1:16pm revealed: -When a resident returned from the hospital, the MA on duty reviewed the resident's green folder for orders and faxed the orders to the pharmacy	D 344		

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D 344	Continued From page 21	D 344		

and the orders were to be given to him to review and follow up.
-He was not employed at the facility in July 2025 when Resident #6 returned from the 07/17/25 hospital visit.
-When a resident returned from a hospital visit, he reviewed all their paperwork and the discharge summaries for orders or clarifications.
-He assumed the previous HWD reviewed hospital records and orders then.
-Whoever reviewed the "Order for Facility" from the facility's contracted behavioral health provider that was dated 07/18/25 to discontinue risperidone 0.5mg should have contacted the provider to clarify the discontinue order since Resident #6 was taking risperidone 0.25mg and not 0.5mg.
-He could not say why the discontinue order for Resident #6's risperidone was not clarified and discontinued as recommended.

Interview with the Administrator on 07/09/26 at 1:44pm revealed:
-When residents returned from the hospital, the MAs reviewed their paperwork for new orders and faxed the orders to the facility's contracted pharmacy.
-If there were any questions about the orders, she expected the MAs to contact the residents' provider for clarification.

Telephone interview with a Certified Medical Assistant (CMA) at Resident #6's outside PCP's office on 07/08/25 at 4:37pm revealed:
-Risperidone was not prescribed for Resident #6 by their office.
-She knew Resident #6's RP had concerns about medications being ordered for Resident #6 by the facility's contracted providers.
-Resident #6's extended care pharmacy had sent

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D 344	Continued From page 22 a letter to their office on behalf of Resident #6 on 07/29/25 requesting to discontinue the risperidone, which the PCP agreed, and the letter was returned to Resident #6's extended care pharmacy on 08/01/25. -A letter was sent to the facility in November 2025 that Resident #6 was only to be seen by their office for her PCP needs. Attempted telephone interview with Resident #6's outside PCP on 07/08/26 at 4:37pm was unsuccessful. Attempted telephone interview with Resident #6's outside PCP on 07/09/25 at 10:52am was unsuccessful. Attempted telephone interview with Resident #6's behavioral health provider on 07/08/26 at 3:33pm was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#2) observed during the medication pass	D 358		

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D 358	Continued From page 23 including errors with a medication used to help prevent heart attack and stroke, a medication used to treat symptoms of enlarged prostate, and an eye drop used to glaucoma, and for 1 of 6 residents (#6) sampled for record review including errors with medications to treat arthritic pain, an antihistamine, an anti-depressant, a medication used to treat nerve pain, medication used to treat Alzheimer's Disease, and a medication used to treat influenza.. The findings are: Review of the facility's Documenting Medication Pass policy dated 06/11/24 revealed all medications are administered per physician orders. 1. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am medication pass on 07/08/26. Review of Resident #2's current FL-2 dated 10/01/25 revealed: -Diagnoses included type 2 diabetes mellitus, dementia, sensorineural hearing loss, and cochlear implants. -There was an order for aspirin (used to prevent blood clots causing heart attack or stroke) 81mg, one daily. -There was an order for tamsulosin (used to treat urinary retention associated with enlarged prostate) 0.4mg, one tablet daily. -There was an order for brimonidine (used to reduce intraocular pressure associated with glaucoma) 0.2%, one drop in each eye daily. -His level of care was Special Care Unit (SCU). a. Review of Resident #2's signed physician order sheet dated 03/24/26 revealed an order aspirin	D 358		

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D 358	Continued From page 24 81mg enteric coated (EC), take one tablet every day, do not crush. Observation of the 8:00am medication pass on 07/08/26 revealed: -Resident #2 was sitting in a wheelchair at the medication cart. -The medication aide (MA) prepared 7 oral medications for Resident #2 in a medication cup including one aspirin 81mg EC tablet. -She poured the prepared medications excluding a gel type capsule and a capsule into a small plastic bag and placed the bag into the pill crusher and crushed the medications that included one aspirin 81mg EC tablet, and then mixed the crushed medications with apple sauce, she added the gel type capsule and the capsule to the apple sauce, crushed tablet mixture. -She administered the applesauce which included the crushed aspirin 81mg EC tablet to Resident #2 with a spoon at 7:35am. Review of Resident #2's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg EC tablet, take one tablet every day "do not crush", scheduled at 8:00am. -Aspirin 81mg EC tablet was documented as administered at 8:00am on 07/01/26 through 07/08/26. Observation of Resident #2's medications on hand on 07/08/26 at 9:58am revealed: -There was a medication bubble card with a prescription label, containing Resident #2's name for aspirin 81mg EC tablets, take one tablet every day "do not crush" with a dispense date of 06/11/26 for 28 tablets. -There was one remaining tablet of aspirin 81mg	D 358		

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D 358	Continued From page 25 EC in the medication bubble card. Interview with the MA on 07/08/26 at 9:59am revealed: -Resident #2 had difficulty swallowing, so his medications were crushed. -She knew the gel type capsule and the capsule could not be crushed. -She knew EC meant enteric coated. -She had not noticed the "do not crush" instructions on the medication label of the aspirin 81mg EC tablets or on the eMAR entry for aspirin 81mg EC tablets. -She should not have crushed Resident #2's aspirin 81mg EC tablet. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 10:26am revealed: -The MAs were to always read and compare the residents' medication label to their eMAR. -When the MAs clicked the medication profile on the eMAR, any special instructions appeared. -She expected the MAs to review and follow the instructions on the medication label and eMAR. -Crushing an enteric coated medication could affect the absorption of the medication or cause stomach upset. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am revealed; -The MAs were to always match the residents' medication label to the eMAR entry. -The MAs were to always review the eMAR and medication label thoroughly for any special instructions related to administration of a medication. -If a medication was not to be crushed it was noted on the medication label and on the eMAR. -He requested the facility's contracted pharmacy to note medications that could not be crushed.	D 358		

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D 358	Continued From page 26 -The MAs could always come to him if they had a question about a medication, and there was a Do Not Crush list, the MAs could refer to if there were any question if a medication could or could not be crushed. Interview with the Administrator on 07/08/26 at 10:45am revealed: -If a medication could not be crushed, it was noted in the eMAR entry and on the medication label. -She expected the MAs to review the residents' eMAR and medication label for all instructions for administration of medications. Based on observations and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. b. Review of Resident #2's signed physician order sheet dated 03/24/26 revealed an order for tamsulosin 0.4mg capsule, take one capsule every day (do not open, Give 30 minutes after a meal, do not crush). Observation of the 8:00am medication pass on 07/08/26 revealed: -Resident #2 was sitting in a wheelchair at the medication cart. -The MA prepared 7 oral medications for Resident #2 in a medication cup including one tamsulosin 0.4mg capsule. -She poured the prepared medications excluding a gel type capsule and the tamsulosin 0.4mg capsule into a small plastic bag and placed the bag into the pill crusher and crushed the medications, and then mixed the crushed	D 358		

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D 358	Continued From page 27 medications with apple sauce, she added the gel type capsule and the tamsulosin 0.4mg capsule to the apple sauce, crushed tablet mixture. -She administered the applesauce which included the tamsulosin 0.4mg capsule to Resident #2 with a spoon at 7:35am. -The breakfast meal had not been served. Observation of Resident #2 on 07/08/26 at 8:28am revealed he was in the dining room eating breakfast. Review of Resident #2's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for tamsulosin 0.4mg, take one capsule every day (do not open, give 30 minutes after a meal, do not crush), scheduled at 8:00am. -Tamsulosin 0.4mg capsule was documented as administered at 8:00am on 07/01/26 through 07/08/26. Observation of Resident #2's medications on hand on 07/08/26 at 9:59am revealed; -The there was the top portion a medication bubble card for with a prescription label containing Resident #2's name for tamsulosin 0.4mg, take one capsule every day (do not open, give 30 minutes after a meal, do not crush) with dispense date of 06/11/26 for 28 capsules. -The bubble card portion of the medication card had been torn off. Interview with the MA on 07/08/26 at 9:59am revealed: -The new medication batch cycle medications for Resident#2 would be placed on the medication cart tonight. -She had not noticed that Resident #2's	D 358		

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D 358	Continued From page 28 tamsulosin was to be given 30 minutes after a meal. -She usually administered Resident #2's medications after he ate breakfast. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 10:22am revealed: -The MAs were to always read and compare the residents' medication label to their eMAR. -When the MAs clicked the medication profile on the eMAR, any special instructions appeared. -She expected the MAs to review and follow the instructions on the medication label and eMAR. -Administering Resident #2's tamsulosin prior to a meal could affect the absorption and effectiveness of the medication. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am revealed; -The MAs were to always match the residents' medication label to the eMAR entry. -The MAs were to always review the eMAR and medication label thoroughly for any special instructions related to administration of a medication. Interview with the Administrator on 07/08/26 at 10:45am revealed: -She expected the MAs to review the residents' eMAR and medication label for all instructions for administration of medications. -She expected the MAs to administer medications as ordered per the medication label and instructions on the eMAR. Based on observations and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/09/26 at	D 358		

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D 358	Continued From page 29 10:46am was unsuccessful. c. Review of Resident #2's signed physician order sheet dated 03/24/26 revealed an order for brimonidine 0.2%, instill one drop each into each eye every 12 hours (wait 3-5 minutes between different eye drops). Observation of the 8:00am medication pass on 07/08/26 revealed: -Resident #2 was sitting in a wheelchair at the medication cart. -The medication aide (MA) prepared and administered Resident #2's oral medications. -The MA donned gloves and retrieved a bottle of brimonidine 0.2% eye drops for Resident #2. -She had difficulty getting Resident #2 to open his eyes. -She removed her gloves and pulled Resident #2's lower eye lid down and administered one drop of brimonidine 0.2% to his right eye. -She attempted to administer brimonidine 0.2% to Resident #2's left eye but the drop of brimonidine rolled down his left cheek. -She did not attempt to re-administer brimonidine 0.2% to Resident #2's left eye. Review of Resident #2's July 2026 electronic medication administration (eMAR) revealed: -There was an entry for brimonidine 0.2%, instill on drop into each eye every 12 hours (wait 3-4 minutes between different eye drops), scheduled at 8:00am and 8:00pm. -Brimonidine 0.2% was documented as administered at 8:00am on 07/01/26 through 07/07/26. -Brimonidine 0.2% was documented as not administered at 8:00am on 07/08/26 with the exception documented as "no pass reason, other".	D 358		

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D 358	Continued From page 30 -Brimonidine 0.2% was documented as administered at 8:00pm on 07/01/26 through 07/07/26. Observation of Resident #2's medications on hand on 07/08/26 at 10:00am revealed: -There was brown prescription bottle with a white cap with a prescription label containing Resident #2's name, for brimonidine 0.25 solution, instill one drop into each eye every 12 hours, (wait 3-5 minutes between different eye drops) with a dispense date of 05/29/26. -The brown prescription bottle contained a 5ml bottle of brimonidine eye drops, labeled with Resident #2's name and instructions to instill one drop into each eye every 12 hours. Interview with the MA on 07/08/26 at 9:57am revealed: -She usually administered Resident #2's brimonidine 0.2% before he got up. -It was much easier to administer his eye drops while he was lying down. -It was hard to get Resident #2 to hold his head back while he was sitting up. -She should have tried to re-administer the brimonidine to the Resident #2's left eye. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 10:28am revealed: -If the MAs had difficulty administering medications to a resident they should either cycle back to the resident and attempt again or ask for assistance from either her or another MA. -The MA should have attempted at least twice to administer Resident #2's brimonidine to ensure he received the proper dose. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am revealed:	D 358		

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D 358	Continued From page 31 -He had instructed the MAs on how to administer eye drops. -The MA should have attempted to re-administer Resident #2's eye drops to his left eye or ask for assistance. Interview with the Administrator on 07/08/26 at 10:45am revealed: -The MA should have attempted to re-administer Resident #2's drops to his right eye. -She expected the MAs to administer medications as ordered. Based on observations and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. 2. Review of Resident #6's current FL2 dated 12/02/25 revealed diagnoses included mixed Alzheimer's Disease, vascular dementia, obstructive sleep apnea, hypertension, gait disturbance, expressive aphasia, anxiety disorder, overactive bladder, and irritable bowel syndrome. Review of Resident #6's previous FL2 dated 05/13/25 revealed diagnoses included obstructive sleep apnea, mixed Alzheimer's Disease, vascular dementia, hypertension, gait disturbance, anxiety disorder, overactive bladder, expressive aphasia, and irritable bowel syndrome. a. Review of a signed physician order sheet dated 10/30/25 revealed: -There was an order for meloxicam (a non-steroidal anti-inflammatory used to treat	D 358		

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D 358	Continued From page 32 symptoms of arthritis such as inflammation, swelling and joint pain) 7.5mg , twice a day. -The order for meloxicam 7.5mg, was signed by the facility's contracted primary care provider (PCP) on 10/30/25. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included meloxicam 15mg. -The physician order sheet did not have a provider signature. Review of Resident #6's October 2026 electronic medication administration record (eMAR) revealed: -There was no entry for meloxicam 7.5mg, -The eMAR only reflected medications administered on 10/01/25. Additional eMAR or handwritten medication administration records (MARs) for October 2025 were requested on 07/08/26 and 07/09/26 and not provided by survey exit. Review of Resident #6's handwritten November 2025 MAR revealed: -There was an entry for meloxicam 15mg, take a half of a tablet twice daily, scheduled at 9:00am and at 9:00pm. -Meloxicam 15mg, a half tablet was documented as administered at 9:00am from 11/01/25 through 11/4/25. -Meloxicam 15mg, a half tablet was documented as not administered at 9:00am on 11/05/25 and	D 358		

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D 358	Continued From page 33 on 11/06/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Meloxicam 15mg, a half tablet was documented as administered at 9:00am from 11/07/25 through 11/10/25. -Meloxicam 15mg, a half tablet was documented as administered at 9:00pm from 11/01/25 through 11/03/25. -Meloxicam 15mg, a half tablet was documented as not administered at 9:00pm on 11/04/25 and on 11/05/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Meloxicam 15mg, a half tablet was documented as administered at 9:00pm on 11/06/25. -Meloxicam 15mg, a half tablet was documented as not administered at 9:00pm on 11/07/25, the was no exception sheet provided with Resident #6's handwritten November 2025 MAR. -Meloxicam 15mg, a half tablet was documented as administered at 9:00pm on 11/08/25. -Meloxicam 15mg. a half tablet was not documented as administered at 9:00pm on 11/09/25 and on 11/10/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Meloxicam 15mg, half tablet was documented as not administered on 11/11/25 through 11/30/25 at 9:00am and "on hold per spouse" was written on the MAR. Review of Resident #6's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for meloxicam 7.5mg, take one tablet twice a day, scheduled at 8:00am and 8:00pm. -Meloxicam 7.5mg was documented as administered at 8:00am on 11/11/25 through	D 358		

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D 358	Continued From page 34 11/20/25. -Meloxicam 7.5mg was documented as not administered at 8:00am on 11/21/25 with the exception documented as "resident refused". -Meloxicam 7.5mg was documented as administered at 8:00am in 11/22/25 and on 11/23/25. -Meloxicam 7.5mg was documented as not administered at 8:00am on 11/24/25 with the exception documented as "resident refused". -Meloxicam 7.5mg was documented was not documented as administered at 8:00am on 11/25/25, the space for initials was blank. -Meloxicam 7.5mg was documented as not administered at 8:00am on 11/26/25, with the exception documented as "other" discontinued ". -Meloxicam 7.5mg was documented as administered at 8:00am on 11/27/25 and on 11/28/25. -Meloxicam 7.5mg was documented as not administered at 8:00am on 11/29/25 with the exception documented as "no pass per physician order" and on 11/30/25 with the exception documented as "medication discontinued waiting on pharmacy to take off of eMAR. -Meloxicam 7.5mg was documented as administered at 8:00pm on 11/11/25 through 11/18/25. -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/19/25 with the exception documented as "other". -Meloxicam 7.5mg was documented as administered at 8:00pm on 11/20/25. -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/21/25 with the exception documented as "other" -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/22/25 with the exception documented as "resident refused, discontinued per resident's spouse".	D 358		

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D 358	Continued From page 35 -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/23/25 with the exception documented as resident refused. -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/24/25 and on 11/25/25 with the exception documented as "other". -Meloxicam 7.5mg was documented as administered at 8:00pm on 11/26/25 and 11/27/25. -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/28/25 with the exception documented as "refused by resident". -Meloxicam 7.5mg was documented as not administered at 8:00pm on 11/29/25 with the exception documented as "other, discontinued". -Meloxicam 7.5mg was documented as administered at 8:00pm on 11/30/25. Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received from Resident #6's outside primary care provider (PCP) on 11/20/25 to discontinue meloxicam 7.5mg, take one tablet twice a day. -25 tablets of Resident #6's meloxicam 15mg were returned to the pharmacy on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge. -He did not request meloxicam to be discontinued.	D 358		

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D 358	Continued From page 36 Interview with the Health and Wellness Director (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and felt some of the medications caused Resident #6 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the medications he wanted discontinued and which included meloxicam. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications including meloxicam to be discontinued and notified her that he placed the medication on hold, and she advised him that she would come and review the discontinued request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included meloxicam, but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included meloxicam that was dated 11/20/25. Attempted telephone interview with the facility's contracted pharmacy provider on 07/09/25 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025039	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF NEW BERN	1309 MCCARTHY BLVD NEW BERN, NC 28562

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D 358	Continued From page 37 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26 at 10:52am was unsuccessful. Refer to interview with the Administrator on 07/09/26 at 1:44pm. Refer to review of an email received from the Administrator on 07/13/26 at 2:18pm. .b Review of Resident #6's signed physician order sheet dated 10/30/25 revealed: -There was an order for trazodone (trazodone is used to treat major depressive disorder and can be used to treat insomnia) 50mg, take one tablet twice a day. -The trazadone 50mg order was signed by the facility's contracted primary care provider (PCP) on 10/30/25. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included trazodone 50mg. -The physician order sheet did not have a provider signature. Review of Resident #6's October 2025 electronic medication administration record (eMAR)	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 38 revealed: -There was no entry for trazodone 50mg. -The eMAR only reflected medications administered on 10/01/25. Additional eMAR or handwritten medication administration records (MAR) for October 2025 were requested on 07/08/26 and 07/09/26 and not provided by survey exit. Review of Resident #6's handwritten November 2025 MAR revealed: -There was a handwritten entry for trazodone 50mg. take one tablet twice daily (hold for sedation), scheduled at 9:00am and 9:00pm. -Trazodone 50mg was documented as administered at 9:00am on 11/01/25 through 11/04/25. -Trazodone 50mg was documented as not administered at 9:00am on 11/05/25 and on 11/06/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Trazodone 50mg was documented as administered at 9:00am on 11/07/25 through 11/10/25. -Trazodone 50mg was documented as administered at 9:00pm on 11/01/25 through 11/03/25. -Trazodone 50mg was not documented as administered at 9:00pm on 11/04/25 and on 11/05/25 and the space on the MAR was blank. -Trazodone 50mg was documented as administered at 9:00pm on 11/06/25. -Trazodone 50mg was not documented as administered at 9:00pm on 11/07/25 and the space was blank. -Trazodone 50mg was documented as administered at 9:00pm on 11/08/25. -Trazodone 50mg was not documented as administered at 9:00pm on 11/09/25 and 11/10/25	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 39 and the space was blank. -Trazodone 50mg was documented as not administered on 11/11/25 through 11/30/25 at 9:00am and 9:00pm and "on hold per spouse" was written on the MAR. Review of Resident #6's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 50mg, take one tablet twice a day, hold for sedation, scheduled at 8:00am and 8:00pm. -Trazodone 50mg was documented as administered at 8:00am on 11/11/25 through 11/20/25. -Trazodone 50mg was documented as not administered at 8:00am on 11/21/25 with the exception documented as "refused by resident". -Trazodone 50mg was documented as administered at 8:00am on 11/22/25 and on 11/23/25. -Trazodone 50mg was documented as not administered at 8:00am on 11/24/25 with the exception documented as "refused by resident". -Trazodone 50mg was documented as administered at 8:00pm on 11/11/25 through 11/18/25. -Trazodone 50mg was documented as not administered at 8:00pm on 11/19/25 with the exception documented as "other". -Trazodone 50mg was documented as administered at 8:00pm on 11/20/25. -Trazodone 50mg was documented as not administered at 8:00pm on 11/21/25 with the exception documented as "other". -Trazodone 50mg was documented as not administered at 8:00pm on 11/22/25 with the exception documented as "refused by resident, discontinued per resident's family". -Trazodone 50mg was documented as not	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 40 administered at 8:00pm on 11/23/25 with the exception documented as refused by resident. -Trazodone 50mg was documented as not administered at 8:00pm on 11/24/25 as "other". Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received for Resident #6 for trazodone 50mg. take one tablet twice a day on 10/30/25 from the facility's contracted primary care provider (PCP). -Trazodone 50mg #50 tablets for a 25-day supply to take one twice a day was dispensed on 10/30/25. -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue trazodone 50mg,one twice daily. -25 tablets of Resident #6's trazodone 50mg were returned to the pharmacy on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge including trazodone 50mg. -He did request trazodone 50mg to be discontinued. Interview with the Health and Wellness Director (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and	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 41 felt some of the medications caused Resident #6 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the medications he wanted discontinued and which included trazodone. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications including trazodone to be discontinued and notified her that he placed the medication on hold, and she advised him that she would come and review the discontinue request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included trazodone, but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included trazodone that was dated 11/20/25. Attempted telephone interview with the facility's contracted pharmacy provider on 07/09/25 at 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26	D 358		

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D 358	Continued From page 42 at 10:52am was unsuccessful. Refer to interview with the Administrator on 07/09/26 at 1:44pm. Refer to review of an email received from the Administrator on 07/13/26 at 2:18pm. c. Review of Resident #6's signed physician order sheet dated 10/30/25 revealed: -There was an order for hydroxyzine (hydroxyzine is an antihistamine that can be used to treat anxiety, allergic skin reactions and can be used as a sleep aid) 50mg, take one tablet twice a day. -The hydroxyzine 50mg order was signed by the facility's contracted primary care provider (PCP) on 10/30/25. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included hydroxyzine 50mg. -The physician order sheet did not have a provider signature. Review of Resident #6's October 2025 electronic medication administration record (eMAR) revealed: -There was no entry for hydroxyzine 50mg. -The eMAR only reflected medications administered on 10/01/25. Additional eMAR or handwritten medication administration records (MAR) for October 2025 were requested on 07/08/26 and 07/09/26 and	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 43 not provided by survey exit. Review of Resident #6's handwritten November 2025 MAR revealed: -There was a handwritten entry for hydroxyzine 50mg. take one tablet twice daily (hold for sedation), scheduled at 9:00am and 9:00pm. -Hydroxyzine 50mg was documented as administered at 9:00am on 11/01/25. -Hydroxyzine 50mg was not documented as administered at 9:00am on 11/02/25 and the space was blank. -Hydroxyzine 50mg was documented as administered at 9:00am on 11/03/25 and on 11/04/25. -Hydroxyzine 50mg was documented as not administered at 9:00am on 11/05/25 and on 11/06/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Hydroxyzine 50mg was documented as administered at 9:00am on 11/07/25 through 11/10/25. -Hydroxyzine 50mg was documented as administered at 9:00pm on 11/01/25 through 11/03/25. -Hydroxyzine 50mg was not documented as administered at 9:00pm on 11/04/25 and on 11/05/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Hydroxyzine 50mg was documented as administered at 9:00pm 11/06/25. -Hydroxyzine 50mg was not documented as administered at 9:00pm on 11/07/25, and the space was blank. -Hydroxyzine 50mg was documented as administered at 9:00pm on 11/08/25 and on 11/09/25. -Hydroxyzine 50mg was not documented as administered at 9:00pm on 11/10/25 and the space was blank.	D 358		

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D 358	Continued From page 44 -Hydroxyzine 50mg was documented as not administered on 11/11/25 through 11/30/25 at 9:00am and 9:00pm and "on hold per spouse" was written on the MAR. Review of Resident #6's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydroxyzine 50mg, take one tablet twice a day, hold for sedation, scheduled at 8:00am and 8:00pm. -Hydroxyzine 50mg was documented as administered at 8:00am on 11/11/25 through 11/20/25. -Hydroxyzine 50mg was documented as not administered at 8:00am on 11/21/25 with the exception documented as "refused by resident". -Hydroxyzine 50mg was documented as administered at 8:00am on 11/22/25 and on 11/23/25. -Hydroxyzine 50mg was documented as not administered at 8:00am on 11/24/25 with the exception documented as "refused by resident". -Hydroxyzine 50mg was documented as administered at 8:00pm on 11/11/25 through 11/18/25. -Hydroxyzine 50mg was documented as not administered at 8:00pm on 11/19/25 with the exception documented as "other, did not give per nurse". -Hydroxyzine 50mg was documented as administered at 8:00pm on 11/20/25. -Hydroxyzine 50mg was documented as not administered at 8:00pm on 11/21/25 with the exception documented as "other". -Hydroxyzine 50mg was documented as not administered at 8:00pm on 11/22/25 with the exception documented as "refused by resident, discontinued per resident's spouse. -Hydroxyzine 50mg was documented as not administered at 8:00pm on 11/23/25 with the	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 45 exception documented as refused by resident. -Hydroxyzine 50mg was documented as not administered at 8:00pm on 11/24/25 as "other". Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received for Resident #6 for hydroxyzine 50mg. take one tablet twice a day on 10/30/25 from the facility's contracted primary care provider (PCP). -Hydroxyzine 50mg #50 tablets for a 25-day supply to take one twice a day was dispensed on 10/30/25. -An order was received from Resident #6's outside PCP on 11/20/25 to discontinue hydroxyzine 50mg,one twice daily. -25 tablets of Resident #6's hydroxyzine 50mg were returned to the pharmacy on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge including hydroxyzine 50mg. -He did request hydroxyzine 50mg to be discontinued. Interview with the Health and Wellness Director (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and felt some of the medications caused Resident #6	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 46 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the medications he wanted discontinued and which included hydroxyzine. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications including hydroxyzine to be discontinued and notified her that he placed the medication on hold, and she advised him that she would come and review the discontinue request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included hydroxyzine, but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included hydroxyzine that was dated 11/20/25. Attempted telephone interview with the facility's contracted pharmacy provider on 07/09/25 at 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26	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 47 at 10:52am was unsuccessful. Refer to interview with the Administrator on 07/09/26 at 1:44pm. Refer to review of an email received from the Administrator on 07/13/26 at 2:18pm. d. Review of Resident #6's signed physician order dated 07/18/25 revealed an order for gabapentin (gabapentin is used to treat seizure disorders and nerve pain) 300mg, take two capsules two times a day. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included gabapentin 300mg. -The physician order sheet did not have a provider signature. Review of Resident #6's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300mg, take 2 capsules twice a day scheduled at 9:00am and 9:00pm. -Gabapentin 300mg, take 2 capsules twice a day was documented as administered at 9:00am and 9:00pm on 10/01/25. -There was no documentation that gabapentin 300mg, 2 tablets was administered at 9:00am and 9:00pm on 10/02/25 through 10/31/25. -The eMAR only reflected medications administered on 10/01/25 only.	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 48 Additional eMAR or handwritten medication administration records (MAR) for October 2025 were requested on 07/08/26 and 07/09/26 and not provided by survey exit. Review of Resident #6's handwritten November 2025 MAR revealed: -There was an entry for gabapentin 300mg, take 2 capsules twice a day, scheduled at 9:00am and 9:00pm. -Gabapentin 300mg was documented as administered at 9:00am on 11/01/25 through 11/04/25. -Gabapentin 300mg was documented as not administered at 9:00am on 11/05/25 and on 11/06/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Gabapentin 300mg was documented as administered at 9:00am on 11/07/25 through 11/10/25. -Gabapentin 300mg was documented as administered at 9:00pm on 11/01/25 through 11/03/25. -Gabapentin 300mg was not documented as administered at 9:00pm on 11/04/25 and on 11/05/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Gabapentin 300mg was documented as administered at 9:00pm on 11/06/25 through 11/08/26. -Gabapentin 300mg was not documented as administered at 9:00pm on 11/09 and on 11/10/25, and the space was blank. -Gabapentin 300mg was documented as not administered on 11/11/25 through 11/30/25 at 9:00am and 9:00pm, and "on hold per spouse" was written on the MAR. Review of Resident #6's November 2025	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF NEW BERN	1309 MCCARTHY BLVD NEW BERN, NC 28562

(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 49 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300mg, take 2 capsules twice a day, scheduled at 8:00am and 8:00pm. -Gabapentin 300mg was documented as administered at 8:00am on 11/11/25 through 11/14/25. -Gabapentin 300mg was not documented as administered at 8:00am on 11/15/25 and the space was blank. -Gabapentin 300mg was documented as administered at 8:00am on 11/16/25 through 11/20/25. -Gabapentin 300mg was documented as not administered at 8:00am on 11/21/25 with the exception documented as "refused by resident". -Gabapentin 300mg was documented as administered at 8:00am on 11/22/25 and on 11/23/25. -Gabapentin 300mg was documented as not administered at 8:00am on 11/24/25 with the exception documented as "refused by resident". -Gabapentin 300mg was documented as administered at 8:00pm on 11/11/25 through 11/18/25. -Gabapentin 300mg was documented as not administered at 8:00pm on 11/19/25 with the exception documented as "other, did not give per nurse". -Gabapentin 300mg was documented as administered at 8:00pm on 11/20/25. -Gabapentin 300mg was documented as not administered at 8:00pm on 11/21/25 with the exception documented as "other". -Gabapentin 300mg was documented as not administered at 8:00pm on 11/22/25 with the exception documented as "refused by resident, discontinued by resident's spouse". -Gabapentin 300mg was documented as not	D 358		

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D 358	Continued From page 50 administered at 8:00pm on 11/23/25 with the exception documented as "refused by resident". -Gabapentin 300mg was documented as not administered at 8:00pm on 11/24/25 with the exception documented as "other". Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received from Resident #6's outside primary care provider (PCP) on 11/20/25 to discontinue gabapentin 300mg, take two capsules twice a day. -52 tablets of Resident #6's gabapentin 300mg were returned to the pharmacy on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge. -Resident #6 had been on gabapentin for over 20 years for lumbar stenosis and he did not request gabapentin to be discontinued. Interview with the Health and Wellness Director (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and felt some of the medications caused Resident #6 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the	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 51 medications he wanted discontinued and which included gabapentin. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications including gabapentin to be discontinued and notified her that he placed the medication on hold, and she advised him that she would come and review the discontinue request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included gabapentin, but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included gabapentin that was dated 11/20/25. Attempted telephone interview with the facility's contracted pharmacy provider on 07/09/25 at 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26 at 10:52am was unsuccessful. Refer to interview with the Administrator on 07/09/26 at 1:44pm.	D 358		

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D 358	Continued From page 52 Refer to review of an email received from the Administrator on 07/13/26 at 2:18pm. e. Review of Resident #6's signed physician's order sheet dated 07/08/25 revealed an order for memantine (memantine is used to treat moderate to severe dementia associated with Alzheimer's Disease) 10mg, take one capsule every morning. Review of an unsigned physician order sheet for Resident #6 dated 11/20/25 revealed: -Under nurse's assessment of problem, per resident spouse to discontinue all of these medications, he doesn't want resident taking these medications, her spouse wants to stop all medications below. -The discontinue request included memantine 10mg. -The physician order sheet did not have a provider signature. Review of Resident #6's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for memantine 10mg, take one capsule every morning scheduled at 9:00am. -Memantine 10mg, take one capsule daily was documented as administered at 9:00am on 10/01/25. -There was no documentation that memantine 10mg, one capsule was administered at 9:00am on 10/02/25 through 10/31/25. -The eMAR only reflected medications administered on 10/01/25 only. Additional eMAR or handwritten medication administration records (MAR) for October 2025 were requested on 07/08/26 and 07/09/26 and not provided by survey exit.	D 358		

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D 358	Continued From page 53 Review of Resident #6's handwritten November 2025 MAR revealed: -There was an entry for memantine 10mg, take one capsule every morning, scheduled at 9:00am. -Memantine 10mg was documented as administered at 9:00am on 11/01/25 through 11/04/25. -Memantine 10mg was documented as not administered at 9:00am on 11/05/25 and 11/06/25, there was no exception sheet provided with the handwritten November 2025 MAR. -Memantine 10mg was documented as administered at 9:00am on 11/07/25 through 11/10/25. -Memantine 10mg was documented as not administered at 9:00am on 11/11/25 through 11/30/25, and "on hold per spouse" was written on the MAR. Review of Resident #6's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for memantine 10mg, take one capsule every morning, scheduled at 8:00am. -Memantine 10mg was documented as administered at 8:00am on 11/11/25 through 11/20/25. -Memantine 10mg was documented as not administered at 8:00am on 11/21/25 with the exception documented as "refused by resident". -Memantine 10mg was documented as administered at 8:00am on 11/22/25 and 11/23/25. -Memantine 10mg was documented as not administered at 8:00am on 11/24/25 with the exception documented as "refused by resident". -Memantine 10mg was not documented as	D 358		

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D 358	Continued From page 54 administered at 8:00am on 11/25/25 and the space was blank. -Memantine 10mg was documented as not administered at 8:00am on 11/26/25, with the exception documented as "other, discontinued (discontinued)". -Memantine 10mg was documented as administered at 8:00am on 11/27/25 and on 11/28/25. -Memantine 10mg was documented as not administered at 8:00am on 11/29/25, with the exception documented as "no pass per physician order". -Memantine 10mg was documented as not administered at 8:00am on 11/30/25, with the exception documented as 'no pass per physician order, medication discontinued, awaiting pharmacy to take off MAR". Interview with a pharmacist with Resident #6's preferred pharmacy provider on 07/09/26 at 10:18am revealed: -An order was received from Resident #6's outside primary care provider (PCP) on 11/20/25 to discontinue memantine 10mg, take one capsule every morning. -10 capsules of Resident #6's memantine 10mg were returned to the pharmacy on 11/26/25. Interview with Resident #6's responsible party (RP) on 07/09/26 at 10:52am revealed: -Resident #6 had to be transported to the hospital on 11/04/25 for altered level of consciousness. -Shortly after she was discharged on 11/06/25, he received a statement from the retail pharmacy for medications prescribed to Resident #6. -There were sedating medications that were prescribed to Resident #6 without his knowledge. -Resident #6 had been on memantine for 4 to 5 years and he did not request memantine to be	D 358		

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D 358	Continued From page 55 discontinued. Interview with the Health and Wellness Director (HWD) on 07/09/26 at 9:58am revealed: -Resident #6's RP came to the facility on 11/11/25 upset that medications had been prescribed for Resident #6 by the facility's contracted primary care provider (PCP) that he was not aware of and felt some of the medications caused Resident #6 to be over-sedated and contributed to Resident #6's hospital visit in November 2025. -He went through all Resident #6's current medications with the RP and the RP told him the medications he wanted discontinued which included memantine. -He contacted the facility's contracted PCP on 11/12/25 and notified her of Resident #6's RP's request for medications including memantine to be discontinued and notified her that he placed the medication on hold, and she advised him that she would come and review the discontinue request. -He felt the facility's contracted PCP reviewed the medications that Resident #6's RP requested to be discontinued but did not know why she did not place discontinue orders for the medications. -He did not document this conversation with the facility's contracted PCP regarding the RP's request for Resident #6's medications to be discontinued. -He was certain he sent orders to be signed to the facility's PCP to discontinue medications for Resident #6 which included memantine, but he was unable to locate it in her record. -He was not sure who wrote the discontinue medications request for Resident #6's medications which included memantine that was dated 11/20/25. Attempted telephone interview with the facility's	D 358		

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D 358	Continued From page 56 contracted pharmacy provider on 07/09/25 at 9:16am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 07/09/26 at 10:46am was unsuccessful. Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26 at 10:52am was unsuccessful. Refer to interview with the Administrator on 07/09/26 at 1:44pm. Refer to review of an email received from the Administrator on 07/13/26 at 2:18pm. Interview with the Administrator on 07/09/26 at 1:44pm revealed: -She was not sure why Resident #6's handwritten MAR showed medications were held as of 11/11/25 but a discontinue order was not received for Resident #6 until 11/20/25. -She was sure the HWD had contacted the facility's contracted PCP and expected there to be documentation of the contact and conversation about medications being held and discontinued for Resident #6. Review of an email received from the Administrator on 07/13/26 at 2:18pm revealed: -Resident #6's RP stated that, as his wife's healthcare power of attorney, he wanted to hold her medication, as her healthcare power of attorney, he should be permitted to make this decision on her behalf. -I have attached North Carolina General Statute § 32A-15, "General Purpose of This Article," under Article 3 regarding healthcare powers of attorney. Please include this supporting documentation	D 358		

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D 358	Continued From page 57 with our survey information for review. f. Review of a hospital after visit summary (AVS) for Resident #6 dated 12/27/25 revealed: -Admission date was 12/24/25, discharge date was 12/27/25. -Under the heading "your medications have changed" start taking oseltamivir (oseltamivir is often sold under the brand name Tamiflu and is a prescription anti-viral used to treat influenza A and B). -Under medication list, there were instructions to start oseltamivir 75mg, take one capsule two times a day for four doses. -Last dose was of oseltamivir was 12/27/25 at 8:54am. Review of Resident #6's December 2025 electronic medication administration record (eMAR) revealed there was no entry for oseltamivir 75mg, take one capsule twice a day for four doses. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 07/08/26 at 3:14pm revealed there was no order received for oseltamivir for Resident #6 in December 2025. Telephone interview with a pharmacist from Resident #6's long term care pharmacy provider on 07/08/26 at 3:51pm revealed an order for oseltamivir for Resident #6 was sent to the same company's retail pharmacy; the retail pharmacy placed the oseltamivir prescription for Resident #6 on hold because the medication was not in stock. Telephone interview with a pharmacist from the local grocery store pharmacy on 07/08/26 at	D 358		

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D 358	Continued From page 58 4:12pm revealed: -A prescription was received for Resident #6 on 12/27/25 for oseltamivir 75mg, take one tablet twice a day for four doses. -The prescription for oseltamivir 75mg for Resident #6 was paid for and picked up on 12/27/25. Interview with Resident #6's Responsible Party (RP) on 07/09/26 at 10:53am revealed: -Resident #6 had to be transported to the hospital on 12/24/25 and was diagnosed with the flu. -She was started on oseltamivir while in the hospital and given a prescription of four additional tablets to complete the dosage when she was discharged. -He picked up the oseltamivir prescription for Resident #6 at a local grocery store retail pharmacy because it was late on a Saturday when she was discharged and gave the oseltamivir prescription to a medication aide (MA) at the facility. -Resident #6 was supposed to receive a dose of the oseltamivir on Saturday evening 12/27/25, two doses on Sunday 12/28/25, and the final dose on Monday morning 12/29/25. -Resident #6 was transferring to new facility on 12/29/25. -When the new facility received Resident #6 and her medications, there were three doses of oseltamivir remaining with her medications. Interview with a medication aide (MA) on 07/08/26 at 4:08pm revealed: -When a resident was sent to the hospital, a green folder was sent with them that contained their medical information. -When a resident returned from the hospital, the green folder was given to the MA on duty when the resident returned.	D 358		

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D 358	Continued From page 59 -All hospital paperwork was in the green folder and the MA reviewed the green folder for orders. -If there were orders, an order tracking sheet was completed, and the order was faxed to the pharmacy and then the order was given to the Health and Wellness Director (HWD). -If a family member brought in medications from an outside pharmacy, the MAs contacted the pharmacy to obtain and copy of the order, and the order was forwarded to the facility's contracted pharmacy for profile only to be placed on the eMAR. -The MA should also make a progress note in the resident's record if outside medications were brought in. Interview with the Resident Care Coordinator (RCC) on 07/08/26 at 4:36pm revealed: -When a resident returned from the hospital, the MA on duty reviewed the green folder for any orders. -The orders were copied, a copy was placed in the resident's record, and a copy was faxed to the pharmacy and documented on the pharmacy tracking sheet. -The MA should notify her or the HWD of any new orders and was to report to the next shift if there was a pending order. Interview with the RCC on 07/09/26 at 11:35am revealed: -She was new to the role of the RCC. -She was a MA in December 2025. -She thought Resident #6 may have had a prescription for oseltamivir when she returned from the hospital in December 2025, but she could not remember for sure. Interview with the Special Care Coordinator (SCC) on 07/09/26 at 9:41am revealed:	D 358		

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D 358	Continued From page 60 -She was new to the position of the SCC and previously worked as a MA. -When a resident returned from the hospital, the MA reviewed discharge paperwork for orders. -New orders were faxed to the pharmacy and placed in a folder for the resident's primary care provider to review when she was in the facility and a copy of the order was given to the HWD. -She was working when Resident #6 returned from the hospital on 12/27/25. -In December 2025 there were many residents in the facility that were very sick with flu and pneumonia, and it was very busy and many of the residents were on oseltamivir. -She thought Resident #6 may have had a prescription for oseltamivir when she returned from the hospital in December 2025, but she could not remember for certain. -If Resident #6 had a prescription for oseltamivir, the first dose could have been recorded on a paper MAR until the order was added by the pharmacy to the electronic MAR. -She could not remember if Resident #6's RP brought a prescription to her for oseltamivir. Interview with the HWD on 07/09/26 at 1:16pm revealed: -When a resident returned from the hospital, the MA on duty reviewed the resident's green folder for orders and faxed the orders to the pharmacy and the orders were to be given to him to review and follow up. -He was out of town when Resident #6 returned from the hospital on 12/27/25 but it was his understanding that her RP did not come to the facility when she was discharged on 12/27/25 and never brought in medications for her. -If a prescription for oseltamivir was received it would have been sent to the pharmacy and appeared on her eMAR.	D 358		

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D 358	Continued From page 61 -He reviewed all orders and paperwork before a resident was accepted back to the facility to make sure they could meet their needs and have medications available. -Resident #6 was discharged to another facility on 12/29/25. -There was a form completed that listed the medications that Resident #6 was discharged with, but he was unable to locate it in her record. Interview with the Administrator on 07/09/26 at 1:44pm revealed: -When residents returned from the hospital, the MAs reviewed the paperwork for new orders and faxed the orders to the facility's contracted pharmacy. -A hospital after visit summary was not an order, therefore the facility did not have an order for Resident #6 for oseltamivir from the December 2025 hospitalization. -She reviewed Resident #6's hospital after visit summary (AVS) dated 12/27/25 during this interview and questioned the timing, the hospital AVS was documented as printed at 1:01pm on 12/27/25 and the oseltamivir prescription was documented as sent to a local retail pharmacy that closed at 2:00pm on Saturdays and was closed on Sunday. -She questioned how Resident #6's RP could have gone to one pharmacy to find out the prescription was not in stock and have the prescription transferred to another pharmacy before the first pharmacy closed at 2:00pm, giving him 59 minutes to complete this due to the AVS being documented as printed at 1:01pm and the first retail pharmacy closing at 2:00pm. -If Resident #6's RP brought in an outside prescription for Resident #6, the facility would still need an order for it as the hospital AVS was not a signed physician's order.	D 358		

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HOMEPLACE OF NEW BERN	1309 MCCARTHY BLVD NEW BERN, NC 28562

(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 62 Attempted telephone interview with Resident #6's outside primary care provider (PCP) on 07/09/26 at 10:52am was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 2 of 2 medication aides (Staff C, Staff D), observed during the 8:00am medication pass on 07/08/26, who did not sanitize her hands between the preparation and administration of medications to each resident to prevent the transmission of disease, infection, prevent cross-contamination, to provide a safe and sanitary environment for residents. The findings are: 1. Observation of the medication aide (MA), Staff C, during the medication pass on 07/08/26 between 7:09am and 7:47am in the Special Care Unit revealed: -There was hand sanitizer located on a side	D 371		

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D 371	Continued From page 63 compartment of the medication cart located in the Special Care Unit. -She used keys to unlock the medication cart. -The MA placed a plastic liner in the trash receptacle of the medication cart. -She plugged in the computer. -She dropped a Sharpie type pen on the floor and picked it up. -The MA used keys to unlock the medication cart and retrieved medication cards from the medication cart. -She used her hands on the computer keyboard and checked each medication card to the electronic medication administration record (eMAR) on the computer screen. -She popped the oral medications into a medication cup. -She locked the medication cart. -She poured a cup of water from a dispenser on the medication cart. -She took the medication cup and cup of water to a resident's room. -She hugged the resident. -She picked up a resident's shoe that was laying in the middle of the resident's room. -The resident was agitated. -She gently spoke to the resident and coaxed her into taking her medication. -A tablet was dropped on the floor, and the MA picked it up and placed it in the medication cup. -The MA returned to the medication cart and identified the dropped pill and documented on the computer keyboard using her hands. -She took the dropped pill in the medication cup to the medication room and disposed of it in the pill buster. -She returned to the medication cart and did not sanitize her hands. -She used her hands to look up the next resident on the computer.	D 371		

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D 371	Continued From page 64 -She used her keys to unlock the medication cart. -She retrieved a stack of medication cards, a bottle of lotion, a bottle of powdered laxative, and a bottle of eye drops for resident from the medication cart. -She poured 8 ounces of water from the water dispenser on the medication cart and mixed the powdered laxative with the cup of water she poured. -She popped some of the oral medications into a medication cup. -She donned gloves, as one of the medications had a handling precaution warning and popped the remaining medications into the medication cup. -She returned the medication cards to the medication cart and locked the medication cart. -She removed a capsule and a gel type capsule from the medication cup and poured the remaining tablets into a small plastic bag and crushed the medications using the pill crusher. -She removed the gloves. -She placed some applesauce into a medication cup and mixed the crushed tablets with the applesauce and returned the capsule and gel type capsule to the medication cup with the applesauce and crushed tablets. -She donned gloves and applied lotion to the resident's face and neck. -She removed her gloves and administered the medications mixed with applesauce to the resident using a spoon. -She offered the water mixed with the powdered laxative between bites of the applesauce with the crushed medications. -She observed the resident drink all the water mixed with the powdered laxative. -She donned gloves and retrieved the bottle of eye drops and attempted to get the resident's right eye open to administer the eye drop.	D 371		

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D 371	Continued From page 65 -She had trouble getting his right eye open, so she removed her gloves and administered an eye drop to the resident's right eye. -She attempted to administer an eye drop to the resident's left eye, but the drop rolled down his cheek. -She returned to the medication cart and documented using her hands on the computer keyboard. -She unlocked the medication cart and returned the eye drops and bottle of lotion to the medication cart. -She used her hands on the computer keyboard to look up the next resident. -She did not sanitize her hands. Interview with Staff C on 07/08/26 at 9:57am revealed: -She washed her hands before the start of each medication pass. -She used hand sanitizer between each resident. -She used her own hand sanitizer but did not have it with her. -She knew she was to use sanitizer between each resident but was anxious during the medication pass. -As for the eye drops, she usually administered this resident's eye drops when he was laying down. -She could not get a good grasp on his eye lid with the gloves, and the gloves were tight and she was afraid she was going to hurt the resident, so she removed the gloves to administer the eye drops. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 10:22am revealed: -The MAs were taught to use hand sanitizer between each resident during the medication pass.	D 371		

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D 371	Continued From page 66 -The MAs were to wash their hands between every 2 to 3 residents and when hands were visibly soiled. -The MAs were to always use gloves for administering eye drops and topical medications. -The use of gloves while applying eye drops was important to prevent contamination of the medication and to protect the resident. Refer to interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am. Refer to interview with the Administrator on 07/08/26 at 10:45am. 2. Observation of a second medication aide (MA), Staff D during the medication pass on 07/08/26 between 7:52am and 8:10am on the Assisted Living side of the facility revealed: -There was sanitizer on a side compartment of the medication cart. -She sanitized her hands. -She used her hands to look up the next resident on the computer. -She unlocked the medication cart and pulled medication cards from the drawer of the medication cart. -She popped the medications into a medication cup. -She returned the pill cards to the medication cart and locked the medication cart. -She poured all the medications except for a capsule into a small plastic bag and crushed the medications using a pill crusher. -She placed some applesauce in a medication cup and added the crushed medications to the applesauce. -She picked up the remaining capsule in the medication cup with her bare hands and emptied the contents of the capsule in the medication cup	D 371		

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D 371	Continued From page 67 that contained the applesauce and crushed medications. -She took the medications to a resident in the dining room. -She feed the applesauce that contained the crushed medications and the contents of the capsule with a spoon and offered water. -She returned to the medication cart and left to wash her hands. -She returned to the medication cart after washing her hands and started preparing medications for the next resident. Interview with Staff D on 07/08/26 at 10:13am revealed: -She sanitized between each resident during the medication pass and washed her hands after every third resident. -She always used gloves to administer topical medications, and eye drops. -She should not have touched a resident's medications with the bare hands. Interview with the Resident Care Coordinator (RCC) on 07/08/26 at 10:20am revealed: -The MAs were to wash their hands before starting the medication pass. -She expected the MAs to sanitize their hands before and after each resident. -The MAs should always use gloves for eye drops and topical medications. -An MA should never touch a resident's oral medications with bare hands. Refer to interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am. Refer to interview with the Administrator on 07/08/26 at 10:45am.	D 371		

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D 371	Continued From page 68 Interview with the Health and Wellness Director (HWD) on 07/08/26 at 10:36am revealed: -He expected the MAs to hand sanitizer between each resident during the medication pass. -He expected the MAs to wash their hands after every third resident and to wash their hands before and after using gloves. -MAs should never handle a resident's medication with bare hands and he taught the MAs to heed handling warnings on medications to protect themselves as well as the residents. -Gloves should be worn when administering eye drops to prevent contamination of the medication and to help prevent the spread of germs and disease. Interview with the Administrator on 07/08/26 at 10:45am revealed: -The MAs should wash their hands before going to the medication cart. -The MAs were to use hand sanitizer between each resident during the medication pass. -The MAs were to use gloves when administering eye drops and topical medications such as creams.	D 371		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	D 378		

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D 378	Continued From page 69	D 378		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, and the facility failed to ensure medications stored securely in the Special Care Unit (SCU) for a resident who had a medication used to treat and prevent hemorrhoids stored unsecured in the resident's room.

The findings are:

Review of the facility's current license effective 01/01/26 revealed:
-The facility's Special Care Unit (SCU) was licensed for 20 beds.
-The facility's SCU occupancy was 16 on 07/07/26.

Observation of a resident's room on the SCU on 07/07/26 at 9:27am revealed there was a tube of Preparation H ointment (a medication used to treat hemorrhoids) on a side table next to a reclining chair.

Observation of the SCU on 07/07/26 at 9:30am and 2:30pm revealed there were two residents wandering in the hall.

Interview with a personal care aide (PCA) on 07/07/26 at 9:35am revealed:
-She took the resident to the bathroom around 7:45am.
-She did not see the medication sitting on the table.
-All medications were to be locked on the medication cart.
-There were residents on the Special Care Unit (SCU) who wandered but had not wandered in

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D 378	Continued From page 70 other residents' rooms. Interview with the medication aide (MA) on 07/07/26 at 9:40am revealed: -She was not aware the Preparation H ointment was in a resident room. -She was supposed to administer the medication at 8:00am but the resident was at breakfast. -She did not go in the resident's room that morning. -She did not leave the medication in the resident's room. -The medication could have been left in the room overnight by the third shift staff. -She had not noticed the medication was missing from the medication cart. -The medication was supposed to be locked in the medication cart. -She did a medication check of each resident's room after her medication pass but had not completed a check that morning. Interview with a second MA on 07/08/26 at 3:40pm revealed: -The resident was scheduled to receive Preparation H ointment medication on 07/06/26 at 8:00pm. -She applied Preparation H ointment on 07/06/26 and signed off on the medication administration records that she administered the medication at 7:33pm. -She replaced the Preparation H ointment back on the medication cart after administering the medication. -The resident was scheduled to receive Preparation H ointment medication the next morning at 8:00am. -She did not leave the medication in the resident's room on 07/06/26.	D 378		

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D 378	Continued From page 71 Interview with the Special Care Coordinator (SCC) on 07/07/26 at 9:45am revealed: -She was not aware Preparation H was left in a resident room. -There were residents who wandered on the SCU, but she had not seen any residents going in other rooms. -The MA was to do a walk through during each shift to be sure no medications were left in residents' rooms. -She does a walkthrough of every room daily at 9:30am looking for medications but she had not completed a walk through that morning. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 3:20pm revealed: -He was not aware Preparation H ointment was in a resident's room. -The MA was responsible to remove the medication after applying the medication. -The MA was to do a walkthrough during each shift to be sure no medications were left in residents' rooms. -The SCC was responsible to do a daily sweep of all rooms to ensure no medications were left in the rooms. Interview with the Administrator on 07/08/26 at 11:15am revealed: -She was not aware Preparation H was left in a resident's room. -Medication should not be left in rooms because there were residents who wander. -The PCA and MA conducted rounds every shift three times a day to make sure there were no medications in the rooms. -The SCC conducted rounds daily to ensure no medications were in residents' room. -She, the SCC, and the HWD were responsible to ensure no medications were in residents' rooms.	D 378		

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D 378	Continued From page 72 Based on observations, interviews, and record reviews, it was determined the resident was not interviewable.	D 378		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of accidents or incidents (A/I) for 1 of 5 sampled residents requiring emergency evaluation (#3). The findings are: Review of the facility's Accident and Incident Policy dated 06/11/24 revealed: -An internal occurrence report is completed by staff for all unusual occurrence, injuries, injuries of unknown origin, and incidents. -All internal occurrence reports are reviewed by the Director of Health and Wellness and Executive Director. -An incident report is completed in the electronic	D 451		

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D 451	Continued From page 73	D 451		

health record, including all that are state reportable.
-The incident report or applicable state form is used to submit written reports to state agencies.
-Other state required incident reports will be submitted per regulatory requirements.

Review of Resident #3's current FL-2 dated 04/29/26 revealed:
-Diagnoses included falls, early onset Alzheimer's, and right grade 2 renal laceration.
-Resident #3 was constantly disoriented.

Review of Resident #3's Resident Register revealed the resident's admission date was 03/05/25.

Review of Resident #3's hospital after visit summary (AVS) dated 04/30/26 revealed:
-Resident #3 was sent to the hospital on 04/30/26.
-The reason for the visit was for a fall.
-Resident #3's testing consisted of a computed tomography (CT) head without contrast and basic metabolic panel.
-Resident #3 was discharged back to the facility on 04/30/26.

Interview with county Department of Social Services (DSS) Adult Home Specialist (AHS) on 07/08/26 at 2:35pm revealed:
-She did not receive an A/I report regarding Resident #3's fall on 04/30/26 requiring emergency evaluation.
-The facility should fax or electronic mail (email) her A/I report within 24 hours regarding any A/I with an injury needing more than first aid.

Interview with the Special Care Coordinator (SCC) on 07/08/26 at 2:54pm revealed:

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D 451	Continued From page 74 -She was not aware the A/I report was not faxed to Department of Social Services (DSS) Adult Home Specialist (AHS) within 24 hours after the incident occurred on 04/30/26. -The medication aide (MA) completed the A/I report. -She was responsible to forward the completed A/I report to the Health and Wellness Director (HWD). -The HWD was responsible to fax the A/I report to DSS. Interview with the Health and Wellness Director (HWD) on 07/08/26 at 3:30pm revealed: -He was not aware the A/I report was not faxed to DSS within 24 hours after Resident #3's incident occurred on 04/30/26. -The previous Resident Care Coordinator (RCC) said that she would fax the A/I report to DSS/AHS. -He was aware to notify the county DSS regarding any resident who needed medical attention other than first aid. -He could not recall why he did not follow up to ensure the A/I report was sent to DSS. -He could not recall why he did not sign the A/I report. -The MA was responsible to complete the A/I report and contacting him immediately of all accident and incidents. -He was responsible to sign the A/I report and notified the Administrator to review and sign. -He was responsible to fax the A/I report to DSS/AHS within 24 hours. Interview with the Administrator on 07/08/26 at 3:05pm revealed: -She was not aware the A/I report was not faxed to DSS within 24 hours after Resident #3's incident occurred on 04/30/26.	D 451		

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D 451	Continued From page 75 -She was aware to notify the county DSS regarding any resident who needed medical attention other than first aid. -The MA was responsible to complete the A/I form. -The HWD was responsible to notify the county DSS/AHS of A/I reports.	D 451		