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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 08/26/26 through 08/28/26 with an exit via telephone on 08/28/26.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 6 sampled staff (Staff E) who administered medications had completed the state-approved 5-hour, 10-hour, or 15-hour medication aide (MA) training courses as required. The findings are: Review of Staff E's personnel record revealed: -Staff A was hired as a medication aide (MA) on 09/04/18. -There was an orientation sheet signed on 09/12/18 and 01/10/23. -There was documentation Staff E completed the Medication Administration Competency Validation Clinical Skills Checklist on 09/11/18. -There was documentation Staff E passed the MA	D 125		

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written exam on 08/11/10.
-There was no documentation Staff E completed the state-approved 5, 10, or 15-hour MA training courses.
-There was an incomplete MA employment verification form for Staff E with only 1 one date of qualified work of 08/15/18.

Observation on 08/27/26 at 7:32am revealed Staff E was in the Special Care Unit (SCU) administering medications to the residents.

Review of the residents' August 2026 electronic medication administration records (eMARs) revealed there was documentation Staff E administered medications on 08/01/26, 08/02/26, 08/04/26-08/06/26, 08/10/26-08/13/26, 08/15/26, 08/16/26, 08/18/26-08/21/26, and 08/24/26-08/27/26.

Interview with Staff E on 08/28/26 at 9:38am revealed:
-She did not have a copy of the 5, 10, or 15-hour MA training courses certificates.
-She had been a MA for a while.
-She was unsure if she ever taken the 5, 10, or 15-hour MA training courses because she had been a MA so long.
-She thought her previous employer completed the MA employment verification form correctly.
-She worked at a previous facility for 14 years prior to becoming employed by this facility.
-The previous facility where she was employed changed ownership a couple of times, so she did not know how to obtain a copy of any paperwork.
-She last passed medication at the facility yesterday, 08/27/26.

Interview with the Business Office Manager (BOM) on 08/27/26 at 5:45pm revealed:

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D 125	Continued From page 2 -She did not have a 5, 10, or 15-hour MA training course certificate for Staff E. -She thought the MA employment verification form was all that was needed for Staff E and that it was completed correctly. Second interview with the BOM on 08/28/26 at 9:41am revealed: -Staff E passed medications at the facility. -Staff E last passed medications at the facility yesterday, 08/27/26. -The company Staff E previously worked for changed ownership and employee information was not available. Interview with the Administrator on 08/27/26 at 5:32pm revealed: -Staff E's previous employer completed the MA employment verification form. -The hiring manager was responsible for reviewing the MA employment verification form to ensure it was completed correctly. -She was not familiar with the MA employment verification form. -She usually required the MAs to complete the 5, 10, or 15-hour MA training courses. -Staff E left the facility for years and was rehired in 2018. Second interview with the Administrator on 08/28/26 at 9:53am revealed: -She reviewed the personnel records after becoming the Administrator and Staff E's MA employment verification form appeared to be correct, so she did not think Staff E needed to complete the 5, 10, or 15-hour MA training courses. -Staff E last passed medications yesterday, 08/27/26.	D 125		

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D 163	10A NCAC 13F .0504(d) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (d) If a physician certifies that care can be provided to a resident in an adult care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs (b) and (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the adult care home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure unlicensed staff had been certified by a physician to be competency validated by a registered nurse for a resident (#6) who was administered an intramuscular (IM) antipsychotic injection without an order by a medication aide (MA). The findings are: Review of Resident #6's current FL-2 dated 11/19/25 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, mitral valve regurgitation,	D 163		

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hypertensive pulmonary disease, gastroesophageal reflux disease, and thrombocytopenia (low blood platelet count).
-The resident was documented as being constantly disoriented and non-ambulatory.
-The resident was documented as requiring total personal care assistance with bathing, dressing, and feeding.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 11/20/25.

Review of Resident #6's facility progress note dated 06/12/26 at 10:38pm revealed new medication came in and was approved on the electronic medication administration record (eMAR) and added to the cart.

Review of Resident #6's June 2026 eMAR revealed:
-There was an entry for Haldol Decanoate 100mg/ml inject 1ml (=100mg) intramuscularly (IM) once every 4 weeks for schizophrenia scheduled at 8:00am. (Haldol Decanoate is a long-acting injectable antipsychotic used to treat schizophrenia for adults who were previously taking a stable dosage of an immediate-released oral Haldol product.)
-Haldol Decanoate IM injection was documented as administered once on 06/13/26 at 8:00am in the left shoulder by a MA.
-Haldol Decanoate IM injection was documented as discontinued on 06/14/26.

Review of Resident #6's physician's orders revealed there were no orders for the resident to receive Haldol Decanoate IM injection.

Review of Resident #6's record revealed there

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was no documentation of a physician's certification that an unlicensed personnel could perform the task of IM injection on a temporary basis if trained by a registered nurse for Resident #6.

Review of Resident #6's facility progress notes revealed:
-On 06/13/26 at 11:00pm: The resident was doing well with no adverse reactions noted this shift.
-On 06/14/26 at 3:05pm: the resident was nauseous and vomiting all morning; staff had been pushing fluids, water and ginger ale; the resident's family sat with her all morning.

Review of Resident #6's Incident Form dated 06/14/26 at 2:45pm revealed:
-The resident was nauseous and vomiting all morning.
-Staff had been pushing fluids, water and ginger ale.
-The resident's family sat with her all morning.
-The resident was sent to the hospital emergency department (ED) for evaluation and returned to the facility the next day.

Review of Resident #6's hospital ED physician's progress note dated 06/14/26 revealed:
-The resident was at the ED for nausea and vomiting.
-Family told emergency medical services (EMS) that the resident had been acting at her cognitive baseline.
-Per the resident's family member, the resident was recently started on an antipsychotic, and the family was not sure why.
-It was never explained to the family.
-The resident woke up vomiting and shaking which was abnormal for her.

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D 163	Continued From page 6 Review of Resident #6's Medication Variance Report dated 06/14/26 revealed: -The date of variance detection was 06/14/26. -The medication variance section indicated wrong medication and medication not ordered. -The medications listed were Haldol 100mg/ml IM injection and an oral tablet for treating side effects of antipsychotics. -Haldol IM and the oral tablet were administered to Resident #6 without proper orders even though the medications were on the eMAR. -For injury or adverse reaction, it was noted the resident was transferred to the hospital for nausea and vomiting. -There were two MAs listed as being involved in the medication variance. -The resident's responsible party and primary care provider (PCP) were notified at 10:30am. -The report was signed by the Administrator. Interview with a second shift MA on 08/26/26 at 4:25pm revealed: -She was working on second shift on 06/12/26 and checked in the medication delivery. -There was a Haldol vial for injection and 1 or 2 syringes and a supply of a new oral medication with Resident #6's name on the labels. -She could not find a medication form or orders for the Haldol injection or the oral medication for Resident #6. -She remembered questioning herself in her mind about putting the Haldol IM injection in the medication cart because MAs did not usually administer IM injections. -Since it was late, toward the end of her shift and Friday, she went ahead and put both medications in the medication cart since both labels had Resident #6's name on them. -She thought a home health nurse (HHN) would be coming to do the Haldol injection since it was	D 163		

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IM and she wanted to make sure it was available if a HHN came to administer it.
-She should have called the Special Care Coordinator (SCC) but it was late and at the end of the shift so she thought it would be safe to leave it in the medication cart since MAs did not administer IM injections.
-She planned to talk to the SCC about it on Monday, 06/15/26.
-When she came into work on second shift on Saturday, 06/13/26, she spoke to the first shift MA who reported she gave the Haldol IM injection to Resident #6 that morning, 06/13/26.
-The first shift MA reported she gave the Haldol IM injection because it "popped up" on the eMAR.
-She told the first shift MA that MAs did not administer IM injections but the first shift MA had another job as a medical assistant and the first shift MA gave IM injections at her other job.
-The first shift MA did not report any issues with the resident at that time.
-Resident #6 had to go to the hospital ED on that Saturday (06/13/26) or Sunday (06/14/26) because of vomiting and diarrhea.
-The first shift MA reached out to the Administrator and notified her of the medication errors.

Telephone interview with the first shift MA on 08/27/26 at 4:38pm revealed:
-She worked as a MA at the facility every other weekend.
-She started her shift at 7:00am on 06/13/26 and noticed new orders "popped" on the eMAR for Resident #6 and the medications were in the cart.
-There was a Haldol IM injection with a syringe and another new oral tablet (could not recall name) in the medication cart for Resident #6.
-She administered a 1ml IM injection of Haldol and one of the new tablets to Resident #6

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because they were on the eMAR and the medication labels matched.
-She administered the IM injection because she was a certified medical assistant (CMA) at her other job Monday - Friday and administered IM injections every day.
-It was "just routine" for her to administer IM injections at her other job so she "did not even give it a second thought".
-She had never administered any IM injections at the facility prior to the Haldol IM injection.
-She monitored Resident #6 per protocol the rest of her shift (7:00am - 3:00pm) and did not see any changes in the resident.
-When she returned to work the next morning on 06/14/26, the Administrator was monitoring Resident #6 because the resident was vomiting.
-Resident #6 was sent to the hospital ED via EMS.

Telephone interview with Resident #6's family member on 08/26/26 at 2:06pm revealed:
-He came to the facility on Sunday, 06/14/26), to visit and Resident #6 had been vomiting.
-He was contacted later that day by the Administrator and told that Resident #6 was administered a new oral tablet that belonged to another resident in another facility.
-The Administrator did not mention anything about a Haldol IM injection to him at that time.
-The facility staff and the family member continued monitoring the resident and trying to get her to drink fluids, but she kept vomiting.
-EMS was called and the resident was taken to the hospital ED.
-He was not aware of the Haldol IM injection at the time the resident was taken to the ED on 06/14/26 and he told the ED provider about the new oral tablet.
-It was his understanding there were no

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physician's orders for Resident #6 to receive those medications, but the resident's name was on the labels.
-When Resident #6 returned to the facility the next morning, he spoke with a MA who reported the resident had also received a Haldol IM injection.
-The MA also gave him a copy of the resident's eMAR and Haldol 100mg IM injection was documented as administered.
-He later spoke with the Administrator again who claimed she told him about both the Haldol injection and the oral tablet.
-The MAs were not supposed to administer Haldol IM injections.
-After Resident #6 returned from the ED visit on 06/14/26, the resident was in bed and quiet for a while; they eventually got the resident up into a recliner, but the resident was tired.
-As the days went on, the resident's legs got stiff to the point the resident could not separate her knees.
-Later in July 2026, the resident was in the hospital for 13 days because he wanted to have her evaluated again.
-The resident went to a rehabilitation facility from the hospital for therapy because the hospital providers said she needed a higher level of care.

Interview with the SCC on 08/27/26 at 11:59am revealed:
-She was off on the weekend the medication errors with Resident #6 occurred in June 2026.
-When she returned to work on Monday, 06/15/26, it was reported to her that a MA had approved medications on the eMAR for Resident #6 without an order and another MA had administered the medications.
-The MAs were not allowed to administer IM injections.

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D 163	Continued From page 10 -She was concerned about MAs administering IM injections because they may not use proper technique because they had not been trained to do IM injections. Interview with the Administrator on 08/27/26 at 12:25pm revealed: -She was filling in as the supervisor on duty at the facility on third shift (11:00pm - 7:00am) on 06/13/26. -She was also a nurse and staff asked her to check on Resident #6 at 6:30am on 06/14/26. -Staff reported the resident was vomiting. -When she assessed Resident #6, the resident was alert and verbal and stated she did not feel good. -The resident's vital signs were stable, the resident vomited a small amount and they helped get the resident cleaned up. -She listened to the resident's abdomen and they gave her some ginger ale to drink. -The first shift MA asked her if she thought the resident's vomiting had anything to do with the Haldol she administered to the resident yesterday. -She questioned the MA about it and they looked at the eMAR. -The MA reported there was a syringe in the bag with the Haldol vial and she administered the Haldol IM injection to Resident #6 along with one new oral tablet. -She had to leave a message for the pharmacy but never heard back and called the pharmacy back on Monday, 06/15/26. -The pharmacy reported the Haldol and the oral tablet were actually for a different resident at a different facility and they made a date entry error. -She spoke with Resident #6's family member on Sunday (06/14/26) about mid-morning via cell phone and let him know about the error with	D 163		

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Haldol and the oral tablet.
-She spoke with the family member again later that day and the resident continued to vomit, so the resident was sent to the ED.
-When the resident returned from the ED to the facility, the resident was quiet and sleepy but was not vomiting.
-The first shift MA who administered the Haldol IM injection and the oral tablet reported she administered them because they were active orders on the eMAR so they would have already been verified when the medications were received from the pharmacy.
-MAs were not allowed to administer IM injections and the MAs were aware of this.
-When she asked the first shift MA about administering the Haldol IM injection, the MA stated, "I know, I know", indicating she was aware she should not have administered it.
-The MA had another job as a CMA and administered IM injections every day in her role at that job.
-The MA reported she did not think about not administering the IM injections because she did that task at her other job.
-There was no physician's certification for any MA to administer Haldol IM injection to Resident #6 or any other resident.
-She was concerned about a MA administering an IM injection because she did not know if the MA used the proper technique.
-The resident's family wanted her re-evaluated so the resident was sent to the hospital at the end of July 2026 and did not return to the facility.

Interview with Resident #6's PCP on 08/27/26 at 1:42pm revealed:
-She was notified by the facility that Resident #6 was administered a Haldol IM injection and a new oral tablet by a MA.

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-She nor the resident's mental health provider (MHP) in her practice ever prescribed either medication for Resident #6.
-She was concerned about the Haldol IM injection causing nausea, vomiting, tremors, lethargy, and changes in physical function such as not being as active.
-Resident #6 had dementia and had been having a slow decline prior to the medication errors.
-She felt like the medication errors exacerbated the resident's decline and made the symptoms more obvious.
-MAs were not supposed to administer IM injections due not being trained and educated about technique and understanding the medication and its effects.
-Not using proper technique with IM injections could cause infection or injury.

Telephone interview with Resident #6's MHP on 08/27/26 at 5:10pm revealed:
-She saw Resident #6 on 06/08/26 and staff reported no behaviors or mood disturbances.
-She had not ordered any Haldol IM injections or new oral tablet for Resident #6.
-She would not have ordered a Haldol IM injection for Resident #6 because someone had to be stable on oral Haldol for 3 to 6 months prior to starting IM Haldol.
-Resident #6 did not have orders for and was not receiving oral Haldol.
-She believed Resident #6's nausea, vomiting, and lethargy were directly caused by the resident receiving the Haldol IM injection.
-She saw the resident again on 07/13/26 and staff reported the resident had declined some in the last month.
-An unlicensed MA should not be administering IM injections.
-She was concerned about the MA not using

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D 163	Continued From page 13 proper technique which could affect the absorption and effectiveness of a medication. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration.] _____ The facility failed to ensure unlicensed staff had been certified by a physician to be competency validated by a registered nurse for Resident #6 who was administered an intramuscular (IM) antipsychotic injection without an order by a medication aide (MA). The MA administered the antipsychotic IM injection on 06/13/26 and the resident was sent to the hospital emergency department (ED) on 06/14/26 with severe nausea and vomiting. The MA did not follow protocol and administered an IM injection when she was aware MAs were not allowed to administer IM injections putting the resident at risk of infection or injury. This was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 12, 2026.	D 163		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 5 sampled residents (#2) with a texture modified diet order.

The findings are:

Review of Resident #5's current FL-2 dated 05/05/26 revealed:
-Diagnoses included dementia, type 2 diabetes with hyperglycemia, and encephalopathy.
-There was an order for texture modified diet of mechanical soft.

Review of Resident #5's diet order sheet dated 05/05/26 revealed there was an order for a diet of consistent carbohydrates with a texture modified diet of mechanical soft.

Review of Resident #5's hospice notes revealed Resident #5 had a diagnosis of dementia with dysphagia as of 06/01/26.

Observations during the initial kitchen tour on 08/26/26 at 9:54am revealed:
-There was a list of "Modified Diets" posted over the steam table.
-Resident #5 was listed on the Modified Diets list as requiring a consistent carbohydrate diet with a texture modified diet of mechanical soft.

Review of the facility's therapeutic diet spreadsheet revealed the sausage patty for the Mechanical Soft diet (listed under L2MECH)

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D 310	Continued From page 15 should be served pureed. Observation of breakfast meal service for Resident #5 on 08/27/26 at between 7:29am and 8:32am revealed: -Sausage patty, wheat toast, hashbrown potatoes, fruit of choice, cereal of choice, juice of choice, coffee or tea, and milk were on the menu. -There was a hospice personal care aide sitting with Resident #5. -Resident #5 was initially served cereal, juice, milk, water, and coffee. -Resident #5 was later served eggs, grits, and crumbled sausage. -Resident #5 was already eating the meal when the plate was observed. -Resident #5 had no issues feeding herself or swallowing any of the food served. Interview with the cook on 08/27/26 at 8:54am revealed: -She knew each resident's diet because there was a sheet with diets posted over the stove. -She knew how to prepare each diet because there was a menu book as well as a sheet detailing how to prepare each diet posted behind the menu. -She used the spreadsheet to prepare every meal because she wanted to make sure residents received the right texture of food. -Dietary staff used the "L2MECH" heading to prepare mechanical soft diets. -"PU" on the therapeutic diet spreadsheet meant puree. -She was not aware the mechanical soft sausage patty was supposed to be pureed. -She looked at the spreadsheet this morning (08/27/26) but did not see the "PU" beside the sausage patty. -The Dietary Manager was responsible for	D 310		

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ensuring the modified diet textures were correct.
-The medication aide (MA) called out the resident's name and diet order, and the cook plated the food based on what the MA called out.
-The cook determined how the food was prepared for each texture modified diet.

Interview with the Dietary Manager on 08/27/26 at 8:34am revealed:
-She thought the mechanical soft diet sausage patty was supposed to be ground.
-The sausage patty was put in the food processor and chopped with no additives.
-Dietary staff use the "L2MECH" heading for the mechanical soft diets.
-The "PU" beside the sausage patty under the "L2MECH" heading meant to puree the sausage.
-She did not think a mechanical soft texture modified diet was supposed to be pureed.
-The purpose of the therapeutic diet spreadsheet was to show the dietary staff how each meal was to be prepared.
-Dietary staff utilized the therapeutic diet spreadsheet to prepare the meals.
-She did not look at the therapeutic diet spreadsheet to prepare breakfast this morning (08/27/26).
-She and the cook were responsible for ensuring texture modified diets were prepared correctly, according to the therapeutic diet spreadsheet.
-The concern with Resident #5 getting ground sausage instead of pureed sausage was choking.

Interview with the Resident Care Director (RCD) on 08/27/26 at 5:14pm revealed:
-Diet orders were posted in the kitchen in front of the person preparing the plates.
-Instructions on how the food was to be prepared for therapeutic diets were posted in the kitchen.
-The DM and Cook were responsible for ensuring

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D 310	Continued From page 17 the therapeutic diets were prepared correctly. Interview with the Administrator on 08/27/26 at 8:47am revealed: -The Dietary Manager was responsible for ensuring texture modified diets were prepared correctly. -She was not aware that sausage patties for the mechanical soft diet were to be pureed. -The cook plated the food and was responsible for ensuring they were plating the right consistency of food for each resident. -The concern with Resident #5 getting ground sausage instead of pureed sausage was aspiration/choking. Telephone interview with Resident #5's primary care provider (PCP) on 08/28/26 at 8:00am revealed: -She could not recall Resident #5's diet. -If the food consistency was incorrect based on the facility's therapeutic diet spreadsheet, she would be concerned for choking with Resident #5. -Resident #5 had cognitive deficits with the risk of interference with her swallowing function. Based on observations, interviews and record reviews, it was determined that Resident #5 was not interviewable.	D 310		
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	D 358		

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D 358	Continued From page 18 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#7) observed during the medication pass including errors with a medication for heart and blood pressure, a laxative, and a probiotic; and for 1 of 6 residents (#6) sampled for record review related to the resident receiving two medications without orders including an intramuscular antipsychotic injection and a medication used to treat side effects of antipsychotic medications. The findings are: Review of the facility's Medication Management Policies and Procedures dated February 2022 revealed: -The facility would comply with all state and federal laws for administering, documenting, and storing medications. -All medications must be checked against the physician's order to ensure it was the right medication, right resident, right dosage, right time, and the right route. -Any variance in medication must be documented on the Medication Variance Report. -To achieve safe medication administration, the facility required that the medication system had checks and balances. -The facility did not administer medications to a resident if they did not have a physician's order for the medication.	D 358		

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-The facility did not administer medications if they could not verify the six rights of medication administration.
-Step 1 in receiving medications was to verify the physician's order with the package from the pharmacy to be sure the label had the same information as the physician's order.
-The pharmacy was to always be notified if there were any questions or concerns.
-When preparing medications for administration to the resident, always make sure the medication order was complete.
-Compare physician medication order and administration records to ensure accuracy of the order.

1. The medication error rate was 9% as evidenced by 3 errors out of 32 opportunities during the 8:00am medication pass on 08/27/26.

a. Review of Resident #7's current FL-2 dated 04/02/26 revealed diagnoses included dysphagia following cerebral infarction (stroke), Raynaud's syndrome, Sjogren syndrome, hyperlipidemia, depression, osteoporosis, and left femur fracture.

Review of Resident #7's physician's orders sheet dated 05/05/26 revealed:
-There was an order for Culturelle capsule take 1 capsule every day. (Culturelle is probiotic supplement used for digestive health that can be opened and sprinkled into food or drink if it cannot be swallowed.)
-There was an order for "may crush crushable medications for easier swallowing".

Observation of the 8:00am medication pass on 08/27/26 revealed:
-The medication aide (MA) prepared morning medications for Resident #7, including one

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D 358	Continued From page 20 Culturelle capsule. -The MA crushed Resident #7's oral medications, including the Culturelle capsule and mixed the crushed medications in applesauce. -The MA stated she was going to administer the crushed medications in applesauce to the resident. -At 8:50am, the surveyor intervened and stopped the MA from administering the crushed medications to Resident #7, which included the crushed Culturelle capsule. Interview with the MA on 08/27/26 at 8:50am revealed: -She usually crushed Resident #7's medications because the resident had swallowing problems. -She did not know if any of Resident #7's medications should not be crushed. Observation of Resident #7's medications on hand on 08/27/26 4:02pm revealed: -There was a supply of Culturelle capsules dispensed on 08/11/26, with instructions to take 1 capsule every day. -There were 12 of 30 capsules remaining. -There was no warning on the prescription label not to crush the capsule. Review of Resident #7's August 2026 electronic medication administration record (eMAR) dated 08/01/26 - 08/27/26 revealed: -There was an entry for Culturelle capsule take 1 capsule every day scheduled at 8:00am. -Culturelle capsule was documented as administered daily from 08/01/26 - 08/27/26. -There was no information noted on the eMAR to indicate the medication should not be crushed. -There were no instructions to open the capsule and sprinkle the contents into food when the capsule could not be swallowed.	D 358		

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D 358	Continued From page 21 -There was an entry that read "may crush crushable medications for easier swallowing". Interview with Resident #7 on 08/27/26 at 3:43pm revealed: -She usually received medication every day, but she was not sure what medication she took. -She could swallow her medications better when they were crushed and put in applesauce. Telephone interview with the Resident Care Director (RCD) on 08/28/26 at 9:54am revealed: -The MAs had training on which medications should not be crushed. -She was not aware the MA was crushing Resident #7's Culturelle capsule. -Pieces of the crushed capsule could cause the resident to get choked. Interview with the Administrator on 08/27/26 at 1:14pm revealed: -The MAs should never crush any capsules. -The MAs knew better; the MAs knew they should open capsules because that was how they had been trained. -Resident #7's Culturelle capsule should not have been crushed. Interview with Resident #7's primary care provider (PCP) on 08/27/26 at 1:34pm revealed: -Capsules should not be crushed and administered to a resident. -Crushing the Culturelle capsule could cause pieces of the crushed capsule to injure Resident #7's throat or esophagus during administration. b. Review of Resident #7's physician's order dated 08/14/26 revealed an order to start Metoprolol extended-released (ER) 25mg ½ tablet once daily. (Metoprolol ER lowers heart	D 358		

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D 358	Continued From page 22 rate and blood pressure. Metoprolol ER is extended-released and should not be crushed or chewed. Metoprolol ER is designed to release the medication slowly over time. Crushing Metoprolol ER would lead to rapid release of the medication which could increase the risk of side effects and decrease its effectiveness.) Review of Resident #7's physician's orders sheet dated 05/05/26 revealed an order for "may crush crushable medications for easier swallowing". Observation of the 8:00am medication pass on 08/27/26 revealed: -The medication aide (MA) prepared morning medications for Resident #7, including ½ tablet of Metoprolol ER 25mg. -The MA crushed Resident #7's oral medications, including the ½ tablet of Metoprolol ER and mixed the crushed medications in applesauce. -The MA stated she was going to administer the crushed medications in applesauce to the resident. -At 8:50am, the surveyor intervened and stopped the MA from administering the crushed medications to Resident #7, which included the crushed 1/2 tablet of Metoprolol ER. Interview with the MA on 08/27/26 at 8:50am revealed: -She usually crushed Resident #7's medications because the resident had swallowing problems. -She did not know if any of Resident #7's medications should not be crushed. Second interview with the MA on 08/27/26 at 8:55am revealed she was not aware of a "do not crush" (DNC) list of medications to reference for medications that should not be crushed.	D 358		

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D 358	Continued From page 23 Observation of the MA on 08/27/26 at 8:55am revealed the MA found a DNC list in the back of the medication notebook in the medication cart. Interview with the MA on 08/27/26 at 8:56am revealed: -She did not realize there was a DNC list in the medication notebook kept in the medication cart. -Metoprolol ER was listed on the DNC list and she should not have crushed Resident #7's Metoprolol ER tablet. Review of Resident #7's August 2026 electronic medication administration record (eMAR) dated 08/01/26 - 08/27/26 revealed: -There was an entry for Metoprolol ER 25mg take ½ tablet every day for hypertension scheduled at 8:00am. -Metoprolol ER was documented as administered daily from 08/15/26 - 08/27/26. -There was no information noted on the eMAR to indicate the medication should not be crushed. -There was an entry that read "may crush crushable medications for easier swallowing". Observation of Resident #7's medications on hand on 08/27/26 4:02pm revealed: -There was a supply of Metoprolol ER 25mg half tablets dispensed on 08/14/26, with instructions to take ½ tablet (12.5mg) every day for hypertension. -There was no warning on the prescription label not to crush the medication. Review of the facility's DNC list revised October 2018 revealed: -Metoprolol ER was included on the list as a medication that should not be crushed. -Metoprolol ER should not be crushed because it was a time-released formulation.	D 358		

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D 358	Continued From page 24 Interview with Resident #7 on 08/27/26 at 3:43pm revealed: -She could swallow her medications better when they were crushed and put in applesauce. -She was not sure what medication she took. -Her blood pressure was checked "off and on" and her blood pressure usually ran low. Telephone interview with the RCD on 08/28/26 at 9:54am revealed: -The MAs had training on which medications should not be crushed. -She was not aware the MA was crushing Resident #7's Metoprolol ER tablet. -Crushing Resident #7's Metoprolol ER tablet could cause the resident's blood pressure to drop too low. -If the MAs had notified her about crushing Resident #7's medication, she could have contacted the primary care provider (PCP) to get a different formulation of Metoprolol that could be crushed. Interview with the Administrator on 08/27/26 at 1:14pm revealed: -The MAs should use the DNC list kept in the medication cart to determine what medications should not be crushed. -Resident #7's Metoprolol ER tablet should not be crushed because it could lower the resident's blood pressure exponentially. Interview with Resident #7's PCP on 08/27/26 at 1:34pm revealed: -Metoprolol ER should not be crushed because it was extended-released. -Crushing Metoprolol ER increased the risk of low blood pressure and low heart rate because of the medication being released all at once instead of	D 358		

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throughout the day.
-That could also affect the stability of the resident's blood pressure.
-Crushing Metoprolol ER could also cause orthostatic hypotension (when the blood pressure drops upon standing) which could lead to falls.
-She was not aware of Resident #7 having any current issues with low blood pressure or heart rate.

c. Review of Resident #7's physician's order dated 05/05/26 revealed an order to start Miralax 17 grams (g) in 8 ounces of fluid daily for constipation. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap lining.)

Review of Resident #7's electronic prescription dated 08/13/26 revealed an order for Miralax 17g once a day, mix in 8 ounces of water and drink daily.

Observation of the 8:00am medication pass on 08/27/26 revealed:
-The medication aide (MA) retrieved Resident #7's Miralax bottle from the medication cart.
-There was a white inner lining inside of the blue cap on the Miralax bottle.
-There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white inner lining inside the cap.
-The MA poured the Miralax powder approximately halfway below the marking for the 17g dose.
-The MA mixed the Miralax powder in a cup of water and gave it to Resident #7 to drink at

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9:08am.
-The resident drank all the water with Miralax.
-A 17g dosage of Miralax was not prepared and administered to Resident #7 as ordered.

Review of Resident #7's August 2026 electronic medication administration record (eMAR) dated 08/01/26 - 08/27/26 revealed:
-There was an entry for Miralax mix 17g in 8 ounces of orange juice or water and drink once a day for constipation scheduled at 8:00am.
-Miralax 17g was documented as administered daily from 08/01/26 - 08/12/26.
-There was documentation on 08/13/26 that Miralax 17g daily had been discontinued.
-There was a second entry for Miralax, mix ½ capful (= 8.5g) in 8 ounces of orange juice or water and drink every morning for constipation scheduled at 8:00am.
-Miralax 8.5g was documented as administered daily from 08/14/26 - 08/27/26.

Observation of Resident #7's medications on hand on 08/27/26 at 4:02pm revealed:
-There was a bottle of Miralax dispensed on 08/13/26 labeled with Resident #7's name.
-The instructions were to mix ½ capful (=8.5g) in 8 ounces of orange juice or water and drink every morning.

Review of Resident #7's physician's orders revealed:
-There was no signed physician's order to discontinue Miralax 17g daily.
-There was no signed physician's order for Miralax 8.5g daily.

Interview with the MA on 08/27/26 at 2:08pm revealed:
-She measured the Miralax dosage using the

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white inner cap.
-She usually measured the Miralax powder by estimating half a capful because there was no marking to measure 8.5g.
-She was not aware there was no order for Resident #7 to receive 8.5g of Miralax because she went by the instructions on the eMAR.
-She did not notify anyone she was estimating the measurement when she prepared the Miralax because she did not realize she had to use a device with an exact measurement.
-The resident used to get a whole 17g capful and she was not sure when the instructions on the eMAR changed.
-Resident #7 was not having any current issues with constipation.

Interview with Resident #7 on 08/27/26 at 3:43pm revealed:
-She received medication every day, but she could not recall which ones.
-She denied any current issues with constipation.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/28/26 at 10:47am revealed:
-The pharmacy staff usually entered orders into the eMAR system and the facility staff approved orders in the eMAR system.
-Resident #7's Miralax order dated 08/13/26 was a refill order.
-The pharmacy staff keyed the Miralax refill order as a new order instead of a refill order.
-When the Miralax order was keyed in as a new order, the wrong instructions were entered into the eMAR system by accident.
-There was no order for 8.5g, the order was supposed to be for 17g of Miralax daily.

Telephone interview with the Resident Care

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D 358	Continued From page 28 Director (RCD) on 08/28/26 at 9:54am revealed: -The MAs should have notified her about having no way to measure 8.5g for Resident #7's Miralax. -If there were any questions about how much Miralax the resident should receive and she had been notified, she would have contacted the primary care provider to clarify. Interview with the Administrator on 08/27/26 at 1:14pm revealed: -She was not aware of any orders to change Resident #7's Miralax from 17g to 8.5g daily. -If the MAs had any questions about a medication order, the MAs should notify her, the RCD, or the Special Care Coordinator (SCC). Second interview with the Administrator on 08/27/26 at 3:54pm revealed: -She checked with the pharmacy today and found out that Resident #7's Miralax was a refill order that was input incorrectly by the pharmacy. -The facility did not notice an error with the Miralax because they did not have to approve refill orders in the eMAR system. -If the MAs had questions about measuring medication, they should notify her, the RCD, or the SCC. Interview with Resident #7's primary care provider (PCP) on 08/27/26 at 1:34pm revealed: -Resident #7 should be receiving 17g of Miralax in 8 ounces of fluid daily. -She sent an electronic prescription for Miralax 17g to the pharmacy on 08/13/26 because there was a request for refills. -She did not change the instructions for Resident #7's Miralax. -There was never an order for 8.5g of Miralax for Resident #7.	D 358		

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D 358	Continued From page 29 -Resident #7 had constipation issues in the past but none recently. 2. Review of Resident #6's current FL-2 dated 11/19/25 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, mitral valve regurgitation, hypertensive pulmonary disease, gastroesophageal reflux disease, and thrombocytopenia (low blood platelet count). -The resident was documented as being constantly disoriented and non-ambulatory. -The resident was documented as requiring total personal care assistance with bathing, dressing, and feeding. Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 11/20/25. -The resident required assistance with dressing, bathing, nail care, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. Review of Resident #6's Special Care Plan and Profile dated 07/08/26 revealed: -The resident was always disoriented, had significant memory loss and must be directed. -The resident was non-ambulatory and used a wheelchair for ambulation. -The resident required limited assistance from staff with bathing, dressing, grooming, eating, and toileting. Review of Resident #6's facility progress note dated 06/12/26 at 10:38pm revealed:	D 358		

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-The resident was doing well this shift.
-The resident's family member came to visit.
-A new medication came in and was approved on the electronic medication administration record (eMAR) and added to the cart.

Review of Resident #6's June 2026 eMAR revealed:
-There was an entry for Benztropine 0.5mg 1 take 1 tablet every morning for extrapyramidal symptoms (EPS) scheduled at 8:00am. (Benztropine is used to treat Parkinson's-like symptoms and EPS caused by antipsychotics. EPS can include stiffness, rigidity, tremors, and slow movement.)
-Benztropine 0.5mg was documented as administered once on 06/13/26 at 8:00am by a medication aide (MA).
-Benztropine was documented as being discontinued on 06/14/26.
-There was an entry for Haldol Decanoate 100mg/ml inject 1ml (=100mg) intramuscularly (IM) once every 4 weeks for schizophrenia scheduled at 8:00am. (Haldol Decanoate is a long-acting injectable antipsychotic used to treat schizophrenia for adults who were previously taking a stable dosage of an immediate-released oral Haldol product.)
-Haldol Decanoate IM injection was documented as administered once on 06/13/26 at 8:00am in the left shoulder by a MA.
-Haldol Decanoate IM injection was documented as discontinued on 06/14/26.

Review of Resident #6's physician's orders revealed there were no orders for the resident to receive Haldol Decanoate IM injection or Benztropine.

Review of Resident #6's mental health provider

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(MHP) visit note dated 06/08/26 revealed:
-The resident had a history of dementia and was a poor historian due to her dementia.
-The resident was able to answer some basic questions today and occasionally made eye contact.
-Staff reported no behavioral or mood disturbances that warranted medication adjustment as she was large at her baseline.
-Staff reported the resident did have a history of hallucinations and would often talk to herself and other people who the resident thought was in the room with her.
-The resident did not have associated agitation or combativeness with these behaviors.
-The resident had no significant difficulties with sleep at night as the resident was receiving Melatonin (for sleep) at night.
-The only other medication listed was Alprazolam (for anxiety and agitation) as needed (prn) for anxiety.

Review of Resident #6's primary care provider (PCP) visit note dated 06/11/26 revealed:
-The resident was being seen for a follow-up visit for blood pressure management.
-The resident was a poor historian due to cognitive/psychiatric impairment.
-No acute concerns were verbalized by facility staff on this visit.
-Haldol Decanoate and Benztropine were not included in the resident's medication list.
-There was an order to restart a blood pressure medication, but no orders to start Haldol Decanoate or Benztropine.

Review of Resident #6's facility progress notes revealed:
-On 06/13/26 at 11:00pm: The resident was doing well with no adverse reactions noted this shift.

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D 358	Continued From page 32 -On 06/14/26 at 3:05pm: the resident was nauseous and vomiting all morning; staff had been pushing fluids, water and ginger ale; the resident's family sat with her all morning. Review of Resident #6's Incident Form dated 06/14/26 at 2:45pm revealed: -The resident was nauseous and vomiting all morning. -Staff had been pushing fluids, water and ginger ale. -The resident's family sat with her all morning. -The resident was sent to the emergency department (ED) for evaluation and returned to the facility the next day. Review of Resident #6's hospital ED After Visit Summary (AVS) dated 06/14/26 revealed: -The reason for the resident's visit to the ED was vomiting. -The resident's diagnoses were documented as nausea and vomiting, unspecified vomiting type, history of dementia, and hypokalemia (low potassium levels). -The resident's vital signs were documented as: blood pressure 105/48; temperature 98.6 degrees Fahrenheit (°F); pulse 59; respirations 18; and oxygen saturation 97%. Review of Resident #6's hospital ED physician's progress note dated 06/14/26 revealed: -The resident was at the ED for nausea and vomiting. -Family told emergency medical services (EMS) that the resident had been acting at her cognitive baseline. -Per the resident's family member, the resident was recently started on an antipsychotic, and the family was not sure why. -It was never explained to the family.	D 358		

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D 358	Continued From page 33 -The resident woke up vomiting and shaking which was abnormal for her. Review of Resident #6's Medication Variance Report dated 06/14/26 revealed: -The date of variance detection was 06/14/26. -The medication variance section indicated wrong medication and medication not ordered. -The medications listed were Haldol 100mg/ml IM injection and Benztropine 0.5mg tablet. -Haldol IM and Benztropine were administered to Resident #6 without proper orders even though the medications were on the eMAR. -For injury or adverse reaction, it was noted the resident was transferred to the hospital for nausea and vomiting. -There were two MAs listed as being involved in the medication variance. -The resident's responsible party and PCP were notified at 10:30am. -The report was signed by the Administrator. Review of a copy of an electronic prescription from the facility's contracted pharmacy dated 06/11/26 revealed: -The date written for the electronic prescription was 06/11/26 at 1:57pm. -The name and date of birth listed on the prescription as the "patient" was not Resident #6's name or date of birth. -Resident #6's name and date of birth were computer printed in a small block in the upper right corner of the prescription along with the name of the facility. -The medication ordered on the prescription was Benztropine 0.5mg 1 tablet in the morning. -The quantity was 30 tablets with 6 refills. -The prescriber who electronically prescribed the medication was not one of Resident #6's providers.	D 358		

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D 358	Continued From page 34 Review of a copy of a second electronic prescription from the facility's contracted pharmacy dated 06/11/26 revealed: -The date written for the electronic prescription was 06/11/26 at 1:57pm. -The name and date of birth listed on the prescription as the "patient" was not Resident #6's name or date of birth. -Resident #6's name and date of birth were computer printed in a small block in the upper right corner of the prescription along with the name of the facility. -The medication ordered on the prescription was Haldol Decanoate 100mg/ml IM Solution administer 1ml IM every 4 weeks. -The quantity was 1 vial with 6 refills. -The prescriber who electronically prescribed the medication was not one of Resident #6's providers. Review of a picture of a bubble pack of Benztropine dispensed by the facility's contracted pharmacy on 06/12/26 revealed: -The prescription label on the bubble pack had Resident #6's first and last name. -The instructions were to take 1 tablet every morning for EPS. -There were 29 Benztropine 0.5mg tablets dispensed on 06/12/26. -There were 28 of 29 tablets remaining in the bubble card. -The prescribing practitioner's name on the prescription label was not Resident #6's PCP or MHP. -The facility's name was listed on the prescription label in the bottom right-hand corner near a bar code. Review of a Pharmacy Dispensing Occurrence	D 358		

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D 358	Continued From page 35 Report from the facility's contracted pharmacy dated 06/15/26 revealed: -Resident #6's name was listed on the report. -The medications listed were Haldol Decanoate 100mg/ml and Benztropine 0.5mg tablet. -The date/time of occurrence was listed as 06/12/26 - 06/14/26. -The date reported was 06/15/26. -The resident received one dose of each medication. -The original prescriptions were noted to be electronic. -The type of incident was documented as the "wrong patient". -The contributing factor documented was failure to follow procedure. -Electronic prescriptions were received by the pharmacy, entered and filled under the "wrong patient". -The facility approved orders in the eMAR system and administered the medications. -The resident was found lethargic Sunday morning and sent to the hospital. Review of Resident #6's facility progress notes revealed: -On 06/14/26 at 10:24am, the resident was still in the hospital. -On 06/15/26 at 9:45am, the resident was resting comfortably and family was at bedside; the resident drank a large sweet tea and ate a biscuit; the resident was status post hospital transfer on 06/14/26 at 2:55pm for change in status with nausea and vomiting; staff would continue to observe the resident and encourage fluids. -On 06/15/26 at 2:01pm, the resident returned from the hospital this morning around 8:00am; the resident's family was with her; staff offered breakfast but the resident's family member stated he would feed her; the resident slept until	D 358		

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D 358	Continued From page 36 11:00am; staff assisted the resident with getting dressed and walked her to the dining room; the resident did well during the shift and family was with her most of the day. Interview with a second shift MA on 08/26/26 at 4:25pm revealed: -The pharmacy usually entered orders into the eMAR system, and the MAs approved the orders in the eMAR system. -Once an order was approved by the MAs, it became active and "popped up" for administration on the eMAR at the scheduled time. -The MAs were supposed to check the medications delivered from the pharmacy against the medication tracking form and the attached orders. -The medication tracking form with attached orders were usually kept in the medication room on the desk. -The pharmacy totes were usually delivered to the facility on second shift between 9:00pm and 11:00pm. -She was working on second shift on 06/12/26 and checked in the medication delivery. -There was a Haldol vial for injection with 1 or 2 syringes and a supply of Benztropine with Resident #6's name on the labels. -She could not find a medication form or orders for the Haldol injection or Benztropine for Resident #6. -She remembered questioning herself in her mind about putting the Haldol injection in the medication cart because MAs did not usually administer IM injections. -Since it was late, toward the end of her shift and Friday, she went ahead and put both medications in the medication cart since both labels had Resident #6's name on them. -She thought a home health nurse (HHN) would	D 358		

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be coming to do the Haldol injection since it was IM and she wanted to make sure it was available if a HHN came to administer it.
-She should have called the Special Care Coordinator (SCC) but it was late and at the end of the shift so she thought it would be safe to leave it in the medication cart since MAs did not administer IM injections.
-She planned to talk to the SCC about it on Monday, 06/15/26.
-When she came into work on second shift on Saturday, 06/13/26, she spoke to the first shift MA who reported she gave the Haldol IM injection to Resident #6 that morning, 06/13/26.
-The first shift MA reported she gave the Haldol IM injection because it "popped up" on the eMAR.
-She told the first shift MA that MAs did not administer IM injections but the first shift MA had another job as a medical assistant and gave IM injections at her other job.
-The first shift MA did not report any issues with the resident at that time.
-She did not ask the first shift MA about the Benztropine.
-Resident #6 had to go to the hospital ED on that Saturday (06/13/26) or Sunday (06/14/26) because of vomiting and diarrhea.
-The first shift MA reached out to the Administrator and notified her of the medication errors.
-Before Resident #6 received the Haldol and Benztropine, the resident sometimes walked independently and sometimes she could not walk.
-Resident #6 was not oriented to place or self, but she could talk and sing along to songs.
-After the Resident #6 received Haldol and Benztropine, the resident was different.
-When the resident first returned from the hospital ED, the resident used a wheelchair and could stand and walk with staff to the bathroom.

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D 358	Continued From page 38 -Resident #6 was quieter and less verbal. -Resident #6 could stand but not walk and was back to using a wheelchair. -Resident #6 could not move as much and staff always fed her. -Resident #6 was not as verbal and did not sing along anymore. -Resident #6 went to the hospital a second time because her family wanted her to be checked. Telephone interview with the first shift MA on 08/27/26 at 4:38pm revealed: -She worked as a MA at the facility every other weekend. -She started her shift at 7:00am on 06/13/26 and noticed new orders "popped" on the eMAR for Resident #6 and the medications were in the cart. -If medications orders were in the eMAR that usually meant they orders had already been checked and approved against the actual physician's order. -There was a Haldol IM injection with a syringe and another new oral tablet (could not recall name) in the medication cart for Resident #6. -She administered a 1ml IM injection of Haldol and one new tablet to Resident #6 because they were on the eMAR and the medication labels matched. -She administered the IM injection because she was a certified medical assistant (CMA) at her other job Monday - Friday and she administered IM injections every day. -It was "just routine" for her to administer IM injections at her other job, so she "did not even give it a second thought". -She had never administered any IM injections at the facility prior to the Haldol IM injection. -She monitored Resident #6 per new medication protocol the rest of her shift (7:00am - 3:00pm) and did not see any changes in the resident.	D 358		

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-When she returned to work the next morning on 06/14/26, the Administrator was monitoring Resident #6 because the resident was vomiting.
-The Administrator was checking the resident's vital signs and giving her fluids.
-She initially thought the resident had a stomach virus but then she asked the Administrator if it could be the resident's new medication.
-The Administrator asked her, "what new medication?".
-She pulled up the eMAR to show the Administrator the medications and then they searched for orders but could not find any.
-The Administrator contacted the resident's PCP and the pharmacy.
-Resident #6 was sent to the hospital ED via EMS.
-She gave Resident #6's blue folder to an EMS staff person including a copy of the resident's June 2026 eMAR.
-She noticed after Resident #6 returned to the facility, the resident was really lethargic and confused more than normal.
-Resident #6 was "wobbly" and not steady when walking like before.
-After a couple of weeks, Resident #6 seemed to improve and started walking more steady.

Telephone interview with Resident #6's family member on 08/26/26 at 2:06pm revealed:
-He came to the facility on Sunday, 06/14/26, to visit and Resident #6 had been vomiting.
-The personal care aides (PCAs) had contacted the Administrator to let her know Resident #6 had been vomiting.
-He was contacted later that day by the Administrator and told that Resident #6 was administered Benztropine that belonged to another resident in another facility.
-The Administrator did not mention anything

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about a Haldol injection to him at that time.
-The facility staff and the family member continued monitoring the resident and trying to get her to drink fluids, but she kept vomiting.
-Another family member who was a physician came to the facility later that day and thought the resident was dehydrated so they called the Administrator, then EMS was called and the resident was taken to the hospital ED.
-He was not aware of the Haldol IM injection being administered at the time the resident was taken to the ED on 06/14/26 and he told the ED provider about the Benztropine.
-The resident also received a low dose of Haldol in the ER because she was agitated when they tried to start intravenous (IV) fluids.
-It was his understanding there were no physician's orders for Resident #6 to receive those medications, but the resident's name was on the labels.
-The resident had never taken those medications previously to his knowledge.
-When Resident #6 returned to the facility the next morning, he spoke with a MA who reported the resident had also received a Haldol injection.
-The MA also gave him a copy of the resident's eMAR and Haldol 100mg injection was documented as administered.
-He later spoke with the Administrator again who claimed she told him about both the Haldol injection and the Benztropine.
-The MAs were not supposed to administer Haldol injections.
-He was not sure if Resident #6 had a MHP at the facility.
-After Resident #6 returned from the ED visit on 06/14/26, the resident was in bed and quiet for a while; they eventually got the resident up into a recliner, but the resident was tired.
-As the days went on, the resident's legs got stiff

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D 358	Continued From page 41 to the point the resident could not separate her knees. -The resident had two falls after the ED visit. -The resident was less verbal and only called his name once or twice after the medication errors. -Two staff had to transfer the resident after the medication errors. -When he visited, Resident #6 would be slumped over in a chair. -Before the medication errors, Resident #6 could walk a little and shuffle her feet. -Resident #6 received therapy at the facility and could walk with or without a walker and dance. -Resident #6 could raise her arms and scratch her nose and head. -Resident #6 had dementia, but she could speak and sing along to music. -Resident #6 could call his name and another family member's name prior to the medication errors. -Later in July 2026, Resident #6 was in the hospital for 13 days because he wanted to have her evaluated again. -He was told at the hospital that the medication effects would wear off but they did not. -The hospital providers were trying to figure out what to give Resident #6 to help her muscles. -Resident #6 was finally given Benztropine and another medication at the hospital to get her muscles working and she was still receiving both medications now. -Resident #6 went to a rehabilitation facility from the hospital for therapy because the hospital providers said she needed a higher level of care. -Resident #6 had improvement in her upper body and as time passed, the resident was able to reuse her arms and could scratch her nose and head. -Resident #6's legs were still stiff and "locked together".	D 358		

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D 358	Continued From page 42 Review of Resident #6's PCP visit note dated 06/23/26 revealed: -The resident was seen to follow up on the resident's status in regard to a recent medication error with Haldol injection and Benztropine. -No acute resident concerns were verbalized by staff on this visit. -The resident was observed sitting in a recliner. -The resident responded verbally to commands and could answer yes/no to questions. -The resident showed no signs of pain/discomfort. -The PCP spoke with the resident's family member via telephone today and notified him of the resident's assessment findings and vital signs. -The resident would continue to be monitored for changes. Review of Resident #6's MHP visit note dated 07/13/26 revealed: -The resident had a history of dementia. -The resident was a poor historian due to her dementia. -The resident was able to answer some basic questions today and occasionally made eye contact, but staff reported the resident had declined some in the last month. -The resident routinely got feeding assistance, but this was at the request of the family. -Staff reported no behavioral or mood disturbances that warranted medication adjustment as she was large at her baseline. -Staff reported the resident did have a history of hallucinations and would often talk to herself but she did not have associated agitation or combativeness with these behaviors. Review of Resident #6's Incident Form dated	D 358		

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D 358	Continued From page 43 07/28/26 at 9:30am revealed: -The resident was sent out via non-emergent medical transport for evaluation per family request. -There was no incident and there was no change in mental or physical status at the time. -The resident's family member discussed his wishes with the resident's PCP and transport was arranged per family request. -The resident was admitted to the hospital for evaluation per family request. Review of Resident #6's facility progress note dated 07/29/26 at 2:25pm revealed the resident was still at the hospital ED per family request. Review of Resident #6's hospital admission and history and physical forms dated 07/28/26 revealed: -The resident presented to the ED with weakness and altered mental status ongoing since mid-June 2026. -The resident was minimally responding to questions in triage. -The resident was alert and oriented to self and stated her first name. -The resident was leaning over in a wheelchair. -According to her family, the resident was mistakenly given a Haldol injection and Benztropine about a month ago, after which she became severely weak, rigid, and markedly disoriented. -According to her family, since the medication error, the resident had been disoriented even to herself and minimally responsive, unable to ambulate, and rigid in all extremities. -The resident's baseline included dementia, with orientation to self but disorientation to year and situation. -During the evaluation, the resident was unable to	D 358		

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participate meaningfully in the interview.
-Upon physical exam, the resident appeared elderly, well-nourished, lethargic, nonverbal, comfortable, and in no acute distress.
-The resident was able to move all four extremities (withdrew from pain).
-There was no tenderness to palpitation, joint swelling, or deformities noted.
-The resident was awake, confused, and nonverbal.
-The resident remained stable while in the ED and was admitted for further workup.
-Upon mental health evaluation, the resident had notable rigidity, with lower extremities worse than the upper extremities.
-The left upper extremity was notable worse than the right upper extremity.
-The MHP noted catatonia (a neuropsychiatric condition involving significant disturbances in movement and behavior) was unlikely as the rigidity was not equal bilaterally.
-Drug-induced parkinsonism (conditions that affect movement) was more likely due to tremors and rigidity.
-If the resident still took an antipsychotic, it was not recommended to restart it.

Interview with the SCC on 08/27/26 at 11:59am revealed:
-She was off on the weekend the medication errors with Resident #6 occurred in June 2026.
-When she returned to work on Monday, 06/15/26, it was reported to her that a MA had approved medications on the eMAR for Resident #6 without an order and another MA had administered the medications.
-The MAs on duty approved medication orders in the eMAR system and once approved, the orders became active on the eMAR.
-The MAs were supposed to compare the

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medication labels with the signed physician's orders to make sure everything matched before they approved orders in the eMAR system.
-The MAs were also supposed to use new order tracking forms that were in the medication office to track orders.
-If the MA could not find a medication order, the MA should notify her or the on-call supervisor.
-The MAs or she could contact the pharmacy or the provider to get a copy of an order if an order could not be found.
-She was not contacted or notified there was no orders for Resident #6 to receive Haldol IM injection or Benztropine.
-The MAs were not allowed to administer IM injections.
-Prior to the medication errors, Resident #6 was ambulatory and could walk on her own with supervision by staff.
-Resident #6 would sometimes walk off on her own and she had good use of her arms and legs.
-Resident #6 was sometimes resistant to care.
-Resident #6 would sing along, dance, clap her hands, and tap her feet.
-Resident #6 was oriented to herself and a family member and would talk and have conversations.
-After the medication errors, Resident #6 had a setback and was not as ambulatory and required more physical assistance with ambulation.
-Other days, Resident #6 would get up and walk with staff holding her hand but not as often as before.
-Resident #6 still knew herself and her family member.
-Resident #6 would still tap her feet and rock her head to music, but she talked a little less than before.
-There were times when Resident #6 would have her head down and her eyes closed but she would acknowledge staff when her name was

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called.
-She never saw Resident #6 in a contracted position with her knees locked together after the medication error.
-Resident #6's family member wanted her evaluated again so she went to the hospital in July 2026 and never returned to the facility.

Interview with the Administrator on 08/27/26 at 12:25pm revealed:
-She was filling in as the supervisor on duty at the facility on third shift (11:00pm - 7:00am) on 06/13/26.
-She was also a nurse and staff asked her to check on Resident #6 at 6:30am on 06/14/26.
-Staff reported the resident was vomiting.
-When she assessed Resident #6, the resident was alert and verbal and stated she did not feel good.
-The resident's vital signs were stable, the resident vomited a small amount and they helped get the resident cleaned up.
-She listened to the resident's abdomen and they gave her some ginger ale to drink.
-When the first shift arrived, she spoke to staff who indicated the resident was "fine" yesterday.
-The first shift MA asked her if she thought the resident's vomiting had anything to do with the Haldol she administered to the resident yesterday.
-She questioned the MA about it and they looked at the eMAR.
-The MA reported there was a syringe in the bag with a Haldol vial and she administered the Haldol IM injection to the resident along with one Benztropine tablet.
-She had to leave a message for the pharmacy but never heard back and called the pharmacy back on Monday, 06/15/26.
-The pharmacy reported the Haldol and

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D 358	Continued From page 47 Benztropine were actually for a different resident at a different facility, and they made a date entry error. -She spoke with Resident #6's family member on Sunday (06/14/26) about mid-morning via cell phone and let him know about the error with Haldol and Benztropine. -The family member indicated later he was only told about Benztropine, but she recalled telling him about the Haldol injection as well. -She spoke with the family member again later that day and the resident continued to vomit so the resident was sent to the hospital ED. -Resident #6's paperwork including the current eMAR were sent with EMS per the facility's protocol. -When Resident #6 returned from the hospital ED to the facility, the resident was quiet and sleepy but was not vomiting. -The pharmacy entered orders into the eMAR system and the MAs approved orders in the eMAR system. -Once approved, orders became active in the eMAR system. -The MAs should not approve any orders in the eMAR system until they compared the medication label with the physician's order and the eMAR entry. -The MAs also used a new order tracking form and if everything matched, the MAs approved the order. -If there was no order, the MAs should call the pharmacy to see if there was an electronic prescription but that did not occur in this situation. -She did not know why the MA did not follow procedure with the Haldol and Benztropine. -The MA should have reported the discrepancy to her or the SCC or the Resident Care Director (RCD) but that was not done. -The first shift MA who administered the Haldol	D 358		

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injection and the Benztropine reported she administered them because they were active orders on the eMAR so they would have already been verified when the medications were received from the pharmacy.
-MAs were not allowed to administer IM injections and the MAs were aware of this.
-Prior to the medication errors, Resident #6 was ambulatory but had been declining.
-Resident #6 would walk some but not as much.
-Resident #6 had a walker and wheelchair but did not use either as much because of the decline.
-Resident #6 would talk about babies and music; the resident would light up and sing and react to music.
-Resident #6 was oriented to herself and family but was becoming disoriented to the family.
-After the medication errors, Resident #6 was a little bit sleepy at first but then she started coming out of it some.
-Resident #6 was usually in a recliner or wheelchair and staff assisted with transfers.
-Resident #6's family would bring her food.
-Resident #6 was not as "spunky" as she was before.
-Resident #6 was not ambulatory as much but her ability to walk started coming back.
-Resident #6's family wanted her re-evaluated so the resident was sent to the hospital at the end of July 2026 and did not return to the facility.
-She was concerned about Resident #6 receiving Haldol and Benztropine without an order because it could cause lethargy which could lead to falls.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/28/26 at 10:47am revealed:
-A pharmacy technician keyed in orders for electronic prescriptions for a Haldol IM injection and Benztropine under the wrong resident profile.

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D 358	Continued From page 49 -She did not catch the error when she checked the medications. -A copy of the electronic prescriptions would have been faxed to the facility. -The orders were keyed and dispensed on 06/12/26. -The pharmacy usually entered orders into the eMAR system and the facility approved the orders so the orders would become active on the eMAR. -No one from the facility contacted the pharmacy prior to administering the medications. -She was not sure if Resident #6 / had any adverse reactions except she thought the resident was sedated. -The pharmacy immediately stopped and removed the orders from the eMAR once they were notified. Interview with Resident #6's PCP on 08/27/26 at 1:42pm revealed: -She was notified by the facility that Resident #6 was administered a Haldol IM injection and Benztropine by a MA. -She nor the resident's MHP in her practice ever prescribed either medication for Resident #6. -She was concerned about the Haldol injections causing nausea, vomiting, tremors, lethargy, changes in physical function such as not being as active. -Resident #6 had dementia and had been having a slow decline prior to the medication errors. -The resident was always quiet but she was sleepier after the medication errors. -She felt like the medication errors exacerbated the resident's decline and made the symptoms more obvious. -She felt like the medication errors contributed to the resident's nausea, vomiting, tremors, and increased sleepiness because the resident was not as interactive after the errors.	D 358		

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D 358	Continued From page 50 -The resident was experiencing progression of her dementia and she did not remember the resident being in a fetal position or her knees being contracted or "locked" together. Telephone interview with Resident #6's MHP on 08/27/26 at 5:10pm revealed: -She saw Resident #6 on 06/08/26 and staff reported no behaviors or mood disturbances. -She had not ordered any Haldol IM injections or Benztropine for Resident #6. -She would not have ordered a Haldol IM injection for Resident #6 because someone had to be stable on oral Haldol for 3 to 6 months prior to starting IM Haldol. -Resident #6 did not have orders for and was not receiving oral Haldol. -She believed Resident #6's nausea, vomiting and lethargy were directly caused by the resident receiving the Haldol IM injection. -She saw the resident again on 07/13/26 and staff reported the resident had declined some in the last month. -The family had requested staff feed the resident to make sure she was eating enough. -The resident was largely at baseline on the 07/13/26 visit. _____ The facility failed to administer medications as ordered to Resident #6 who was administered two medications without orders that did not belong to the resident. Resident #6 was administered an intramuscular (IM) injection of Haldol (an antipsychotic) and one Benztropine tablet (used to treat side effects of antipsychotics) on 06/13/26 by a medication aide (MA). The MA did not follow protocol to compare the medications with the actual orders prior to activating the orders. A second MA did not follow protocol and administered an IM injection when	D 358		

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D 358	Continued From page 51 she was aware MAs were not allowed to administer IM injections. The morning after receiving the medications without an order, Resident #6 had severe nausea and vomiting requiring evaluation at the hospital emergency department (ED). The resident experienced other symptoms after the medication errors including lethargy, tremors, rigidity, increased sleepiness, less verbal and less movement. This failure of the facility resulted in serious physical harm to a resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2026.	D 358		