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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 08/20/25 - 08/22/25.	D 000		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the floors were kept in good repair related to the hallways in the assisted living. The findings are: Review of the environmental inspection report from the local county health department dated	D 074		

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06/09/25 revealed:
-The facility received 13 demerits.
-The carpet was pulled up to be replaced and baseboards missing and exposed rough surfaces.
-This was a repeat deficiency from the 12/17/24 inspection.

Observation of the Jordan Hall on 08/20/25 at 8:45am revealed the floor in the hallway was exposed uneven concrete and there were no baseboards.

Observation of Townsend Hall on 08/20/25 at 9:00am revealed the floor in the hallway was exposed uneven concrete and there were no baseboards.

Interview with a resident on 08/21/25 at 9:05am revealed:
-The carpet in the hallways had been removed months ago and the facility had not fixed the issue.
-The concrete floors were dirty and nasty because they could not be properly cleaned.
-She would prefer to have the flooring done in the halls to make the facility more comfortable.

Interview with a second resident on 08/21/25 9:15am at revealed:
-The floor in the hallways had been incomplete for over a month.
-She had a harder time using her walker on the concrete floors because they were uneven.
-She would like for the hallways to have proper flooring because it would be more presentable.

Interview with a third resident on 08/21/25 at 9:20am revealed:
-The hallway floors had been incomplete since

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she could remember.
-She had some difficulty walking on the concrete floor with her walker because it was not even.
-The facility would look nicer and she would be more comfortable if the hallways were done.

Interview with a housekeeper on 08/21/25 at 9:00am revealed:
-The hallways in the facility used to be carpet.
-The carpet was pulled up 2-3 months ago to be replaced.
-She swept the floors in the halls but was not able to mop it because it was concrete.

Interview with another housekeeper on 08/21/25 at 9:25am revealed:
-The hallway floors had been incomplete for about 8 months.
-There was previously carpet on the floors that had been pulled up to be replaced.
-She was not able to properly clean the floors because it was concrete.

Interview with the Maintenance Director (MD) on 08/21/25 at 9:35am revealed:
-The hallway floors on Assisted Living had been incomplete for about two months.
-The carpet and baseboards had been pulled up in order to be replaced.
-There was no scheduled time for the floors to be completed.
-He was concerned that the exposed concrete floors in the hallways were not sanitary.
-The incomplete floors and baseboards did not look good.

Interview with the Resident Care Coordinator (RCC) on 08/21/25 at 10:15am revealed:
-The facility began to pull up the carpet and baseboards in April.

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-She did not know why the carpet was pulled up.
-The Owner was responsible for scheduling and ensuring the floors were complete.
-The exposed concrete floors were not aesthetically pleasant.
-The concrete floors could not be properly cleaned and sanitized.

Interview with the Administrator on 08/21/25 at 1:15pm revealed:
-The hallway floors on Assisted Living were pulled up in April and new floors were supposed to be put in.
-She believed the new flooring was scheduled to be replaced the following week.
-She believed the incomplete hallway floors looked tacky.
-She was concerned with resident safety because residents could fall on the concrete floor and injure themselves.
-The Vice President (VP) and Owner were responsible for ensuring the floors were done properly.

Interview with the VP of Operations on 08/21/25 at 4:45pm revealed:
-She initially contracted a local flooring installer in March or April to have the hallway floors completed.
-She had to get a new vendor on 05/21/25 to complete the work because the initial company had failed to order the materials and were not prepared to complete the work.
-She had to contract with a third flooring company because the second vendor had not done adequate work on the Special Care Unit floors.
-The floors were scheduled to be completed no later that 09/15/25.

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D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation has not been abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#1, #2, #5) sampled for record review including errors with a controlled substance for moderate to severe pain (#1), a topical patch for pain (#2), and a medication used to treat nerve pain (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 03/18/25 revealed: -Diagnoses included chronic bilateral low back pain with right-sided sciatica (pain in the lower back caused by irritation or pressure affecting the sciatic nerve), primary osteoarthritis, right hip pain, type 2 diabetes mellitus, hypertension, osteoporosis, hyperlipidemia, and pernicious anemia. -There was an order for Acetaminophen	D 358		

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(APAP)/Codeine 300/30mg 1 tablet twice a day. (APAP/Codeine is a controlled substance used to treat moderate to severe pain.)

Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for APAP/Codeine 300/30mg 1 tablet twice a day scheduled at 7:00am and 7:00pm.
- APAP/Codeine 300/30mg was documented as not administered from 7:00am on 07/01/25 through 7:00am on 07/19/25 due to medication not on cart, medication on order, and waiting on delivery.
-There was an entry for Tylenol 500mg 2 tablets every 6 hours as needed (prn) for pain. (Tylenol is an over-the-counter medication used tor treat mild to moderate pain.)
-Resident #1 requested and received prn Tylenol on 2 occasions when the resident's APAP/Codeine 300/30mg was unavailable.
-Resident #1 received prn Tylenol on 07/09/25 at 12:17pm and 07/10/25 at 9:51am for pain, which was documented as effective.

Review Resident #1's June 2025 and July 2025 controlled substance (CS) logs for APAP/Codeine 300/30mg revealed:
-There was a CS log for a supply of 60 APAP/Codeine 300/30mg tablets dispensed on 05/28/25 with the last dose administered on 06/30/25 at 7:00pm, leaving a balance of 0.
-There was no APAP/Codeine 300/30mg documented as administered and declined from the CS log from 7:00am on 07/01/25 through 7:00am on 07/19/25.
-There was a CS log for a supply of 60 APAP/Codeine 300/30mg tablets dispensed on 07/17/25.

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-The first dose documented as administered and declined from the count was at 8:00pm on 07/19/25.

Telephone interview with the Quality Assurance Staff at the facility's contracted pharmacy on 08/22/25 at 11:20am revealed:
-The pharmacy dispensed 60 APAP/Codeine 300/30mg tablets for Resident #1 on 05/28/25.
-The pharmacy received a request for refill of the APAP/Codeine 300/30mg tablets by the facility on 06/20/25.
-The pharmacy faxed a controlled substance reorder request template for the APAP/Codeine 300/30mg tablets to the facility on the same day as the request, 06/20/25.
-Since APAP/Codeine was a controlled substance, the pharmacy needed a new prescription to refill the medication.
-The pharmacy's procedure was to send the controlled substance reorder request template to the facility so the facility could send the reorder request template to the resident's primary care provider (PCP) for signature for a new prescription.
-The pharmacy did not receive the signed reorder request template back from the facility until 07/17/25.
-The pharmacy dispensed 60 APAP/Codeine 300/30mg tablets for Resident #1 on 07/17/25 and it was delivered to the facility the night of 07/17/25.
-There was no documentation in their notes that the facility contacted them about Resident #1's APAP/Codeine 300/30mg tablets after the initial request on 06/20/25 until they received the reorder request template back on 07/17/25.
-She did not currently have access to see the signed delivery sheet for the APAP/Codeine tablets, but the facility would have a copy of who

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signed for the medication on 07/17/25.
-The pharmacy dispensed 60 APAP/Codeine 300/30mg tablets for Resident #1 on 08/12/25.

Observation of Resident #1's medications on hand on 08/21/25 at 10:26am revealed:
-There was a supply of 60 APAP/Codeine 300/30mg tablets dispensed on 08/12/25.
-The instructions were to take 1 tablet twice a day.
-There were 54 of 60 tablets remaining.

Review of Resident #1's June 2025 - July 2025 facility progress notes revealed:
-There was no documentation the facility attempted to contact Resident #1's PCP or the facility's contracted pharmacy to obtain APAP/Codeine 300/30mg prior to the medication running out on 06/30/25.
-On 07/03/25 at 3:33pm: the RCC called Resident #1's PCP's office in regard to the APAP/Codeine 300/30mg tablet that was not on the medication cart; the RCC noted she faxed the request to the PCP on 07/01/25: the PCP's nurse said they received it and they would try to get the PCP to send over the request today.
-There was no documentation the facility attempted to contact Resident #1's PCP or the facility's contracted pharmacy regarding the APAP/Codeine 300/30mg from 07/04/25 - 07/15/25.
-On 07/16/25 at 2:00pm: the RCC called the facility's contracted pharmacy in reference to Resident #1's APAP/Codeine 300/30mg tablets; the RCC was told the PCP never responded to the refill request.
-On 07/16/25 at 2:15pm: the RCC called Resident #1's PCP's office in regard to the APAP/Codeine 300/30mg; the RCC was told the PCP's office had the request but could not find the original

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order to refill; the PCP was not in the office today, but the PCP's office would call back tomorrow with an update.
-There was no further documentation regarding Resident #1's APAP/Codeine 300/30mg tablets.

Interview with Resident #1 on 08/22/25 at 10:48am revealed:
-She had shoulder pain and lower back pain but not every day.
-She could not recall taking medication for the pain except for Tylenol when she asked for it.
-Tylenol usually helped with her pain.
-She did not know if the facility had ran out of any of her medications.

Telephone interview with Resident #1's family member on 08/22/25 at 9:07am revealed:
-She was not aware Resident #1 had missed any doses of APAP/Codeine in July 2025.
-She usually took Resident #1 to her PCP appointments, and she was able to get a prescription upon request if she knew the resident needed one.
-No one from the facility contacted her in July 2025 to let her know Resident #1 was out of her pain medication or that the resident needed a new prescription.
-Resident #1 was supposed to get APAP/Codeine for chronic lower back pain with sciatica pain.
-She picked up Resident #1 from the facility on 07/04/25 for an outing for a family cookout.
-On 07/04/25, while Resident #1 was at her house, the resident complained of hurting more than usual.
-Resident #1 told her that she did not know why she was hurting more than usual.
-She had to give Resident #1 some Tylenol (for mild to moderate pain) that day, 07/04/25.
-She did not know why Resident #1 was

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complaining of more pain that day because the resident had taken her morning medications before they left the facility on 07/04/25..
-She assumed Resident #1 had taken the APAP/Codeine that morning as well and she was not told any differently by the facility staff.
-Resident #1 would not move from the sofa to the dinner table to eat with the family on 07/04/25 because it hurt too much when the resident moved around.
-She had to use a tray to serve the resident's food while the resident sat on the sofa to eat.

Interview with the RCC on 08/21/25 at 4:16pm revealed:
-For controlled substance refills, the pharmacy would send a form every 30 days that needed to be signed by the resident's PCP.
-Once the facility received the form from the pharmacy, she was responsible for sending the form to the resident's PCP.
-She would call the PCP's office to follow up to see if they received the form sometimes the same day or at least the next day.
-Once she received the signed form back from the PCP, she would send it to the pharmacy.
-Sometimes the PCP would also send the signed form back to the pharmacy.
-The medication aides (MAs) were supposed to let her know when there was a 7-day supply of a controlled substance remaining so she could make sure she had received a form from the pharmacy.
-She did not recall anyone letting her know that Resident #1's supply of APAP/Codeine tablets was low in June 2025.
-She received a form from the pharmacy for Resident #1's APAP/Codeine indicating the resident needed refills, but she could not recall when she received the form.

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-She faxed the form to the resident's PCP on 07/01/25 according to her documented progress note.
-Resident #1 used an outside PCP who was sometimes difficult to get in touch with.
-She called Resident #1's PCP's office on 07/03/25 and was told there were some issues with the instructions on the prescription and they were waiting for the PCP to review it.
-She called the PCP's office other times between 07/03/25 - 07/16/25 but failed to document those calls.
-She thought Resident #1's PCP sent the signed order back to the pharmacy, but she was not sure when the pharmacy received it.

Interview with the Interim Administrator on 08/22/25 at 11:37am revealed:
-She was an Operations Specialist but was currently serving as the Interim Administrator since the former Administrator left the position last week.
-She was not familiar with the facility's medication ordering procedures.
-Medication refill requests should be made prior to the medication running out.
-Someone should have used the back up pharmacy to obtain the medication.

Interview with an Operations Specialist on 08/22/25 at 11:38am revealed:
-Controlled substances were not sent with the monthly cycle fills and had to be ordered by the facility.
-The RCC was responsible for doing weekly cart audits.
-If a controlled substance was down to a one-week supply, the MAs and RCC were responsible for sending a controlled substance template to the resident's PCP for refills.

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-If they did not get a response from the PCP within 24 hours, the MAs and RCC should follow-up with the PCP's office via telephone or in person.
-She did not know why there was a delay in starting the APAP/Codeine 300/30mg tablets that were dispensed and delivered to the facility on 07/17/25.
-She would search for the signed delivery sheet for the APAP/Codeine on 07/17/25.

Resident #1's pharmacy delivery sheet for the APAP/Codeine 300/30mg tablets dispensed on 07/17/25 was requested on 08/22/25 at 11:38am but never received.

Telephone interview with a registered medical assistant (RMA) at Resident #1's PCP's office on 08/22/25 at 9:35am revealed:
-The resident's PCP was out of the office an unavailable for interview.
-Resident #1 took APAP/Codeine for chronic bilateral lower back pain with right-sided sciatica and primary osteoarthritis involving multiple joints.
-They received a faxed form for signature for continuation of therapy for Resident #1's APAP/Codeine.
-She was not sure who sent the form.
-They sent the signed form for the APAP/Codeine to the facility on 07/08/25.
-She did not know if the signed form was sent to the pharmacy or the facility prior to 07/08/25.
-The resident could have pain if the APAP/Codeine was not administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/22/25 at 11:51am revealed:
-Not receiving APAP/Codeine 300/30mg could cause Resident #1 to be in pain.

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-Not receiving APAP/Codeine 300/30mg could cause withdrawal symptoms such as anxiousness, confusion, and irritability.
-The resident could experience withdrawal symptoms for up to 3 days without the medication.

2. Review of Resident #2's current FL2 dated 08/05/25 revealed diagnoses included unspecified dementia, generalized muscle weakness, rheumatoid arthritis, type 2 diabetes mellitus, and essential hypertension.

Review of Resident #2's primary care provider's (PCP) Encounter Note dated 07/08/25 revealed:
-Diagnoses included unspecified lower back pain.
-There was a current medication list which included Lidocaine 5% patch apply 1 patch to lower back in the morning and remove 12 hours later with a start date of 05/16/24 (Lidocaine is a topical medication used to numb and relieve pain).

Review of Resident #2's current Physician Order Sheet dated 08/18/25 revealed an order for Lidocaine 5% patches apply 1 patch topically daily to lower back and remove patch 12 hours after applying.

Review of Resident #2's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 5% patches apply 1 patch topically daily to lower back scheduled at 9:00am.
-Lidocaine patches were documented as applied to Resident #2's lower back every day in June 2025.

Review of Resident #2's July 2025 eMAR

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revealed:
-There was an entry for Lidocaine 5% patches apply 1 patch topically daily to lower back scheduled at 9:00am.
-Lidocaine patches were documented as applied to Resident #2's lower back every day in July 2025 except 07/10/25.
-On 07/10/25, Lidocaine patches were held due to not being on hand at the facility.

Review of Resident #2's August 2025 eMAR from 08/01/25 to 08/20/25 revealed:
-There was an entry for Lidocaine 5% patches apply 1 patch topically daily to lower back scheduled at 9:00am.
-Lidocaine patches were documented as applied to Resident #2's lower back daily from 08/01/25 to 08/20/25.

Observation of Resident #2's medications on hand on 08/22/25 at 9:25am revealed:
-There was a box of Lidocaine 5% patches dispensed on 07/10/25 with a quantity of 30 patches.
-There were 22 of 30 patches remaining.

Interview with a medication aide (MA) on 08/22/25 at 9:30am revealed:
-Lidocaine patches were applied to Resident #2's lower back every morning and removed every evening.
-She did not know why there were 22 patches remaining on hand if Lidocaine patches were applied as ordered.

Interview with Resident #2 on 08/22/25 at 10:50am revealed:
-She had intermittent lower back pain occurring most days but not every day.
-The lower back pain disappeared completely on

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some days but on other days the pain was constant and rated a 2 or 3 on a pain scale of 1 to 10.
-The "pain patch" relieved her lower back pain when applied by facility staff.
-She could not remember if her patch was applied on the days she experienced more pain.

Telephone interview with a Quality Assurance staff member from the facility's contracted pharmacy on 08/22/25 at 11:25am revealed:
-The pharmacy dispensed 30 Lidocaine 5% patches on 07/10/25 and 30 patches on 04/09/25.
-The pharmacy did not dispense the Lidocaine 5% patches on any other dates between April 2025 and July 2025.
-Lidocaine patches were not dispensed automatically by the pharmacy with monthly cycle fills; a facility staff member had to notify the pharmacy that a refill was needed.
-There were 60 Lidocaine patches (a 60-day supply) dispensed from 04/09/25 to 08/22/25, a 135-day time period.

Interview with the Interim Administrator on 08/22/25 at 11:55am revealed:
-Resident #2's Lidocaine patches should have been applied daily in the morning and removed in the evening as ordered.
-Lidocaine patches not being administered as ordered should have been caught by the Resident Care Coordinator (RCC) during weekly cart audits.
-The MAs should not have documented administration of Lidocaine if they did not apply the Lidocaine patch.

Telephone interview with Resident #2's PCP on 08/22/25 at 10:53am revealed:
-She was not aware that Resident #2's Lidocaine

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patch was not being applied as ordered.
-The Lidocaine patches were ordered for Resident #2's lower back pain caused in part by being confined to a gerichair due to being non-ambulatory.
-Resident #2 should have Lidocaine patches applied every morning to relieve her chronic lower back pain.
-The resident would have increased pain if the patch was not applied daily as ordered.

3. Review of Resident #5's current FL-2 dated 09/03/24 revealed diagnoses included vascular dementia, epilepsy, major depressive disorder, anxiety, post trauma stress disorder, and insomnia.

Review of Resident #5's signed physician's orders dated 06/17/25 revealed:
-There was an order for Gabapentin 300mg, 1 capsule three times per day. (Gabapentin is used to treat nerve pain).
-There were 3 refills for the Gabapentin 300mg.

Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Gabapentin 300mg,1 capsule three times per day scheduled for 7:00am, 2:00pm, and 7:00pm.
-Gabapentin 300mg was not documented as administered from 07/21/25 at 7:00pm and from 07/22/25 to 07/28/25 three times per day.
-There was an entry in the exceptions that Gabapentin was not on the medication cart.
-There were entries in the notes that Gabapentin was waiting on delivery, waiting for medication, or on order.
-Ibuprofen 600mg, 1 tablet every 8 hours as needed for pain was documented as

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administered and effective from 07/21/25 to 07/28/25. (Ibuprofen is used to treat mild pain).

Interview with Resident #5 on 03/20/25 at 10:01am revealed:
-He was taking Gabapentin for muscle spasm which caused him pain.
-When he was out of the Gabapentin, he took Ibuprofen which was helpful.

Interview with a medication aide (MA) on 08/21/25 at 11:04am revealed:
-Resident #5's medication came from the veteran affairs (VA) pharmacy.
-Resident #5's medication should be reordered when there were 7 doses remaining.
-Resident #5 should not have waited a week to receive his medication.
-The facility could have ordered Resident #5's medication from the backup pharmacy.
-She did not know why Resident #5's Gabapentin was not ordered from the backup pharmacy.

Interview with the Resident Care Coordinator (RCC) on 08/21/25 at 11:51am revealed:
-The facility attempted to pick up Resident #5's Gabapentin 300mg, but the VA refused to give it to them because it was mailed.
-The facility requested the VA pharmacy to dispense enough of the Gabapentin 300mg for Resident #5 until it was delivered via mail, but the VA pharmacy refused because the medication was a controlled substance.
-The facility could have used the backup pharmacy, but she did not know if the backup pharmacy would have provided the Gabapentin 300mg.
-She was told by the Vice President and the Operations Specialist not to contact the backup pharmacy because Resident #5 had an

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D 358	Continued From page 17 outstanding bill with them. Interview with the Administrator on 08/21/25 at 1:18pm revealed: -She expected facility staff to be proactive and continue to notify the pharmacy to obtain a resident's medication. -She expected facility staff to notify the backup pharmacy if the VA had not sent a resident's medication. _____ The facility failed to administer medications as ordered to 3 of 5 residents sampled. Resident #1 did not receive APAP/Codeine, a controlled substance for moderate to severe pain, for 19 days (37 doses) from 07/01/25 - 07/19/25. Resident #1 experienced more pain than usual on 07/04/25 with her family and was unable to move from the sofa to the dining room table to eat due to the increased pain, which required administration of Tylenol. Resident #1 also required prn Tylenol on 07/09/25 and 07/10/25 when the APAP/Codeine was unavailable. Resident #1 experienced more pain and was at risk of withdrawal symptoms including anxiousness, confusion, and irritability. Resident #2 had 60 Lidocaine patches dispensed from April 2025 - August 2025 which was a 60-day supply. On 08/22/25, there were still 22 of the 60 patches remaining so only 38 Lidocaine patches were applied in a 135-day time period. Resident #2 experienced intermittent back pain and the resident could have increased pain if the patch was not applied daily as ordered. Resident #5 did not receive Gabapentin for pain 3 times a day as ordered from 07/21/25 - 07/28/25 due to the medication being unavailable. Resident #5 experienced pain when he was out of the Gabapentin and required prn Ibuprofen to help	D 358		

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D 358	Continued From page 18 with pain when he did not receive Gabapentin. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Continuing Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/25 for this violation.	D 358		
D 364	10A NCAC 13F .1004 (g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 7 of 7 residents observed (#6, #7, #8, #9, #10, #11, #12) in the assisted living (AL) side of the facility on 08/20/25, resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness. The findings are: Review of the facility's Medication Administration Policies and Procedures dated February 2025 revealed medications would be administered within one hour before or one hour after the	D 364		

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D 364	Continued From page 19 prescribed or scheduled time unless an emergency precluded the administration. Review of the facility's census report dated 08/20/25 revealed: -The facility's current in-house census was 50 residents. -There were 39 residents currently residing in the assisted living (AL) side of the facility. -There were 11 residents currently residing in the special care unit (SCU). Observation of the AL side of the facility on 08/20/25 at 10:40am revealed a medication aide (MA) was administering medications to residents on Jordan Hall. Interview with the MA on 08/20/25 at 10:40am revealed: -She was still administering the 8:00am and 9:00am medications to the residents on the Jordan Hall in the AL side of the facility. -She had to administer medications to seven more residents. -She was running behind with administering the morning medications. Observation of the Jordan Hall on 08/20/25 at 11:20am revealed the MA finished administering morning medications on the AL side of the facility. A second interview with the MA on 08/20/25 at 11:21am revealed: -She had just finished administering medications on the AL side of the facility that were scheduled for 8:00am and 9:00am. -There was usually one MA assigned to administer medications to all residents on both halls in the AL side of the facility and one MA assigned to the SCU on first shift.	D 364		

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-She usually administered medications in the SCU, so she was not as familiar with the residents and medications in the AL side of the facility.
-She started administering medications in the AL on the Townsend Hall that morning, 08/20/25, at 6:30am.
-She finished administering morning medications on Townsend Hall that morning, 08/20/25, around 8:45am.
-The MA assigned to the SCU helped her do treatments on Townsend Hall in the AL side of the facility that morning, 08/20/25.

Interview with the Resident Care Coordinator (RCC) on 08/20/25 at 11:36am revealed:
-The facility's policy was to administer medications within one hour before or one hour after the scheduled time.
-There was usually one MA working on the AL halls and one MA working in the SCU on first shift.
-The morning medication pass could sometimes run "a little late" depending on which MA was working or if the MA had to help with showers.
-She and the Special Care Coordinator (SCC) could check the dashboard in the electronic medication administration record (eMAR) system to see what times medications were administered.
-The morning medication pass had been from 30 minutes to 1 hour late at times on the AL side of the facility.
-The MAs should notify her or the SCC if they were running late with a medication pass.
-The MA working in the AL side of the facility that morning, 08/20/25, usually worked in the SCU, so she was slower at administering medications in the AL side of the facility.
-If medications were administered late and

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ordered more than once a day, she or the MAs would need to contact the residents' primary care providers (PCPs) to determine if the next dose should be administered or held.
-She noticed the MA was still administering medications on Jordan Hall about 30 minutes ago, so a MA Supervisor helped with the medication pass on 08/20/25.

Interview with the MA Supervisor on 08/20/25 at 3:51pm revealed:
-There was usually one MA working on the AL halls and one MA working in the SCU on first shift.
-If she saw that a MA was struggling to finish a medication pass on time, she usually checked with the MA to see if they needed help.
-The MA working on the AL side of the facility today, 08/20/25, did not usually work on the AL side of the facility.
-She helped administer medications frequently to make sure medications were administered on time.
-She noticed the MA on the AL side of the facility was struggling today, 08/20/25, so she helped by administering medications on Townsend Hall that were scheduled for lunch time since the morning medications for that hall had already been completed.
-If medications were administered late, the PCP should be contacted to see if the next dose should be held or administration times adjusted.

Interview with the Interim Administrator on 08/20/25 at 12:34pm revealed:
-The facility's policy was to administer medications within one hour before or one hour after the scheduled time.
-The MAs had been trained and checked off on administering medications within the required

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time frame.
-There was usually one MA working on the AL halls and one MA working in the SCU on first shift.
-She and the Operations Manager usually checked eMAR reports daily for missed medications which included late medications.
-She had not seen any issues with medication being administered late, but she had only been serving as the Interim Administrator about one week.
-The previous Administrator did not report any issues with late medications.
-If the MA was running late with a medication pass, the MA should ask the MA Supervisor or RCC for help.

Interview with the Operations Specialist on 08/20/25 at 12:36pm revealed:
-She was in the process of working on staggering some of the scheduled medication times to help with the medication passes.
-If medication was administered late, the RCC or MA should contact the PCP or a pharmacist to see if the next dosage should be administered or held.
-If medication dosages were administered too close together, it could cause side effects.

Review of the August 2025 eMARs for 7 residents on the Jordan Hall on the AL side of the facility who received late medications on 08/20/25 revealed:
-All 7 residents had morning medications scheduled at 8:00am, 8:30am, and/or 9:00am.
-Seven of 7 residents had medications ordered either twice daily, 3 times daily, and/or 6 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse

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D 364	Continued From page 23 reactions.] a. Review of Resident #10's current FL-2 dated 08/05/25 revealed diagnoses included type 2 diabetes mellitus, venous embolism (blood clot), essential hypertension, chronic obstructive pulmonary disease, radiculopathy (pinched nerve), chronic kidney disease, contracture of the left thigh muscle, and pain in left knee. Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed: -The MA administered Resident #10's medications scheduled for 8:00am at 11:13am, 2 hours and 13 minutes beyond the allowed time frame. -The MA administered Resident #10's medications scheduled for 8:30am at 11:13am, 1 hour and 43 minutes beyond the allowed time frame. -The MA administered Resident #10's medications scheduled for 9:00am at 11:13am, 1 hour and 13 minutes beyond the allowed time frame. Review of Resident #10's August 2025 electronic medication administration record (eMAR) revealed: -Gabapentin (for nerve pain) was scheduled 3 times a day at 8:00am, 12:00pm, and 8:00pm. -Carvedilol (for heart and high blood pressure) was scheduled twice a day at 8:30am and 6:30pm. -Eliquis (a blood thinner used to prevent stroke and heart attack) was scheduled twice a day at 9:00am and 9:00pm. Interview with Resident #10 on 08/20/25 at	D 364		

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D 364	Continued From page 24 3:45pm revealed: -Most of the time, he received morning medications after he ate breakfast, but he could not recall what time. -He did not recall having any side effects or symptoms while waiting to receive his morning medications. Telephone interview with Resident #10's primary care provider (PCP) on 08/22/25 at 10:53am revealed: -Resident #10's medications should be administered on time to ensure therapeutic effectiveness. -Resident #10's Eliquis should be administered about the same time every day to ensure consistent therapeutic levels. -Receiving Gabapentin late, could cause Resident #8 to have breakthrough pain and receiving the doses too close together could cause oversedation, confusion, and altered mental status. -The RCC contacted her on 08/20/25 about the late medications and she told them not to administer the next dose of Gabapentin until 2:00pm, instead of 12:00pm. b. Review of Resident #11's current FL-2 dated 10/23/24 revealed diagnoses included atrial fibrillation, Parkinson's disease, hypertension, major depressive disorder, generalized anxiety, hypothyroidism, and unspecified dementia. Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed: -The MA administered Resident #11's medications scheduled for 8:00am at 11:18am, 2 hours and 18 minutes beyond the allowed time	D 364		

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frame.
-The MA administered Resident #11's medications scheduled for 8:30am at 11:18am, 1 hour and 48 minutes beyond the allowed time frame.
-The MA administered Resident #11's medications scheduled for 9:00am at 11:18am, 1 hour and 18 minutes beyond the allowed time frame.

Review of Resident #11's August 2025 electronic medication administration record (eMAR) revealed:
-Hyoscyamine (an anticholinergic that may be used for excessive secretions) was scheduled 6 times a day at 8:00am, 2:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am.
-Sinemet (used to treat Parkinson's disease) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm.
-Lorazepam (for anxiety and agitation) was scheduled twice a day at 8:00am and 8:00pm.
-Isosorbide Dinitrate (for heart and high blood pressure) was scheduled twice a day at 8:30am and 6:30pm.
-Acetaminophen (for mild to moderate pain) was scheduled 3 times a day at 9:00am, 3:00pm, and 9:00pm.
-Eliquis (a blood thinner used to prevent stroke and heart attack), Metoprolol Tartrate (for heart and high blood pressure), and Senna-S (for constipation) were scheduled twice a day at 9:00am and 9:00pm.

Interview with Resident #11 on 08/20/25 at 3:12pm revealed:
-Her medications were sometimes administered late.
-She recalled getting her medications late one day (could not recall when), including the

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Hyoscyamine and she had more oral secretions that day.
-She sometimes had pain in her shoulders and pain in her contracted right hand.
-She did not recall having any breakthrough tremors when her medications were administered late.

Attempted telephone interview with Resident #11's hospice provider on 08/22/25 at 12:18pm was unsuccessful.

c. Review of Resident #8's current FL-2 dated 10/23/24 revealed there were no diagnoses listed on the FL-2.

Review of Resident #8's August 2025 electronic medication administration record (eMAR) revealed diagnoses included chronic atrial fibrillation, thyrotoxicosis (overactive thyroid gland), major depressive disorder, anxiety disorder, essential hypertension, chronic obstructive pulmonary disease, chronic kidney disease - stage 3, and lower back pain.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed:
-The MA administered Resident #8's medications scheduled for 8:30am at 10:52am, 1 hour and 22 minutes beyond the allowed time frame.
-The MA administered Resident #8's medications scheduled for 9:00am at 10:52am, 52 minutes beyond the allowed time frame.

Review of Resident #8's August 2025 eMAR revealed:
-Ferrous Sulfate (an iron supplement used to treat and prevent anemia) was scheduled twice a

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day at 8:30am and 6:30pm.
-Eliquis (a blood thinner used to prevent stroke and heart attack) and Gabapentin (for nerve pain) were scheduled twice a day at 9:00am and 9:00pm.

Interview with Resident #8 on 08/20/25 at 3:30pm revealed:
-She received her morning medications late sometimes, but not every time.
-She received her medications late that morning on 08/20/25.
-She had pain in her hands, lower back, and knees every morning when she woke up.
-Her hands, lower back, and knees were hurting that morning, 08/20/25, when her medications were administered late.
-Her pain got better when she received her medications.

Telephone interview with Resident #8's primary care provider (PCP) on 08/22/25 at 10:53am revealed:
-Resident #8's medications should be administered on time to ensure therapeutic effectiveness.
-Resident #8's Eliquis should be administered about the same time every day to ensure consistent therapeutic levels.
-Receiving Gabapentin late, could cause Resident #8 to have breakthrough pain.

d. Review of Resident #9's current FL-2 dated 03/07/25 revealed diagnoses included type 2 diabetes mellitus, hypertension, mood disorder, anemia, hyperlipidemia, and Vitamin B12 deficiency.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility

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administering morning medications on 08/20/25 revealed:
-The MA administered Resident #9's medications scheduled for 8:00am at 11:10am, 2 hours and 10 minutes beyond the allowed time frame.
-The MA administered Resident #9's medications scheduled for 8:30am at 11:10am, 1 hour and 40 minutes beyond the allowed time frame.
-The MA administered Resident #9's medications scheduled for 9:00am at 11:10am, 1 hour and 10 minutes beyond the allowed time frame.

Review of Resident #9's August 2025 electronic medication administration record (eMAR) revealed:
-Lorazepam (for anxiety and agitation) and Risperdal (an antipsychotic) were scheduled twice a day at 8:00am and 8:00pm.
-Metformin (for diabetes mellitus) and Calcium (a calcium supplement) were scheduled twice a day at 8:30am and 6:30pm.
-Atenolol and Valsartan (for heart and high blood pressure); Omeprazole (for acid reflux); Glimepiride, Januvia, and Actos (for diabetes mellitus); and Zyrtec (for seasonal allergies) were all scheduled once a day at 9:00am.

Interview with Resident #9 on 08/20/25 at 3:31pm revealed:
-She sometimes received her morning medications late, depending on which MA was working.
-She did not recall having any side effects or symptoms when her medications were administered late.

Telephone interview with Resident #9's primary care provider (PCP) on 08/22/25 at 10:53am revealed:
-Resident #9 had behaviors at times and could

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possibly have breakthrough anxiety when her Lorazepam was administered late.
-The anxiety could cause the resident to have increased behaviors.
-Resident #9's Metformin was ordered at 8:30am to make sure it was administered with food to prevent stomach upset.

e. Review of Resident #12's current FL-2 dated 11/04/24 revealed diagnoses included dementia, gastroesophageal reflux disease, and fatigue.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed the MA administered Resident #12's medications scheduled for 8:00am at 11:20am, 2 hours and 20 minutes beyond the allowed time frame.

Review of Resident #12's August 2025 electronic medication administration record (eMAR) revealed Amlodipine (for heart and high blood pressure) was scheduled twice a day at 8:00am and 8:00pm.

Based on observations, interviews, and record reviews, it was determined that Resident #12 was not interviewable.

Telephone interview with Resident #12's primary care provider (PCP) on 08/22/25 at 12:43pm revealed:
-If Resident #12's medications were administered late, it could cause some dosages to be administered too close together if ordered more than once a day, putting the resident at risk of side effects.
-Administering Resident #12's Amlodipine late could cause the resident's blood pressure to be

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D 364	Continued From page 30 higher. f. Review of Resident #6's current FL-2 dated 04/02/25 revealed diagnoses included hypertension, dementia, hypothyroidism, generalized anxiety disorder, depressive disorder, chronic back pain, and muscle weakness. Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed the MA administered Resident #6's medications scheduled for 9:00am at 10:45am, 45 minutes beyond the allowed time frame. Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed: -Sertraline (an antidepressant) and Docusate Sodium (a stool softener for constipation) were scheduled 2 times a day at 9:00am and 9:00pm. -Acetaminophen (for mild to moderate pain) was scheduled once a day at 9:00am. Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. Telephone interview with Resident #6's primary care provider (PCP) on 08/22/25 at 10:53am revealed: -Resident #6's medications should be administered on time to ensure therapeutic effectiveness. -The resident took Acetaminophen for arthritis pain and receiving it late could cause the resident to have pain. -She was not concerned about the Sertraline and Docusate Sodium being administered late since the next doses were not due again until 9:00pm.	D 364		

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g. Review of Resident #7's current FL-2 dated 08/15/25 revealed diagnoses included mild dementia with behavioral disturbances, anxiety disorder, hyperlipidemia, and chronic obstructive pulmonary disease.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 08/20/25 revealed:
-The MA administered Resident #7's medications scheduled for 8:00am at 10:49am, 1 hour and 49 minutes beyond the allowed time frame.
-The MA administered Resident #7's medications scheduled for 8:30am at 10:49am, 1 hour and 19 minutes beyond the allowed time frame.
-The MA administered Resident #7's medications scheduled for 9:00am at 10:49am, 49 minutes beyond the allowed time frame.

Review of Resident #7's August 2025 electronic medication administration record (eMAR) revealed:
-Lorazepam (for anxiety and agitation) was scheduled twice a day at 8:00am and 8:00pm.
-Carvedilol (for heart and high blood pressure) was scheduled twice a day at 8:30am and 6:30pm.
-Amlodipine (for heart and high blood pressure) and Quetiapine (an antipsychotic) were scheduled twice a day at 9:00am and 8:00pm.

Interview with Resident #7 on 08/20/25 at 3:25pm revealed:
-She received her morning medications late sometimes, at least a couple of times per week.
-She did not recall having any side effects or symptoms when her medications were administered late.

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D 364	Continued From page 32 Telephone interview with Resident #7's primary care provider (PCP) on 08/22/25 at 10:53am revealed: -Resident #7's medications should be administered on time to ensure therapeutic effectiveness. -She was not concerned about the resident's morning medications being late on 08/20/25 because the next doses were not due again until later that evening or night.	D 364		