STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL097015	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GLEN MANOR	240 INDEPENDENCE AVENUE NORTH WILKESBORO, NC 28659

(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 000	Initial Comments The Adult Care Licensure Section and the Wilkes County Department of Social Services conducted an annual survey from 08/19/25 to 08/20/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and records reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#5 and #7) related to a medication to treat pain (#5) and observation during the medication pass on 08/19/25 with an error of an allergy medication (#7). The findings are: The medication error rate was 4.2% as evidenced by the observation of 1 error out of 27 opportunities during the 9:00am medication pass on 08/19/25. 1. Review of Resident #5's current FL2 dated 03/06/25 revealed diagnoses included urinary incontinence, type 2 diabetes, chronic obstructive pulmonary disease, hypertension, and emphysema.	D 358		

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Review of Resident #5's hospice orders dated 06/10/25 revealed there was an order for morphine concentrate (a medication to treat pain) 100mg/5ml administer 5mg every four hours as needed.

Review of Resident #5's facility Primary Care Provider's (PCP) orders dated 06/12/25 revealed:
-Resident #5 was unable to tolerate morphine.
-Resident #5's treatment plan was discussed with the hospice Registered Nurse (RN).
-Resident #5's morphine concentrate 100mg/5ml administer 5mg every four hours as needed was discontinued.

Review of Resident #5's hospice orders dated 06/12/25 revealed there was an order to discontinue morphine concentrate 100mg/5ml 5mg every four hours as needed.

Interview with a medication aide (MA) on 07/11/25 at 2:33pm revealed:
-She administered morphine concentrate 100mg/5ml 5mg to Resident #5 on 06/14/25, after it was discontinued.
-The Resident Care Coordinator (RCC) was responsible for removing discontinued medications from the medication cart.
-The RCC was not at the facility at the time the medication was discontinued.
-The policy was if a medication was discontinued, the order was given to the RCC and then faxed to pharmacy.
-She was working the first time Resident #5 was given morphine due to air hunger and was informed a few days later that Resident #5 was sent to the hospital due to having an allergic to the morphine which included vomiting.
-The MA stated "I messed up and wasn't paying attention" when she administered morphine

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concentrate 100mg/5ml 5mg to Resident #5 on 06/14/25.
-There was no one in the facility authorized to remove controlled substances from the cart until the PCP or the RCC came into the building the following Monday (06/16/25).

Interview with Resident #5's Primary Care Provider (PCP) on 06/26/25 at 9:26am revealed:
-She was notified of the medication error by the RCC on Monday afternoon (06/16/25).
-Resident #5 was already anticipated to pass and was in poor health based on her condition and vital signs.

Interview with the RCC on 07/31/25 at 9:30am revealed:
-Resident #5's morphine concentrate was discontinued because the resident had kidney failure and was not able to metabolize the morphine concentrate through her kidneys.
- The second shift MA on 06/16/25 informed her Resident #5's morphine concentrate 100mg/5ml count was not accurate.

-Interview with the hospice RN on 08/20/25 at 1:44pm revealed:
-Resident #5 was admitted to hospice on 06/10/25.
-At that time (06/10/25) an order was given for Resident #5 for morphine concentrate 100mg/5ml 5mg every four hours as needed.
-The morphine concentrate was discontinued on 06/12/25.

Interview with the RCC on 08/20/25 at 2:17pm revealed:
-The MA who made the medication error when she administered morphine sulfate to Resident #5 on 06/14/25 would not have been able to scan the

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medication because it was discontinued.
-If the MA had tried to scan the morphine sulfate for Resident #5 on 06/14/25 the eMAR system would have let the MA know the medication was discontinued.
-The discontinued medication process if the RCC and Administrator were not in the facility was the MAs were to label the medication as discontinued, two MAs were to write the quantity and initial the medication and turn it backwards and place in the back of the medication cart.
-She was made aware of the error when she came back into the facility on Monday 06/16/25 when the second shift MA made her aware the controlled substance counts did not match for Resident #5's morphine concentrate.

Interview with the Administrator on 07/31/25 at 9:30am revealed:
-Resident #5's discontinued morphine concentrate order was not received by the facility until the RCC had left for the day.
-On 06/12/25, the MAs did not feel comfortable removing the morphine concentrate from the cart without the RCC or Administrator being present.
-The night of 06/12/25, two MAs put the morphine concentrate injections that were left in a large Ziploc bag, rolled it up, wrote "d/c" on the bag, both MAs initialed the bag, wrote the number of syringes remaining on it, and put it in the back of the drawer of the medication cart.
-The discontinued morphine concentrate was not with Resident #5's active medications.

2. Review of Resident #7's current FL2 dated 01/16/25 revealed:
-Diagnoses included arthritis, pain and system lupus erythematous (an immune system disease that attacks healthy tissue.
-There was an order for cetirizine (a medication to

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D 358	Continued From page 4 treat allergies) 10mg, one-half tablet daily. Review of Resident #7's signed physician orders dated 03/20/25 revealed an order for cetirizine 10mg, one-half tablet daily. Observation of the medication pass for Resident #7 on 08/19/25 at 9:14am revealed: -The morning medication aide (MA) removed a multi-dose medication pack labeled for morning, 08/19/25 containing 6 oral medications from the weekly supply sent by the facility's contracted pharmacy. -The label indicated the multi-dose medication pack included cetirizine 10mg one tablet. -The MA scanned the quick response (QR) code on the medication pack into the electronic medication administration (eMAR) software. -The MA placed the 6 tablets/capsules in a plastic souffle cup and administered the medications to Resident #7. Observation of medication on hand for administration on 08/19/25 at 2:22pm revealed Resident #7 had 6 days of multi-dose medications packs labeled for morning containing cetirizine 10mg one tablet. Interview with the morning MA on 08/19/25 at 1:36pm revealed: -She was trained when administering medications to compare the medication label with the order in the eMAR system. -The multi-dose medication packs had a QR code on each of the packs that the MAs were to scan into the eMAR system. -After the MA scanned the QR code, the eMAR system "prepped" the medication in the system and was ready to be signed off by the MA after the medications were administered.	D 358		

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-If a medication order had changed, the eMAR system would flag that medication and notify the MA there was an issue.
-Scanning the medication packs were to cut down on medication errors but in this case, the eMAR system approved cetirizine 10mg one tablet for Resident #7.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/20/25 at 1:07pm revealed:
-Resident #7 had a current order for cetirizine 10mg, one-half tablet daily.
-Pharmacy records revealed the pharmacy had mistakenly put a full tablet of cetirizine 10mg in the multidose packs for Resident #7 for the week beginning 08/19/25.
-Resident #7 could experience cognitive issues if she did not receive the lowered dose of cetirizine 10mg one-half tablet daily as ordered.

Interview with the Resident Care Coordinator (RCC) on 08/20/25 at 2:17pm revealed:
-The MAs were responsible to administer medications as ordered.
-The MAs were to compare the label and the medication, including half-tablet or whole tablet, with the orders in the eMAR system.
-Utilizing the QR code scanning for the morning medication pass on 08/19/25 did not "catch" it was a whole tab of cetirizine 10mg in the multi-dose pack and not a half-tablet.

Interview with the Administrator on 08/20/25 at 2:33pm revealed:
-The MAs were trained when hired to compare the medication label with the order in the eMAR system when administering medications.
-The MAs were responsible to look at the medication, checking if the medication is a whole

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D 358	Continued From page 6 tablet or half-tablet, when administering medications.	D 358		
D 397	10A NCAC 13F .1008 (f) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on interviews and records reviews, the facility failed to store discontinued controlled substances securely in a locked area separately from actively used medication until disposed of for 1 of 1 sampled residents (Resident #5). The findings are: Review of Resident #5's current FL2 dated 03/06/25 revealed diagnoses included urinary incontinence, type 2 diabetes, chronic obstructive pulmonary disease, hypertension, and emphysema. Review of Resident #5's hospice orders dated 06/10/25 revealed there was an order for morphine concentrate (a medication to treat pain) 100mg/5ml 5mg every four hours as needed. Review of Resident #5's facility Primary Care Provider's (PCP) orders dated 06/12/25 revealed: -Resident #5 was unable to tolerate morphine. -Resident #5's treatment plan was discussed with	D 397		

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the hospice Registered Nurse (RN).
-Resident #5's morphine concentrate 100mg/5ml 5mg every four hours as needed was discontinued.

Review of Resident #5's hospice orders dated 06/12/25 revealed there was an order to discontinue morphine concentrate 100mg/5ml 5mg every four hours as needed.

Interview with a medication aide (MA) on 07/11/25 at 2:33pm revealed:
-The Resident Care Coordinator (RCC) was responsible for removing any discontinued medication from the medication cart.
-The RCC was not in the facility at the time Resident #5's morphine sulfate was discontinued (06/12/25).
-She understood the policy for discontinuing medication was the order would be given to the RCC and then faxed to pharmacy.
-The RCC was responsible for confirming with the pharmacy that the medication was discontinued.
-There was no one in the facility authorized to remove controlled substances from the cart until the PCP or the RCC were available in the building.
-The RCC did not return to the facility until 06/16/25.

Interview with RCC on 08/20/25 at 2:17pm revealed:
-The discontinued medication process if the RCC and Administrator were not in the facility was the MAs were to label the medication as discontinued, two MAs were to write the quantity and initial the medication and turn it backwards and place in the back of the medication cart.
-Resident #5's morphine concentrate was wrapped in a Ziploc bag, bound with a rubber

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D 397	Continued From page 8 band and had "d/c" written on the bag. -Resident #5's morphine concentrate was stored behind the "active" medications in the medication cart. -The MA unwrapped the bag to administer morphine concentrate to Resident #5 and did not notice "d/c" written on the bag. Interview with the Administrator on 07/31/25 at 9:30am revealed: -Resident #5's discontinued morphine concentrate order was not received by the facility until the RCC had left for the day. -On 06/12/25, the MAs did not feel comfortable removing the morphine concentrate from the cart without the RCC or Administrator being present. -The night of 06/12/25, two MAs put the morphine concentrate injections that were left in a large Ziploc bag, rolled it up, wrote "d/c" on the bag, both MAs initialed the bag, wrote the number of syringes remaining on it, and put it in the back of the drawer of the medication cart. -The discontinued morphine concentrate was not with Resident #5's active medications. -The discontinued morphine concentrate should have been pulled from the medication cart and placed in a locked cabinet in the medication room.	D 397		