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D 000	Initial Comments The Adult Care Licensure Section and Johnston County Department of Social Services conducted an annual, follow-up, and complaint investigation on 09/03/25-09/05/25.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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, interviews, and record reviews, the facility failed to maintain an environment free of hazards including personal care products and cleaning products that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's daily census report dated 09/03/25 revealed the special care unit (SCU) had a census of 19 residents.	D 079		

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Review of the facility's SCU disclosure statement revealed:
-The facility would provide a safe environment for residents.
-Personal items that could be ingested were maintained by staff to include all liquid personal items in a secure location until needed for resident use.
-Resident rooms were inspected regularly for unsafe items that could be accidentally ingested or harmful.
-Staff were trained to monitor resident rooms for substances that could be ingested.

Observation of the SCU on 09/03/25 during the initial tour at 9:10am revealed:
-Residents ambulated freely in the halls to and from their rooms and to the other areas of the SCU.
-Many doors to resident rooms were locked, but some were unlocked.

Observation of room 502 in the SCU on 09/04/25 at 9:20am revealed:
-The main door leading to 2 resident rooms was unlocked.
-There was one resident present in one of the rooms, and the other room was unoccupied.
-There were multiple personal care items on the bathroom shelves including a bottle of moisturizing lotion, a bottle of acetone nail polish remover, 4 bottles of gel nail polish, a bottle of body wash, and a container of deodorant.
-The nail polish label included a warning that the product was for external use only.
-The acetone nail polish remover included a warning to give fluids and call the poison control center immediately if ingested.

Based on observations and interviews, it was

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determined the residents residing in room 502 were not interviewable.

Observation of the bathroom in resident room 603 on 09/03/25 at 9:28am revealed:
-There were two containers of bleach disinfectant wipes on the top shelf beside the shower stall.
-There was a bottle of medicated foot powder on the right side of the top shelf beside the shower stall.
-Warnings on the product labels included: hazardous to humans and domestic animals; keep out of reach of children; causes moderate eye irritation; avoid contact with eyes or clothing; do not use or store near heat or open flame; and call a poison control center (PCC) for treatment advice.

Based on observations and interviews, it was determined that the resident residing in resident room 603 was not interviewable.

Observation of the shared bathroom in resident room 612 on 09/03/25 at 9:50am revealed:
-There was a bottle of shampoo/body wash on the counter beside the sink.
-Warnings on the product label included: for external use only and avoid contact with eyes.

Based on observations and interviews, it was determined that the residents residing in resident room 612 were not interviewable.

Interview with a medication aide (MA) on 09/03/25 at 10:05am revealed:
-Personal care hygiene products for residents in the SCU and cleaning products should be stored in the locked medication room.
-Each resident had a storage area with their names labeled.

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-Personal care aides (PCAs) assisted residents with bathing and stayed with residents while the personal care products were being used.
-The personal care products were then locked back in the medication room when residents' bathing and/or grooming was finished.
-There should not be any personal care products or cleaning products left in resident's rooms or bathrooms.
-The Special Care Coordinator (SCC), the MAs, or the PCAs did room sweeps 2 to 3 times per week to check for any unsecured products.
-The last room sweep to her knowledge was on Monday, 09/01/25.
-She was not aware of any residents ingesting any personal care products or cleaning products.

Interview with a PCA on 09/03/25 at 10:10am revealed:
-Personal care products and items should have been secured in the residents' individual storage compartment in the locked medication room.
-Residents could have ingested the nail polish, nail polish remover, lotion, or deodorant.
-She would secure the discovered personal care items immediately.
-No residents had attempted ingestion as far as she was aware and she had no explanation for why items were not secured.

Interview with the SCC on 09/03/25 at 10:14am revealed:
-Personal care items should be secured in the medication room when not in use by a resident with supervision from a PCA.
-Cleaning products should be stored in the locked medication room.
-When a resident needed a personal care item, the PCA should have notified the medication aide (MA), supervised the resident's use of the item,

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D 079	Continued From page 4 and then brought the item back to the MA and had it secured in the medication room. -The MAs and PCAs conducted room sweeps twice a week to ensure no personal care items or cleaning products were accessible to residents. -He thought the last room sweep was done on last Thursday, 08/28/25. -Families were often bringing and leaving personal care items in rooms instead of giving those items to facility staff members. -Personal care items and cleaning products being unsecured per facility policy could have led to ingestion of harmful products or inappropriate use of products. Interview with the Administrator on 09/03/25 at 3:35pm revealed: -Residents' personal care items were supposed to be secured in the locked medication room unless in use by a resident or staff member with staff member supervision in the SCU. -Cleaning supplies should be locked in a housekeeping closet unless they belonged to a resident, which could then be stored with the reisdent's personal care products, locked in the medication room. -PCAs, MAs, and the SCC were responsible for checking residents' rooms for personal care items stored inappropriately on their shifts and securing any unsecured personal care items in the medication room. -Items unsecured in resident rooms 502, 603,and 612 could have led to ingestion of items meant for external use only and caused harm to the residents.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements	D 113		

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D 113	Continued From page 5 (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 4 of 20 sinks located in resident bathrooms in the facility. The findings are: Review of the Environmental Health Section inspection report dated 05/19/25 revealed a demerit for hot water temperatures throughout the facility being less than 105°Fehrenheit (F). Observation of water temperatures on 09/03/25 from 8:40am to 9:15am in resident bathrooms revealed: -In room 117 the hot water temperature of the sink was 87.1°F. -In room 201 the hot water temperature of the sink was 118.1°F. -In room 111 the hot water temperature of the sink was 119.5°F. -In room 101 the hot water temperature of the sink was 86.7°F.	D 113		

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D 113	Continued From page 6 Interview with a resident residing in room 117 on 09/03/25 at 9:10am revealed: -She had an issue with the water in her bathroom not getting warm enough. -The water in her bathroom could often be cold depending on the time of day she used it. -The water in her bathroom had been cool for months. Interview with a resident residing in room 111 on 09/03/25 at 9:25am revealed the water temperatures in her bathroom were often not warm enough. Interview with a resident residing in room 110 on 09/03/25 at 9:30am revealed: -The water temperatures in his bathroom were often not warm enough. -He had to take cold showers multiple times in the past couple months. Interview with the President of Resident Council on 09/04/25 at 10:00am revealed the water temperatures had been an ongoing issue brought up in the resident council meetings for quite a while. Interview with a Maintenance Manager on 09/03/25 at 2:35pm revealed: -He was responsible for the water temperatures in the facility being in range. -He checked the water temperatures in the facility weekly. -There were some rooms where the hot water did not get above the mid 80's. -He has turned the water heaters up, and the other bathroom's water temperatures got too hot. -The hot water in the facility should range from 100°F - 116°F. -He believed the facility needed to get a	D 113		

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contractor to address the water temperature issue.

Review of the facility's monthly water temperature logs dated June 2025 through September 2025 revealed water temperatures ranged from 88°F - 120°F.

Recheck of the hot water temperature on 09/03/25 at 2:50pm revealed:
-In room 117 the hot water temperature of the sink was 84°F.
-In room 101 the hot water temperature of the sink was 91.8°F.

Interview with the Administrator on 09/05/25 at 2:35pm revealed:
-The hot water temperature should be 100°F - 116°F.
-He was not aware of water temperatures being out of range in the facility.
-He made corporate aware of the water temperatures in the facility being out of range.
-The Maintenance Manager and himself were responsible for ensuring water temperatures were within the correct range in the facility.
-He was concerned the residents could be miserable if water temperatures were cold during showers.
-He was concerned that residents could blister their skin if the water temperatures were too hot.

Interview with the Campus Director on 09/05/25 at 2:55pm revealed:
-She was aware of water temperatures in the facility were out of range since January 2025.
-The Maintenance Manager had been working to figure out the issue with the water heaters.
-The Maintenance Manager was responsible for ensuring water temperatures were within the

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D 113	Continued From page 8 correct range in the facility.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#3) who required staff assistance with fingernail care and dressing. The findings are: Review of Resident #3's current FL-2 dated 03/14/25 revealed: -Diagnoses included dementia, altered mental status, Parkinson's disease, anemia, fatigue, muscle weakness, fractured sacrum, and gastroesophageal reflux disease. -The resident was intermittently disoriented. -The resident was non-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing, dressing, and feeding. Review of Resident #3's Resident Assessment Tool / Pre-Admission Screening for the special care unit (SCU) dated 05/21/23 revealed: -The resident required extensive assistance with	D 269		

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bathing, nail care, and putting on and removing clothing, socks, and shoes.
-Nail care was to be provided at least once a week.
-Bathing and putting on and removing clothing, socks and shoes were to be done 7 days per week.

Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility on 05/24/23.
-The resident required assistance for dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, hair/grooming, skin care, and scheduling appointments.

Review of Resident #3's SCU resident profile and care plan dated 09/04/25 revealed:
-The resident was non-ambulatory.
-The resident required total assistance with bathing, dressing, grooming, and transferring.

Review of Resident #3's current assessment and care plan dated 01/16/25 revealed:
-The resident was non-ambulatory and had limited strength and range of motion in her upper extremities.
-The resident had limited eye-hand coordination.
-The resident had daily incontinence of bladder and bowel.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident required limited assistance by staff with eating.
-The resident required total assistance by staff with toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #3 on 09/03/25 from

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D 269	Continued From page 10 1:38pm - 1:44pm revealed: -The resident was sitting in a geri-chair in the activity room in the SCU. -The resident was wearing a black t-shirt and dark gray athletic pants. -The resident was wearing black, white, and red socks with the head and face of a cartoon character on the socks. -The fingernails on both of Resident #3's hands were long and jagged. -The resident's left hand was contracted with the fourth and fifth fingers pressed against the palm of her hand. -The fingernails on the contracted fingers on her left hand pressed into the palm of her hand but there were no open areas of skin. -The resident's fingernails had a dark brown substance underneath the nails on both hands. Interview with the medication aide (MA) in the SCU on 09/03/25 at 1:44pm revealed: -The personal care aides (PCAs) were responsible for cleaning and trimming a resident's fingernails if the resident was not diabetic. -The PCAs should clean and trim a resident's fingernails when they saw that the fingernails needed to be cut and cleaned. -Resident #3 was not diabetic, so the PCAs would be responsible for cleaning and trimming the resident's fingernails. -If the PCAs had any concerns about cleaning or trimming a resident's fingernails, the PCAs should let the MA or the Special Care Coordinator (SCC) know. -No one had reported any concerns about Resident #3's fingernails to her. -She was not aware Resident #3's fingernails needed cutting and cleaning. Interview with a PCA in the SCU on 09/03/25 at	D 269		

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D 269	Continued From page 11 1:47pm revealed: -She was assigned to provide care for Resident #3 today, 09/03/25. -She was new and had just finished training. -She had not trimmed or cleaned any resident's fingernails, including Resident #3. -She did not know who was responsible for cutting and cleaning residents' fingernails. Second observation of Resident #3 on 09/04/25 at 8:45am revealed: -The resident was sitting in a geri-chair in the activity room in the SCU. -The resident was wearing a different shirt and different pants than she was wearing on 09/03/25. -The resident was wearing the same black, white, and red socks with the head and face of a cartoon character as she was wearing on 09/03/25. -The fingernails on both of Resident #3's hands had been trimmed and cleaned. Second interview with the same MA in the SCU on 09/04/25 at 8:45am revealed: -She and another staff person trimmed and cleaned Resident #3's fingernails yesterday, 09/03/25. -Resident #3's hospice aide was at the facility earlier this morning, 09/04/25. -The hospice aide told her that providing fingernail care to Resident #3 was no longer on the resident's hospice plan of care because the resident had jerked her hand back in the past when the hospice aide tried to provide nail care. Third observation of Resident #3 on 09/05/25 at 11:08am revealed: -The resident was taken to her room in a geri-chair by a PCA.	D 269		

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-The resident was wearing a different shirt and different pants than she was wearing on 09/03/25 and 09/04/25.
-The resident was wearing the same black, white, and red socks with the head and face of a cartoon character as she was wearing on 09/03/25 and 09/04/25.
-After being prompted by surveyor, a PCA removed the resident's socks.
-The resident had dry, flaky skin on both feet.
-The PCA cleaned the resident's feet with a skin wipe and put on a clean pair of socks.

Interview with a second PCA in the SCU on 09/05/25 at 11:08am revealed:
-She did not know why Resident #3's socks had not been changed since 09/03/25.
-The PCA assigned to Resident #3 would be responsible for getting the resident up and dressed in the mornings and should put on clean socks every day.

Third interview with the same MA in the SCU on 09/05/25 at 11:08am revealed:
-The PCAs were responsible for making sure residents were changed into clean clothes every day including clean socks.
-She did not know why Resident #3 wore the same socks on 09/03/25, 09/04/25, and 09/05/25.
-The PCAs assigned to Resident #3 should have changed the resident's socks each day.

Review of Resident #3's personal care services (PCS) logs dated 08/01/25 - 09/04/25 revealed:
-There was a section for nail care, once a day on Tuesday, Thursday, and Saturday.
-Resident #3's nail care was documented as done on 21 occasions from 08/01/25 - 08/31/25.
-Resident #3's nail care was documented as done on 2 occasions from 09/01/25 - 09/04/25,

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D 269	Continued From page 13 which included 09/01/25 at 5:44am and 09/02/25 at 10:34am. Review of Resident #3's shower skin assessment forms for August 2025 and September 2025 revealed: -There was a shower skin assessment dated 08/13/25 at 8:13pm with "yes" checked indicating the resident's fingernails needed to be cut. -There was a shower skin assessment dated 09/02/25 at 10:35am with "yes" checked indicating the resident's fingernails needed to be cut. -There was no follow-up documentation on the form to indicate any actions taken for the resident's fingernails needing to be cut. Interview with a third PCA in the SCU on 09/05/25 at 12:05pm revealed: -She documented the resident's fingernails needed to be cut on the shower assessment dated 09/02/25 because the resident's fingernails were long and jagged. -She did not trim the resident's fingernails because she thought the hospice aide usually provided nail care to the resident. -Sometimes, when the PCAs had "downtime", the PCAs would clean, file, and paint residents' fingernails. -She could not explain why nail care was documented as completed on Resident #3's PCS logs. Interview with the SCC on 09/05/25 at 11:30am revealed: -The PCAs should trim and clean resident's fingernails. -The PCAs should complete a shower skin assessment form each time they bathed a resident.	D 269		

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-The PCAs should note on the form if a resident's fingernails needed to be cut or if there were any other concerns.
-He usually reviewed the shower skin assessment forms.
-If he saw that a PCA had marked that a resident's fingernails needed trimming or cleaning, then he would ask the PCA to make sure it was done.
-He did not recall seeing Resident #3's shower assessment forms being checked "yes" for needing fingernail care.
-The PCAs were also supposed to document when tasks were completed on the personal care service logs.
-The PCAs should not document a task was completed on the PCS logs if it was not done.
-The PCAs were responsible for changing Resident #3's socks every day when the PCAs helped the resident get dressed.
-There was no system to check behind the PCAs to ensure personal care tasks were completed but if he observed a problem, he would address it with staff.

Interviews with the Administrator on 09/03/25 at 3:47pm and 09/05/25 at 2:55pm revealed:
-Fingernail care should be provided to residents as indicated on their care plans.
-PCAs should trim and clean underneath Resident #3's fingernails on shower days.
-Resident #3 was also assisted with bathing by a hospice aide 2 to 3 times a week.
-The PCAs were responsible for doing shower assessments for each resident, including Resident #3.
-The PCAs were responsible for making sure Resident #3's socks were changed every day to ensure good hygiene.
-The SCC was responsible for observing

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residents daily to ensure personal care tasks were being completed by staff.

Telephone interview with a hospice nurse at Resident #3's hospice provider's office on 09/05/25 at 12:26pm revealed:
-Hospice aides provided care to Resident #3 at the facility twice a week.
-Hospice aides did not usually provide nail care because some residents were diabetic.
-The facility staff usually provided fingernail care to residents.
-If a hospice aide had any concerns about a resident, they would report it to a MA or the Administrator.
-His last visit with Resident #3 was on 08/18/25 and he did not remember any issues with the resident's fingernails at that time.

Interview with Resident #3's primary care provider (PCP) on 09/05/25 at 12:35pm revealed:
-She last saw Resident #3 on 08/15/25 and did not notice any personal care issues that day.
-The facility staff should provide personal care assistance with personal care tasks, including fingernail care and getting dressed.
-She was concerned the brown substance under Resident #3's fingernails on 09/03/25 could have been dirt and feces, which could increase the risk of infection.
-Resident #3 had Parkinson's disease and dementia and needed help with getting dressed.
-The resident was not able to tell staff she wanted her clothing changed.
-Everyone liked to be clean, and staff should be changing Resident #3's clothing, including socks daily.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was

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D 269	Continued From page 16 not interviewable.	D 269		
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 matching therapeutic menus for food service guidance for 3 of 3 sampled residents (#3, #5, #6) with physician orders for therapeutic diets. The findings are: Review of the facility's diet list on 09/04/25 revealed there were six residents in the facility with physician orders for therapeutic diets. Observation of the kitchen on 09/04/25 at 10:00am revealed there was no corresponding menu posted for residents on therapeutic diets. 1. Review of Resident #3's current FL-2 dated 05/27/25 revealed diagnoses included schizoaffective disorder bipolar type, stress urine incontinence, tardive dyskinesia, and left arm reflex sympathetic dystrophy.	D 296		

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D 296	Continued From page 17 Review of Resident #3's Resident Register revealed an admission date of 05/14/24. Review of Resident #3's physician order dated 01/23/25 revealed a diet order for chopped entire meal. Observation of breakfast on 09/04/25 from 8:00am to 9:00am revealed Resident #3 was served chopped sausage, scrambled eggs, a biscuit, water, apple juice, and milk. Observation of lunch on 09/04/25 from 12:00pm to 1:00pm revealed Resident #3 was served chopped ham, macaroni and cheese, a dinner roll, collard greens, tea, water, and milk. Refer to interview with the Kitchen Manager on 09/04/25 at 10:00pm. Refer to interview with the Administrator on 09/05/25 at 2:35pm. Refer to interview with the Campus Director on 09/05/25 at 2:55pm. 2. Review of Resident #5's current FL-2 dated 05/27/25 revealed diagnoses included hypertension, gouty arthropathy, and type 2 diabetes with neuropathy. Review of Resident #5's Resident Register revealed an admission date of 08/09/24. Review of Resident #5's physician order dated 03/24/25 revealed a diet order for regular no added salt (NAS). Observation of breakfast on 09/04/25 from	D 296		

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D 296	Continued From page 18 8:00am to 9:00am revealed Resident #5 was served bacon, eggs, a biscuit, water, and apple juice. Observation of lunch on 09/04/25 from 12:00pm to 1:00pm revealed Resident #5 was served ham, macaroni and cheese, a dinner roll, collard greens, tea, and water. 3. Review of Resident #6's current FL-2 dated 06/11/25 revealed diagnoses included osteoporosis, hypertension, chronic obstructive pulmonary disease, and aortic stenosis. Review of Resident #6's Resident Register revealed an admission date of 05/24/23. Review of Resident #6's physician order dated 06/06/25 revealed a diet order for mechanical soft with nectar thick liquids. Observation of breakfast on 09/04/25 from 8:00am to 9:00am revealed Resident #6 was served bacon, eggs, a biscuit, and nectar thick juice. Observation of lunch on 09/04/25 from 12:00pm to 1:00pm revealed Resident #6 was served chopped ham, macaroni and cheese, a dinner roll, collard greens, and nectar thick juice. Interview with a personal care aide (PCA) on 09/04/25 at 10:15pm revealed: -She assisted in serving residents in the dining room during breakfast and lunch in the Assisted Living. -She assisted in serving residents their meals in their bedrooms in the Assisted Living. -She knew each resident who had a therapeutic diet.	D 296		

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D 296	Continued From page 19 -Resident #6's therapeutic diet was for small portions. -Resident #6 should not have gotten bacon or a biscuit with her breakfast. Refer to interview with the Kitchen Manager on 09/04/25 at 10:00pm. Refer to interview with the Administrator on 09/05/25 at 2:35pm. Refer to interview with the Campus Director on 09/05/25 at 2:55pm. _____ Interview with the Kitchen Manager on 09/04/25 at 10:00pm revealed: -The kitchen did not have a therapeutic diet extension menu. -The facility had never had a therapeutic diet extension menu since she became kitchen manager approximately four months prior. -She knew how to substitute regular menu items for therapeutic diet items. Interview with the Administrator on 09/05/25 at 2:35pm revealed: -The kitchen should have therapeutic diet extension menus to follow in order to properly prepare therapeutic diets. -He was concerned that it was a choking hazard if residents did not get served therapeutic diets as ordered. Interview with the Campus Director on 09/05/25 at 2:55pm revealed: -The facility had therapeutic diet extension menus. -The Kitchen Manager did not have access to the	D 296		

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D 296	Continued From page 20 system in order to get the therapeutic diet extension menus. -The kitchen needed therapeutic diet extension menus in order to properly prepare therapeutic diets. -She had concerns for residents choking if they did not get their therapeutic diets served as ordered.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 2 of 3 sampled resident (#3, #6) who had a physician's order for a mechanical soft diet (#6) and chopped diet (#3). The findings are: Observation of the a list of residents on special diets in the kitchen on 09/04/25 at 10:00am revealed: -Resident #3's diet order was chopped entire meal. -Resident #6's diet order was mechanical soft with necter thick liquids. 1. Review of Resident #3's current FL-2 dated 05/27/25 revealed diagnoses included schizoaffective disorder bipolar type, stress urine	D 310		

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incontinence, tardive dyskinesia, and left arm reflex sympathetic dystrophy.

Review of Resident #3's Resident Register revealed an admission date of 05/14/24.

Review of Resident #3's physician order dated 01/23/25 revealed a diet order for regular with chopped entire meal.

Observation of breakfast on 09/04/25 from 8:00am to 9:00am revealed Resident #3 was served chopped sausage, scrambled eggs, a biscuit, water, apple juice, and milk.

Observation of lunch on 09/04/25 from 12:00pm to 1:00pm revealed Resident #3 was served chopped ham, macaroni and cheese, a dinner roll, collard greens, tea, water, and milk.

Refer to interview with the Kitchen Manager on 09/04/25 at 10:00pm.

Refer to interview with the primary care provider (PCP) on 09/05/25 at 12:25pm.

Refer to interview with the Administrator on 09/05/25 at 2:35pm.

Refer to interview with the Campus Director on 09/05/25 at 2:55pm.

2. Review of Resident #6's current FL-2 dated 06/11/25 revealed diagnoses osteoporosis, hypertension, chronic obstructive pulmonary disease, and aortic stenosis.

Review of Resident #6's Resident Register revealed an admission date of 05/24/23.

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D 310	Continued From page 22 Review of Resident #6's physician order dated 06/06/25 revealed a diet order for mechanical soft with nectar thick liquids. Observation of breakfast on 09/04/25 from 8:00am to 9:00am revealed Resident #6 was served bacon, eggs, a biscuit, and nectar thick juice. Observation of lunch on 09/04/25 from 12:00pm to 1:00pm revealed Resident #6 was served chopped ham, macaroni and cheese, a dinner roll, collard greens, and nectar thick juice. Interview with a personal care assistant (PCA) on 09/04/25 at 10:15pm revealed: -She assisted in serving residents in the dining room during breakfast and lunch in the Assisted Living. -She assisted in serving residents their meals in their bedrooms in the Assisted Living. -She knew each resident who had a therapeutic diet. -Resident #6's therapeutic diet was for small portions. -Resident #6 should not have gotten bacon or a biscuit with her breakfast. Refer to interview with the Kitchen Manager on 09/04/25 at 10:00pm. Refer to interview with the primary care provider (PCP) on 09/05/25 at 12:25pm. Refer to interview with the Administrator on 09/05/25 at 2:35pm. Refer to interview with the Campus Director on 09/05/25 at 2:55pm.	D 310		

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D 310	Continued From page 23 Interview with the Kitchen Manager on 09/04/25 at 9:00am and 1:50pm revealed: -Resident #3 and Resident #6 were not served therapeutic diets as ordered for breakfast and lunch on 09/04/25. -She did not know that Resident #6 had an order for mechanical soft diet. -She thought that Resident #6 was only ordered to have nectar thick liquids. -She should have reviewed the therapeutic diet order list. -She was responsible for ensuring each resident received their proper diet. -She was concerned with choking if a resident did not receive the proper diet. Interview with Resident #3's and #6's primary care provider (PCP) on 09/05/25 at 12:25pm revealed: -She had concerns of choking and aspirations for residents that did not get served their therapeutic diets as ordered. -She expected the facility to follow therapeutic diets as ordered. Interview with the Administrator on 08/22/25 at 12:45pm revealed: -The Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) were responsible for getting diet orders to the Kitchen Manager. -He expected the Kitchen staff to follow therapeutic diet orders as they were written. -He was concerned that it was a choking hazard if residents did not get served therapeutic diets as ordered. Interview with the Campus Director on 09/05/25 at 2:55pm revealed: -The breakfast and lunch served to Resident #3	D 310		

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D 310	Continued From page 24 and Resident #6 on 09/04/25 were not prepared correctly. -She expected the kitchen staff to serve therapeutic diets as ordered. -She had concerns for residents choking if they did not get their therapeutic diets served as ordered.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were clarified for 1 of 5 sampled residents (#3) including a nasal spray for seasonal allergies and a medication for diarrhea. The findings are: Review of Resident #3's current FL-2 dated 03/14/25 revealed: -Diagnoses included dementia, Parkinson's disease, gastroesophageal reflux disease,	D 344		

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anemia, fatigue, muscle weakness, altered mental status, and fractured sacrum.
-There was an order for Flonase 50mcg Nasal Spray, instill 1 spray in each nostril once daily as needed (prn). (Flonase is used to treat and prevent symptoms associated with seasonal allergies.)
-There was an order for Imodium 2mg take 1 tablet as needed (prn) with each loose stool/diarrhea, not to exceed 8 doses in 24 hours. (Imodium is used to treat diarrhea.)

Review of Resident #3's hospice orders dated 04/30/25, 06/25/25, 07/23/25, 08/06/25, and 08/20/25 revealed:
-There were orders for Flonase 50mcg Nasal Spray, 1 spray into each nostril daily prn nasal congestion.
-There were orders for Imodium 2mg 1 tablet with each loose stool, not to exceed 8 doses in 24 hours.

Review of Resident #3's primary care provider (PCP) visit dated 08/15/25 revealed:
-There was an order to discontinue Flonase.
-There was an order to discontinue Imodium.

Review of Resident #3's physician's orders and progress notes revealed no documentation that the resident's PCP or hospice provider were contacted to clarify the orders for Flonase Nasal Spray and Imodium.

Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase 50mcg Nasal Spray instill 1 spray in each nostril once daily prn.
-There was no Flonase documented as administered in July 2025.

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-There was an entry for Imodium 2mg take 1 tablet prn with each loose stool/diarrhea, not to exceed 8 doses in 24 hours.
-There was no Imodium documented as administered in July 2025.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Flonase 50mcg Nasal Spray instill 1 spray in each nostril once daily prn.
-Flonase was documented as discontinued on 08/18/25.
-There was no Flonase documented as administered in August 2025.
-There was an entry for Imodium 2mg take 1 tablet prn with each loose stool/diarrhea, not to exceed 8 doses in 24 hours.
-There was no Imodium documented as administered in August 2025.

Review of Resident #3's September 2025 eMAR dated 09/01/25 - 09/04/25 revealed:
-There was no entry for Flonase 50mcg Nasal Spray and none was documented as administered.
-There was an entry for Imodium 2mg take 1 tablet prn with each loose stool/diarrhea, not to exceed 8 doses in 24 hours.
-There was no Imodium documented as administered in September 2025.

Observation of Resident #3's medications on hand on 09/05/25 at 10:50am revealed:
-There was a bottle of Flonase 50mcg Nasal Spray dispensed on 11/02/24.
-The instructions were to instill 1 spray into each nostril once a day as needed.
-There were handwritten open dates of 11/03/24 and 11/04/24 written on the label.
-There was no Imodium available for

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THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

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administration for Resident #3.

Interview with a medication aide (MA) on 09/05/25 at 10:50am revealed:
-Resident #3 did not have any seasonal allergy symptoms currently and had not used the Flonase Nasal Spray recently.
-She had not noticed Flonase Nasal Spray had been discontinued on the eMAR in August 2025.
-Resident #3 had not had any issues with diarrhea.
-She was not aware Resident #3 did not have any Imodium on hand.
-She was not aware there were different orders for Flonase and Imodium from the PCP and the hospice provider.

Interview with the Special Care Coordinator (SCC) on 09/05/25 at 11:30am revealed:
-He was responsible for clarifying medication orders.
-He had not clarified Resident #3's orders for Flonase Nasal Spray and Imodium because he had not noticed the discrepancies.

Interview with the Administrator on 09/05/25 at 2:55pm revealed:
-He was not aware Resident #3's hospice and PCP orders for Flonase and Imodium did not match.
-The SCC and the Resident Care Coordinator (RCC) were responsible for clarifying medication orders.
-Resident #3's orders should have been clarified.

Telephone interview with a nurse at Resident #3's hospice provider's office on 09/05/25 at 12:26pm revealed:
-There were no hospice orders to discontinue Resident #3's Flonase or Imodium.

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D 344	Continued From page 28 -There was no documentation the facility had contacted them to clarify any orders. -The facility staff should contact them if there were any questions about Resident #3's medications. Interview with Resident #3's PCP on 09/05/25 at 12:35pm revealed: -She took over from the previous PCP and started seeing residents at the facility in August 2025. -She discontinued Resident #3's Flonase Nasal Spray and Imodium on 08/15/25 due to non-use. -She was not aware Flonase and Imodium were active hospice orders for the resident. -No one from the facility had contacted her for clarification. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D 358		

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reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 residents (#2, #8, #9) observed during the medication pass including errors with medications for allergies (#2, #9), a topical medication for skin irritation (#2), a medication for pain (#8), and a laxative for constipation (#9); and for 2 of 5 sampled residents (#3, #4) for record review including errors with a blood thinner (#4), a topical medication for skin irritation (#3), medications for acid reflux (#3, #4), and medications for congestive heart failure and high blood pressure, underactive thyroid disease, depression, nerve pain, high cholesterol, restless leg syndrome, and Cushing's disease (#4).

The findings are:

1. The medication error rate was 15% as evidenced by the observation of 5 errors out of 33 opportunities during the 8:00am/9:00am medication pass on 09/04/25.

a. Review of Resident #2's current FL-2 dated 06/12/25 revealed:
-Diagnoses included dementia, Alzheimer's disease, essential hypertension, and peripheral edema.
-There was an order for Fluticasone Propionate 50mcg nasal spray give 2 sprays in each nostril once daily (Fluticasone Propionate is used to treat allergy symptoms).

Observation of the 8:00am/9:00am medication pass on 09/04/25 revealed:
-The medication aide (MA) prepared and administered Fluticasone to Resident #2 by inserting the tip of the bottle into each nostril and spraying the medication once into each nostril at 9:23am.

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D 358	Continued From page 30 -Resident #2 was administered 1 spray in each nostril instead of 2 sprays in each nostril as ordered. Observation of Resident #2's medications on hand on 09/04/25 at 2:25pm with a dispense date of 07/23/25 revealed instructions on the label of Fluticasone Propionate 50mcg nasal spray were instill 2 sprays in each nostril once daily. Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Fluticasone Propionate 50mcg nasal spray instill 2 sprays in each nostril once daily at 9:00am. -Fluticasone Propionate 50mcg was documented as administered 09/01/25 through 09/04/25. Interview with Resident #2 on 09/04/25 at 2:30pm revealed: -She denied having a runny nose or any other allergy symptoms. -She could not recall how many Fluticasone Propionate sprays in each nostril she received daily. Interview with the MA on 09/04/05 at 2:30pm revealed: -She realized this morning after administration of Fluticasone Propionate 50mcg to Resident #2 that she administered one spray to each nostril instead of 2 sprays to each nostril as ordered. -She was nervous and typically administered 2 sprays to each nostril. -Resident #2 had not complained of allergy symptoms or exhibited any allergy symptoms since administration this morning. Interview with the Administrator on 09/04/25 at	D 358		

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D 358	Continued From page 31 3:45pm revealed: -Resident #2's Fluticasone Propionate should have been administered as ordered. -Any medication administration error should have been documented with an exception on the eMAR, and the primary care provider (PCP) should have been notified of the error. Interview with Resident #2's PCP on 09/05/25 at 12:20pm revealed: -Fluticasone Propionate was ordered for Resident #2's seasonal allergies. -She had no concerns about Resident #2 missing 1 spray in each nostril of Fluticasone Propionate during the 8:00am/9:00am administration yesterday, 09/04/25. b. Review of Resident #2's current FL-2 dated 06/12/25 revealed there was an order for Desitin paste 40% apply topically to affected areas twice daily (Desitin paste 40% is a topical medication used to treat irritated or inflamed skin). Review of Resident #2's physician's orders revealed no documentation of an order to clarify where the Desitin paste 40% should have been applied. Observation of the 8:00am/9:00am medication pass on 09/04/25 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #2 at 9:23am. -The MA did not prepare and administer Desitin paste to Resident #2. -The MA documented an exception for Desitin paste as not administered because the red area on Resident #2's sacrum was healed. -The MA did not look at Resident #2's sacrum or buttocks to ensure the area was healed.	D 358		

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D 358	Continued From page 32 Observation of Resident #2's medications on hand on 09/04/25 at 2:25pm revealed a dispense date of 08/15/25 quantity one tube and instructions on the label of Desitin paste 40% were to apply topically to affected areas twice daily. Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Desitin paste 40% apply topically to affected areas twice daily at 9:00am and 9:00pm. -Desitin paste 40% was documented as administered twice daily 09/01/25 through 09/03/25 and the 9:00am dose was documented as held today, 09/04/25, because the area was healed. Observation of Resident #2 on 09/04/25 at 2:35pm revealed the skin between her buttocks was red and inflamed. Interview with the MA on 09/04/05 at 2:30pm revealed: -There was no specific location identified in the entry for Desitin paste 40% but she knew Resident #2 previously had reddened areas to her sacrum. -She should have checked Resident #2's sacrum and buttocks before holding the Desitin paste and documenting the area as healed. -She should have notified Resident #2's primary care provider (PCP) to get an order to hold Desitin. Interview with the Administrator on 09/04/25 at 3:45pm revealed: -Topical medications should not be held and	D 358		

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documented as area healed unless the MA checked the resident's skin that day and ensured the area was healed.
-Resident #2 should continue to receive Desitin due to redness.

Interview with Resident #2's PCP on 09/05/25 at 12:20pm revealed the MA should have visualized a resident's skin prior to documenting an area as healed.

c. Review of Resident #8's current FL-2 dated 04/17/25 revealed diagnoses included left humerus fracture, muscle weakness, left knee replacement, and chronic kidney disease.

Review of Resident #8's primary care provider's (PCP) progress note dated 08/29/25 revealed there was an order to increase Tylenol Extended Release (ER) 650mg to 2 tablets three times a day for chronic right knee pain (Tylenol ER is a medication used to treat mild pain).

Observation of the 8:00am/9:00am medication pass on 09/04/25 revealed:
-There was one Tylenol ER 650mg tablet in the morning medication multi-dose pack (MDP) for Resident #8.
-The medication aide (MA) prepared and administered one Tylenol ER 650mg tablet to Resident #8 at 8:10am instead of 2 tablets as ordered.

Observation of Resident #8's medications on hand on 09/04/25 at 2:35pm revealed label instructions to administer 1 Tylenol ER 650mg tablet three times daily and there was 1 Tylenol ER tablet in each MDP.

Review of Resident #8's September 2025

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electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol ER 650mg take 1 tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-Tylenol ER one 650mg tablet was documented as administered at 8:00am, 2:00pm, and 8:00pm from 09/01/25 to the 8:00am dose on 09/04/25.
-There was no entry for Tylenol ER 650mg take 2 tablets three times daily.

Interview with Resident #8 on 09/04/25 at 3:10pm revealed:
-He had intermittent right knee pain, but his pain had been better lately, including today.
-He did not recall how many Tylenol ER tablets he received at each dose.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/05/25 at 9:35am revealed Resident #8's order to increase Tylenol ER 650mg from 1 to 2 tabs three times daily was not received by the pharmacy.

Interview with the MA on 09/04/25 at 2:35pm revealed:
-She did not know there was an order to increase Resident #8's Tylenol ER 650mg to give 2 tablets per dose instead of 1.
-If there was an order change for any medication, she should have been alerted on the eMAR after she scanned the MDP, but there was no alert.
-When there was a new order, the order was sent to the pharmacy by the PCP, the MA, or the Resident Care Coordinator (RCC), and the pharmacy changed the eMAR entry.
-MAs could send new orders to the pharmacy but only the RCC, Special Care Coordinator (SCC), or Administrator could approve the new entry on the eMAR.

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D 358	Continued From page 35 Interview with the Administrator on 09/04/25 at 3:45pm revealed: -New orders were sent to the pharmacy by the MA, PCP, RCC, or the SCC and the pharmacy then entered the order onto the eMAR. -The RCC, SCC, or Administrator had to approve any new entries. -The order to increase Tylenol ER 650mg from 1 to 2 tabs three times daily was never sent to the pharmacy. -He was implementing a new system of checks and balances to ensure that new orders were not missed. -Resident #2 should have received 2 tablets of Tylenol ER as ordered. Interview with Resident #8's PCP on 09/05/25 at 12:20pm revealed: -New orders she wrote were often not reaching the pharmacy and being implemented at the facility. -Resident #8 told her his pain was managed better even though his Tylenol increase was never implemented. d. Review of Resident #9's current FL-2 dated 10/23/24 revealed: -Diagnoses included Cushing's syndrome, unspecified dementia, unspecified anxiety disorder, primary hypertension, fusion of spine, and long-term drug therapy. -There was an order for Miralax mix 17 grams into 8 ounces of fluid and drink every day (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17 grams that should be used to measure the dosage at the top of the white inner lining of the cap).	D 358		

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D 358	Continued From page 36 Observation of the 8:00am/9:00am medication pass on 09/04/25 revealed: -The medication aide (MA) poured approximately two-thirds of a capful of Miralax 17 gram powder and mixed it in 8 ounces of water. -The MA administered the Miralax in water to Resident #9 at 8:20am and the resident drank all of the Miralax and water. -The MA did not prepare or administer the full 17 gram dose of Miralax as ordered. Observation of Resident #9's medications on hand on 09/04/25 at 2:35pm revealed: -There was an empty bottle of Miralax labeled mix 1 capful to the indicated line (17 grams) in 8 ounces fluid and take by mouth daily dispensed on 07/23/25. -The bottle was emptied on the morning medication pass today, 09/04/25, when the MA prepared the partial dose of Miralax. Review of Resident #9's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17 grams mix 1 capful to the indicated line (17 grams) in 8 ounces of fluid and take by mouth daily at 8:00am. -Miralax 17 grams was documented as administered daily from 09/01/25 to 09/04/25. Interview with Resident #9 on 09/04/25 at 3:00pm revealed: -Her last bowel movement was yesterday, 09/03/25. -She stated, "I'm constipated now", repeatedly during the interview. Interview with the MA on 09/04/25 at 2:35pm revealed:	D 358		

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-She only administered two-thirds of Resident #9's Miralax dose this morning because there was not enough Miralax remaining in the bottle for a full dose.
-She should have documented an exception on the eMAR to indicate Resident #9 received a partial dose.
-She requested a refill of Miralax from the pharmacy today, 09/04/25.
-Resident #9 often reported constipation and diarrhea within moments of the previous report, stating during the same shift that she was both constipated and had diarrhea.

Interview with the Administrator on 09/04/25 at 3:45pm revealed MAs should request refills of non-cycle filled medications such as Miralax 7 days before the medication was out to avoid missed or partial doses.

Interview with Resident #9's PCP on 09/05/25 at 12:20pm revealed:
-Resident #9 often complained of both constipation and diarrhea in the same day when she visited the facility, but her bowel movements were managed on her current regimen.
-She had no concerns regarding Resident #9 receiving a partial dose of daily Miralax due to the resident's other medications ordered to relieve constipation.

e. Review of Resident #9's current FL-2 dated 10/23/24 revealed there was an order for Cetirizine 5mg take 1 tablet daily (Cetirizine is a medication used to treat allergy symptoms).

Review of Resident #9's primary care provider's (PCP) progress note dated 08/22/25 revealed an order to discontinue Cetirizine.

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D 358	Continued From page 38 Observation of the 8:00am/9:00am medication pass on 09/04/25 revealed: -The medication aide (MA) prepared Cetirizine 5mg that was in Resident #9's morning multi-dose pack (MDP). -The MA administered Cetirizine 5mg to Resident #9 at 8:20am. -Resident #9 was administered Cetirizine after the order had been discontinued. Observation of Resident #9's medications on hand on 09/04/25 at 2:35pm revealed: -There was 1 Cetirizine 5mg tablet in each morning medication MDP labeled as take one tablet once daily. -Cetirizine 5mg 1 tablet was present in each morning MDP. -The MDPs were dispensed on 09/01/25, and there was a quantity of 6 Cetirizine tablets remaining. Review of Resident #9's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Cetirizine 5mg tablet take 1 tablet once daily at 8:00am. -Cetirizine 5mg was administered daily from 09/01/25 to 09/04/25. -There was no documentation indicating Cetirizine was discontinued on 08/22/25. Interview with Resident #9 on 09/04/25 at 3:00pm revealed she did not recall having allergy symptoms currently or in the past. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/05/25 at 9:35am revealed Resident #9's order to discontinue Cetirizine was never received by the pharmacy.	D 358		

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D 358	Continued From page 39 Interview with the MA on 09/04/25 at 2:35pm revealed: -If there was an order change for any medication, this should have alerted her on the eMAR after she scanned the MDP, but there was no alert this morning. -When there was a new order, the order was sent to the pharmacy, and the pharmacy changed the eMAR entry. -She did not know there was an order to discontinue Resident #9's Cetirizine. Interview with the Administrator on 09/04/25 at 3:45pm revealed: -Resident #9's Cetirizine discontinue order should have been sent to the pharmacy by the MA, PCP, Resident Care Coordinator (RCC), or the Special Care Coordinator (SCC). -The order to discontinue Cetirizine for Resident #9 was not sent to the pharmacy. Interview with Resident #9's PCP on 09/05/25 at 12:20pm revealed: -New orders were often not reaching the pharmacy and being implemented at the facility. -She discontinued Resident #9's Cetirizine because she was attempting to reconcile medications and eliminate unnecessary medication. -There were no consequences to Resident #9 continuing Cetirizine since the discontinue order was written, but she still wanted the medication discontinued. 2. Review of the facility's undated Cart Audit/Medications On-Hand Review policy revealed: -The facility should ensure that residents always had current orders in the facility.	D 358		

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-The facility would develop a schedule so that all residents' medication orders were checked on a weekly basis by completing a cart audit.
-Staff would check to see that all medications were available using a copy of the physician's orders.
-Staff would re-order as needed, and the re-order would be placed in the Order Processing System for follow-up.
-Staff would date and sign the physician orders once the cart audit was complete and leave for review by the Care Coordinator.

Review of Resident #4's current FL-2 dated 07/03/25 revealed:
-Diagnoses included type 2 diabetes, neuropathy, Cushing's disease, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease.
-Resident #4 was constantly disoriented.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 07/02/25.

a. Review of Resident #4's physician's orders dated 07/03/25 revealed an order for Eliquis 2.5mg 1 tablet twice daily. (Eliquis is a blood thinner used to prevent blood clots.)

Review of Resident #4's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 2.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Eliquis was documented as not administered at 9:00am on 08/04/25, 08/20/25, and 08/30/25 due to "waiting on pharmacy".
-Eliquis was documented as not administered at 9:00pm on 08/03/25, 08/13/25, 08/24/25,

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D 358	Continued From page 41 08/25/25, 08/26/25, and 08/27/25 due to "drug item unavailable", "waiting on pharmacy", and/or "waiting on order". -Eliquis was documented as not administered at 9:00am and 9:00pm on 08/08/25, 08/14/25 - 08/19/25, 08/21/25 - 08/23/25, 08/28/25, and 08/29/25 due to "drug item unavailable", "waiting on pharmacy", and/or "waiting on order". Review of Resident #4's September 2025 eMAR revealed: -There was an entry for Eliquis 2.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Eliquis was documented as not administered on 09/01/25 at 9:00pm due to drug/item unavailable". Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed: -There was a bottle of Eliquis 2.5mg tablets dispensed on 08/28/25. -There were 52 of 60 tablets remaining. Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed no Eliquis was dispensed. Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed there were 60 Eliquis 2.5 mg tablets dispensed on 08/28/25. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Eliquis could cause a heart blockage and possible blood clots. b. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Gabapentin	D 358		

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D 358	Continued From page 42 600mg 1 tablet twice daily. (Gabapentin is used to treat nerve pain.) Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 600mg, 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Gabapentin was documented as not administered at 9:00am on 07/09/25 due to "resident unavailable". -Gabapentin was documented as not administered on 07/10/25, due to "changed pharmacy". -Gabapentin was documented as not administered at 9:00pm on 07/16/25, due to being "on hold". Review of Resident #4's physician's orders revealed no order to hold Gabapentin. Review of Resident #4's August 2025 eMAR revealed: -There was an entry for Gabapentin 600mg, 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Gabapentin was documented as not administered from 9:00pm on 08/13/25 through 9:00am on 08/30/25 due to "drug/item unavailable", "waiting on pharmacy", "waiting on delivery", and/or "waiting on order". Review of Resident #4's September 2025 eMAR revealed: -There was an entry for Gabapentin 600mg, 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Gabapentin was documented as not administered at 9:00pm on 09/01/25 due to	D 358		

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D 358	Continued From page 43 "drug/item unavailable". Interview with Resident #4 on 09/04/25 at 1:58 pm revealed she had missed some doses of her Gabapentin but could not recall when. Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed: -There were 120 Gabapentin 600mg tablets dispensed on 08/28/25. -There were 108 of 120 tablets remaining. Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 7-day supply of Gabapentin 600 mg tablets were dispensed on 07/04/25. Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed there were 120 Gabapentin 600 mg tablets dispensed on 08/28/25. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Gabapentin could increase nerve pain, numbness, and tingling. c. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Levothyroxine 125mcg 1 tablet once a day. (Levothyroxine is used to treat hypothyroidism.) Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 125mcg 1 tablet once a day scheduled at 6:00am.	D 358		

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-Levothyroxine was documented as not administered from 07/03/25 - 07/07/25 due to "waiting for delivery".
-Levothyroxine was documented as not administered on 07/08/25 due to "changed pharmacy".

Review of Resident #4's August 2025 eMAR revealed:
-There was an entry for Levothyroxine 125mcg 1 tablet every morning scheduled at 6:00am.
-Levothyroxine was documented as not administered on 08/15/25, 08/17/25, 08/18/25, and 08/21/25 - 08/31/25 due to "drug/item unavailable" and/or "waiting on delivery".

Review of Resident #4's September 2025 eMARs revealed:
-There was an entry for Levothyroxine 125mcg 1 tablet every morning scheduled at 6:00am.
-Levothyroxine was documented as not administered from 09/01/25 - 09/04/25 due to "waiting on delivery".

Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed there were no Levothyroxine 125mcg tablets available for administration.

Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 30-day supply of Levothyroxine 125mcg tablets were dispensed on 07/04/25.

Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Levothyroxine was dispensed.

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D 358	Continued From page 45 Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed Levothyroxine was used to treat thyroid issues and stopping it abruptly could cause nausea, headaches and muscle cramps. d. Review of Resident #4's physician's orders dated 07/03/25 revealed an order for Amiloride 5mg take 2 tablets once daily. (Amiloride is used to treat high blood pressure and heart failure.) Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Amiloride 5mg 2 tablets once daily scheduled for 9:00am. -Amiloride was documented as not administered on 07/06/25 due to "waiting for delivery". Review of Resident #4's August 2025 eMAR revealed: -There was an entry for Amiloride 5mg 2 tablets once daily scheduled for 9:00am. -Amiloride was documented as not administered from 08/14/25 - 08/30/25 due to "waiting on pharmacy", "not delivered", and/or "drug/item unavailable". Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed: -There was a supply of Amiloride 5mg tablets dispensed on 08/28/25. -There were 25 of 30 tablets remaining. Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 7-day supply of Amiloride 5mg tablets were dispensed on 07/03/25.	D 358		

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Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed there were 30 Amiloride 5mg tablets dispensed on 08/28/25.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Amiloride could cause Resident #4 to retain fluid resulting in increased congestive heart failure symptoms including shortness of breath.

e. Review of Resident #4's physician's orders dated 07/03/25 revealed an order for Atorvastatin 10mg take 1 tablet once daily. (Atorvastatin is used to treat high cholesterol.)

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 10mg 1 tablet at bedtime scheduled at 9:00pm.
-Atorvastatin was documented as not administered at 9:00pm on 07/09/25 and 07/10/25, due to "changed pharmacy".
-Atorvastatin was documented as not administered at 9:00pm on 07/16/25, due to being "on hold".

Review of Resident #4's physician's orders revealed no order to hold Atorvastatin.

Review of Resident #4's August 2025 eMAR revealed:
-There was an entry for Atorvastatin 10mg 1 tablet once daily scheduled at 9:00pm.
-Atorvastatin was documented as not administered from 08/13/25 - 08/31/25 due to "drug/item unavailable", "waiting on order", and/or

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D 358	Continued From page 47 "waiting on pharmacy". Review of Resident #4's September 2025 eMAR revealed: -There was an entry for Atorvastatin 10mg 1 tablet once a day scheduled at 9:00pm. -Atorvastatin was documented as not administered from 09/01/25 - 09/03/25 due to "drug/item unavailable". Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed there were no Atorvastatin 10mg tablets available for administration. Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 7-day supply of Atorvastatin 10mg tablets were dispensed on 07/03/25. Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Atorvastatin was dispensed. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Atorvastatin could cause plaque buildup and cause heart issues. f. Review of Resident #4's physician's orders dated 07/03/25 revealed an order for Citalopram 40mg ½ tablet once daily. (Citalopram is an antidepressant.) Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 48 -There was an entry for Citalopram 40mg ½ tablet daily scheduled at 9:00am. -Citalopram was documented as not administered on 07/06/25 due to "waiting for delivery". -Citalopram was documented as not administered on 07/09/25 due to "resident unavailable". -Citalopram was documented as not administered on 07/10/25 due to "changed pharmacy". Review of Resident #4's August 2025 eMAR revealed: -There was an entry for Citalopram 40mg ½ tablet daily scheduled at 9:00am. -Citalopram was documented as not administered from 08/14/25 - 08/30/25 due to "waiting on pharmacy" and/or "drug/item unavailable". Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed: -There was a supply of Citalopram 40mg tablets dispensed on 08/28/25. -There were 25 half tablets remaining out of 30 half tablets. Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 14-day supply of Citalopram 40mg tablets was dispensed on 07/04/25. Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed there were 15 Citalopram 40mg tablets dispensed on 08/28/25. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Citalopram could increase agitation and stress.	D 358		

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g. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Pantoprazole 20mg 1 tablet every other day. (Pantoprazole is used to treat heartburn and acid reflux.)

Review of Resident #4's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 20mg 1 tablet every other day scheduled on even days at 6:00am.
-Pantoprazole was documented as not administered on 08/06/25, 08/18/25, 08/22/25, 08/24/25, 08/26/25, 08/28/25, and 08/30/25 due to "waiting on pharmacy", "waiting on delivery", and/or "drug/item unavailable".

Review of Resident #4's September 2025 eMAR revealed:
-There was an entry for Pantoprazole 20mg 1 tablet every other day scheduled at 6:00am on odd days of the month.
-Pantoprazole was documented as not administered on 09/01/25 and 09/03/25 due to "waiting on delivery".

Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed there were no Pantoprazole 20mg tablets available for administration.

Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 30-day supply of Pantoprazole 20 mg tablets were dispensed on 07/04/25.

Review of Residents #4's pharmacy dispensing

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records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Pantoprazole was dispensed.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Pantoprazole could result in increased acid reflux and development of ulcers.

h. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Ropinirole 4mg 1 tablet at bedtime. (Ropinirole is used to treat restless legs syndrome.)

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Ropinirole 4mg 1 tablet at bedtime scheduled at 9:00pm.
-Ropinirole was documented as not administered on 07/09/25 and 07/10/25, due to "changed pharmacy".
-Ropinirole was documented as not administered on 07/16/25, due to being "on hold".

Review of Resident #4's physician's orders revealed no order to hold Ropinirole.

Review of Resident #4's August 2025 eMAR revealed:
-There was an entry for Ropinirole 4mg 1 tablet at bedtime scheduled at 9:00pm.
-Ropinirole was documented as not administered from 08/14/25 - 08/31/25 due to "drug/item unavailable", "waiting on order", and/or "waiting on pharmacy".

Review of Resident #4's September 2025 eMAR revealed:

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-There was an entry for Ropinirole 4mg 1 tablet at bedtime scheduled at 9:00pm.
-Ropinirole was documented as not administered from 09/01/25 - 09/03/25 due to "drug/item unavailable".

Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed there were no Ropinirole 4mg tablets available for administration.

Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 13-day supply of Ropinirole 4 mg tablets was dispensed on 07/04/25.

Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed there was no Ropinirole dispensed.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Ropinirole could increase uncontrollable leg movements.

i. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Mifepristone 300mg 1 tablet with meals. (Mifepristone is used to treat symptoms associated with Cushing's disease.)

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Mifepristone 300mg 1 tablet with meals scheduled at 9:00am, 1:00pm, and 9:00pm.
-Mifepristone was documented as not

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administered at 9:00pm on 07/08/25 due to "waiting on delivery".
-Mifepristone was documented as not administered at 9:00am on 07/09/25, due to "resident unavailable".
-Mifepristone was documented as not administered at 1:00pm and 9:00pm on 07/09/25 due to "changed pharmacy".
-Mifepristone was documented as not administered at 9:00am and 9:00pm on 07/10/25 and 9:00am on 07/10/25 due to "changed pharmacy".

Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed:
-There was a bottle of Mifepristone 300mg tablets dispensed on 08/04/25 with 7 of 30 tablets remaining.
-There was a second bottle of Mifepristone 300mg tablets dispensed on 08/27/25 with 30 of 30 tablets remaining.
-The Mifepristone was dispensed by an out of state pharmacy.

Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed no Mifepristone was dispensed.

Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Mifepristone was dispensed.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Mifepristone could increase blood sugars due to the resident's Cushing's disease.

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j. Review of Resident #4's physician's orders dated 07/03/25 revealed an order for Bumetanide 2mg 1 tablet twice a day. (Bumetanide is a diuretic used to treat fluid retention, high blood pressure and congestive heart failure.)

Review of Resident #4's primary care provider's (PCP) order dated 08/07/25 revealed an order to decrease Bumetanide to once daily.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Bumetanide 2mg take 1 tablet twice daily scheduled for 9:00am and 2:00pm.
-Bumetanide was documented as not administered at 9:00am and 2:00pm on 07/06/25 due to "waiting on delivery".
-Bumetanide was documented as not administered on 07/09/25 and 07/10/25 due to "changed pharmacy".
-Bumetanide was documented as not administered at 2:00pm on 7/15/25, 07/18/25, 07/19/25, 07/26/25 and 07/30/25 due to "resident unavailable".

Observation of Resident #4's medications on hand on 09/05/25 at 10:10am revealed:
-Some of the resident's medications were packaged in multi-dose packs (MDPs).
-There was a MDP with a printed date of 09/01/25 that contained one Bumetanide 2mg in each morning MDP.
-There were 6 of 7 Bumetanide 2mg tablets remaining.

Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 13-day

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supply of Bumetanide 2 mg tablets were dispensed on 07/04/25.

Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Bumetanide was dispensed.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Bumetanide could result in increased fluid retention and shortness of breath.

k. Review of Resident #4's physician orders dated 07/03/25 revealed an order for Metoprolol Succinate ER 25mg 1 tablet at bedtime. (Metoprolol Succinate ER is used to treat high blood pressure and congestive heart failure.)

Review of Resident #4's primary care provider's (PCP) order dated 08/07/25 revealed an order to increase Metoprolol Succinate ER to 50mg daily.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Succinate ER 25mg 1 tablet at bedtime scheduled at 9:00pm.
-Metoprolol Succinate ER was documented as not administered on 07/09/25 and 07/10/25 due to "changed pharmacy".
-Metoprolol Succinate ER was documented as not administered on 07/16/25 due to being "on hold".

Review of Resident #4's physician's orders revealed no order to hold Metoprolol Succinate ER.

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D 358	Continued From page 55 Review of Resident #4's pharmacy dispensing records from the facility's contracted pharmacy dated June 2025 - July 2025 revealed a 13-day supply of Metoprolol Succinate ER 25mg tablets was dispensed on 07/04/25. Review of Residents #4's pharmacy dispensing records from the resident's outside pharmacy provider dated 07/01/25 - 09/05/25 revealed no Metoprolol Succinate ER 25mg or 50mg tablets were dispensed. Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed missing doses of Metoprolol could cause a blockage in arteries. Review of Resident #4's monthly vitals signs revealed the resident's blood pressure was 118/78 on 08/02/25 and 124/76 on 09/02/25. Interview with Resident #4 on 09/04/25 at 1:58 pm revealed: -She did not remember if she had missed dose of any other medications. -She denied any symptoms including dizziness, headaches, or shortness of breath. Interview with a medication aide (MA) on 09/04/25 at 2:20pm revealed: -The majority of medications were received on a weekly cycle fill. -The MAs were supposed to notify the Resident Care Coordinator (RCC), Special Care Coordinator (SCC), or Administrator if there were any issues with receiving medications. -She documented Resident #4's missed medication on the daily Facility Activity Reports. -The Administrator and the SCC reviewed daily Facility Activity Reports for missed medications.	D 358		

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D 358	Continued From page 56 Second interview with the MA on 09/05/25 at 9:38am revealed: -If a resident missed 3 consecutive days of a medication, the MAs were supposed to call the physician. -The reason medication was not administered should be documented on the eMAR. -She usually documented a medication was unavailable if there was none on hand to administer. -She thought some MAs just documented any reason including on hold or resident unavailable even though the medication was unavailable for administration. -She tried to contact Resident #4's PCP several times regarding Resident #4's medications but was never able to talk to the physician. -Resident #4 had missed several medications due to the medication not being in the facility. -The resident used the facility's contracted pharmacy when she was admitted but then changed to an outside pharmacy. -She clicked on refill request in the eMAR system for Resident #4's medications but the refill requests went to the wrong pharmacy because at that time, she did not realize the resident had changed pharmacies. Interview with the SCC on 09/04/25 at 1:34pm revealed: -He met with the Administrator every morning to review reports that included missing medications and medication refusals. -He did not recall discussing Resident #4's medications with the Administrator because the MAs had marked Resident #4's medications as being ordered. -If medications were not administered, it should be documented on the eMAR.	D 358		

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-The MAs were responsible for contacting the pharmacy or physician regarding medication orders if a resident missed 3 consecutive days.
-The MAs on duty were responsible for reordering medications.

Interview with the Administrator on 09/04/25 at 1:02pm revealed:
-He was not aware Resident #4 had missed medications.
-The MA on shift was responsible for reordering medications.
-Medications were refilled through the eMAR system.
-The MAs should inform the RCC if there was an issue with reordering medications.
-If the RCC was not available, the MAs should notify the SCC.
-If the RCC and SCC were not available, the MAs should notify him.
-He could not locate the list of medications that Resident #4 brought into the facility on the day of admission.
-The RCC was responsible for checking in medications upon admission and compiling a list.

Second interview with the Administrator on 09/05/25 at 1:55pm revealed:
-The RCC position had been vacant for a couple of months.
-He had not had time to complete eMAR audits.
-He did not know if anyone else had completed any eMAR audits.
-He was not aware Resident #4 had missed so many medications.

Telephone interview with a registered nurse (RN) at Resident #4's PCP office on 09/05/25 at 9:40am revealed:
-The facility did not notify them that the resident

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had missed any medication.
-The resident was last seen at their office on 08/20/25.
-The resident's blood pressure was 102/60 and her heart rate was 76 on 08/20/25.
-The resident reported that her legs and feet were not as swollen as before.
-The resident reported that she had missed some of her medications but was not sure which medications or why she missed them.

3. Review of Resident #3's current FL-2 dated 03/14/25 revealed diagnoses included dementia, Parkinson's disease, gastroesophageal reflux disease, anemia, fatigue, muscle weakness, altered mental status, and fractured sacrum.

a. Review of Resident #3's current FL-2 dated 03/14/25 revealed an order for Omeprazole 20mg 1 capsule once daily. (Omeprazole is used to treat acid reflux.)

Review of Resident #3's primary care provider (PCP) order dated 06/08/25 revealed an order to discontinue Omeprazole 20mg and start Omeprazole 10mg once a day for 14 days, then discontinue.

Review of Resident #3's hospice orders dated 06/25/25 revealed an order for Omeprazole 20mg 1 capsule once daily.

Review of Resident #3's PCP visit note dated 08/15/25 revealed an order to continue Omeprazole.

Review of Resident #3's July 2025 - September 2025 electronic medication administration records (eMARs) revealed:
-There was no entry for Omeprazole.

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-No Omeprazole was documented as being administered.

Observation of Resident #3's medications on hand on 09/05/25 at 10:46am revealed there was no Omeprazole available for administration to the resident.

Interview with a medication aide (MA) on 09/05/25 at 10:46am revealed:
-Resident #3 did not have any Omeprazole on hand because she thought it had been discontinued.
-She could not recall when it had been discontinued.
-She was not aware of the hospice order in June 2025 or the PCP order in August 2025 for the resident to receive Omeprazole.

Interview with the Special Care Coordinator (SCC) on 09/05/25 at 11:30am revealed:
-The MAs usually sent medication orders to the pharmacy.
-The pharmacy usually entered orders into the eMAR system.
-He or the Administrator approved orders in the eMAR system.
-He was not aware Resident #3 was not receiving Omeprazole as ordered.

Interview with Resident #3's PCP on 09/05/25 at 12:35pm revealed:
-She took over from the previous PCP and started seeing residents at the facility in August 2025.
-She thought Resident #3 was receiving Omeprazole so she noted for the resident to continue taking it to prevent acid reflux when she saw the resident in August 2025.
-Not receiving the Omeprazole could cause the

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resident to have heartburn or acid reflux.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

b. Review of Resident #3's primary care provider's (PCP) order dated 05/11/25 revealed an order for Zinc Oxide 20% topical ointment, apply a small amount to buttocks and groin areas for skin breakdown/irritated skin. (Zinc Oxide is a skin protectant used to treat and prevent skin irritation.)

Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Zinc Oxide 20% ointment, apply a small amount to buttocks and groin with skin breakdown/irritated skin twice a day scheduled at 9:00am and 9:00pm.
-Zinc Oxide 20% ointment was documented as administered twice daily from 07/01/25 - 07/31/25.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Zinc Oxide 20% ointment, apply a small amount to buttocks and groin with skin breakdown/irritated skin twice a day scheduled at 9:00am and 9:00pm.
-Zinc Oxide 20% ointment was documented as administered twice daily from 08/01/25 - 08/30/25 except at 9:00am on 08/17/25 and 08/30/25 when it was noted to be unavailable.

Review of Resident #3's September 2025 eMAR revealed:
-There was an entry for Zinc Oxide 20% ointment, apply a small amount to buttocks and groin with

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skin breakdown/irritated skin twice a day scheduled at 9:00am and 9:00pm.
-Zinc Oxide 20% ointment was documented as administered twice daily from 09/01/25 - 09/04/25 (9:00am).

Observation of Resident #3's medications on hand on 09/05/25 at 10:54am revealed:
-There were 2 tubes of Zinc Oxide 17% with the resident's name written on the tube in black marker.
-There was no prescription label.
-There was no Zinc Oxide 20% ointment available for administration to Resident #3.

Interview with a medication aide (MA) on 09/05/25 at 10:54am revealed:
-Resident #3 did not currently have any open areas of skin.
-Her skin was discolored (meaning darker) between her buttocks from previous skin irritation but it was clearing up.
-She had not noticed the Zinc Oxide ointment on hand was 17% and did not match the eMAR which indicated 20% was to be administered.
-She thought the Zinc Oxide on hand may have been supplied by the hospice agency.

Observation of Resident #3 on 09/05/25 at 11:08am revealed the resident had dark, discolored skin between her buttock but no open areas.

Interview with the Special Care Coordinator (SCC) on 09/05/25 at 11:30am revealed:
-The MAs were supposed to compare the medication labels with the eMARs.
-The MAs should do cart audits 3 times a week to ensure the correct medications were on hand.
-He was not aware Resident #3 had the incorrect

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D 358	Continued From page 62 strength of Zinc Oxide on hand. -The MAs should have notified him or the pharmacy or the primary care provider (PCP) of the discrepancy with Resident #3's Zinc Oxide ointment. Telephone interview with a nurse from Resident #3's hospice provider on 09/05/25 at 12:26pm revealed: -They usually ordered supplies weekly through a pharmacy used by hospice. -There should be a new supply of Zinc Oxide ointment coming in tomorrow with the correct strength. Interview with Resident #3's PCP on 09/05/25 at 12:35pm revealed she was not concerned that Resident #3 was receiving a lower strength of Zinc Oxide ointment since there were currently no open areas of skin. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. _____ The facility failed to administer medications as ordered to 3 of 6 residents observed during the medication pass on 09/04/25 including Resident #2 who did not receive a topical ointment for skin irritation and was observed to have red inflamed skin between her buttocks. Resident #4 who was admitted in July 2025 missed multiple medications in July 2025, August 2025, and/or September 2025 due to the medications being unavailable for administration. Resident #4 missed at least 34 doses of a blood thinner putting the resident at risk of heart blockages and blood clots. Resident #4 missed at least 11 doses of one diuretic and 18 doses of a second diuretic putting the resident as risk of retaining fluid which	D 358		

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D 358	Continued From page 63 could increase congestive heart failure symptoms including shortness of breath. Resident #4 missed at least 24 doses of a thyroid medication and stopping it abruptly could cause nausea, headaches and muscle cramps. Resident #4 missed at least 38 doses of a medication used to treat nerve pain putting the resident at risk of increased nerve pain, numbness, and tingling. Resident #4 missed at least 20 doses of an antidepressant putting the resident at risk for increased agitation and stress. Resident #4 missed doses of a medication for acid reflux which could cause the resident to have increased acid reflux and development of ulcers. Resident #4 missed doses of a medication that could cause increased symptoms of Cushing's disease. Resident #4 missed doses of a medication that could result in an increase of uncontrollable leg movements. Resident #4 missed doses of medications that could cause a build up of plaque and blockages in arteries. The failure of the facility to administer medications as ordered put the residents at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/04/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 5, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#3) for a medication used to treat fever and mild to moderate pain.

The findings are:

Review of Resident #3's current FL-2 dated 03/14/25 revealed diagnoses included dementia, Parkinson's disease, gastroesophageal reflux disease, anemia, fatigue, muscle weakness, altered mental status, and fractured sacrum.

Review of Resident #3's hospice order dated

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D 367	Continued From page 65 07/01/25 revealed an order for Acetaminophen 500mg 1 tablet every 6 hours as needed (prn) for pain and/or fever. (Acetaminophen is used to treat fever and mild to moderate pain.) Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 500mg 1 tablet every 6 hours prn pain or fever. -There were no Acetaminophen 500mg tablets documented as administered from 07/01/25 - 07/31/25. Review of Resident #3's August 2025 eMAR revealed: -There was an entry for Acetaminophen 500mg 1 tablet every 6 hours prn pain or fever. -There was one Acetaminophen 500mg tablet documented as administered on 08/01/25 at 11:34am. -There were no other Acetaminophen 500mg tablets documented as administered in August 2025. Review of Resident #3's September 2025 eMAR dated 09/01/25 - 09/04/25 revealed: -There was an entry for Acetaminophen 500mg 1 tablet every 6 hours prn pain or fever. -There were no Acetaminophen 500mg tablets documented as administered in September 2025. Observation of Resident #3's medications on hand on 09/05/25 at 10:58am revealed: -There was a supply of Acetaminophen 500mg tablets dispensed on 07/01/25. -The instructions were to take 1 tablet every 6 hours prn pain or fever. -There were 22 of 30 tablets remaining.	D 367		

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Observation and record review of Resident #3's Acetaminophen revealed:
-There were 8 doses of Acetaminophen used from a supply dispensed on 07/01/25.
-There was only 1 dose of Acetaminophen 500mg documented as administered to Resident #3 on the eMARs from 07/01/25 - 09/04/25.
-The eMAR did not accurately reflect the administration of Resident #3's Acetaminophen 500mg tablets.

Interview with a medication aide (MA) on 09/05/25 at 10:46am revealed:
-If a prn medication was administered, the MAs should document it on the eMAR.
-She could not explain why Resident #3's eMAR documentation for Acetaminophen did not match the number of tablets that had been administered from the supply on hand.

Interview with the Special Care Coordinator (SCC) on 09/05/25 at 11:30am revealed:
-The MAs had been trained and should document the administration of any prn medication on the eMAR at the time the medication was administered.
-There was no system to compare the medications in the cart with the eMARs to ensure documentation on the eMARs was accurate.

Interview with the Administrator on 09/05/25 at 2:55pm revealed:
-The SCC and the Resident Care Coordinator (RCC) were responsible for checking eMARs for accuracy.
-Resident #3's eMAR documentation for Acetaminophen should be done when the MAs administered the medication.

Interview with Resident #3's primary care provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 367	Continued From page 67 (PCP) on 09/05/25 at 12:35pm revealed: -The accuracy of documentation for prn medications on the eMAR was important. -She used the eMARs to determine how often a resident needed a prn medication and whether it was effective. -She made therapy decisions based on documentation on the eMARs, so the documentation needed to be accurate. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.	D 367		