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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING	95 MORNINGSTAR LANE SYLVA, NC 28779

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 08/25/26-08/26/26.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff C) had completed the 5, 10, or 15-hour medication aide (MA) training prior to administering medications. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a MA on 07/03/26. -Staff C had a MA Clinical Skills Competency Validation checklist completed on 07/13/26. -Staff C completed the state written MA examination on 11/05/13. -There was no documentation Staff C had completed the 5, 10, or 15-hour medication aide training.	D 125		

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D 125	Continued From page 1 Review of Resident #3's current FL2 dated 07/16/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD) (a long-term lung condition that makes breathing difficult by blocking airflow from the lungs), type 2 diabetes mellitus, and dementia. Review of Resident #3's August 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Symbicort (used to prevent the worsening of chronic obstructive pulmonary disease (COPD) symptoms) 160-4.5mcg two puffs twice daily scheduled at 8:00am and 8:00pm. -Staff C documented not administering Symbicort 160-4.5mcg inhaler to Resident #3 on 08/13/26 at 8:00am due to "medication awaiting pharmacy delivery". Observation of Resident #3's medications on hand on 08/26/26 at 11:16am revealed: -There was one Symbicort 160-4.5mcg inhaler on the medication cart. -The pharmacy label directions were inhale two puffs twice daily with a dispense date of 08/10/26. -There were 69 remaining actuations (measured dose of medication) in the inhaler. Telephone interview with the facility's contracted backup pharmacy on 08/26/26 at 11:06am revealed Resident #3's Symbicort 160-4.5mcg inhaler was filled on 08/10/26. Telephone interview with Resident #3's primary care provider (PCP) on 08/26/26 at 10:49am revealed missing doses of Symbicort 160-4.5mcg inhaler could put Resident #3 at a higher risk for worsening COPD symptoms.	D 125		

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D 125	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 08/26/26 at 11:20am revealed: -She picked up Resident #3's Symbicort 160-4.5mcg inhaler on 08/10/26. -She told the MAs on duty on 08/10/26, Resident #3's Symbicort 160-4.5mcg inhaler was refilled and placed on the medication cart. Review of Resident #5's current FL2 dated 11/18/25 revealed diagnoses included atrial fibrillation (irregular heart rate), history of aortic aneurysm (a balloon-like bulge in the wall of the aorta), chronic kidney disease and hypotension. Review of Resident #5's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin (a medication used to prevent blood clots) 5mg daily at 9:00am. -Staff C documented not administering warfarin 5mg on 08/19/26 due to "medication awaiting pharmacy delivery". Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/25/26 at 3:00pm revealed: -The pharmacy received a request to refill warfarin 5mg on 08/18/26 and they dispensed 30 tablets and mailed it. -Because there was going to be a delivery delay they sent a request to the facility's back-up pharmacy for 3 tablets so they had the warfarin 5mg available immediately. Observation of medications on hand on 08/25/26 at 3:23pm revealed: -There was a bottle containing 3 tablets of warfarin 5mg dispensed on 08/18/26.	D 125		

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D 125	Continued From page 3 -There was a bubble pack containing 25 tablets of warfarin 5mg dispensed on 08/18/26. Interview with the RCC on 08/26/26 at 11:20am revealed: -She picked up Resident #5's warfarin 5mg on 08/18/26. -She told the MAs on duty on 08/18/26, Resident #5's warfarin 5mg was refilled and placed on the medication cart. Telephone interview with Resident #5's PCP on 08/26/26 at 10:45am revealed: -Resident #5 was ordered warfarin because he had a mechanical heart valve and was at risk of developing blood clots. -Missing 4 days of warfarin put Resident #5 at increased risk of developing a blood clot. Interview with the Administrator on 08/26/26 at 1:50pm revealed: -She was unable to find Staff C's 5, 10, 15-hour MA training certificate in Staff C's personnel file. -Staff C worked as a MA in another assisted living facility before coming to work for them. -Staff C told her she completed the 15-hour MA training at another assisted living facility where she had worked. -Staff C had 13 years experience as a MA. -She previously contacted the other assisted living facility to get a copy of Staff C's 15-hour MA training certificate, but the facility had not yet sent a copy of the training. -She would remove Staff C from the responsibilities of a MA until she could take the 15-hour MA training class that was scheduled in two weeks. Interview with Staff C, MA, on 08/26/26 at 1:55pm revealed:	D 125		

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D 125	Continued From page 4 -She completed the 15-hour MA training at the previous assisted living facility where she worked. -She took the 15-hour MA training in 2013. -She did not get a copy of the 15-hour MA training certificate, but her former employer would have a copy. -She did not know she needed to carry the certificate as proof she had taken the training when she changed employers. Interview with the Business Office Manager (BOM) on 08/26/26 at 2:24pm revealed: -She started her position as BOM on 06/01/26. -She, the Resident Care Coordinator (RCC), and the Administrator shared responsibility in ensuring staff qualifications were completed for each employee. -The Administrator was primarily responsible for scheduling the staff to take the 5, 10, 15-hour MA training. -She was aware MAs were required to take at least a 5-hour MA training class prior to administering medications and complete a total of 15 hours of MA training within the first 60 days of employment as a MA. -Staff C's new hire employee checklist indicated she had completed the 15-hour MA training. -She had trusted the information on the new hire employee checklist and had not checked for the actual documents in the personnel file. [Refer to tag D358, 10A NCAC 13F .1004(a) Medication Administration] The facility failed to ensure Staff C, MA, received the 5, 10, 15 hour MA training prior to administering medications which resulted in Staff C's failure to administer Symbicort inhaler to Resident #3 increasing his risk of worsening symptoms of COPD and warfarin to Resident #5	D 125		

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D 125	Continued From page 5 increasing his risk of developing a blood clot. This was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with the G.S. 131D-34 on 08/26/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 9, 2026.	D 125		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews the facility failed to administer medications as ordered to 4 of 5 sampled residents (#1, #2, #3, #5) related to a medication used to treat depressive episodes associated with bipolar 1 disorder (#1), a medication used to treat migraines (#2), an inhaler used to treat chronic	D 358		

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obstructive pulmonary disease (COPD) (#3), and a medication used to prevent blood clots (#5).

The findings are:

Review of the facility's 2019 medication administration policy revealed:
-Medications and treatments will be administered in accordance with the prescribing practitioner's orders.
-For PRN (as needed) medications and treatments, the Medication Administration Record will include the reason for use and results of use to the resident.
-In the event of a medication error, omission or adverse reaction the facility staff will notify the physician or appropriate health professional and document any events leading up to the error, as well as, any corrective actions taken to prevent further errors.

1. Review of Resident #5's current FL2 dated 11/18/25 revealed diagnoses included atrial fibrillation (irregular heart rate), history of aortic aneurysm (a balloon-like bulge in the wall of the aorta), chronic kidney disease and hypotension.

Review of Resident #5's physician's orders revealed:
-There was an order dated 04/15/26 for warfarin (a medication used to prevent blood clots)5mg daily.
-There was an order dated 07/13/26 for warfarin 1mg every Wednesday to be added to 5mg daily for a total of 6mg on Wednesday's.
-There was an order dated 08/03/26 for warfarin 6mg daily.
-There was an order dated 08/24/26 for warfarin 7.5mg daily.

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D 358	Continued From page 7 Review of Resident #5's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin 5mg daily at 9:00am with a stop date of 08/24/26 at 3:46pm and an original order date of 02/02/26. -Warfarin 5mg was documented as not administered on 08/17/26 through 08/20/26 due to "medication awaiting pharmacy delivery". -Warfarin 5mg was documented as administered on 08/25/26. -There was an entry for warfarin 1mg to be administered with warfarin 5mg to equal 6mg total, daily at 9:00am with a stop date of 08/24/26 at 3:47pm and an original order date of 02/08/26. -There was documentation warfarin 1mg was administered from 08/03/26 through 08/25/26. -There was an entry for warfarin 5mg daily to be administered with 2.5mg to equal 7.5mg total, daily at 9:00am with an order date of 08/24/26 that was documented on 08/25/26 as not administered due to "withheld per doctor order: -There was an entry for warfarin 2.5 mg daily to be administered with 5mg to equal 7.5mg total, daily at 9:00am with an order date of 08/24/26 that was documented on 08/25/26 as not administered due to "withheld per doctor order: Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/25/26 at 3:00pm revealed: -Warfarin was not supplied with the facility's cycle fill and needed to be requested monthly. -The pharmacy received a request to refill warfarin 5mg on 08/18/26 and they dispensed 30 tablets and shipped it to the facility and they should have received it on either 08/19/26 or 08/20/26. -Because there was going to be a delivery delay they sent a request to the facility's back-up	D 358		

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pharmacy for 3 tablets so they had the warfarin 5mg available until the shipment arrived.
-The pharmacy received an order for warfarin 1mg weekly on 07/13/26 and dispensed 4 tablets in a bubble pack.
-The pharmacy received an order for warfarin 1mg on 08/03/26 and they dispensed 30 tablets in a bubble pack.
-The pharmacy received an order for warfarin 7.5mg daily on 08/24/26 and they sent one bubble pack with 30 tablets of 5mg and one bubble pack with 30 tablets of 2.5mg and both bubble packs should have been delivered to the facility on 08/25/26.

Observation of medications on hand on 08/25/26 at 3:23pm revealed:
-There was a bubble pack with 30 tablets of warfarin 5mg dispensed from the facility's contract pharmacy on 08/18/26 with 25 tablets remaining.
-There was a bubble pack with 30 tablets of warfarin 1mg dispensed from the facility's contract pharmacy on 08/03/26 with 10 tablets remaining.
-There was a bottle of warfarin 5mg dispensed from the facility's back-up pharmacy on 08/18/26 with 3 tablets remaining in the bottle.
-There was a bubble pack with 30 tablets of warfarin 5mg dispensed from the facility's contracted pharmacy on 08/24/26 with 29 tablets remaining.
-There was a bubble pack with 30 tablets of warfarin 2.5mg dispensed from the facility's contract pharmacy on 08/24/26 with 29 tablets remaining.

Interview with the Resident Care Coordinator (RCC) on 08/25/26 at 2:53pm and 3:39pm and 08/26/26 at 8:38am revealed:

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D 358	Continued From page 9 -She was not aware Resident #5's warfarin was not administered as ordered from 08/17/26 through 08/20/26. -A medication aide (MA) told her on either 08/17/26 or 08/18/26 that Resident #5 was out of warfarin 5mg and she called the contract pharmacy for a refill. -A supply of 3 tablets was called into the back-up pharmacy since the warfarin was going to be mailed from the contract pharmacy on 08/18/26 and would not arrive until 08/18/26 or 08/20/26. -She put the bottle containing 3 tablets of warfarin 5mg in the medication cart and told the MA working at that time it was available. -All the MAs knew warfarin was not delivered with the cycle fill and needed to be requested monthly. -MAs were responsible for reordering warfarin when there were 5 or 6 tablets left in the bubble pack because it took a couple days for it to be delivered. -Resident #5's warfarin 7.5mg arrived at the facility on 08/25/26 about 10:00am and there was one bubble pack that contained 30- 5mg tablets and one bubble pack that contained 30- 2.5mg tablets. -She put the newly arrived bubble packs of warfarin 5mg and warfarin 2.5mg in the medication cart as soon as it arrived at the facility. -Because there was one tablet removed from the warfarin 5mg and warfarin 2.5mg bubble packs she assumed the MA who worked on 08/25/26 administered it. Interview with a MA on 08/26/26 at 8:06am revealed: -Resident #5 was out of warfarin 5mg when she worked on 08/17/26. -She told the RCC a refill request needed to be submitted to the pharmacy.	D 358		

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-She did not notice there was a bottle containing 3 warfarin tablets in the medication cart on 08/18/26 and 08/20/26 so she documented "medication awaiting pharmacy delivery".
-She was used to looking for bubble packs and did not look further when there was no bubble pack available.
-MAs were responsible for requesting a refill of warfarin monthly when there were 5 or 6 tablets left in the bubble pack because it did not come with the monthly cycle fill.
-She did not know why a refill request for warfarin was not submitted when the bubble pack started getting low.

Telephone interview with another MA on 08/26/26 at 8:43 revealed:
-She was the MA who worked on 08/25/26 and administered Resident #5's medications in the morning.
-She administered Resident #5's warfarin 7.5mg around 10:00am on 08/25/26, after it was delivered from the pharmacy.
-She could not remember if she administered Resident #5's 6mg dose at 9:00 but she probably did if she documented it that way.
-MAs were responsible for requesting a refill of warfarin monthly when there were 5 or 6 tablets left in the bubble pack because it did not come with the monthly cycle fill.
-She could not remember if she requested a refill of Resident #5's warfarin when she worked on 08/11/26 or 08/12/26 when he had 5 or 6 warfarin tablets left.

Interview with Resident #5 on 08/25/26 at 4:45pm revealed:
-He did not know what dose of warfarin he was ordered.
-The MA administered his morning medications

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D 358	Continued From page 11 around 9-9:30am and could not remember if the MA administered anything later. Review of an electronic mail communication from Resident #5's primary care provider (PCP) dated 08/24/26 revealed: -Resident #5's PCP informed the RCC she was increasing warfarin dose to 7.5 because his recent PT/INR level was low. -The PCP requested the RCC "be on the lookout for doses being held or missed" because Resident #5's PT/INR had been "on the lower side lately". Telephone interview with Resident #5's PCP on 08/26/26 at 10:45am revealed: -Resident #5 was ordered warfarin because he had a mechanical heart valve and was at risk of developing blood clots. -She was not informed Resident #5 missed 4 days of warfarin from 08/17/26 through 08/20/26. -Missing 4 days of warfarin put Resident #5 at increased risk of developing a blood clot. -She was informed on 08/25/26 in the afternoon there was a possibility Resident #5 received 2 doses of warfarin on 08/25/26. -Receiving 2 doses of warfarin on 08/25/26 increased his risk of bleeding excessively so she ordered his warfarin to be held on 08/26/26 and ordered labs to check his prothrombin time and International Normalized Ratio (PT/INR), (blood test that measures how long it takes for blood to form a clot). -She increased Resident #5's warfarin dose on 08/24/26 based on the labwork he had recently. Interview with the Administrator on 08/25/26 at 4:11pm revealed: -She did not know Resident #5's warfarin was not administered from 08/17/26 through 08/20/26.	D 358		

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D 358	Continued From page 12 -She knew Resident #5's PCP increased his dose on 08/24/26 but she did not know why. -The MAs were trained to reorder warfarin when it got to the blue area on the bubble pack because it was not filled with the routine cycle fill. -They were supposed to reorder the medication through the eMAR and let the RCC know so she was aware to make sure the medication arrived from the pharmacy or pickup the medication from the backup pharmacy. -The business office manager or the RCC were responsible for picking up medications from the back-up pharmacy. -The MAs should have seen the bottle of warfarin in the medication cart and not just look for a bubble pack. -She did not know the MA administered both 6mg and 7.5mg doses of warfarin on 08/25/26. 2. Review of Resident #2's current FL2 dated 08/12/26 revealed diagnoses included anxiety, bipolar disorder, and migraines. Review of Resident #2's physician's orders revealed Sumatriptan (used to treat migraines) 100mg every 4 hours as needed, maximum dose 200mg in 24 hours. Review of Resident #2's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Sumatriptan 100mg every 4 hours as needed, maximum dose 200mg in 24 hours. -There was a note highlighted in yellow next to the order documenting "max dose is 2 tablets / 24 hours". -There was documentation 3 doses of Sumatriptan 100mg were administered on 08/01/26, 08/13/26 and 08/23/26.	D 358		

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D 358	Continued From page 13 Interview with a medication aide (MA) on 08/25/26 at 3:24pm revealed: -She usually worked the 3:00pm to 11:00pm shift. -Resident #2 was ordered Sumatriptan for migraines and could have 2 per day maximum. -Even though Sumatriptan was not a scheduled medication, Resident #2 requested it every day and would request more than 2 daily if there was not a limit. -Before she could administer it she had to check to see how many she had received earlier in the day. -If more than 2 Sumatriptan tablets were attempted to be administered, the eMAR screen displayed a message "You are not to exceed 2 tablets in a 24 hour period. Cancel or click okay to give anyway". -She did not remember getting a message on the eMAR screen when she administered a third dose on 08/13/26 and 08/23/26. -She was usually careful and double checked before administering Resident #2's Sumatriptan. Interview with the RCC on 08/26/26 at 8:59am revealed: -MAs were trained and knew to not administer more than 2 tablets of Sumatriptan in a day. -They should not have the option to override the warning message. -Resident #2 could be persistent about getting Sumatriptan but that was not an excuse for staff to administer more than the maximum daily dose. -She requested the primary care provider (PCP) change the order from an as needed to a scheduled medication since Resident #2 requested it every day but the PCP would not change it. Telephone interview with Resident #2's PCP on	D 358		

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D 358	Continued From page 14 08/26/26 at 10:45am revealed: -Resident #2 was ordered Sumatriptan for migraines. -Sumatriptan was a medication used to treat migraines, not a medication to prevent them. -She counseled Resident #2 on multiple occasions to not request the medication daily but she continued to ask the MAs. -Exceeding 200mg of Sumatriptan can cause dizziness and tachycardia (rapid heart rate). -She was not aware the MAs exceeded Resident #2's Sumatriptan 200mg maximum dose three times in August 2026. -She expected the MAs to follow the order as written and not exceed 200mg per day. Interview with the Administrator on 08/25/26 at 4:11pm revealed: -She audited Resident #2's July 2026 eMAR to confirm MAs were not administering more than 2 doses of Sumatriptan in a day. -She audited Resident #2's August 2026 eMAR earlier in the day to confirm MAs were not administering more than 2 doses of Sumatriptan in a day and noticed there were three days that documented more than 2 doses. -She did not know the MAs were able to override the pop-up message and administer more than 2 doses of Sumatriptan each day. -In June 2026, all the MAs were educated about not exceeding 2 doses daily, the pharmacy put the extra note in the eMAR and they programmed a pop-up message to warn MAs they were about to exceed maximum dose. -She expected the MAs to follow the order and not exceed 2 doses daily. 3. Review of Resident #3's current FL2 dated 07/16/26 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) (a long-term lung	D 358		

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condition that makes breathing difficult by blocking airflow from the lungs), type 2 diabetes mellitus, and dementia.
-There was an order for Symbicort (used to prevent worsening symptoms of COPD) 160-4.5mcg two puffs two times a day.

Review of Resident #3's July 2026 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5mcg two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort 160-4.5mcg was documented as administered for 52 occurrences out of 62 opportunities.
-On 07/06/26 at 7:01pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/07/26 at 8:01am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/07/26 at 7:02pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/08/26 at 7:40am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/08/26 at 7:18pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/10/26 at 8:06am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/10/26 at 7:04pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 07/11/26 at 7:27pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".

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D 358	Continued From page 16 -On 07/12/26 at 8:13am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 07/12/26 at 7:56pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". Review of Resident #3's August 2026 eMAR revealed: -There was an entry for Symbicort 160-4.5mcg two puffs twice daily scheduled at 8:00am and 8:00pm. -Symbicort 160-4.5mcg was documented as administered for 37 occurrences out of 49 opportunities. -On 08/06/26 at 7:56pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/07/26 at 9:19am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/07/26 at 7:37pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/08/26 at 8:48am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/08/26 at 8:04pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/09/26 at 11:09am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/10/26 at 8:26am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/10/26 at 8:02pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery". -On 08/11/26 at 9:18am, Symbicort 160-4.5mcg	D 358		

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was documented as not administered due to "medication awaiting pharmacy delivery".
-On 08/12/26 at 7:33am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 08/12/26 at 7:06pm, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".
-On 08/13/26 at 8:01am, Symbicort 160-4.5mcg was documented as not administered due to "medication awaiting pharmacy delivery".

Observation of Resident #3's medications on hand on 08/26/26 at 11:16am revealed:
-There was one Symbicort 160-4.5mcg inhaler on the medication cart.
-The pharmacy label directions were inhale two puffs twice daily with a dispense date of 08/10/26.
-There was a handwritten open date of 08/13/26 written on the front of the box where the inhaler was stored.
-There were 69 remaining actuations (measured dose of medication) in the inhaler.

Telephone interview with a representative from the facility contracted pharmacy on 08/26/26 at 11:03am revealed Resident #3's Symbicort 160-4.5mcg inhalers were filled by the backup pharmacy because it was less expensive for Resident #3.

Telephone interview with a representative from the facility's contracted backup pharmacy on 08/26/26 at 11:06am revealed:
-They had filled Resident #3's Symbicort 160-4.5mcg for the last four months.
-They dispensed a Symbicort 160-4.5mcg inhaler on 04/24/26, 05/27/26, 07/10/26, and 08/10/26.
-Each Symbicort 160-4.5mcg inhaler was a 30-day supply of the medication with the current

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D 358	Continued From page 18 order for Resident #3. Interview of Resident #3 on 08/26/26 at 11:30am revealed: -He did not remember if he missed doses of the Symbicort in July and August 2026. -He did not remember if he had an increase in his symptoms during July and August 2026. -He did have a "rescue inhaler" in case he did not have the Symbicort inhaler available. Telephone interview with Resident #3's primary care provider (PCP) on 08/26/26 at 10:49am revealed: -Symbicort was ordered for Resident #3 to prevent COPD exacerbation. -When Resident #3 missed consecutive doses of the Symbicort 160-4.5mcg inhaler there was an increased risk of COPD exacerbation or worsening shortness of breath. Interview with the Resident Care Coordinator (RCC) on 08/26/26 at 11:20am revealed: -She picked up Resident #3's Symbicort 160-4.5mcg inhaler from the backup pharmacy on 08/10/26. -She placed the Symbicort 160-4.5mcg inhaler in the medication cart upon return to the facility. -She told the medication aides (MAs) who were on duty the Symbicort was available for Resident #3. Interview with a medication aide (MA) on 08/26/26 at 11:14am revealed: -She documented she did not administer the Symbicort 160-4.5mcg to Resident #3 on 08/13/26 at 8:01am on Resident #3's eMAR. -If the Symbicort 160-4.5mcg inhaler was filled on 08/10/26 and placed on the medication cart then it was an "error" on her part.	D 358		

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D 358	Continued From page 19 -She just "missed it" on the medication cart. Interview with the Administrator on 08/26/26 at 11:20am and 11:46am revealed: -When she picked up a medication filled by the backup pharmacy, she would always tell the MAs the medication was available. -Then she would then place the medication in the medication cart. -The Symbicort 160-4.5mcg inhaler picked up on 08/10/26 from backup pharmacy was in a different colored box because it was produced by a different manufacturer. -The MAs should have still looked for the Symbicort in the medication cart and reordered it before it ran out. -The Symbicort inhaler had a dial which indicated how many doses were left so staff should have reordered the inhaler before the medication ran out. -They should have told the RCC and herself Resident #3's Symbicort 160-4.5mcg inhaler was getting low and a refill was needed. -The MAs did not inform the RCC or herself so they could get the Symbicort for Resident #3 before it ran out. 4. Review of Resident #1's current FL2 dated 07/14/26 revealed: -Diagnoses included bipolar 1 disorder, breast cancer, chronic kidney disease, hyperlipidemia, hypertension, lymphedema, and peripheral neuropathy. -There was an order for lurasidone (used to treat depressive episodes associated with bipolar 1 disorder) 60mg one tablet every evening. Review of Resident #1's Resident Register revealed an admission date of 07/16/26.	D 358		

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Review of Resident #1's emergency department (ED) discharge summary dated 07/25/26 revealed lurasidone 60mg one tablet every evening must administer with food at least 350 calories.

Review of Resident #1's ED discharge summary dated 08/05/26 revealed lurasidone 60mg one tablet every evening must administer with food at least 350 calories.

Review of Resident #1's ED discharge summary dated 08/16/26 revealed lurasidone 60mg one tablet every evening.

Review of Resident #1's August 2026 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lurasidone 60mg one tablet every evening scheduled at 5:00pm.
-Lurasidone was documented as administered 16 occurrences out of 20 opportunities.
-On 08/20/26 at 4:41pm, the lurasidone was documented as not administered due to "medication awaiting pharmacy delivery".
-On 08/21/26 at 5:32pm, the lurasidone was documented as not administered due to "medication awaiting pharmacy delivery".

Observation of Resident #1's medications on hand on 08/26/26 at 10:23am revealed:
-There were 24 lurasidone 60mg tablets available with a dispense date of 08/07/26.
-The pharmacy label instructions were lurasidone 60mg one tablet every evening.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/26/26 at 9:39am revealed:
-Resident #1's lurasidone 60mg was a "cycle fill"

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medication.
-On 07/14/26, the pharmacy sent a "short fill" of 23 tablets of lurasidone 60mg to the facility for Resident #1.
-On 07/31/26, the pharmacy sent 28 tablets of lurasidone 60mg to the facility for Resident #1.

Interview with Resident Care Coordinator (RCC) on 08/25/26 at 4:50pm revealed:
-The medication aides (MA) were trained to reorder medications 5 days prior to the medication running out.
-The MAs were supposed to do medication cart audits one to two residents every shift.
-The audit included printing out the physician orders and checking the physician orders against the eMAR and the medication packages.
-They were also supposed to be checking to ensure an adequate supply of each medication and let her know if there was a medication running low so she could reorder it.

Interview with the RCC on 08/26/26 at 9:50am revealed:
-The MAs were not looking in the overflow supply of medications when a bubble pack of medication ran out.
-The overflow supply of medications was kept in a separate drawer on the medication cart.
-She tried to pull medication exception reports daily Monday through Friday to see missed doses of medications so she could find out how to resolve the problems.
-The MAs were not telling her when medications were not available for administration.

Telephone interview with Resident #1's mental health provider (MHP) on 08/26/26 at 12:28pm revealed:
-She had not yet seen Resident #1 as she was a

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new admission.
-The lurasidone was ordered for mood stabilization.
-She did not know Resident #1 and could not say whether missing two consecutive doses of lurasidone could not say how that would affect Resident #1.
-She was not sure how the lurasidone was even working for Resident #1.

Interview with the Administrator on 08/26/26 at 11:46am revealed:
-She did not know how the MAs missed giving Resident #1 the lurasidone.
-The MAs were not looking in the overflow supply of medications when they ran out of a medication.
-The MAs were told to reorder medications when it got to the blue area on the bubble cards which ensured 5 days for a refill to be processed and arrive from the pharmacy.
-They were supposed to reorder the medication through the eMAR and let the RCC know so she was aware to make sure the medication arrived from the pharmacy or pickup the medication from the backup pharmacy.

_____

The facility failed to administer four consecutive doses of warfarin to Resident #5 increasing his risk of developing a blood clot and gave him two doses of warfarin in one day putting him at risk of excessive bleeding; administered 300mg of Sumatriptan when there was an order not to exceed 200mg daily on three different days in August 2026 to Resident #2 putting her at risk of having an elevated heart rate and becoming dizzy and failed to administer Symbicort to Resident #3 ten times in July and twelve times in August increasing his risk of worsening COPD symptoms. This was detrimental to the health, safety, and welfare of the residents and

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D 358	Continued From page 23 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/25/26 for this violation.	D 358		