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HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

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D 000	Initial Comments The Adult Care Licensure Section and Rutherford County Department of Social Services conducted a follow up survey and complaint investigation on October 6, 2026 through October 9, 2026. The Rutherford County Department of Social Services initiated the complaint investigations on September 15, 2026 and on September 23, 2026.	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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled medication aides (Staff B and the Administrator) completed the 5 and 10 or 15-hour medication class and completed the Medication Aide Clinical Skills Competency Validation prior to administering medications. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on	D 125		

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03/16/25.
-Staff B completed the 15-hour MA training course on 03/22/25.
-Staff B completed the MA test on 03/03/25.
-There was no documentation Staff B completed the MA Clinical Skills Competency Validation checklist.

Review of a resident's electronic medication administration record (eMAR) for September 2026 revealed Staff B administered buspirone on 09/04/26, 09/09/26, 09/11/26, 09/14/26, 09/23/26 - 09/26/26, and 09/29/26 - 09/30/26 at 1:00pm.

Review of the same resident's eMAR for 10/01/26 - 10/05/26 revealed Staff B administered buspirone on 10/04/26 and 10/05/26 at 1:00pm.

Review of a second resident's eMAR for September 2026 revealed:
-Staff B administered gabapentin on 09/11/26 at 1:00pm.
-Staff B administered oxycodone on 09/29/26 at 12:00pm and 6:00pm, and 09/30/26 at 12:00pm and 6:00pm

Review of the second resident's eMAR for 10/01/26 - 10/05/26 revealed Staff B administered oxycodone on 10/04/26 and 10/15/26 at 12:00pm and 6:00pm.

Review of a third resident's eMAR for August 2026 revealed Staff B administered oxycodone on 08/19/26 at 6:00pm, 8/20/26 at 12:00am, 6:00am, 12:00pm, and 6:00pm, and 8/26/26 at 8:00am, 12:00pm, and 4:00pm.

Review of a fourth resident's eMAR for September 2026 revealed Staff B administered oxycodone on 09/04/26 at 8:00am, 12:00pm, and

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4:00pm, 09/09/26 at 12:00pm and 4:00pm, 09/11/26 at 8:00am, 12:00pm, and 4:00pm, 09/15/26 at 12:00pm and 4:00pm, 09/17/26 at 8:00am and 12:00pm, 09/21/26 at 8:00am, 12:00pm, 4:00pm, and 8:00pm, 09/24/26 at 10:00am, 2:00pm, and 6:00pm.

Review of the fourth resident's eMAR for 10/01/26 - 10/05/26 revealed Staff B administered oxycodone on 10/04/26 at 10:00am and 6:00pm, and 10/05/26 at 10:00am, 2:00pm, and 6:00pm.

Interview with Staff B on 10/07/26 at 3:35pm revealed:
-She was the lead MA and administered medications to residents.
-She thought she completed the medication clinical skills checklist with a nurse in the past two years but did not have any documentation of it.

Refer to the interview with the Administrator on 10/07/26 at 3:51pm.

2. Review of the Administrator's personnel record revealed:
-She was hired as the Administrator on 07/13/26.
-She completed the MA test on 03/28/17.
-There was no documentation she completed the MA Clinical Skills Competency Validation checklist or the 5 and 10 or 15-hour MA training course.

Review of a resident's eMAR for July 2026 revealed the Administrator administered oxycodone on 07/17/26 at 12:00pm, 4:00pm, 8:00pm, 07/18/26 - 07/19/26 at 8:00am, 12:00pm, 4:00pm, and 8:00pm, 07/20/26 - 07/21/26 at 8:00am, 12:00pm, and 4:00pm, and 07/31/26 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

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Review of the same resident's eMAR for August 2026 revealed the Administrator administered oxycodone on 08/21/26 - 08/22/26 at 12:00am and 6:00am.

Review of a second resident's electronic medication administration record (eMAR) for August 2026 revealed the Administrator administered Hyoscyamine (decreases secretions) on 08/09/26 at 7:00am and 7:00pm, 08/10/26 at 7:00am, 08/14/26 at 7:00pm, 08/15/26 at 7:00am, 08/21/26 at 7:00am and 7:00pm, and 08/22/26 at 7:00pm.

Interview with the Administrator on 10/07/26 at 3:51pm revealed:
-She did not complete a medication clinical skills checklist.
-She thought she may have taken a 15-hour MA training course but did not have any documentation and did not know when.

Refer to the interview with the Administrator on 10/07/26 at 3:51pm.

Refer to Tag 338, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).

Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation).

Interview with the Administrator on 10/07/26 at 3:51pm revealed:
-She thought MAs were only required to pass the MA test before administering medications.
-She did not know MAs were required to complete a medication clinical skills checklist.
-She was responsible for ensuring that all staff completed all training required to administer medications.

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D 125	Continued From page 4 -She was responsible for auditing personnel records, but she had not done any audits. _____ The facility failed to ensure 2 of 5 sampled staff (Staff B and the Administrator) who administered medications to residents, completed the medication clinical checklist and the state approved 5-hour and 10-hour, or 15-hour medication aide training courses prior to administering medications. This failure was detrimental to the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 7, 2026 for this violation. THE CORRECTION DATE FOR THIS B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2026.	D 125		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way	D 167		

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D 167	Continued From page 5 valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure there was at least one staff on premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, for 1 of 3 sampled staff (Staff A). The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 06/16/26 as a medication aide (MA). -There was no documentation of CPR certification. Interview with Staff A on 10/07/26 at 3:20pm revealed: -She worked on 10/03/26 from 7:00pm - 7:00am with no other staff inthe facility because the other staff did not show up for work. -She thought she had CPR in the past but did not know where her CPR certification card was or if it was expired. Interview with the Administrator on 10/07/26 at 3:51pm revealed: -She did not know that Staff A did not have documentation of CPR. -She was responsible for ensuring that staff had	D 167		

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D 167	Continued From page 6 all their requirements to include CPR. -She was responsible for auditing personnel records but had not conducted any audits.	D 167		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the Administrator failed to ensure the overall management and day to day operations of the facility to meet and maintain rules related to	D 176		

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D 176	Continued From page 7 qualifications of medication staff, training on cardio-pulmonary resuscitation, health care, nutrition and food service, activities program, resident rights, medication administration, and controlled substances. The findings are: Review of the facility's license revealed it was effective 01/01/26 through 12/31/26 for a capacity of 44 residents. Review of the facility's census on 10/06/26 revealed there were 15 residents residing in the facility. Interview with the Administrator on 10/09/26 at 8:11am revealed: -She worked Monday through Friday from 9:00am to 5:00pm and was available during the weekends. -She was responsible for the daily operations of the facility. -She and the lead medication aide (MA) were responsible for medication cart audits. -She had not completed a medication cart audit since she became the administrator in July 2026. -She did not know when medication cart audits were supposed to be completed. Interview with the Director of Regional Operations on 10/09/26 at 10:51am revealed: -The Administrator was hired sometime in the middle of July 2026. -The Administrator was responsible for ensuring compliance of state regulations, staffing and review of medication carts. -The Administrator was expected to manage the day to day operations of the facility.	D 176		

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D 176	Continued From page 8 Interview with the Administrator on 10/06/26 at 3:40pm revealed: -No one was assigned to do medication cart audits. -She did not know why some scheduled medications were running out before the new cycle fill supply of medication was scheduled to start. -At the end of September 2026, the lead MA and another MA informed her of missing residents' medications and she did not do anything because she knew cycle fill medications were due to start the next day or the day after. Interview with the Administrator on 10/07/26 at 8:46am, 1:18pm, and 3:51pm revealed: -There was not any documentation by staff of a resident's fall which resulted in a fractured hip but she knew it happened after 5:00pm. -She did not document anything about the resident's fall. -She did not ask the staff any questions about the resident's fall. -When asked why she did not question staff or document anything about the fall, she did not respond. -She was responsible for auditing personnel records but had not conducted any audits. -She thought medications aides (MAs) were only required to pass the North Carolina Medication Aide Exam to administer medications because it was a state exam. -She did not know the MAs were required to have 15 hours of MA training and have a MA clinical skills checklist. -She did not know that there should be 14 hours of group activities each week. Interview with the Administrator on 10/07/26 at 2:36pm and 3:23pm revealed:	D 176		

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D 176	Continued From page 9 -She did not send in a 5-Day Investigation Report to HCPR regarding missing oxycodone (treats pain). -She was unaware she was required to send in a 5-Day Investigation Report to HCPR. -She did not keep documentation of any of the interviews she conducted with the staff. -She did not document the staff she drug tested or the results. -The drug screens were "instant" and she threw them away without documenting the results. -She did not report a resident's missing oxycodone to the facility's contracted pharmacy. -She did not audit any other controlled substances for any of the other residents in the facility. Interview with the Administrator on 10/08/26 at 2:30pm revealed she did not report a second resident's oxycodone was missing to the facility's contracted pharmacy, local law enforcement and HCPR because she did not know medications were missing. Telephone interview with a former employee on 10/08/26 at 3:00pm revealed: -She discussed with the Administrator that residents' pain medication was missing. -The Administrator did not "act like she cared" that medication was missing. -The Administrator hired anyone that just had to pass the MA test to administer medications but did not have the required 5, 10, or 15 hour MA training or the medication aide clinical skills checklist. Non-compliance was identified at a violation level in the following rule areas: 1. Based on observations, interviews, and record	D 176		

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reviews, the facility failed to ensure 1 of 4 sampled residents (Resident #6) was protected from neglect and treated with dignity and respect related to withholding a wheelchair required for mobility [Refer to tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 5 sampled residents (#1, #2, #3, #4, #5) related to medications used to treat pain (#2, #4, #5), atrial fibrillation (#5), hypothyroidism (#5), high blood pressure (#3), depression (#3), and sleep (#1). [Refer to tag 358, NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].

3. Based on observations, interviews and record reviews the facility failed to ensure a record of controlled substances that reconciled the receipt, administration, and disposition of controlled medications for 2 of 2 sampled residents (#4 and #5) related to controlled pain relievers (#4 and #5) [Refer to tag 392, 10A NCAC 13F .1008(a) Controlled Substance (Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to report known drug diversion of controlled substances to the pharmacy and submit a 5 day report to the Health Care Personnel Registry as required by state law for 1 resident (Resident #5) for a controlled medication used to treat moderate to severe pain [Refer to tag 399, 10A NCAC 13F .1008(h) Controlled Substance (Type B Violation)].

5. Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled medication aides (Staff B and Administrator) completed the 5 and 10 or 15-hour medication class and

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D 176	Continued From page 11 completed the Medication Aide Clinical Skills Competency Validation prior to administering medications [Refer to tag 125, 10A NCAC 13F.0403(a) Qualification of Medication Staff (Type B Violation)]. _____ The Administrator failed to ensure the overall operations and management of the facility to maintain substantial compliance with the rules and statutes governing adult care homes as related to qualifications of medication staff, resident rights, medication administration, controlled substance, and Health Care Personnel Registry. This failure resulted in serious physical harm due to medication errors, a resident who sustained a fractured hip during a fall after his wheelchair was not returned to him, a resident who was hospitalized due to opioid withdrawal symptoms after not being administered oxycodone and a second resident experienced opioid withdrawal symptoms after not being administered oxycodone, failure to investigate and complete a 24-hour and 5-day Health Care Personnel Registry report for missing oxycodone and failure to report to local law enforcement a resident's missing oxycodone which allowed drug diversion to continue. This failure resulted in serious neglect and serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 9, 2026 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2026	D 176		

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D 273	Continued From page 12	D 273		
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 reviews, the facility failed to notify the primary care provider for 3 of 5 sampled residents (#2, #4, #5) related to requesting timely narcotics refills and missed doses of medications. The findings are: 1. Review of Resident #5's FL2 dated 06/17/26 revealed diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in body tissues), paroxysmal atrial fibrillation (heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days), atrial flutter (abnormal heart rhythm), and type 2 diabetes. a. Review of Resident #5's FL2 dated 06/17/26 revealed oxycodone 15mg IR (used to treat moderate to severe pain) one tablet every six hours. Review of a copy of Resident #5's electronic prescription dated 07/10/26 revealed: -Discontinue oxycodone 15mg IR one tablet every six hours. -Start oxycodone 15mg IR one tablet every four hours. Review of a copy of Resident #5's electronic prescription dated 07/10/26 revealed oxycodone	D 273		

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15mg IR one tablet every four hours.

Review of a copy of Resident #5's electronic prescription dated 09/02/26 revealed oxycodone 30mg IR one half tablet every four hours.

Review of Resident #5's current FL2 dated 10/01/26 revealed oxycodone 15mg IR one tablet every four hours.

Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone 15mg IR one tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 06/29/26 and stop date of 07/10/26.
-The oxycodone 15mg IR every 6 hours was documented as administered 28 occurrences out of 38 opportunities.
-The oxycodone was documented as not administered on 07/03/26 at 6:00am due to "medication out of stock."
-There was an entry for oxycodone 15mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR every 4 hours was documented as administered 123 occurrences out of 129 opportunities.

Review of Resident #5's August 2026 eMAR revealed:
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR every 4 hours was

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documented as administered 173 occurrences out of 186 opportunities.
-The oxycodone 15mg IR was documented as not administered on 08/30/26 at 8:00pm, 08/31/26 at 12:00am, 08/31/26 at 4:00am, 08/31/26 at 8:00am, 08/31/26 at 12:00pm, 08/31/26 at 4:00pm, and 08/31/26 at 8:00pm due to "medication out of stock-reordered".

Review of Resident #5's September 2026 eMAR revealed:
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR every 4 hours was documented as administered 2 occurrences out of 12 opportunities.
-The oxycodone 15mg IR was documented as not administered on 09/01/26 at 8:00am, 09/01/26 at 12:00pm, 09/01/26 at 4:00pm, 09/01/26 at 8:00pm, 09/02/26 at 12:00am, and 09/02/26 at 4:00am, 09/02/26 at 12:00pm, 09/02/26 at 4:00pm, 09/02/26 at 8:00pm, on 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock."
-The oxycodone 15mg IR was documented as not administered on 09/02/26 at 8:00am due to resident out of facility.
-There was an entry for oxycodone 30mg half tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/02/26 and stop date of 09/09/26.
-The oxycodone 30mg IR half tablet every 4 hours was documented as administered 37 occurrences out of 42 opportunities.
-The oxycodone 30mg IR half tablet was documented as not administered on 09/03/26 at

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D 273	Continued From page 15 12:00am, 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/10/26 and stop date of 09/25/26. -The oxycodone 15mg IR was documented as administered 102 occurrences out of 115 opportunities. -The oxycodone 15mg IR was documented as not administered on 09/10/26 at 8:00pm and 09/11/26 at 12:00am due to "medication out of stock." Review of Resident #5's October 2026 eMAR 10/01/26 to 10/06/26 revealed: -There was an entry for oxycodone 15mg IR one tablet every four hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 8:00pm, and 10:00pm with a start date of 9/10/26. -The oxycodone 15mg IR was documented as administered for 27 occurrences out of 29 opportunities. -The oxycodone was documented as not administered on 10/02/26 at 10:00am due to staff was working with another resident and missed administration time. -The oxycodone was documented as not administered on 10/04/26 at 2:00pm due to "resident refused." Observation of Resident #5's oxycodone 15mg IR on hand on 10/07/26 at 9:57am revealed: -There was one bubble pack of oxycodone 15mg IR tablets with 11 tablets remaining. -The pharmacy label directions were oxycodone 15mg IR one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.	D 273		

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Review of Resident #5's controlled substance count sheets (CSCS) in a book on the top of the medication cart on 10/07/26 at 9:50am revealed:
-The CSCS for the bubble pack of oxycodone 15mg IR tablets was available in the CSCS book.
-The entries on the CSCS matched the number of oxycodone in the bubble pack.

Observation of Resident #5's oxycodone 15mg IR stored in the safe in the Administrator's office on 10/07/26 at 9:59am revealed:
-There was one bubble pack of oxycodone 15mg IR tablets with 30 tablets remaining.
-The pharmacy label directions were oxycodone 15mg IR one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.
-The CSCS dated 09/25/26 was kept with the bubble pack of oxycodone 15mg IR tablets in the Administrator's safe.

Telephone interview with a representative from the facility's contracted pharmacy on 10/07/26 at 4:22pm revealed:
-The pharmacy received electronic medication orders for Resident #5's pain medication from the primary care provider (PCP).
-The pharmacy received an electronic medication order dated 07/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity of 180 on 07/11/26.
-The pharmacy received an electronic medication order dated 08/11/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 180 on 08/11/26.
-The pharmacy received an electronic medication order dated 09/02/26 for oxycodone 30mg IR one half tablet every four hours and dispensed quantity 21 on 09/02/26.
-The pharmacy received an electronic medication order dated 09/10/26 for oxycodone 15mg IR one

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tablet every four hours and dispensed quantity 90 on 09/10/26.
-The pharmacy received an electronic medication order dated 09/25/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/25/26.
-The pharmacy received an electronic medication order dated 10/05/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 42 on 10/07/26.

Interview with Resident #5 on 10/07/26 at 10:20am revealed:
-She recently missed doses of oxycodone and she "hurt so bad" and was "miserable".
-The oxycodone was ordered for pain she experienced in her left shoulder and hip.
-She went through "withdrawals" due to missing the oxycodone.
-She had no appetite, did not want to get out of bed, experienced changes in her attitude, and withdrew from other people as a result of missing the oxycodone.

Telephone interview with Resident #5's primary care provider (PCP) on 10/08/26 at 11:15am revealed:
-She was notified on 09/02/26 Resident #5's oxycodone 15mg IR tablet supply was missing from the facility.
-She ordered the oxycodone to treat Resident #5's shoulder pain.
-She was not aware Resident #5 missed seven doses of oxycodone 15mg IR 08/30/26-08/31/26 and 10 doses 09/01/26-09/02/26.
-Missing consecutive doses of oxycodone could cause Resident #5 to have withdrawal symptoms including diarrhea, gastrointestinal upset, anxiety, headaches, agitation, and pain.

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D 273	Continued From page 18 Refer to the interview with the Lead MA on 10/08/26 at 10:00am. Refer to the interview with the Administrator on 10/08/26 at 3:40pm. b. Review of Resident #5's FL2 dated 06/17/26 revealed flecainide acetate 50mg (used to treat atrial fibrillation) one tablet at bedtime. Review of Resident #5's current FL2 dated 10/01/26 revealed flecainide acetate 50mg one tablet at bedtime. Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for flecainide acetate 50mg one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26. -The flecainide acetate 50mg was documented as administered 23 out of 31 opportunities. -The flecainide acetate 50mg was documented as not administred on 07/22/26, 07/24/26, and 07/25/26 due to medication "out of stock-reordered". Review of Resident #5's August 2026 eMAR revealed: -There was an entry for flecainide acetate 50mg one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26. -The flecainide acetate 50mg was documented as administered 30 out of 31 opportunities. -The flecainide acetate 50mg was documented as not administered on 08/23/26 due to "medication out of stock-reordered". Review of Resident #5's September 2026 eMAR revealed:	D 273		

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D 273	Continued From page 19 -There was an entry for flecainide acetate 50mg one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26. -The flecainide acetate 50mg was documented as administered 27 occurrences out of 29 opportunities. Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/07/26 at 10:52am revealed they dispensed flecainide acetate 50mg tablets for Resident #5 in cycle fill on 06/24/26, 07/21/26, 08/18/26, 09/15/26 each dispense provided a 28-day supply. Interview with Resident #5 on 10/07/26 at 10:20am revealed: -She had a pacemaker. -She did not know she missed flecainide acetate 50mg doses in July and August 2026. -She could not recognize flecainide acetate in with her other medications in a cup. -The medication aides (MA) brought her medications to her in a cup. -She would not recognize if one medication was missing from the cup. -She did not know if she felt differently by missing doses. Telephone interview with Resident #5's primary care provider (PCP) on 10/08//26 at 11:15am revealed: -The facility did not let her know Resident #5 missed doses of flecainide acetate 50mg in July 2026 and August 2026. -Missed doses of flecainide acetate could cause an episode of uncontrolled atrial fibrillation symptoms of which would include chest pain or shortness of breath. Refer to the interview with the Lead MA on	D 273		

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10/08/26 at 10:00am.

Refer to the interview with the Administrator on 10/08/26 at 3:40pm.

d. Review of Resident #5's FL2 dated 06/17/26 revealed levothyroxine 88mcg (used to treat hypothyroidism) one tablet daily.

Review of Resident #5's current FL2 dated 10/01/26 revealed levothyroxine 88mcg one tablet daily.

Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26.
-The levothyroxine 88mcg was documented as administered 22 occurrences out of 31 opportunities.
-The levothyroxine 88mcg was documented as not administered on 07/20/26-07/24/26, and 07/26/26 due to "medication out of stock-reordered".

Review of Resident #5's August 2026 eMAR revealed:
-There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26.
-The levothyroxine 88mcg was documented as administered 26 occurrences out of 31 opportunities.
-The levothyroxine 88mcg was documented as not administered on 07/22/26 and 07/24/26 due to "medication out of stock-reordered".

Review of Resident #5's September 2026 eMAR

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revealed:
-There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26.
-The levothyroxine 88mcg was documented as administered 24 occurrences out of 29 opportunities.
-The levothyroxine 88mcg was documented as not administered on 09/17/26, 09/18/26, and 09/22/26 due to "medication out of stock-reordered".

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/07/26 at 10:52am revealed they dispensed levothyroxine 88mcg tablets for Resident #5 in cycle fill on 06/24/26, 07/21/26, 08/18/26, 09/15/26 each dispense provided a 28-day supply.

Interview with Resident #5 on 10/07/26 at 10:20am revealed:
-She had taken the levothyroxine "her whole life" and it was a medication she needed everyday.
-When she missed multiple consecutive doses of levothyroxine, she felt "faraway" like she did not want to do "anything".

Telephone interview with Resident #5's primary care provider (PCP) on 10/08//26 at 11:15am revealed:
-The facility did not let her know Resident #5 missed doses levothyroxine in July 2026, August 2026, and September 2026.
-Missing doses of levothyroxine could cause the levothyroxine to be less effective in treating underactive thyroid.

Refer to the interview with the Lead MA on 10/08/26 at 10:00am.

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Refer to the interview with the Administrator on 10/08/26 at 3:40pm.

2. Review of Resident #3's current FL2 dated 04/09/26 revealed diagnoses included dilation of aorta (abnormal stretching of the aorta), coronary artery disease (a condition in which the major blood vessels supplying the heart muscle become narrowed or blocked), chronic obstructive pulmonary disease (a progressive, long-term lung condition that makes it increasingly difficult to breathe by causing chronic inflammation and obstructed airflow), chronic kidney disease, and major depressive disorder.

a. Review of Resident #3's primary care provider (PCP) order dated 05/04/26 revealed olmesartan 20mg (used to treat high blood pressure) one tablet daily.

Review of Resident #3's September electronic medication administration record (eMAR) revealed
-There was an entry for olmesartan 20mg one tablet daily scheduled at 8:00am with a start date of 04/21/26.
-The olmesartan 20mg was documented as administered 29 occurrences out of 30 opportunities.
-The olmesartan 20mg was documented as not administered on 09/22/26 due to "medication out of stock-reordered".

Telephone interview with the facility's contracted pharmacy representative on 10/07/26 at 1:19pm revealed the pharmacy dispensed olmesartan 20mg tablets on 7/21/26, 8/18/26, and 9/15/26 28-day supply.

Telephone interview with Resident #3's primary

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care provider (PCP) on 10/08//26 at 11:15am revealed:
-The facility did not let her know Resident #3 missed olmesartan 20mg on 09/22/26 due to the medication being out of stock.
-The olmesartan 20mg was ordered to treat high blood pressure.
-Resident #3 could have experienced a high blood pressure as a result of missing a dose of the olmesartan.

Interview with a medication aide (MA) on 10/06/26 at 11:58am revealed:
-They ran out of some scheduled medications early in September 2026.
-She told the Lead MA she was out of olmesartan for Resident #3.
-The Lead MA started medications received for cycle fill a day early so the residents had the scheduled medications they needed.
-She was instructed to let the Lead MA and the Administrator know when medications were not available for administration.

Interview with the Lead MA on 10/08/26 at 10:15am revealed:
-She took over the responsibility of scanning cycle fill delivery from the contracted pharmacy on 09/17/26.
-She scanned all of Resident #3's medications received from the pharmacy into the eMAR system and placed them on the medication cart.
-She did not know why the MAs documented not having the medications to administer because the medications were available.

Refer to the interview with the Lead MA on 10/08/26 at 10:00am.

Refer to the interview with the Administrator on

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D 273	Continued From page 24 10/08/26 at 3:40pm. b. Review of Resident #3's primary care provider's (PCP) order dated 05/04/26 revealed duloxetine (used to treat depression) 60mg one capsule every morning. Review of Resident #3's mental health provider (MHP) order dated 08/28/26 revealed: -Discontinue duloxetine 60mg one tablet daily. -Start duloxetine 40mg one tablet twice daily for depression. Review of Resident #3's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for duloxetine 60mg one capsule every morning scheduled at 8:00am with a start date of 04/21/26 and stop date of 08/28/26. -The duloxetine 60mg was documented administered 28 occurrences out of 29 opportunities. -The duloxetine 60mg was documented as not administered on 08/24/26 due to "medication out of stock-reordered". -There was an entry for duloxetine 40mg one capsule twice a day scheduled at 7:00am and 7:00pm with a start date of 08/28/26. -The duloxetine 40mg was documented as not administered on 08/29/26 due to "requires approval or prior authorization" and 08/31/26 due to "medication out of stock-reordered". Review of Resident #3's September 2026 eMAR revealed: -There was an entry for duloxetine 40mg one capsule twice a day scheduled at 7:00am and 7:00pm with a start date of 08/28/26. -The duloxetine 40mg was documented	D 273		

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administered 49 occurrences out of 60 opportunities.
-The duloxetine 40mg was documented as not administered on 09/01/26 at 7:00am, 09/03/26 at 7:00am, 09/03/26 at 7:00pm, 09/04/26 at 7:00am, 09/05/26 a 7:00am, 09/19/26 at 7:00pm, 09/20/26 at 7:00am, 09/20/26 at 7:00pm, 09/21/26 at 7:00pm, and 09/22/26 at 7:00am due to "medication out of stock-reordered".

Observation of Resident #3's medications on hand on 10/06/26 at 11:32am revealed there were ten capsules of duloxetine 40mg available for administration with a dispense date of 09/22/26.

Telephone interview with the facility's contracted pharmacy representative on 10/07/26 at 1:19pm revealed:
-The pharmacy dispensed a 15-day supply of duloxetine 40mg capsules were sent on 8/28/26.
-The pharmacy dispensed 56 capsules duloxetine 40mg capsules on 09/15/26 to start cycle fill on 09/22/26.
-There was enough duloxetine sent Resident #3 should not have been without the medication.

Telephone interview with Resident #5's primary care provider (PCP) on 10/08//26 at 11:15am revealed:
-The facility did not let her know Resident #3 missed one dose of duloxetine 40mg in August 2026 and 10 doses of in September 2026 due to the medication being out of stock.
-The duloxetine was ordered for major depressive disorder.
-The duloxetine should not be stopped and restarted after missed consecutive doses.
-Missing doses of duloxetine could affect Resident #5's mental health.

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D 273	Continued From page 26 Interview with the Lead MA on 10/08/26 at 10:15am revealed: -She took over the responsibility of scanning cycle fill delivery from the contracted pharmacy on 09/17/26. -She scanned all of Resident #3's medications received from the pharmacy into the eMAR system and placed them on the medication cart. -She did not know why the MAs documented not having the medications to administer because the medications were available. Refer to the interview with the Lead MA on 10/08/26 at 10:00am. Refer to the interview with the Administrator on 10/08/26 at 3:40pm. _____ Interview with the Lead MA on 10/08/26 at 10:00am revealed: -The MAs were supposed to contact her with any issues they had with missing medications. -She was responsible for communicating medication issues to the PCP through an electronic communication application. Interview with the Administrator on 10/08/26 at 3:40pm revealed: -The medication aides should communicate with the primary care provider (PCP) when medications were not available for administration. -The MAs should use the telehealth application to communicate any issues with medications to the PCP. -Her expectation was for the MAs to report medications out of stock to the PCP on the day they realized the medications were not available. 3. Review of Resident #2's current FL2 dated 07/16/26 revealed:	D 273		

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-Diagnoses included acute respiratory failure with hypoxia (lungs cannot properly oxygenate blood), chronic obstructive pulmonary disease, muscle weakness, type 2 diabetes mellitus without complications, bilateral primary osteoarthritis of hip, benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate without noticeable voiding problems).

Review of Resident #2's Resident Register revealed an admission date of 08/04/26.

Review of Resident #2's physician orders dated 08/10/26 revealed gabapentin 600mg 1 tab 3 times daily for chronic pain and restless legs.

Review of Resident #2's electronic medication administration record (eMAR) for September 2026 revealed there was an entry for gabapentin 600mg 1 tablet 3 times daily and documentation the gabapentin was not administered 09/18/26 - 09/22/26 due to medication out of stock - reordered.

Interview with Resident #2's PCP on 10/08/26 at 11:45am revealed:
-Gabapentin was prescribed for pain management.
-She was not aware Resident #2 was not administered gabapentin from 09/18/26 through 09/22/26.
-Doses should be tapered and not suddenly stopped.
-Resident #2 would have experienced increased pain if medication were suddenly stopped.
-Resident #2 was safe to restart gabapentin.

Interview with the Lead MA on 10/08/26 at 9:58am revealed:
-Medication Aides (MA) were responsible for

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communicating medication issues to the Lead MA.
-She was responsible for communicating with the Administrator about issues with medications that can't be resolved.
-She was not sure why Resident #2 did not receive gabapentin from 09/18/26 through 09/22/26.
-The cycle fill was delivered on 09/17/26 and Resident #2's medications should have been in the cart.
-She would check in the overstock drawer if a medication was not on the cart.
-She would reorder medications if none were found in the overstock drawer.
-She checked the cart 2 or 3 times per week to review all residents' medications and reorders as needed.

Interview with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 8:11am revealed:
-Medications should be scanned on the cart and extra medications should be locked in the office safe.
-She expected staff to give medications as prescribed.
-MAs should call the pharmacy to reorder medications when they were out of stock.
-The Lead MA should have called the PCP multiple times and documented the call if a residents' medication was out of stock.
-She was responsible for the daily operations of the facility.
-She and the lead medication aide (MA) were responsible for medication cart audits.
-She had not completed a medication cart audit since she became the administrator in July 2026.
-She did not know when medication cart audits were supposed to be completed.

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4. Review of Resident #4's current FL2 dated 05/13/26 revealed:
-Diagnoses included muscle wasting and atrophy, poly neuropathy, chronic embolism, thrombosis of left femoral vein, type 2 diabetes, paroxysmal atrial fibrillation(where the heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days).
-There was an order for oxycodone HCl 10mg (used to treat moderate to severe pain) one tablet every four hours as needed.

Review of Resident #4's physician orders dated 07/10/26 revealed oxycodone 10mg one tablet every four hours.

Review of Resident #4's July 2026 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm and 8:00pm with a start date of 07/10/26.
-The oxycodone 15mg every 6 hours was documented as administered 126 occurrences out of 129 opportunities.
-The oxycodone was documented as not administered on 07/12/26 at 12:00am due to "resident was asleep."
-The oxycodone was documented as not administered on 07/17/26 at 4:00am due to "resident was asleep."
-The oxycodone was documented as not administered on 07/31/26 at 12:00am due to "resident was asleep."

Review of Resident #4's physician order dated 07/27/26 revealed Resident #4 was to

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self-administer oxycodone 10mg every 4 hours as needed.

Review of Resident #4's August 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stopped on 08/06/26.
-There were no entries for oxycodone 10mg from 8:00pm on 08/06/26 through 8:00am on 08/19/26.
-The oxycodone 10mg every 4 hours was documented as administered 97 occurrences out of 101 opportunities.
-The oxycodone 10mg was documented as not administered on 08/24/26 at 8:00pm due to "withheld per Dr/RN orders."
-The oxycodone 10mg was documented as not administered on 08/25/26 at 12:00am due to "withheld per Dr/RN orders."
-The oxycodone 10mg was documented as not administered on 08/25/26 at 4:00am due to "withheld per Dr/RN orders."
-Review of Resident #4's records revealed no orders available to withhold oxycodone.

Review of Resident #4's September 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 08/26/26 and stop date on 09/12/26.
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/12/26 and stop date on 10/05/26.
-The oxycodone 10mg every 4 hours was

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documented as administered 179 occurrences out of 180 opportunities.
-The oxycodone 10mg was documented as not administered on 09/04/26 at 8:00am due to "requires prior approval or prior authorization."

Review of Resident #4's October 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 10/05/26/26 and no stop date.
-The oxycodone 10mg every 4 hours was documented as administered 44 occurrences out of 46 opportunities.
-The oxycodone 10mg was documented as not administered on 10/02/26 at 10:00am due to "resident refused."
-The oxycodone 10mg was documented as not administered on 10/04/26 at 2:00pm due to "resident refused."

Observation of Resident #4's oxycodone 10mg stored in the safe in the Administrator's office on 10/08/26 at 2:30pm and review of the Administrator's notes on 10/09/26 at 2:45pm revealed there were three bubble packs of oxycodone 10mg tablets with a quantity of 90 tablets remaining.

Interview with Resident #4 on 10/09/26 at 8:32am revealed:
-He was prescribed oxycodone for right shoulder pain due to surgical repair of a torn rotator cuff and several vertebrae being fused in his spine.
-He was "miserable" due to pain when he did not receive his oxycodone as it was ordered.
-His current order was for him to receive oxycodone every 4 hours.
-If he missed one dose, he had pain, but it was

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not excruciating.
-If he missed two to three days of his oxycodone it "takes a while" when it was restarted to get relief from the pain.
- "Consistency was key" with pain medications.
-He recently went without his oxycodone.
-He did not know what happened to his supply of oxycodone.
-The oxycodone was sent from the pharmacy, but he did not know what happened to them after they were delivered to the facility.
-In August 2026, he had gone at least 48 hours without his oxycodone and was in full withdrawal.
-He had to go to the hospital to be stabilized.
-The hospital gave him a prescription for a week's worth of oxycodone, since there were none available at the facility.
-The hospital prescription for oxycodone was filled at a local pharmacy.
-The facility's contracted pharmacy sent another supply of oxycodone the evening he returned from the hospital.
-The facility staff stored his oxycodone for him.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 10/08/26 at 11:45am and 10/09/26 at 11:48am revealed:
-Resident #4 was without his oxycodone for approximately 2 days in August.
-Resident #4 had gastrointestinal pain which is a symptom of withdrawal from oxycodone.
-She had concerns about Resident #4's oxycodone disappearing.
-She prescribed for Resident #4 to self-administer to help control medications from disappearing.
-She prescribed for Resident #4 to self-administer medication on 07/27/26.
-Resident #4 was approximately 1 day short of oxycodone from her last count.
-Resident #4 was self-administering his own

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D 273	Continued From page 33 medications including oxycodone for a period of time. -She felt Resident #4 was capable of self-administering his own medications. -She did not have Resident #4's records with her and couldn't recall exact dates. Interview with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 10:34am revealed: -Resident #4 was prescribed to self-administer medications including oxycodone. -She was informed on 08/19/26 by the Director of Regional Operations that residents were not permitted to self-administer controlled substances. -She did not recall if Resident #4's PCP was informed that he was not permitted to self-administer controlled substances.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to have a matching therapeutic diet menu for 1 of 1 sampled resident	D 296		

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D 296	Continued From page 34 (#1) with a physician-ordered therapeutic diet for guidance of food service staff related to a pureed diet with honey thickened liquids. The findings are: Observation of the kitchen during initial tour on 10/06/26 at 10:00am revealed therapeutic diet menus were not available for guidance. Review of Resident #1's current FL2 dated 09/10/26 revealed diagnoses included severe dementia, cervicalgia (acute neck pain in the cervical spine), hypertension, failure to thrive, hyperlipidemia, osteoporosis and headaches. Review of Resident #1's physician's orders dated 09/22/26 revealed a pureed diet with honey thickened liquids. Observation of Resident #1's lunch meal on 10/06/26 from 12:00pm to 12:45pm revealed she was served a pureed hot dog, apple sauce and honey thickened unsweetened tea. Interview with a cook on 10/06/26 at 3:57pm revealed: -He did not have a menu for a pureed honey thickened liquid diet. -He used the regular menu as guidance for everyone's diet. -He was not sure who was responsible for updating menus. Interview with the Administrator on 10/09/26/26 at 8:11am revealed: -She was responsible for the daily operation of the facility. -The facility did not have menus for therapeutic	D 296		

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D 296	Continued From page 35 diets, only the regular menu. -She knew a current list of residents on therapeutic diets was supposed to be posted in the kitchen. -She knew therapeutic diet menus needed to be available for kitchen staff. -She did not know why therapeutic diet menus are not available in the kitchen. Interview with the Director of Regional Operations on 10/09/26 at 10:51am revealed: -The administrator was expected to manage the day to day operations of the facility. -The Administrator was expected to ensure each department was in compliance with regulations.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff related to 1 resident (#1) who had a pureed	D 309		

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diet with honey thickened liquids (#1).

The findings are:

Observation of the kitchen during initial tour on 10/06/26 at 10:00am revealed a list of residents ordered therapeutic diets was not updated and available for staff guidance.

Interview with the cook on 10/06/26 at 3:57pm and 10/07/26 at 9:10am revealed:
-He knew one resident was on a pureed honey thickened liquid diet.
-The Administrator or personal care aides (PCA) would inform him when a residents therapeutic diet changed.
-He was not sure who was responsible for updating diet lists.
-He did not know why the list of residents with therapeutic diets was not updated.

Review of Resident #1's current FL2 dated 09/10/26 revealed diagnoses included severe dementia, cervicalgia (acute neck pain in the cervical spine), hypertension,
failure to thrive, hyperlipidemia, osteoporosis and headaches.

Review of Resident #4's physician's orders dated 09/22/26 revealed a pureed diet with honey thickened liquids.

Observation of Resident #1's lunch meal on 10/06/26 from 12:00pm to 12:45pm revealed she was served a pureed hot dog, apple sauce and honey thickened unsweetened tea.

Interview with the cook on 10/06/26 at 3:57pm and 10/07/26 at 9:10am revealed:
-He knew Resident #1 was on a pureed honey

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D 309	Continued From page 37 thickened liquid diet. -He did not recall who informed him when Resident #1's diet changed to pureed honey thickened liquids. Interview with the Administrator on 10/09/26/26 at 8:11am revealed: -She was responsible for the daily operation of the facility. -The facility did not have menu for therapeutic diets, only the regular menu. -She knew a current list of residents on therapeutic diets was supposed to be posted in the kitchen. -She knew therapeutic diet menus needed to be available for kitchen staff. -She did not know why therapeutic diet menus are not available in the kitchen. Interview with the Director of Regional Operations on 10/09/26 at 10:51am revealed: -The administrator was expected to manage the day to day operations of the facility. -The Administrator was expected to ensure each department was in compliance with regulations.	D 309		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 317		

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facility failed to ensure a minimum of 14 hours of group activities were provided each week for the residents.

The findings are:

Review of the facility's activity calendar for October 2026 on 10/06/26 revealed:
-It was posted on a wall in a main hallway.
-There were scheduled activities listed each day of the month but there were not any start and stop times for each activity.

Interview with one resident on 10/06/26 at 8:45am revealed:
-She did not know why the activity calendar had scheduled activities when the facility did not do what was posted except bingo.
-She would like to do something besides go to medical appointments or sit in her room.

Interview with a second resident on 10/06/26 at 9:12am revealed the facility only offered bingo and he would like to go shopping.

Interview with a third resident on 10/06/26 at 9:14am revealed activities were not offered daily.

Interview with a fourth resident on 10/06/26 at 8:47am revealed:
-He did not know what activities the facility offered.
-He would only participate in an activity if it involved food.
-He did not remember the last activity he participated in.

Interview with a fifth resident on 10/06/26 at 9:08am revealed:
-The facility offered bingo as an activity.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 317	Continued From page 39 -Residents would also come together in the living room to talk and be with each other. -She thought there was a gentleman who visited and shared spiritual thoughts with the residents. -She did not know of any other activities offered at the facility. Interview with a sixth resident on 10/06/26 at 9:00am revealed: -The facility offered activities sometimes. -She would play bingo, sing and occasionally play games. Telephone interview with a visitor on 10/06/26 at 10:26am revealed she was in the facility weekly and she never saw residents doing an activity other than sitting in the living room watching television. Interview with the Maintenance Director on 10/07/26 at 8:42am revealed: -He conducted the activities in the facility, made the acitivity calendar, and knew there should be 14 hours each week of scheduled group activities. -The activity times were not on the calendar because he was new and learning. -The activities consisted of bingo, memory ball and feeding the ducks. Interview with the Administrator on 10/07/26 at 8:46am revealed: -The medication aides (MAs) and personal care aides (PCAs) helped conduct activities. -She did not know that there should be 14 hours of group activities each week.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 sampled residents (Resident #6) was treated with dignity and respect related to withholding a wheelchair required for mobility.

The findings are:

Review of Resident #6's current FL2 dated 06/19/26 revealed:
-Diagnoses included abnormalities of gait and mobility, muscle weakness, cognitive communication deficit, reduced mobility, and diabetes (a chronic condition when blood sugar is too high).
-Ambulatory status was marked as non-ambulatory.
-Sight and hearing were marked as functional limitations.

Review of Resident #6's Resident Register revealed an admission date of 05/01/26.

Review of Resident #6's Care Plan dated 05/04/26 revealed:
-He was oriented and had adequate hearing, vision, memory, and communication.
-He required supervision with grooming.
-He required limited assistance with ambulation, dressing, and toileting.
-He required extensive assistance with bathing

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and transfers.
-He required a wheelchair for ambulation.

Review of Resident #6's Licensed Health Professional Support assessment dated 05/14/26 revealed he used a wheelchair for mobility and required staff assistance with transfers.

Review of a local Department of Social Services (DSS) Adult Protective Services (APS) intake report for Resident #6 dated 07/16/26 revealed:
-He was sent to a local hospital on 07/14/26 for high blood sugar and the facility did not want the resident to return due to uncontrolled high blood sugars.
-The facility did not follow the required 30-day discharge.
-The local hospital discharged Resident #6 back to the facility, but the facility staff refused to transport him back to the facility.
-Resident #6 had a below the knee amputation and his prosthetic leg was left at the facility, and he did not have his wheelchair or walker for use.
-Staff from the local hospital transported Resident #6 back to the facility and facility staff refused to assist him back to his room or give him his wheelchair.
-Resident #6 returned to the hospital on 07/15/26 after a fall that resulted in a fractured hip.

Telephone interview with a Case Manager at the local hospital on 10/07/26 at 11:03am revealed:
-She knew the facility did not want Resident #6 to return to the facility because she received an email on 07/14/26 from the facility's Director of Regional Operations that requested the hospital not discharge Resident #6 back to the facility because he required a higher level of care.
-A 30-day discharge notice dated 07/14/26 was attached to the email.

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-Hospital staff transported Resident #6 back to the facility on 07/14/26.

Review of Resident #6's Notice of Discharge dated 07/14/26 revealed:
-He was discharged to a local hospital because the facility was unable to meet his needs.
-Resident #6's blood sugar continued to be high, and the facility was unable to improve his condition.

Telephone interview with a personal care aide (PCA) on 10/07/26 at 11:15am revealed:
-Resident #6 was admitted to the facility with only a walker.
-Resident #6 used a wheelchair and had a prosthetic leg.
-Resident #6 received physical therapy (PT) and would walk with a walker during PT sessions.
-The facility staff gave Resident #6 a wheelchair to use and he would self-propel.
-Resident #6 required assistance at times with transfers in and out of bed and to the toilet.
-She was instructed by the Director of Regional Operations and the Director of Sales and Marketing to give Resident #6's wheelchair to a new resident because Resident #6 was at the hospital.

Telephone interview with a medication aide (MA) on 10/07/26 at 11:25am revealed:
-She worked the evening of 07/15/26 when Resident #6 fell.
-She heard Resident #6 screaming from his room and found him on the floor.
-Resident #6's wheelchair had been taken out of his room and was informed that he was not to use the wheelchair anymore, because it was the facility's wheelchair and he used it longer than he was supposed to.

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-Resident #6 told her he was trying to get to the bathroom from the bed when he fell.
-Resident #6 had a prosthetic leg, but he still did not walk well.

Telephone interview with Resident #6's primary care provider (PCP) on 10/07/26 at 10:56am revealed:
-Resident #6 had a right leg below the knee amputation.
-Resident #6 left ankle was deformed, and he used a brace on that leg.
-Resident #6 was receiving PT at the facility but required a wheelchair for ambulation.
-Staff should not have taken Resident #6's wheelchair, this led to a fall and fractured hip.

Telephone interview with a registered nurse (RN) at a local home health agency on 10/07/26 at 11:40am revealed:
-Resident #6 received PT services and was last seen on 07/13/26.
-Resident #6 required use of a wheelchair due to weakness and poor endurance.
-Resident #6 required minimal assistance with transfers due to unsteady gait and poor endurance.

Interview with the Director of Sales and Marketing on 10/07/26 at 11:52am revealed:
-The facility did not think Resident #6 was coming back to the facility since he was issued a 30-day discharge notice on 07/14/26 but he was discharged from the hospital back to the facility on 07/14/26.
-The Director of Regional Operations instructed staff to take the wheelchair out of Resident #6's room to be used by a resident they expected to be admitted to the facility.
-Staff should have gotten another wheelchair for

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Resident #6 when he returned to the facility.
-There was a room at the facility with extra wheelchairs.

Observation of Resident #6 on 10/08/26 at 10:00am revealed:
-He resided in a local skilled nursing facility.
-He was in a wheelchair and staff assisted him into a conference room.
-He had a right below the knee amputation.

Interview with Resident #6 on 10/08/26 at 10:00am revealed:
-He always required the use of a wheelchair and could walk with PT at times during his stay at the facility.
-He fractured his right hip after a fall at the facility but could not recall the events that led up to the fall.

Interview with the Administrator on 10/07/26 at 1:18pm revealed:
-She was not at the facility when Resident #6 fell in his room, but she knew it happened after 5:00pm.
-Staff did not document anything about the fall.
-She did not ask any questions about the fall.
-She was informed by staff that Resident #6's wheelchair was taken from him because it was the facility's wheelchair and they did not expect him to return from the hospital.

Telephone interview with Director of Regional Operations on 10/07/26 at 1:30pm revealed:
-The hospital was informed that Resident #6 could not return to the facility because he was issued a 30-day discharge notice on 07/14/26 because he required a higher level of care due to his diabetes.
-She asked staff to "grab" Resident #6's

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D 338	Continued From page 45 wheelchair for a new resident. -The hospital wanted to discharge the Resident #6 back to the facility. -Staff did not bring the wheelchair back to Resident #6 when the hospital staff transported him back to the facility on 07/14/26. -She was aware Resident #6 fell and fractured his hip on 07/15/26. -There was a breakdown in communication with staff. -She was not aware of any extra wheelchairs in the facility. _____ The facility failed to ensure a resident was treated with dignity and respect and free from neglect. A resident (#6), who was wheelchair bound due to a below the knee amputation, a deformed ankle and was weak with poor endurance who had returned from the hospital. Upon his return he was refused a wheelchair as it was given to another resident. Resident #6 attempted to use the bathroom without his wheelchair, fell and sustained a fractured hip. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 7, 2026 for this violation. THE CORRECTION DATE FOR THIS A1 VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2026.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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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:
FOLLOW-UP TO TYPE B VIOLATION

Non-compliance continues with increased severity resulting in serious physical harm.

THIS IS A TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 5 sampled residents (#1, #2, #3, #4, #5) related to medications used to treat pain (#2, #4, #5), atrial fibrillation (#5), hypothyroidism (#5), high blood pressure (#3), depression (#3), and sleep (#1).

The findings are:

1. Review of Resident #4's current FL2 dated 05/13/26 revealed:
-Diagnoses included muscle wasting and atrophy, poly neuropathy, chronic embolism, thrombosis of left femoral vein, type 2 diabetes, paroxysmal atrial fibrillation(where the heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days).
-There was an order for oxycodone HCl 10mg (used to treat moderate to severe pain) one tablet every four hours as needed.

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Review of Resident #4's physician orders dated 07/10/26 revealed oxycodone 10mg one tablet every four hours.

Review of Resident #4's July 2026 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm and 8:00pm with a start date of 07/10/26.
-The oxycodone 15mg every 6 hours was documented as administered 126 occurrences out of 129 opportunities.
-The oxycodone was documented as not administered on 07/12/26 at 12:00am due to "resident was asleep."
-The oxycodone was documented as not administered on 07/17/26 at 4:00am due to "resident was asleep."
-The oxycodone was documented as not administered on 07/31/26 at 12:00am due to "resident was asleep."

Review of Resident #4's physician order dated 07/27/26 revealed Resident #4 to self-administer oxycodone 10mg every 4 hours as needed.

Review of Resident #4's August 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stopped on 08/06/26.
-There were no entries for oxycodone 10mg from 8:00pm on 08/06/26 through 8:00am on 08/19/26.
-The oxycodone 10mg every 4 hours was documented as administered 97 occurrences out of 101 opportunities.

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-The oxycodone 10mg was documented as not administered on 08/24/26 at 8:00pm due to "withheld per Dr/RN orders."
-The oxycodone 10mg was documented as not administered on 08/25/26 at 12:00am due to "withheld per Dr/RN orders."
-The oxycodone 10mg was documented as not administered on 08/25/26 at 4:00am due to "withheld per Dr/RN orders."

Review of Resident #4's September 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 08/26/26 and stopped on 09/12/26.
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/12/26 and stopped on 10/05/26.
-The oxycodone 10mg every 4 hours was documented as administered 179 occurrences out of 180 opportunities.
-The oxycodone 10mg was documented as not administered on 09/04/26 at 8:00am due to "requires prior approval or prior authorization."

Review of Resident #4's October 2026 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 10/05/26 and no stop date.
-The oxycodone 10mg every 4 hours was documented as administered 44 occurrences out of 46 opportunities.
-The oxycodone 10mg was documented as not administered on 10/02/26 at 10:00am due to

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"resident refused."
-The oxycodone 10mg was documented as not administered on 10/04/26 at 2:00pm due to "resident refused."

Observation of Resident #4's oxycodone 10mg stored in the safe in the Administrator's office on 10/08/26 at 2:30pm and review of the Administrator's notes on 10/09/26 at 2:45pm revealed there were three bubble packs of oxycodone 10mg tablets with a quantity of 90 tablets remaining.

Review of Resident #4's pharmacy packing slips revealed there was no packing slip available for the oxycodone 10mg quantity 180 dispensed on 07/10/26.

Review of Resident #4's CSCS revealed no documentation of oxycodone 10mg 59 tablets dispensed on 07/10/26.

Review of Resident #4's CSCS revealed no documentation of oxycodone 10mg 60 tablets dispensed on 08/05/26.

Interview with Resident #4 on 10/09/26 at 8:32am revealed:
-He was prescribed oxycodone for right shoulder pain due to surgical repair of a torn rotator cuff and several vertebrae being fused in his spine.
-He was "miserable" due to pain when he did not receive his oxycodone as it was ordered.
-His current order was for him to receive oxycodone every 4 hours.
-If he missed one dose, he had pain, but it was not excruciating.
-If he missed two to three days of his oxycodone it "takes a while" when you started it back to get relief from the pain.

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- "Consistency was key" with pain medications.
-He recently went without his oxycodone.
-He did not know what happened to his supply of oxycodone.
-The oxycodone was sent from the pharmacy, but he did not know what happened to them after they were delivered to the facility.
-In August, he had gone at least 48 hours without his oxycodone and was in full withdrawals.
-He had to go to the hospital to be stabilized.
-The hospital gave him a prescription for a week's worth of oxycodone, since there were none available at the facility.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 10/08/26 at 11:45am and 10/09/26 at 11:48am revealed:
-Oxycodone should be given as ordered to prevent Resident #4 running out of doses.
-Resident #4 was without his oxycodone for approximately 2 days in August.
-Resident #4 had gastrointestinal pain which is a symptom of withdrawal from oxycodone.
-She had concerns about Resident #4's oxycodone "disappearing".
-She prescribed for Resident #4 to self-administer to help control medications.
-She prescribed for Resident #4 to self-administer medication on 07/27/26.
-Resident #4 was self-administering his own medications including oxycodone for a period of time.
-She felt Resident #4 was capable of self-administering his own medications.
-She did not have Resident #4's records with her and couldn't recall exact dates.

Interviews with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 8:11am revealed:
-She was not aware Resident #4's medications

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were missing.
-Resident #4 was prescribed to self-administer medications including oxycodone.
-Staff was expected to give medications as prescribed.
-She and the lead medication aide (MA) were responsible for medication cart audits.
-She had not completed a medication cart audit since she became the administrator in July 2026.
-She did not know how often medication cart audits were supposed to be completed.

2. Review of Resident #2's current FL2 dated 07/16/26 revealed diagnoses included acute respiratory failure with hypoxia (lungs cannot properly oxygenate blood), chronic obstructive pulmonary disease, muscle weakness, type 2 diabetes mellitus without complications, bilateral primary osteoarthritis of hip, benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate without noticeable voiding problems).

Review of Resident #2's Resident Register revealed an admission date of 08/04/26.

Review of Resident #2's physician orders dated 08/10/26 revealed gabapentin 600mg 1 tab 3 times daily for chronic pain and restless legs.

Review of Resident #2's electronic medication administration record (eMAR) for September 2026 revealed there was an entry for gabapentin 600mg 1 tablet 3 times daily and documentation the gabapentin was not administered 09/18/26 - 09/22/26 due to medication out of stock - reordered.

Interview with Resident #2's PCP on 10/08/26 at 11:45am revealed:

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HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 52 -Gabapentin was prescribed for pain management. -She was not aware Resident #2 was not administered gabapentin from 09/18/26 through 09/22/26. -Doses should not suddenly be stopped. -Resident #2 could have experienced increased pain if medication were suddenly stopped. Interview with the Lead MA on 10/08/26 at 9:58am revealed: -Medication aides (MA) were responsible for communicating medication issues on the medication cart. -She was responsible for communicating with the Administrator about issues with medications that could not be resolved. -She was not sure why Resident #2 did not receive gabapentin from 09/18/26 through 09/22/26. -The cycle fill was delivered on 09/17/26 and Resident #2's medications should have been in the cart. -She would check in the overstock drawer if a medication was not on the cart. -She would reorder medications if none were found in the overstock drawer. -She checked the cart 2 or 3 times per week to review all residents' medications and reorder as needed. Interview with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 8:11am revealed: -Medications should be scanned on the cart and extra medications should be locked in the office safe. -Staff were expected to give medications as prescribed. -She was responsible for the daily operations of the facility.	D 358		

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-She and the lead medication aide (MA) were responsible for medication cart audits.
-She had not completed a medication cart audit since she became the administrator in July 2026.
-She did not know when medication cart audits were supposed to be completed.

3. Review of Resident #5's FL2 dated 06/17/26 revealed diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in body tissues), paroxysmal atrial fibrillation (heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days), atrial flutter (abnormal heart rhythm), and type 2 diabetes.

a. Review of Resident #5's FL2 dated 06/17/26 revealed oxycodone 15mg IR (used to treat moderate to severe pain) one tablet every six hours.

Review of a copy of Resident #5's electronic prescription dated 07/10/26 revealed:
-Discontinue oxycodone 15mg IR one tablet every six hours.
-Start oxycodone 15mg IR one tablet every four hours.

Review of a copy of Resident #5's electronic prescription dated 07/10/26 revealed oxycodone 15mg IR one tablet every four hours.

Review of Resident #5's current FL2 dated 10/01/26 revealed oxycodone 15mg IR one tablet every four hours.

Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 54 -There was an entry for oxycodone 15mg IR one tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 06/29/26 and stop date of 07/10/26. -The oxycodone was documented as not administered on 07/03/26 at 6:00pm, 07/04/26 at 12:00am, 07/04/26 at 6:00am, 07/04/26 at 12:00pm, 07/04/26 at 6:00pm, 07/05/26 at 12:00am, 07/05/26 at 6:00am, and 07/05/26 at 12:00pm due to "out of facility". -The oxycodone 15mg IR was documented as not administered on 07/05/26 at 6:00pm due to withheld per physician orders. -There was an entry for oxycodone 15mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26. -The oxycodone 15mg IR was documented as not administered on 07/13/26 at 8:00pm, 07/13/26 at 12:00am, 07/13/26 at 4:00am, and 07/13/26 at 8:00am due to "out of facility". -The oxycodone 15mg IR was documented as not administered on 07/14/26 at 4:00am and 07/29/26 at 4:00am due to resident was asleep. -The oxycodone was documented as not administered on 07/03/26 at 6:00am due to "medication out of stock." -The oxycodone 15mg IR every 6 hours was documented as administered 28 occurrences out of 38 opportunities. -The oxycodone 15mg IR every 4 hours was documented as administered 123 occurrences out of 129 opportunities. Review of Resident #5's August 2026 eMAR revealed: -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm	D 358		

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with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR was documented as not administered on 08/18/26 at 4:00am due to resident was asleep.
-The oxycodone 15mg IR was documented as not administered on 08/24/26 at 4:00pm, 08/25/26 at 12:00am, 08/25/26 at 4:00am, 08/25/26 at 4:00pm due to "out of facility".
-The oxycodone 15mg IR was documented as not administered on 08/30/26 at 8:00pm, 08/31/26 at 12:00am, 08/31/26 at 4:00am, 08/31/26 at 8:00am, 08/31/26 at 12:00pm, 08/31/26 at 4:00pm, and 08/31/26 at 8:00pm due to "medication out of stock-reordered".
-The oxycodone 15mg IR every 4 hours was documented as administered 173 occurrences out of 186 opportunities.

Review of Resident #5's September 2026 eMAR revealed:
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR was documented as not administered on 09/02/26 at 8:00am due to resident out of facility.
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/10/26 and stop date of 09/25/26.
-The oxycodone 15mg IR was documented as not administered on 09/12/26 at 4:00pm, 09/12/26 at 10:00pm, 09/13/26 at 12:00am, 09/13/26 at 4:00am, 09/13/26 at 8:00am, 09/13/26 at 12:00pm, 09/13/26 at 4:00pm, 09/13/26 at 8:00pm, 09/14/26 at 12:00am,

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D 358	Continued From page 56 09/14/26 at 4:00am, and 09/19/26 at 4:00pm due to "out of facility." -The oxycodone 15mg IR was documented as not administered on 09/01/26 at 8:00am, 09/01/26 at 12:00pm, 09/01/26 at 4:00pm, 09/01/26 at 8:00pm, 09/02/26 at 12:00am, and 09/02/26 at 4:00am, 09/02/26 at 12:00pm, 09/02/26 at 4:00pm, 09/02/26 at 8:00pm, on 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -The oxycodone 15mg IR was documented as not administered on 09/10/26 at 8:00pm and 09/11/26 at 12:00am due to "medication out of stock." -The oxycodone 15mg IR every 4 hours was documented as administered 2 occurrences out of 12 opportunities. -The oxycodone 15mg IR was documented as administered 102 occurrences out of 115 opportunities. Review of Resident #5's October 2026 eMAR 10/01/26 to 10/06/26 revealed: -There was an entry for oxycodone 15mg IR one tablet every four hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 8:00pm, and 10:00pm with a start date of 9/10/26. -The oxycodone was documented as not administered on 10/02/26 at 10:00am due to staff working with another resident and missing administration time. -The oxycodone was documented as not administered on 10/04/26 at 2:00pm due to "resident refused." -The oxycodone 15mg IR was documented as administered for 27 occurrences out of 29 opportunities. Observation of Resident #5's oxycodone 15mg IR on hand on 10/07/26 at 9:57am revealed:	D 358		

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-There was one bubble pack of oxycodone 15mg IR tablets with 11 tablets remaining.
-The pharmacy label directions were oxycodone 15mg IR one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.

Review of Resident #5's controlled substance count sheets (CSCS) in a book on the top of the medication cart on 10/07/26 at 9:50am revealed:
-The CSCS for the bubble pack of oxycodone 15mg IR tablets was available in the CSCS book.
-The entries on the CSCS matched the number of oxycodone in the bubble pack.

Observation of Resident #5's oxycodone 15mg IR stored in the safe in the Administrator's office on 10/07/26 at 9:59am revealed:
-There was one bubble pack of oxycodone 15mg IR tablets with 30 tablets remaining.
-The pharmacy label directions were oxycodone 15mg one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.
-The CSCS dated 09/25/26 was kept with the bubble pack of oxycodone 15mg tablets in the Administrator's safe.

Telephone interview with a representative from the facility's contracted pharmacy on 10/07/26 at 4:22pm revealed:
-The pharmacy received an electronic medication order dated 07/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity of 180 on 07/11/26.
-The pharmacy received an electronic medication order dated 08/11/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 180 on 08/11/26.
-The pharmacy received an electronic medication order dated 09/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90

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on 09/10/26.
-The pharmacy received an electronic medication order dated 09/25/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/25/26.
-The pharmacy received an electronic medication order dated 10/05/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 42 on 10/07/26.

Refer to the interview with Resident #5 on 10/07/26 at 10:20am.

Refer to the telephone interview with Resident #5's primary care provider (PCP) on 10/08/26 at 11:15am.

Refer to the interviews with the Administrator on 10/07/26 at 2:36pm and 3:23pm.

Refer to the interview with a medication aide (MA) on 10/08/26 at 9:00am.

b. Review of a copy of Resident #5's electronic prescription dated 09/02/26 revealed oxycodone 30mg IR half tablet every four hours quantity 21 tablets 7 day supply.

Review of September 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone 30mg IR half tablet every four hours scheduled 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date 09/02/26 and stop date of 09/09/26.
-The oxycodone 30mg IR was documented as not administered on 09/06/26 at 12:00pm and 4:00pm due to "out of facility".
-The oxycodone 30mg IR was documented as not administered on 09/03/26 at 12:00am,

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4:00am, and 8:00am due to "medication out of stock-reordered".
-The oxycodone 30mg IR half tablets were documented as administered 37 occurrences out of 42 opportunities.

Review of Resident #5's controlled substance count sheet (CSCS) date received 09/03/26 revealed:
-There were 21 half tablets of oxycodone 30mg IR received.
-The administration dates were 09/03/26 to 09/06/26 with a balance of 0.

Review of Resident #5's CSCS date received 09/04/26 revealed:
-There were 21 half tablets of oxycodone 30mg IR received.
-The administration dates were 09/06/26 to 09/10/26 with a balance of 0.

Telephone interview with a representative from the facility's contracted pharmacy on 10/07/26 at 4:22pm revealed the pharmacy received an electronic medication order dated 09/02/26 for oxycodone 30mg IR half tablet every four hours and dispensed quantity 21 (half tablets equaled 42 doses) on 09/02/26.

Refer to the interview with Resident #5 on 10/07/26 at 10:20am.

Refer to the telephone interview with Resident #5's primary care provider (PCP) on 10/08/26 at 11:15am.

Refer to the interviews with the Administrator on 10/07/26 at 2:36pm and 3:23pm.

Refer to the interview with a medication aide (MA)

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D 358	Continued From page 60 on 10/08/26 at 9:00am. _____ Interview with Resident #5 on 10/07/26 at 10:20am revealed: -She recently missed doses of oxycodone and she "hurt so bad" and was "miserable". -The oxycodone was ordered for pain she experienced in her left shoulder and hip. -She went through "withdrawals" due to missing the oxycodone. -She had no appetite, did not want to get out of bed, experienced changes in her attitude, and withdrew from other people as a result of missing the oxycodone. Telephone interview with Resident #5's primary care provider (PCP) on 10/08/26 at 11:15am revealed: -She ordered the oxycodone to treat Resident #5's shoulder pain. -She was notified on 09/02/26 Resident #5's oxycodone 15mg IR tablet supply was missing from the facility. -She ordered the oxycodone 30mg IR half tablets to "temporarily cover" Resident #5's shoulder pain after the resident's oxycodone 15mg IR tablet supply went missing. -She could not reorder the oxycodone 15mg IR early. -Missing consecutive doses of oxycodone could cause Resident #5 to have withdrawal symptoms including diarrhea, gastrointestinal upset, anxiety, headaches, agitation, and pain. Interviews with the Administrator on 10/07/26 at 2:36pm and 3:23pm revealed: -She found out from two medication aides on 9/01/26 there were 60 oxycodone 15mg tablets missing for Resident #5. -She did not know there were 60 oxycodone	D 358		

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15mg tablets missing from Resident #5's 07/11/26 delivery and 90 oxycodone 15mg tablets missing from the 08/11/26 delivery.

Interview with a medication aide (MA) on 10/08/26 at 9:00am revealed Resident #5 was out of oxycodone 15mg IR missing consecutive doses causing the resident to be "so sick" and "definitely going through withdrawals".

c. Review of Resident #5's FL2 dated 06/17/26 revealed flecainide acetate 50mg (used to treat atrial fibrillation) one tablet at bedtime.

Review of Resident #5's current FL2 dated 10/01/26 revealed flecainide acetate 50mg one tablet at bedtime.

Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for flecainide acetate 50mg one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26.
-The flecainide acetate 50mg was documented as not administered on 07/03/26, 07/04/26, 07/05/26, and 07/13/26 due to "out of facility".
-The flecainide acetate 50mg was documented as not administered on 07/23/26 due to resident refused.
-The flecainide acetate 50mg was documented as not administred on 07/22/26, 07/24/26, and 07/25/26 due to medication "out of stock-reordered".
-The flecainide acetate 50mg was documented as administered 23 out of 31 opportunities.

Review of Resident #5's August 2026 eMAR revealed:
-There was an entry for flecainide acetate 50mg

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one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26.
-The flecainide acetate 50mg was documented as not administered on 08/23/26 due to "medication out of stock-reordered".
-The flecainide acetate 50mg was documented as administered 30 out of 31 opportunities.

Review of Resident #5's September 2026 eMAR revealed:
-There was an entry for flecainide acetate 50mg one tablet at bedtime scheduled at 8:00pm with a start date of 06/05/26.
-The flecainide acetate 50mg was documented as not administered on 09/12/26 and 09/13/25 due to "out of facility".
-The flecainide acetate 50mg was documented as administered 27 occurrences out of 29 opportunities.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/07/26 at 10:52am revealed they dispensed flecainide acetate 50mg tablets for Resident #5 in cycle fill on 06/24/26, 07/21/26, 08/18/26, 09/15/26 each dispense provided a 28-day supply.

Interview with Resident #5 on 10/07/26 at 10:20am revealed:
-She had a pacemaker.
-She did not know she missed flecainide acetate 50mg doses in July 2026 and August 2026.
-She could not recognize flecainide acetate in with her other medications in a cup.
-The medication aides (MA) brought her medications to her in a cup.
-She would not recognize if one medication was missing from the cup.
-She did not know if she felt differently by missing doses.

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Telephone interview with Resident #5's primary care provider (PCP) on 10/08//26 at 11:15am revealed:
-The flecainide acetate was ordered for atrial fibrillation.
-Resident #5 could have experienced an episode of uncontrolled fibrillation resulting in chest pain and shortness of breath by missing doses flecainide acetate.

Interview with the Administrator on 10/06/26 at 3:40pm revealed:
-She became the Administrator at the facility on 07/13/26.
-She had been through two cycle fills since becoming Administrator.
-She did not know why some scheduled medications were running out before the new cycle fill supply of medications was scheduled to start.
-No one was assigned to do medication cart audits.
-She did not do medication cart audits.
-At the end of September 2026, the Lead MA and another MA informed her of missing resident medications.
-She did not do anything because she knew cycle fill was due to start the next day or the day after.

d. Review of Resident #5's FL2 dated 06/17/26 revealed levothyroxine 88mcg (used to treat hypothyroidism) one tablet daily.

Review of Resident #5's current FL2 dated 10/01/26 revealed levothyroxine 88mcg one tablet daily.

Review of Resident #5's July 2026 electronic medication administration record (eMAR)

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HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 64 revealed: -There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26. -The levothyroxine 88mcg was documented as not administered on 07/04/26, 07/05/26, and 07/14/26 due to "out of facility". -The levothyroxine 88mcg was documented as not administered on 07/20/26-07/24/26, and 07/26/26 due to "medication out of stock-reordered". -The levothyroxine 88mcg was documented as administered 22 occurrences out of 31 opportunities. Review of Resident #5's August 2026 eMAR revealed: -There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26. -The levothyroxine 88mcg was documented as not administered on 07/23/26 due to withheld per physician order. -The levothyroxine 88mcg was documented as not administered on 07/25/26 due to "out of facility". -The levothyroxine 88mcg was documented as not administered on 07/22/26 and 07/24/26 due to "medication out of stock-reordered". -The levothyroxine 88mcg was documented as administered 26 occurrences out of 31 opportunities. Review of Resident #5's September 2026 eMAR revealed: -There was an entry for levothyroxine 88mcg one tablet once daily scheduled at 6:00am with a start date of 06/05/26. -The levothyroxine 88mcg was documented as not administered on 09/13/26 and 09/14/26 due	D 358		

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to "out of facility".
-The levothyroxine 88mcg was documented as not administered on 09/17/26, 09/18/26, and 09/22/26 due to "medication out of stock-reordered".
-The levothyroxine 88mcg was documented as administered 24 occurrences out of 29 opportunities.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/07/26 at 10:52am revealed they dispensed levothyroxine 88mcg tablets for Resident #5 in cycle fill on 06/24/26, 07/21/26, 08/18/26, 09/15/26 each dispense provided a 28-day supply.

Interview with Resident #5 on 10/07/26 at 10:20am revealed:
-She had taken the levothyroxine "her whole life" and it was a medication she needed everyday.
-When she missed multiple consecutive doses of levothyroxine, she felt "faraway" like she did not want to do "anything".

Telephone interview with Resident #5's primary care provider (PCP) revealed:
-Resident #5 was ordered levothyroxine for hypothyroidism (when the thyroid gland does not produce enough thyroid hormones to meet the body's needs).
-Missing consecutive doses of levothyroxine could cause the medication to be less effective.

Interview with the Administrator on 10/06/26 at 3:40pm revealed:
-She became the Administrator at the facility on 07/13/26.
-She had been through two cycle fills since becoming Administrator.
-She did not know why some scheduled

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medications were running out before the new cycle fill supply of medications was scheduled to start.
-No one was assigned to do medication cart audits.
-She did not do medication cart audits.
-She did not do anything because she knew cycle fill was due to start the next day or the day after.

4. Review of Resident #3's current FL2 dated 04/09/26 revealed diagnoses included dilation of aorta (abnormal stretching of the aorta), coronary artery disease (a condition in which the major blood vessels supplying the heart muscle become narrowed or blocked), chronic obstructive pulmonary disease (a progressive, long-term lung condition that makes it increasingly difficult to breathe by causing chronic inflammation and obstructed airflow), chronic kidney disease, and major depressive disorder.

a. Review of Resident #3's primary care provider (PCP) order dated 05/04/26 revealed olmesartan 20mg (used to treat high blood pressure) one tablet daily.

Review of Resident #3's September electronic medication administration record (eMAR) revealed
-There was an entry for olmesartan 20mg one tablet daily scheduled at 8:00am with a start date of 04/21/26.
-The olmesartan 20mg was documented as not administered on 09/22/26 due to "medication out of stock-reordered".
-The olmesartan 20mg was documented as administered 29 occurrences out of 30 opportunities.

Telephone interview with the facility's contracted

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pharmacy representative on 10/07/26 at 1:19pm revealed the pharmacy dispensed a 28-day supply of olmesartan 20mg tablets on 7/21/26, 8/18/26, and 9/15/26.

Telephone interview with Resident #3's primary care provider (PCP) on 10/08/26 at 11:15am revealed:
-The olmesartan 20mg was ordered to control Resident #3's high blood pressure.
-Missing one dose of olmesartan could cause Resident #3's blood pressure to be higher than it should be.

Interview with a medication aide (MA) on 10/06/26 at 11:58am revealed:
-They ran out of a lot of scheduled medications early in September 2026.
-The Lead MA had to start cycle fill a day early so the residents had the scheduled medications they needed.
-She was instructed to let the Lead MA and the Administrator know when medications were not available for administration.

Interview with the Administrator on 10/06/26 at 3:40pm revealed:
-She became the Administrator at the facility on 07/13/26.
-She had been through two cycle fills since becoming Administrator.
-She did not know why some scheduled medications were running out before the new cycle fill supply of medication was scheduled to start.
-No one was assigned to do medication cart audits.
-She did not do medication cart audits.

Interview with the Lead MA on 10/08/26 at

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D 358	Continued From page 68 10:15am revealed: -She took over the responsibility of scanning cycle fill delivery from the contracted pharmacy on 09/17/26. -She scanned all of Resident #3's cycle fill medications received from the pharmacy into the eMAR system and placed them on the medication cart. -She did not know why the MAs documented not having the medications to administer because the medications were available. b. Review of Resident #3's primary care provider's (PCP) order dated 05/04/26 revealed duloxetine (used to treat depression) 60mg one capsule every morning. Review of Resident #3's mental health provider (MHP) order dated 08/28/26 revealed: -Discontinue duloxetine 60mg one tablet daily. -Start duloxetine 40mg one tablet twice daily for depression. Review of Resident #3's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for duloxetine 60mg one capsule every morning scheduled at 8:00am with a start date of 04/21/26 and stop date of 08/28/26. -There was an entry for duloxetine 40mg one capsule twice a day scheduled at 7:00am and 7:00pm with a start date of 08/28/26. -The duloxetine 60mg was documented as not administered on 08/24/26 due to "medication out of stock-reordered". -The duloxetine 40mg was documented as not administered on 08/29/26 due to "requires approval or prior authorization" and 08/31/26 due to "medication out of stock-reordered".	D 358		

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-The duloxetine 60mg was documented administered 28 occurrences out of 29 opportunities.

Review of Resident #3's September 2026 eMAR revealed:
-There was an entry for duloxetine 40mg one capsule twice a day scheduled at 7:00am and 7:00pm with a start date of 08/28/26.
-The duloxetine 40mg was documented as not administered on 09/01/26 at 7:00am, 09/03/26 at 7:00am, 09/03/26 at 7:00pm, 09/04/26 at 7:00am, 09/05/26 a 7:00am, 09/19/26 at 7:00pm, 09/20/26 at 7:00am, 09/20/26 at 7:00pm, 09/21/26 at 7:00pm, and 09/22/26 at 7:00am due to "medication out of stock-reordered".
-The duloxetine 40mg was documented administered 49 occurrences out of 60 opportunities.

Observation of Resident #3's medications on hand on 10/06/26 at 11:32am revealed there were ten capsules of duloxetine 40mg available for administration with a dispense date of 09/22/26.

Telephone interview with the facility's contracted pharmacy representative on 10/07/26 at 1:19pm revealed:
-The pharmacydispensed a 15-day supply of duloxetine 40mg capsules were sent on 8/28/26.
-The pharmacy dispensed a 56 capsules of duloxetine 40mg capsules on 09/15/26 to start cycle fill on 09/22/26.
-There was enough duloxetine sent Resident #3 should not have been without the medication.

Telephone interview with Resident #3's primary care provider (PCP) on 10/08//26 at 11:15am revealed:
-The duloxetine was ordered for major depressive

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disorder.
-The duloxetine should not be stopped and restarted.

Interview with a medication aide (MA) on 10/06/26 at 11:58am revealed:
-They ran out of a lot of scheduled medications early in September 2026.
-The Lead MA had to start cycle fill a day early so the residents had the scheduled medications they needed.
-She was instructed to let the Lead MA and the Administrator know when medications were not available for administration.

Interview with the Administrator on 10/06/26 at 3:40pm revealed:
-She became the Administrator at the facility on 07/13/26.
-She had been through two cycle fills since becoming Administrator.
-She did not know why some scheduled medications were running out before the new cycle fill supply of medication was scheduled to start.
-No one was assigned to do medication cart audits.
-She did not do medication cart audits.

Interview with the Lead MA on 10/08/26 at 10:15am revealed:
-She took over the responsibility of scanning cycle fill delivery from the contracted pharmacy on 09/17/26.
-She scanned all of Resident #3's cycle fill medications received from the pharmacy into the eMAR system and placed them on the medication cart.
-She did not know why the MAs documented not having the medications to administer because the

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medications were available.

5. Review of Resident #1's current FL2 dated 09/10/26 revealed:
-Diagnoses included dementia (a decline in memory and thinking that interferes with daily life), failure to thrive, high blood pressure, and headaches.
-Melatonin (induces sleep), 5mg daily at bedtime.

Review of Resident #1's electronic medication administration record (eMAR) for September 2026 revealed there was an entry for melatonin 5mg daily at 7:00pm and documentation the melatonin was not administered 09/12/26 - 09/17/26 due to "medication out of stock - reordered".

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/07/26 at 8:15am revealed:
-The pharmacy received a faxed order for melatonin 5mg daily at bedtime on 04/23/26 for Resident #1.
-The medication was delivered monthly, and 28 tablets were dispensed on 08/18/26 and delivered on 08/20/26 at 2:00am.
-The facility should not have run out of the melatonin.
-The pharmacy did not have any documentation a refill of the melatonin was requested.

Observation of Resident #1's medications available for administration on 10/07/26 at 8:45am revealed:
-There was one bubble pack labeled melatonin 5mg 1 tablet by mouth at bedtime.
-Thirty tablets were dispensed on 09/18/26 and 8 tablets remained.

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D 358	Continued From page 72 Telephone interview with Resident #1's primary care physician (PCP) on 10/07/26 at 8:30am revealed: -She ordered the melatonin for Resident #1 for sleep. -Resident #1 may not have slept well the nights she was not administered the melatonin. Telephone interview with a medication aide (MA) on 10/07/26 at 9:05am revealed: -Resident #1 must have been out of the melatonin. -She was not allowed to order refills of medications. -A lead MA was responsible for ordering medications and she was informed. Telephone interview with a second MA on 10/07/26 at 9:29am revealed: -She was not allowed to order medications. -The lead MA was responsible for ordering medications but she would let medications run completely out before reordering them. Based on observations, interviews and record reviews, Resident #1 was not interviewable. Refer to the interview with the Lead MA on 10/08/26 at 9:58am. Refer to the interview with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 8:11am. _____ Interview with the Lead MA on 10/08/26 at 9:58am revealed: -Medication aides (MA) were responsible for communicating medication issues on the medication cart. -She was responsible for communicating with the Administrator about issues with medications that	D 358		

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D 358	Continued From page 73 could not be resolved. -She would reorder medications if none were found in the overstock drawer. -She checked the cart 2 or 3 times per week to review all residents' medications and reorder as needed. Interview with the Administrator on 10/08/26 at 2:30pm and 10/09/26 at 8:11am revealed: -Medications should be scanned on the cart and extra medications should be locked in the office safe. -Staff were expected to give medications as prescribed. -She was responsible for the daily operations of the facility. -She and the lead medication aide (MA) were responsible for medication cart audits. -She had not completed a medication cart audit since she became the administrator in July 2026. -She did not know when medication cart audits were supposed to be completed. _____ The facility failed to conduct medication audits which lead to medications being out of stock which resulted in failing to administer medications as ordered for 5 of 5 sampled residents. Resident #4 went without his oxycodone for 48 hours in August 2026 resulting in Resident #4 being in withdrawals requiring hospitalization to be stabilized. Resident #5 missed 21 doses of oxycodone 15mg IR which caused Resident #5 to experience increased pain and withdrawal symptoms. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 6, 2026 for this violation.	D 358		

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D 358	Continued From page 74 THE CORRECTION DATE FOR THIS A1 VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2026.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure a record of controlled substances that reconciled the receipt, administration, and disposition of controlled medications for 2 of 2 sampled residents (#4 and #5) related to controlled pain relievers (#4 and #5). The findings are: 1. Review of Resident #4's current FL2 dated 05/13/26 revealed: -Diagnoses included muscle wasting and atrophy, poly neuropathy, chronic embolism, thrombosis of left femoral vein, type 2 diabetes, paroxysmal atrial fibrillation(where the heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days).	D 392		

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D 392	Continued From page 75 -There was an order for oxycodone HCl 10mg (used to treat moderate to severe pain) one tablet every four hours as needed. Review of Resident #4's Resident Register revealed an admission date of 05/14/26. Review of Resident #4's physician order dated 07/10/26 revealed oxycodone 15mg one tablet every four hours. Review of Resident #4's July 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm and 8:00pm with a start date of 07/10/26. -The oxycodone 15mg every 6 hours was documented as administered 126 occurrences out of 129 opportunities. -The oxycodone was documented as not administered on 07/12/26 at 12:00am, 07/17/26 at 4:00am, 07/31/26 at 12:00am due to "resident was asleep." Review of Resident #4's pharmacy packing slips revealed there was no packing slip available for the oxycodone 10mg quantity 180 dispensed on 07/10/26. Review of Resident #4's CSCS for oxycodone 10mg 180 tablets dispensed 07/10/26 revealed: -There were 2 out of 3 CSCS available for the 07/10/26 dispense which documented receipt of 120 tablets out of 180 tablets delivered by the pharmacy. -The CSCS dated 07/10/26 had documented administration entries dated 07/17/26 to 07/27/26 for 60 tablets.	D 392		

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D 392	Continued From page 76 -The second CSCS dated 07/10/26 had documented administration entries dated 07/27/26 to 08/06/26 for 60 tablets. -The third CSCS dated 07/10/26 had documented administration entries dated 08/06/26 for 1 tablet and indicated Resident #4 began self-administering oxycodone on 08/06/26. Review of Resident #4's record revealed there were no CSCS for 59 tablets oxycodone 10mg dispensed on 07/10/26. Review of Resident #4's physician order dated 07/27/26 revealed Resident #4 was to self-administer oxycodone 10mg every 4 hours as needed. Review of Resident #4's August 2026 eMAR revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stopped on 08/06/26. -There were no entries for oxycodone 10mg from 8:00pm on 08/06/26 through 8:00am on 08/19/26. -The oxycodone 10mg every 4 hours was documented as administered 97 occurrences out of 101 opportunities. -The oxycodone 10mg was documented as not administered on 08/24/26 at 8:00pm, 08/25/26 at 12:00am and 08/25/26 at 4:00am due to "withheld per Dr/RN orders." Review of Resident #4's records revealed no orders available to withhold oxycodone. Review of Resident #4's pharmacy packing slips revealed there was no packing slip available for the oxycodone 10mg quantity 60 dispensed on	D 392		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 77 08/05/26. Review of Resident #4's CSCS's for oxycodone 10mg tablets dispensed revealed: -The CSCS had no documented administration entries dated 08/06/26 to 08/19/26 for 60 tablets received on 08/05/26. -The second CSCS had documented administration entries dated 08/19/26 to 08/26/26 for 40 tablets received on 08/19/26. -The third CSCS had documented administration entries dated 08/26/26 to 09/03/26 for 44 tablets received on 08/19/26. -The forth CSCS had documented administration entries dated 09/03/26 to 09/08/26 for 30 tablets received on 08/19/26. Review of Resident #4's record revealed there were no CSCS for 60 tablets oxycodone 10mg dispensed on 08/05/26. Observation of Resident #4's oxycodone 10mg stored in the safe in the Administrator's office on 10/08/26 at 2:30pm and review of the Administrator's notes on 10/09/26 revealed there were three bubble packs of oxycodone 10mg tablets with a quantity of 90 tablets remaining. Interview with Resident #4 on 10/09/26 at 8:32am revealed: -He was prescribed oxycodone for right shoulder pain due to surgical repair of a torn rotator cuff and several vertebrae being fused in his spine. -He was "miserable" due to pain when he did not receive his oxycodone as it was ordered. -His current order was for him to receive oxycodone every 4 hours. -He recently went without his oxycodone. -He did not know what happened to his supply of oxycodone.	D 392		

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 392	Continued From page 78 -The oxycodone was sent from the pharmacy, but he did not know what happened to them after they were delivered to the facility. -In August, he had gone at least 48 hours without his oxycodone and was in full withdrawals. -He had to go to the hospital to be stabilized. Telephone interview with Resident #4's Primary Care Provider (PCP) on 10/08/26 at 11:45am and 10/09/26 at 11:48am revealed: -Oxycodone should be given as ordered to prevent Resident #4 running out of medications. -She had concerns about Resident #4's oxycodone "disappearing". -Resident #4 was approximately 1 day short of oxycodone from her last count. -Resident #4 was self-administering his own medications including oxycodone for a period of time and was not sure of the dates he was self-administering his own medications. -She felt Resident #4 was capable of self-administering his own medications. Refer to the interview with a MA on 10/08/26 at 9:00am. Refer to the interview with the Lead MA on 10/08/26 at 10:00am. Refer to the interview with the Administrator on 10/08/26 at 3:40pm. Refer to the interview with the Sales and Marketing Director on 10/09/26 at 11:25am. Refer to the interview with the Administrator on 10/09/26 at 2:42pm. 2. Review of Resident #5's FL2 dated 06/17/26 revealed:	D 392		

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D 392	Continued From page 79 -Diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in body tissues), paroxysmal atrial fibrillation (heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days), atrial flutter (abnormal heart rhythm), and type 2 diabetes. -There was an order for oxycodone 15mg IR (used to treat moderate to severe pain) one tablet every six hours. Review of Resident #5's current FL2 dated 10/01/26 revealed oxycodone 15mg IR one tablet every four hours. Telephone interview with a representative from the facility's contracted pharmacy on 10/07/26 at 4:22pm revealed: -The pharmacy dispensed controlled medications along with a matching controlled substance count sheet (CSCS) for documenting administration of the medication and accounting for the medication. -The pharmacy received an electronic medication order dated 07/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity of 180 on 07/11/26. -The pharmacy received an electronic medication order dated 08/11/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 180 on 08/11/26. -The pharmacy received an electronic medication order dated 09/02/26 for oxycodone 30mg IR half tablet every four hours and dispensed quantity 21 (half tablets equaled 42 doses) on 09/02/26. -The pharmacy received an electronic medication order dated 09/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/10/26.	D 392		

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D 392	Continued From page 80 -The pharmacy received an electronic medication order dated 09/25/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/25/26. -The pharmacy received an electronic medication order dated 10/05/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 42 on 10/07/26. Review of Resident #5's July 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for oxycodone 15mg IR one tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 06/29/26 and stop date of 07/10/26. -The oxycodone 15mg IR every 6 hours was documented as administered 28 occurrences out of 38 opportunities. -The oxycodone was documented as not administered on 07/03/26 at 6:00am due to "medication out of stock." -The oxycodone 15mg IR was documented as not administered on 07/05/26 at 6:00pm due to withheld per physician orders. -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26. -The oxycodone 15mg IR every 4 hours was documented as administered 123 occurrences out of 129 opportunities. Review of Resident #5's CSCS's for oxycodone 15mg IR 180 tablets dispensed 07/10/26 revealed: -There were 4 out of 6 CSCS's available for the 07/10/26 dispense which documented receipt of 120 tablets out of 180 tablets delivered by the	D 392		

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D 392	Continued From page 81 pharmacy. -The CSCS labeled 1 out of 6 had documented administration entries dated 07/26/26 to 07/31/26 for 30 tablets. -The CSCS labeled 3 out of 6 had documented administration entries dated 07/31/26 to 08/05/26 for 30 tablets. -The CSCS labeled 5 out of 6 had documented administration entries dated 08/05/26 to 08/09/26 for 30 tablets. -The CSCS labeled 6 out of 6 had documented administration entries dated 08/10/26 to 08/14/26 for 30 tablets. -The facility was unable to provide the oxycodone 15mg IR CSCS labeled 2 of 6 for 30 tablets. -The facility was unable to provide the oxycodone 15mg IR CSCS labeled 4 of 6 for 30 tablets. Review of Resident #5's August 2026 eMAR revealed: -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26. -The oxycodone 15mg IR every 4 hours was documented as administered 173 occurrences out of 186 opportunities. -The oxycodone 15mg IR was documented as not administered on 08/30/26 at 8:00pm, 08/31/26 at 12:00am, 08/31/26 at 4:00am, 08/31/26 at 8:00am, 08/31/26 at 12:00pm, 08/31/26 at 4:00pm, and 08/31/26 at 8:00pm due to "medication out of stock-reordered". Review of Resident #5's pharmacy packing slips revealed there was no packing slip available for the oxycodone 15mg IR quantity 180 dispensed on 08/11/26.	D 392		

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D 392	Continued From page 82 Review of Resident #5's CSCS's for oxycodone 15mg IR 180 tablets dispensed 08/11/26 revealed: -There were 3 out of 6 CSCS's available for the 08/11/26 dispense which documented receipt of 90 tablets out of 180 tablets delivered. -The first CSCS had documented administration entries dated 08/15/26 to 08/20/26 for 30 tablets received on 08/15/26. -The second CSCS had documented administration entries dated 08/20/26 to 08/25/26 for 30 tablets received on 08/17/26. -The third CSCS had documented administration entries dated 08/25/26 to 08/30/26 for 30 tablets received on 08/17/26. -The facility was unable to provide the oxycodone 15mg IR CSCS's for 90 tablets. Review of Resident #5's September 2026 eMAR revealed: -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26. -The oxycodone 15mg IR every 4 hours was documented as administered 2 occurrences out of 12 opportunities. -The oxycodone 15mg IR was documented as not administered on 09/01/26 at 8:00am, 09/01/26 at 12:00pm, 09/01/26 at 4:00pm, 09/01/26 at 8:00pm, 09/02/26 at 12:00am, and 09/02/26 at 4:00am, 09/02/26 at 12:00pm, 09/02/26 at 4:00pm, 09/02/26 at 8:00pm, on 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -There was an entry for oxycodone 30mg half tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/02/26 and stop date of	D 392		

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D 392	Continued From page 83 09/09/26. -The oxycodone 30mg IR half tablet every 4 hours was documented as administered 37 occurrences out of 42 opportunities. -The oxycodone 30mg IR was documented as not administered on 09/03/26 at 12:00am, 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/10/26 and stop date of 09/25/26. -The oxycodone 15mg IR was documented as administered 102 occurrences out of 115 opportunities. -The oxycodone 15mg IR was documented as not administered on 09/10/26 at 8:00pm and 09/11/26 at 12:00am due to "medication out of stock." Review of Resident #5's CSCS's for oxycodone 30mg IR 21 tablets dispensed 09/02/26 revealed: -There was a CSCS with administration dates 09/03/26-09/06/26 for quantity 21 half tablets with entries that matched the eMAR. -There was a CSCS with administration dates 09/06/26-09/10/26 for quantity 21 half tablets with entries that matched the eMAR. Review of Resident #5's October 2026 eMAR 10/01/26 to 10/06/26 revealed: -There was an entry for oxycodone 15mg IR one tablet every four hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 8:00pm, and 10:00pm with a start date of 9/10/26. -The oxycodone 15mg IR was documented as administered for 27 occurrences out of 29 opportunities.	D 392		

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D 392	Continued From page 84 Review of Resident #5's CSCS's for oxycodone 15mg IR 90 tablets dispensed 09/25/26 revealed: -There was a CSCS with administration dates 09/27/26-10/07/26 for quantity 60 with a balance of 11 tablets with entries that matched the eMAR. -There was a CSCS for quantity 30 tablets with no documented administrations. Review of a handwritten inventory of controlled substances stored in the Administrator's safe on 10/09/26 at 2:45pm revealed: -Resident #5 had 30 oxycodone 15mg IR tablets from the 09/25/26 dispense. -There was a date of 10/08/26 written on the entry but there was no documented medication or amount received documented. Interview with Resident #5's primary care provider (PCP) on 10/08/26 at 11:15am revealed: -She was notified on 09/02/26 Resident #5's oxycodone 15mg IR tablet supply was missing from the facility. -On 09/02/26, she ordered oxycodone 30mg IR one half tablet every 4 hours for Resident #5 for pain management due to Resident #5's missing oxycodone 15mg IR supply. -She and her supervisor visited the facilty on 09/02/26. -The MAs had not been counting all of the CSCS when responsibility of the medication cart was handed off at shift change. -Instead of storing extra packs of controlled substances on the medication cart, they moved the extra supply of controlled substances to the Sales and Marketing Director's office safe. -Then more controlled substances disappeared again. -Then the extra supply of controlled substances was moved to the safe located in the Administrator's office.	D 392		

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D 392	Continued From page 85 -None had gone missing since the extra inventory was moved to the safe in the Administrator's office. Refer to the interview with a MA on 10/08/26 at 9:00am. Refer to the interview with the Lead MA on 10/08/26 at 10:00am. Refer to the interview with the Administrator on 10/08/26 at 3:40pm. Refer to the interview with the Sales and Marketing Director on 10/09/26 at 11:25am. Refer to the interview with the Administrator on 10/09/26 at 2:42pm. _____ Interview with a MA on 10/08/26 at 9:00am revealed: -Medications were routinely delivered by the pharmacy during night shift. -Prior to changes made by the Administrator after some controlled substances went missing, the night shift MA scanned in the medications delivered by the pharmacy into inventory. -The controlled substances received on the delivery were temporarily stored in the locked controlled substance storage box on the medication cart. -The CSCS's were kept with the bubble packs of controlled substances stored in the locked controlled substance storage box rather than separated and placed in the CSCS book on the top of the medication cart. -At shift change, the controlled substances that were open and in use were counted by the oncoming MA. -The extra controlled substances received from	D 392		

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the pharmacy locked in the controlled substance storage box were not included in the shift change controlled substance counts.
-The extra controlled substances of multiple bubble packs of the same medication would be stored together in a plastic bag locked in the medication cart until the Sales and Marketing Director came by and removed them from the medication cart to store in a safe in her office.
-There was no set routine as to when the Sales and Marketing Director would move the extra controlled substances to the safe in her office.
-The Sales and Marketing Director did not sign or count any of the extra controlled substances with anyone before moving the medications to her office safe.

Interview with the Lead MA on 10/08/26 at 10:00am revealed:
-She became Lead MA on 08/20/26.
-After 08/20/26, she became responsible for scanning and reordering all medications.
-Prior to her becoming the Lead MA, the MA's were scanning medications into electronic inventory and reordering medications.
-She was now responsible for scanning and reordering medications.
-The new process of only the Lead MA scanning and reordering medications started 09/01/26.
-She made sure there was one bubble pack of each controlled substance on the medication cart.
-The MAs now had to get approval from the Administrator before scanning a medication into inventory.
-The extra inventory of controlled substances were stored in a safe in the Administrator's office.
-The Administrator was the only one with access to the safe.
-Prior to 09/01/26, the extra inventory of controlled substances were stored in a safe in the

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D 392	Continued From page 87 Sales and Marketing Director's office. Interview with the Administrator on 10/08/26 at 3:40pm revealed: -The facility did not have a written policy on controlled substances. -The medication aide (MA) who received controlled substances from the pharmacy was supposed to sign the delivery sheet for the medications. -Then the MA should file the signed packing slip in the binder with the other pharmacy delivery sheets. -The MAs were to keep one pack of each controlled substance on the medication cart. -The Lead MA was responsible for scanning all medications into inventory in the eMAR system. -Prior to 09/14/26, all extra controlled substances were kept in a safe in the Sales and Marketing Director's office. -The Sales and Marketing Director would give them to the staff when they were needed for the resident. -After 09/14/26, the extra stock of controlled substances were placed in the safe in her office. -She did not audit the controlled substances being stored in the Sales and Marketing Director's office safe. Interview with the Sales and Marketing Director on 10/09/26 at 11:25am revealed: -The MAs were storing all controlled substances on the medication cart. -She started storing excess controlled substances in a safe in her office. -She started leaving the safe key in the drawer of her desk in her locked office so the Administrator could get to it. -Then an "incident" happened and she told the Administrator she needed to keep the controlled	D 392		

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D 392	Continued From page 88 substances in her office. -"Supposedly," a resident's extra oxycodone was being stored in her safe. -She went to get the resident's extra oxycodone from the safe and it was not there. -The Administrator was not the only staff with knowledge of the access code to get into her office. -The Cook was also given the code to the door to her office. -They had to start locking the kitchen because food was being stolen. -They then began to keep the key to the kitchen in her office. -She did not count with anyone or document the types and amounts of controlled substances stored in the safe in her office. Interview with the Administrator on 10/09/26 at 2:42pm revealed: -She kept a handwritten log of the overstock resident controlled substances she stored in her office safe. -She was the only one with access to office safe. -The Sales and Marketing Director did let her know where she kept the key to the safe in the Sales and Marketing Director's office when resident overstock controlled substances were being kept in that safe. -She knew about the key but she had never used it to access the Sales and Marketing Director's safe. _____ The facility failed to have a system which documented the receipt, administration, and disposition of controlled substances leading to consecutive missed doses due to the medications being unavailable to administer and too early to be refilled causing Resident #4 and Resident #5 to experience opioid withdrawal symptoms	D 392		

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D 392	Continued From page 89 resulting in Resident #4 being hospitalized for gastrointestinal pain and Resident #5 to experience increased pain, no appetite, depressed mood. This failure was detrimental to the health, safety, and welfare of the residents and constituted a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 9, 2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2026.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to report known drug diversion of controlled substances to the pharmacy and submit a 5 day report to the Health Care Personnel Registry as required by state law for 1 resident (Resident #5) for a controlled medication used to treat moderate to severe pain. The findings are:	D 399		

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D 399	Continued From page 90 Review of Resident #5's FL2 dated 06/17/26 revealed: -Diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in body tissues), paroxysmal atrial fibrillation (heart's upper chambers beat chaotically and out of sync with the lower chambers causing episodes that start and stop suddenly and last fewer than seven days), atrial flutter (abnormal heart rhythm), and type 2 diabetes. -There was an order for oxycodone 15mg IR (used to treat moderate to severe pain) one tablet every six hours. Review of Resident #5's current FL2 dated 10/01/26 revealed oxycodone 15mg IR one tablet every four hours. Telephone interview with a representative from the facility's contracted pharmacy on 10/07/26 at 4:22pm revealed: -The pharmacy dispensed controlled medications along with a matching controlled substance count sheet (CSCS) for documenting administration of the medication and accounting for the medication. -The pharmacy received an electronic medication order dated 07/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity of 180 on 07/11/26. -The pharmacy received an electronic medication order dated 08/11/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 180 on 08/11/26. -The pharmacy received an electronic medication order dated 09/02/26 for oxycodone 30mg IR half tablet every four hours and dispensed quantity 21 (half tablets equaled 42 doses) on 09/02/26. -The pharmacy received an electronic medication	D 399		

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order dated 09/10/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/10/26.
-The pharmacy received an electronic medication order dated 09/25/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 90 on 09/25/26.
-The pharmacy received an electronic medication order dated 10/05/26 for oxycodone 15mg IR one tablet every four hours and dispensed quantity 42 on 10/07/26.

Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone 15mg IR one tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 06/29/26 and stop date of 07/10/26.
-The oxycodone was documented as not administered on 07/03/26 at 6:00am due to "medication out of stock."
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR every 6 hours was documented as administered 28 occurrences out of 38 opportunities.
-The oxycodone 15mg IR every 4 hours was documented as administered 123 occurrences out of 129 opportunities.

Review of Resident #5's CSCS's for oxycodone 15mg IR 180 tablets dispensed 07/10/26 revealed:
-There were 4 out of 6 CSCS's available for the 07/10/26 dispense which documented receipt of 120 tablets out of 180 tablets delivered by the

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pharmacy.
-The CSCS labeled 1 out of 6 had documented administration entries dated 07/26/26 to 07/31/26 for 30 tablets.
-The CSCS labeled 3 out of 6 had documented administration entries dated 07/31/26 to 08/05/26 for 30 tablets.
-The CSCS labeled 5 out of 6 had documented administration entries dated 08/05/26 to 08/09/26 for 30 tablets.
-The CSCS labeled 6 out of 6 had documented administration entries dated 08/10/26 to 08/14/26 for 30 tablets.

Review of Resident #5's August 2026 eMAR revealed:
-There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26.
-The oxycodone 15mg IR every 4 hours was documented as administered 173 occurrences out of 186 opportunities.
-The oxycodone 15mg IR was documented as not administered on 08/30/26 at 8:00pm, 08/31/26 at 12:00am, 08/31/26 at 4:00am, 08/31/26 at 8:00am, 08/31/26 at 12:00pm, 08/31/26 at 4:00pm, and 08/31/26 at 8:00pm due to "medication out of stock-reordered".

Review of Resident #5's pharmacy packing slips revealed there was no packing slip available for the oxycodone 15mg IR quantity 180 dispensed on 08/11/26.

Review of Resident #5's CSCS's for oxycodone 15mg IR 180 tablets dispensed 08/11/26 revealed:
-There were 3 out of 6 CSCS's available for the

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D 399	Continued From page 93 08/11/26 dispense which documented receipt of 90 tablets out of 180 tablets delivered. -The first CSCS had documented administration entries dated 08/15/26 to 08/20/26 for 30 tablets received on 08/15/26. -The second CSCS had documented administration entries dated 08/20/26 to 08/25/26 for 30 tablets received on 08/17/26. -The third CSCS had documented administration entries dated 08/25/26 to 08/30/26 for 30 tablets received on 08/17/26. -The facility was unable to provide the oxycodone 15mg IR CSCS's for 90 tablets. Review of Resident #5's September 2026 eMAR revealed: -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 07/10/26 and stop date of 09/02/26. -The oxycodone 15mg IR every 4 hours was documented as administered 2 occurrences out of 12 opportunities. -The oxycodone 15mg IR was documented as not administered on 09/01/26 at 8:00am, 09/01/26 at 12:00pm, 09/01/26 at 4:00pm, 09/01/26 at 8:00pm, 09/02/26 at 12:00am, and 09/02/26 at 4:00am, 09/02/26 at 12:00pm, 09/02/26 at 4:00pm, 09/02/26 at 8:00pm, on 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -There was an entry for oxycodone 30mg half tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/02/26 and stop date of 09/09/26. -The oxycodone 30mg IR half tablet every 4 hours was documented as administered 37 occurrences out of 42 opportunities.	D 399		

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D 399	Continued From page 94 -The oxycodone 30mg IR was documented as not administered on 09/03/26 at 12:00am, 09/03/26 at 4:00am, and 09/03/26 at 8:00am due to "medication out of stock." -There was an entry for oxycodone 15mg IR one tablet every 4 hours scheduled at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 09/10/26 and stop date of 09/25/26. -The oxycodone 15mg IR was documented as administered 102 occurrences out of 115 opportunities. -The oxycodone 15mg IR was documented as not administered on 09/10/26 at 8:00pm and 09/11/26 at 12:00am due to "medication out of stock." Review of Resident #5's CSCS's for oxycodone 30mg IR 21 tablets dispensed 09/02/26 revealed: -There was a CSCS with administration dates 09/03/26-09/06/26 for quantity 21 half tablets with entries that matched the eMAR. -There was a CSCS with administration dates 09/06/26-09/10/26 for quantity 21 half tablets with entries that matched the eMAR. Review of Resident #5's October 2026 eMAR 10/01/26 to 10/06/26 revealed: -There was an entry for oxycodone 15mg IR one tablet every four hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 8:00pm, and 10:00pm with a start date of 9/10/26. -The oxycodone 15mg IR was documented as administered for 27 occurrences out of 29 opportunities. Review of Resident #5's CSCS's for oxycodone 15mg IR 90 tablets dispensed 09/25/26 revealed: -There was a CSCS with administration dates 09/27/26-10/07/26 for quantity 60 with a balance	D 399		

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of 11 tablets with entries that matched the eMAR.
-There was a CSCS for quantity 30 tablets with no documented administrations.

Observation of Resident #5's oxycodone 15mg IR on hand in the medication cart on 10/07/26 at 9:57am revealed:
-There was one bubble pack of oxycodone 15mg IR tablets with 11 tablets remaining.
-The pharmacy label directions were oxycodone 15mg IR one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.

Review of Resident #5's controlled substance count sheets (CSCS) in a book on the top of the medication cart on 10/07/26 at 9:50am revealed:
-The CSCS for the bubble pack of oxycodone 15mg IR tablets was available in the CSCS book.
-The entries on the CSCS matched the number of oxycodone in the bubble pack.

Observation of Resident #5's oxycodone 15mg IR stored in the safe in the Administrator's office on 10/07/26 at 9:59am revealed:
-There was one bubble pack of oxycodone 15mg IR tablets with 30 tablets remaining.
-The pharmacy label directions were oxycodone 15mg IR one tablet every 4 hours with a dispense date of 09/25/26 quantity of 90.
-The CSCS dated 09/25/26 was kept with the bubble pack of oxycodone 15mg IR tablets in the Administrator's safe.

Review of a handwritten inventory of controlled substances stored in the Administrator's safe on 10/09/26 at 2:45pm revealed:
-Resident #5 had 30 oxycodone 15mg IR tablets from the 09/25/26 dispense.
-There was a date of 10/08/26 written on the entry but there was no documented medication or

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amount received documented.

a. Interview with the Administrator on 10/07/26 at 2:36pm and 3:23pm revealed:
-She found out from two medication aides on 9/01/26 there were 60 oxycodone 15mg IR tablets missing for Resident #5.
-She did not report Resident #5's missing oxycodone to the facility's contracted pharmacy.
-The facility's pharmacy knew about the missing oxycodone due to Resident #5's primary care provider (PCP) contacting them to arrange another supply of oxycodone for Resident #5.
-She did not know there were 60 oxycodone 15mg IR tablets missing from Resident #5's 07/11/26 delivery and 90 oxycodone 15mg IR tablets missing from the 08/11/26 delivery.
-Resident #5's oxycodone had been locked up on the medication cart and medication aides were the only staff with access to the medication cart.
-She began storing all the residents' extra bubble packs of controlled substances in a safe in her office on 09/14/26 instead of leaving the extras stored on the medication cart.
-She did not know if she had any overstock of controlled substances to be stored in the safe from 09/01/26-09/14/26.
-She was the only one with the code to open the safe in her office.
-She did not investigate anything further after 09/01/26 since there was nothing she could do because she could not find out which staff had taken the oxycodone.
-She did not audit any other controlled substances for any of the other residents in the facility.

Interview with the Administrator on 10/08/26 at 3:40pm revealed:
-She did not report Resident #5's missing

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oxycodone to the pharmacy until "yesterday" (10/07/26).
-She reported to a pharmacist at the facility's contracted pharmacy they had diversion.
-She reported there were 60 missing oxycodone 15mg IR for Resident #5.
-She asked if someone from the pharmacy would be coming out to do an audit.
-She said the pharmacist said they would, but they have to do "their process on that."

Telephone interview with the facility's contracted pharmacy representative on 10/08/26 at 3:00pm revealed:
-On 09/02/26, there was a triage note regarding a new order for oxycodone 30mg tablets for Resident #5.
-In the complaint section of the triage note, it was noted there was diversion of 90 tablets of Resident #5's oxycodone 15mg IR with no fill dates mentioned.
-The note documented the Administrator notified law enforcement.
-The Administrator's plan was to leave one bubble card of oxycodone 15mg IR tablets on the medication cart at a time.
-The Administrator would be responsible for storing the extra oxycodone 15mg IR tablets.
-On 10/07/26, there was a phone order mentioning there were additional 60 tablets of oxycodone 15mg IR that were missing from Resident #5's supply.

Refer to the interview with a medication aide (MA) on 10/08/26 at 9:00am.

Refer to the interview with the Lead MA on 10/08/26 at 10:00am.

b. Review of local law enforcement report dated

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09/01/26 at 4:01pm revealed:
-On 09/01/26, local law enforcement responded to the facility in reference to larceny of medication.
-The incident was discovered on 08/15/26 at 12:00pm.
-The oxycodone was last known secure on 08/12/26 at 12:00pm.
-The Administrator advised over 60 oxycodone were stolen.
-Facility medication aides were the only staff with access to the missing oxycodone.
-The Administrator did her own investigation but did not find a suspect.

Interview with the Administrator on 10/07/26 at 2:36pm and 3:23pm revealed:
-She found out from two medication aides on 9/01/26 there were 60 oxycodone 15mg IR tablets missing for Resident #5.
-She notified law enforcement on 09/01/26 to report 60 missing oxycodone 15mg IR tablets.
-She did not know there were 60 oxycodone 15mg IR tablets missing from Resident #5's 07/11/26 delivery and 90 oxycodone 15mg IR tablets missing from the 08/11/26 delivery.
-She had not made any other reports to local law enforcement concerning the additional 90 missing oxycodone 15mg IR for Resident #5.

Interview with a local law enforcement officer on 10/07/26 at 4:05pm revealed:
-He came out to the facility on 09/01/26 in response to the Administrator's report of stolen controlled substance medication for Resident #5.
-The Administrator reported oxycodone belonging to Resident #5 stored in a locked drawer that only staff had access to were missing.
-He did not remember how many oxycodone were reported missing, but the number reported

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missing would be available in his report.
-The Administrator reported to him she was investigating the incident.

Refer to the interview with a medication aide (MA) on 10/08/26 at 9:00am.

Refer to the interview with the Lead MA on 10/08/26 at 10:00am.

c. Review of Resident #5's 24-Hour HCPR Report dated 09/01/26 revealed:
-The allegation/incident type was diversion of resident drugs.
-The Administrator was notified on 09/01/26 at 2:30pm, Resident #5 had been out of oxycodone for two days.
-The oxycodone was missing and the staff did not know what happened to the medication.
-The description of physical or mental injury/harm was "pain".
-The accused individual information was documented as "unknown".
-Local law enforcement was notified on 09/01/26 at 4:00pm due to reasonable suspicion of a crime.

Interview with the Administrator on 10/07/26 at 2:36pm and 3:23pm revealed:
-She found out from two medication aides on 9/01/26 there were 60 oxycodone 15mg tablets missing for Resident #5.
-She completed a 24-Hour HCPR Report on 09/01/26 and faxed it to HCPR the same day to report Resident #5's missing oxycodone.
-She did not send in a 5-Day Investigation Report to HCPR concerning Resident #5's missing oxycodone.
-She was unaware she was required to send in a 5-Day Investigation Report to HCPR.

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D 399	Continued From page 100 -She did an investigation into the incident. -She interviewed all of the staff. -She did not keep documentation of any of the interviews she conducted with the staff. -She performed urine drug screens on all staff and they were negative. -She did not document the staff she drug tested or the results. -She could not provide a sample of the drug screen kit she used to conduct the staff drug screens. -She used a urine drug screen she obtained from an online retailer. Refer to the interview with a medication aide (MA) on 10/08/26 at 9:00am. Refer to the interview with the Lead MA on 10/08/26 at 10:00am. _____ Interview with a medication aide (MA) on 10/08/26 at 9:00am revealed: -Medications were routinely delivered by the pharmacy during night shift. -Prior to changes made by the Administrator after some controlled substances went missing, the night shift MA scanned in the medications delivered by the pharmacy into inventory. -The controlled substances received on the delivery were temporarily stored in the locked controlled substance storage box on the medication cart. -The CSCS's were kept with the bubble packs of controlled substances stored in the locked controlled substance storage box rather than separated and placed in the CSCS book on the top of the medication cart. -At shift change, the controlled substances that were open and in use were counted by the oncoming MA.	D 399		

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D 399	Continued From page 101 -The extra controlled substances received from the pharmacy locked in the controlled substance storage box were not included in the shift change controlled substance counts. -The extra controlled substances of multiple bubble packs of the same medication would be stored together in a plastic bag locked in the medication cart until the Sales and Marketing Director came and removed them from the medication cart to store in a safe in her office. -There was no set routine as to when the Sales and Marketing Director would move the extra controlled substances to the safe in her office. -The Sales and Marketing Director did not sign or count any of the extra controlled substances with anyone before moving the medications to her office safe. -Resident #5 was out of oxycodone 15mg IR missing consecutive doses causing the resident to be "so sick" and "definitely going through withdrawals". Interview with the Lead MA on 10/08/26 at 10:00am revealed: -She became Lead MA on 08/20/26. -After 08/20/26, she became responsible for scanning and reordering all medications. -Prior to her becoming the Lead MA, the MA's were scanning medications into electronic inventory and reordering medications. -She was now responsible for scanning and reordering medications. -The new process of only the Lead MA scanning and reordering medications started 09/01/26. -She made sure there was one bubble pack of each controlled substance on the medication cart. -The MAs now had to get approval from the Administrator before scanning a medication into inventory and they had to have a good reason why.	D 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 10/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 399	Continued From page 102 -The extra inventory of controlled substances were stored in a safe in the Administrator's office. -The Administrator was the only one with access to the safe. -Prior to 09/01/26, the extra inventory of controlled substances were stored in a safe in the Sales and Marketing Director's office. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration Refer to Tag 392, 10A NCAC 13F .1008(h) Controlled Substances _____ The facility failed to notify the facility's contracted pharmacy of drug diversion after discovering missing oxycodone for Resident #5. The facility Administrator failed investigate and submit a 5-Day HCPR report for the missing of oxycodone. This resulted in continued drug diversion and residents missing doses of narcotic pain medicaitons which resulted in increased pain. This failure was detrimental to the health, safety and welfare and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 9, 2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2026.	D 399		