STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL062016	A. BUILDING: _____ B. WING _____	R 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

(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 on July 28, 2026 to July 29, 2026.	{D 000}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increase severity resulting in resident placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#6) observed during the medication pass that included nine medications not available at the time of administration for bipolar disorder, cholesterol management, heart failure, high blood pressure, low potassium levels, depression/anxiety, acid reflux, eye health, allergies, and a nutritional supplementation and an enteric coated aspirin which was crushed. Additionally, 2 of 5 sampled residents (#2, #4)	{D 358}		

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{D 358}	Continued From page 1	{D 358}		

were missing medications used to reduce high eye pressure (#4), and two medications used for chronic obstructive pulmonary disease (COPD) and asthma management (#2).

The findings are:

Review of the facility's medication policy and procedure manual dated 2019 revealed:
-Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders.
-The facility will assure medications are provided for residents in accordance with the facility's medication management policies.

1. The medication error rate was 29% as evidenced by 10 errors out of 34 opportunities during the 7:00am/8:00am medication pass on 07/29/25.

a. Review of Resident #6's current FL-2 dated 04/13/26 revealed:
-Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for aripiprazole 5mg one tablet every day (used to treat symptoms of both bipolar I and II depression).

Observation of the 8:00am medication pass on 07/29/26 revealed:
-Resident #6's medications were packaged in bubble packs.
-The medication aide (MA) prepared and administered medications in a medication cup which did not include aripiprazole 5mg to

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{D 358}	Continued From page 2 Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for aripiprazole 5mg 1 tablet daily for mood and behaviors. -Aripiprazole 5mg was not documented as administered on 07/29/26. -There was no other entry for aripiprazole 5mg on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no aripiprazole 5mg available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for aripiprazole 5mg 1 tablet daily. -Resident #6's aripiprazole 5mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. b. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for atorvastatin 80mg one tablet every day (used to lower total blood cholesterol as well as LDL cholesterol, bad cholesterol). Observation of the 8:00am medication pass on 07/29/26 revealed:	{D 358}		

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{D 358}	Continued From page 3 -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include atorvastatin 80mg to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for atorvastatin 80mg one tablet every day -Atorvastatin 80mg was not documented as administered on 07/29/26. -There was no other entry for atorvastatin 80mg on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no atorvastatin 80mg available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for atorvastatin 80mg one tablet every day. -Resident #6's atorvastatin 80mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. c. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for Spironolactone 25mg one tablet every day (used	{D 358}		

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{D 358}	Continued From page 4 to treat heart failure, high blood pressure (hypertension), or hypokalemia (low potassium levels in the blood). Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include spironolactone 25mg to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for spironolactone 25mg 1 tablet every morning. -Spironolactone 25mg was not documented as administered on 07/29/26. -There was no other entry for spironolactone 25mg on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no spironolactone 25mg available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for Spironolactone 25mg one tablet every day. -Resident #6's Spironolactone 25mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful.	{D 358}		

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{D 358}	Continued From page 5 d. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for Escitalopram 20mg one tablet every day (used to treat certain types of depression and anxiety). Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include escitalopram 20mg to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for escitalopram 20mg 1 capsule daily. -Escitalopram 20mg was not documented as administered on 07/29/26. -There was no other entry for escitalopram 20mg on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no escitalopram 20mg available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for escitalopram 20mg 1 capsule daily. -Resident #6's escitalopram 20mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26.	{D 358}		

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{D 358}	Continued From page 6 Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. e. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for omeprazole DR 20 mg one tablet every day (used to treat heartburn and acid reflux). Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include omeprazole DR 20 mg to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for omeprazole DR 20 mg 1 capsule daily. -Omeprazole DR 20 mg was not documented as administered on 07/29/26. -There was no other entry for omeprazole DR 20 mg on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no omeprazole DR 20 mg available for administration. Telephone interview with the facility's contracted	{D 358}		

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{D 358}	Continued From page 7	{D 358}		

pharmacist on 07/29/26 at 1:08pm revealed:
-Resident #6 had an active order for omeprazole DR 20 mg 1 capsule twice a day.
-Resident #6's omeprazole DR 20 mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26.

Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful.

f. Review of Resident #6's current FL-2 dated 04/13/26 revealed:
-Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for QC Ocu Health with lutein two tablets every day (used to help protect eye health).

Observation of the 8:00am medication pass on 07/29/26 revealed:
-Resident #6's medications were packaged in bubble packs.
-The medication aide (MA) prepared and administered medications in a medication cup which did not include QC Ocu Health with lutein to Resident #6 at 7:25am.

Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed:
-There was an entry for QC Ocu Health with lutein 2 tablets daily.
-QC Ocu Health with lutein was not documented as administered on 07/29/26.
-There was no other entry for QC Ocu Health with lutein on the July 2026 eMAR.

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{D 358}	Continued From page 8 Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no QC Ocu Health with lutein available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for QC Ocu Health with lutein 2 tablets daily. -Resident #6's QC Ocu Health with lutein was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. g. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for Omega -3 ethyl esters 1 gm two capsules every day (used to replenish essential nutrients and support macular health to help protect the health of your eyes). Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include Omega -3 ethyl esters 1 gm to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated	{D 358}		

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{D 358}	Continued From page 9 07/01/26 - 07/29/26 revealed: -There was an entry for Omega -3 ethyl esters 1 gm 1 capsule daily. -Omega -3 ethyl esters 1 gm was not documented as administered on 07/29/26. -There was no other entry for Omega -3 ethyl esters 1 gm on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no Omega -3 ethyl esters 1 gm available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for Omega -3 ethyl esters 1 gm two capsules every day. -Resident #6's Omega -3 ethyl esters 1 gm was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. h. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for loratadine 10mg one tablet every day (used to help treat allergy symptoms). Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and	{D 358}		

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administered medications in a medication cup which did not include loratadine 10mg to Resident #6 at 7:25am.

Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed:
-There was an entry for loratadine 10mg 1 capsule daily.
-Loratadine 10mg was not documented as administered on 07/29/26.
-There was no other entry for loratadine 10mg on the July 2026 eMAR.

Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no loratadine 10mg available for administration.

Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed:
-Resident #6 had an active order for loratadine 10mg 1 capsule daily.
-Resident #6's loratadine 10mg was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26.

Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful.

i. Review of Resident #6's current FL-2 dated 04/13/26 revealed:
-Diagnoses included Type 2 diabetes mellitus, disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for vitamin D3 5000 units one capsule every day (used to help absorb calcium and essential for maintaining a healthy immune system to prevent or limit infections).

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{D 358}	Continued From page 11 Observation of the 8:00am medication pass on 07/29/26 revealed: -Resident #6's medications were packaged in bubble packs. -The medication aide (MA) prepared and administered medications in a medication cup which did not include vitamin D3 5000 units to Resident #6 at 7:25am. Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed: -There was an entry for vitamin D3 5000 units1 tablet daily for mood and behaviors. -Vitamin D3 5000 units was not documented as administered on 07/29/26. -There was no other entry for vitamin D3 5000 units on the July 2026 eMAR. Observation of Resident #6's medications on hand on 07/29/26 at 7:25am revealed there was no vitamin D3 5000 units available for administration. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -Resident #6 had an active order for vitamin D3 5000 units 1 tablet daily. -Resident #6's vitamin D3 5000 units was dispensed for 30 days on 06/01/26, 06/24/26 and 07/28/26. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. j. Review of Resident #6's current FL-2 dated 04/13/26 revealed: -Diagnoses included Type 2 diabetes mellitus,	{D 358}		

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disease of the thymus, hyperlipidemia, mild cognitive impairment of uncertain or unknown origin, essential hypertension, and peripheral vascular disease and there was an order for aspirin EC 81mg one tablet daily.

Observation of the 8:00am medication pass on 07/29/26 revealed:
-Resident #6's medications were packaged in bubble packs.
-The medication aide (MA) prepared and administered medications in a medication cup she placed the aspirin EC in a plastic sleeve and crushed it and mixed it in with chocolate pudding and administered it to Resident #6 at 7:25am.

Review of Resident #6's July 2026 electronic medication administration record (eMAR) dated 07/01/26 - 07/29/26 revealed:
-There was an entry that noted may crush appropriate meds and place in pudding or applesauce.
-There was an entry for aspirin EC (enteric coated) 81mg take one tablet daily.
-Aspirin EC 81mg was documented as administered on 07/29/26.

Observation of the medication cart on 07/29/26 at 10:29am revealed there was a laminated list of medications that should not be crushed which included aspirin (Ecotrin) modified release and noted it could be a gastric irritant.

Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed Resident #6 should not have had the enteric coated aspirin crushed because the medication would be released all at once which could cause gastric upset and possible issues with bleeding.

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{D 358}	Continued From page 13 Interview with the medication aide (MA) in the Special Care Unit (SCU) on 07/29/26 at 7:20am revealed: -Before preparing Resident #6's medications, she explained that these were all the medications that were available for administration. -She had looked in the medication room, in the overstock, and checked the cart for any other medications but Resident #6 only had 4 medications available along with his lidocaine patch 5% to be administered this morning (07/29/26). Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. Refer to interview with a MA on 07/29/26 at 7:15am. Refer to interview with a second MA on 07/29/26 at 1:31pm. Refer to interview with the Special Care Coordinator (SCC) on 07/29/26 at 8:21am. Refer to interview with the Administrator on 07/29/26 at 9:33am. 2. Review of Resident #2's current FL-2 dated 03/02/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD), acute	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL062016	A. BUILDING: _____ B. WING _____	R 07/29/2026

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{D 358}	Continued From page 14 hypoxemia, respiratory failure, and paralyzed right arm. a. Review of Resident #2's current FL-2 dated 03/02/26 revealed there was an order for Breo-Ellipta 100-25mcg inhaler, inhale one puff every day for COPD (used for treatment for chronic-obstructive pulmonary disease (COPD) and asthma and helps improve breathing). Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Breo-Ellipta 100-25mcg inhaler, inhale one puff every day for COPD -Breo-Ellipta was not documented as administered from 06/09/26 to 06/11/26. -There were entries on the exceptions page that Breo-Ellipta 100-25mcg inhaler was waiting for pharmacy from 06/09/26 to 06/11/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for Breo-Ellipta 100-25mcg inhaler, inhale one puff every day for COPD. -Breo-Ellipta was not documented as administered from 07/12/26 to 07/14/26. -There were entries on the exceptions page that Breo-Ellipta 100-25mcg inhaler was waiting for pharmacy from 07/12/26 to 07/14/26. Interview with Resident #2 on 07/28/26 at 8:50am revealed: -He had trouble breathing and used oxygen when he needed it during the day and wore oxygen mostly at night. -He knew he had been out of his inhaler (Breo-Ellipta) but didn't remember the exact dates.	{D 358}		

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{D 358}	Continued From page 15 -He had to call the pharmacy himself a couple of times to get them to send his medications to the facility. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -The pharmacy had issues with getting the Breo-Ellipta from the manufacturer to fill it. -The pharmacy had sent one refill to the backup pharmacy which should have lasted Resident #2 a month. -The pharmacy was not aware Resident #2 had been completely out of his Breo-Ellipta. -Resident #2 being without his Breo-Ellipta could have caused him to have an exacerbation of his COPD, difficulty breathing, and could have resulted in him being sent to the hospital. Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. b. Review of Resident #2's current FL-2 dated 03/02/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD), acute hypoxemia, respiratory failure, and paralyzed right arm and there was an order for Spiriva 18mcg CP-handi-haler, inhale one puff every morning (used to reduce COPD flare-ups and prevent and control asthmas symptoms). Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Spiriva 18mcg CP handi-haler, inhale one puff every morning -The Spiriva 18mcg CP handi-haler was not documented as administered from 06/09/26 to 06/11/26. -There were entries on the exceptions page that	{D 358}		

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{D 358}	Continued From page 16 for Spiriva 18mcg CP handi-haler was waiting for pharmacy from 06/09/26 to 06/11/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for Spiriva 18mcg CP handi-haler, inhale one puff every morning. -The Spiriva 18mcg CP handi-haler was not documented as administered from 07/12/26 to 07/16/26. -There were entries on the exceptions page that Spiriva 18mcg CP handi-haler was waiting for pharmacy from 07/12/26 to 07/16/26. Interview with Resident #2 on 07/28/26 at 8:50am revealed: -He had trouble breathing and used oxygen when he needed it during the day and wore oxygen mostly at night. -He knew he had been out of his inhalers (Spiriva) but didn't remember the exact dates. -He had to call the pharmacy himself a couple of times to get them to send his medications to the facility. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 1:08pm revealed: -The pharmacy had issues with getting the Spiriva from the manufacturer to fill it. -The pharmacy had sent one refill to the backup pharmacy which should have lasted Resident #2 a month. -The pharmacy was not aware Resident #2 had been completely out of his Spiriva. -Resident #2 being without his Spiriva could have caused him to have an exacerbation of his COPD, difficulty breathing, and could have resulted in him being sent to the hospital.	{D 358}		

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{D 358}	Continued From page 17 Attempted telephone interview with the facility's contracted primary care provider on 07/29/26 at 1:56pm was unsuccessful. 3. Review of Resident #4's current FL-2 dated 04/13/26 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, intellectual disabilities, obstructive sleep apnea, osteopenia, hypoxemia, and atrial extrasystoles. Review of Resident #4's provider communication form dated 06/19/26 revealed there was an order for Rocklatan, 1 drop into each eye once per day. (Rocklatan is used to reduce high eye pressure in adults with glaucoma). Review of Resident #4's ophthalmology chart note dated 06/19/26 revealed: -Her vision was blurry in both her eyes. -She saw flashes of light on the left side of her eye. -The provider explained to her that glaucoma could cause total blindness, but that risk was minimal with regular treatment. Review of Resident #4's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Rocklatan 0.02%-0.005% eye drop, instill 1 drop into both eyes at bedtime. -Rocklatan was not documented as administered from 06/23/26 to 06/30/26. -There was an entry on the exceptions page that Rocklatan was waiting for pharmacy from 06/23/26 to 06/30/26. Review of Resident #4's July 2026 eMAR revealed:	{D 358}		

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{D 358}	Continued From page 18 -There was an entry for Rocklatan 0.02%- 0.005% eye drop, instill 1 drop into both eyes at bedtime. - Rocklatan was not documented as administered from 07/01/26 to 07/16/26 and 07/21/26 to 07/28/26. -There was an entry on the exceptions page that Rocklatan was waiting for pharmacy from 07/01/26 to 07/16/26 and 07/21/26 to 07/28/26. Observation of Resident #4's medications on hand on 07/28/26 at 3:15pm revealed there were no Rocklatan 0.02%- 0.005% eye drops in the medication cart. Interview with Resident #4 on 07/29/26 at 1:16pm revealed: -She had cataracts removed. -She could see but her vision was blurry. -She had been out of an eye drop for over a month, but she did not know which one. Interview with a medication aide (MA) on 07/29/26 at 7:15am revealed: -She was aware the Rocklatan for Resident #4 was not in the facility. -She was told Resident #4's Rocklatan was not in the facility because the facility's contracted pharmacy and the backup pharmacy could not get the eye drop. -She notified the Special Care Coordinator (SCC) Resident #4 was out of her Rocklatan. Interview with a second MA on 07/29/26 at 1:31pm revealed: -She reordered Resident #4's Rocklatan but the pharmacy had not sent it. -She notified the SCC and Resident #4 that she was out of her eye drops.	{D 358}		

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{D 358}	Continued From page 19 Interview with the SCC on 07/29/26 at 8:21am revealed she did not notify Resident #4's ophthalmology provider she was out of the Rocklatan because she was not aware it was not in the facility. Interview with the Administrator on 07/29/26 at 9:33am revealed she was not aware the Rocklatan was not in the facility for Resident #4. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 10:24am revealed: -Resident #4 had an active order for Rocklatan, 1 drop in both eyes at bedtime. -Resident #4's Rocklatan was last dispensed for a 2-month supply on 05/29/26 through the backup pharmacy. -The Rocklatan was scheduled to be delivered today, 07/29/26. Telephone interview with Resident #4's ophthalmology provider on 07/29/26 at 8:00am revealed: -She was concerned Resident #4 was not administered the Rocklatan because she had a serious stage of glaucoma. -If Resident #4's glaucoma was left untreated the pressure in her eyes could be too high and cause nerve damage and loss of her vision. Refer to interview with a MA on 07/29/26 at 7:15am. Refer to interview with a second MA on 07/29/26 at 1:31pm. Refer to interview with the SCC on 07/29/26 at 8:21am. Refer to interview with the Administrator on	{D 358}		

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{D 358}	Continued From page 20 07/29/26 at 9:33am. b. Review of Resident #4's provider communication form dated 06/19/26 revealed there was an order for Systane, 1 drop into each eye twice per day. (Systane is used to treat and protect against dry eyes). Review of Resident #4's ophthalmology chart note dated 06/19/26 revealed: -She was evaluated for dry eye in the right eye and left eye. -Her vision was blurry in both her eyes. -She saw flashes of light on the left side of her eye. Review of Resident #4's July 2026 eMAR revealed: -There was an entry for Systane 0.3%- 0.4% eye drops, instill 1 drop into both eyes twice daily. -Systane was not documented as administered from 07/21/26 to 07/29/26. -There was an entry on the exceptions page that Systane was waiting for pharmacy from 07/01/26 to 07/16/26 and 07/21/26 to 07/28/26. Observation of Resident #4's medications on hand on 07/28/26 at 3:15pm revealed there were no Systane 0.3%- 0.4% eye drops in the medication cart. Interview with Resident #4 on 07/29/26 at 1:16pm revealed: -She had cataracts removed. -She could see but her vision was blurry. -She had been out of an eye drop for over a month, but she did not know which one. Interview with a medication aide (MA) on 07/29/26 at 7:15am revealed:	{D 358}		

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{D 358}	Continued From page 21 -She was aware Resident #4 was out of her Systane eye drop. -She and other MAs reordered the Systane for Resident #4, but she did not know why it had not arrived from the pharmacy. Interview with a second MA on 07/29/26 at 1:31pm revealed she notified the Special Care Coordinator (SCC) and Resident #4 that she was out of her eye drops. Interview with the SCC on 07/29/26 at 8:21am revealed: -She was aware Resident #4 did not have the Systane eye drops due to billing purposes. -She notified Resident #4's ophthalmology provider that she was out of the Systane eye drop. Telephone interview with the facility's contracted pharmacist on 07/29/26 at 10:24am revealed: -Resident #4 had an active order for Systane, 1 drop in both eyes two times per day. -Resident #4's Systane was last dispensed for 30 days on 06/22/26. Telephone interview with Resident #4's ophthalmology provider on 07/29/26 at 8:00am revealed Resident #4 was prescribed the Systane eye drop for dryness of the eyes related to her blurred vision. Refer to interview with a MA on 07/29/26 at 7:15am. Refer to interview with a second MA on 07/29/26 at 1:31pm. Refer to interview with the SCC on 07/29/26 at 8:21am.	{D 358}		

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{D 358}	Continued From page 22 Refer to interview with the Administrator on 07/29/26 at 9:33am. _____ Interview with a medication aide (MA) on 07/29/26 at 7:15am revealed: -She administered medications to the residents in the facility. -When residents were out of medications she and the other medication aides (MA)s had to immediately notify the Special Care Coordinator (SCC). Interview with a second MA on 07/29/26 at 1:31pm revealed if a residents' medication had not arrived in 3 to 5 days, the MAs were to notify the SCC. Interview with the SCC on 07/29/26 at 8:21am revealed: -She was responsible for sending medication orders to the pharmacy and auditing the medication carts. -When medications for the residents were not in the facility, the MAs should let her or the Administrator know on the day they realized the medications were missing. -If a resident was out of their medication for 24 to 48 hours, she would call the provider to let them know. -The MAs were responsible for reordering medications. -The backup pharmacy could be used but the facility's contracted pharmacy had to send the residents' information to them. Interview with the Administrator on 07/29/26 at 9:33am revealed: -She and the SCC completed medication cart audits monthly.	{D 358}		

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{D 358}	Continued From page 23 -If a resident were out of their medications within 3 days the MAs should notify the SCC or her that the medication had not been delivered and they would notify the pharmacy and alert the primary care provider (PCP) the medication had not been administered. -She expected medications to always be in the facility for the residents. Interview with the Administrator on 07/29/26 at 9:33am revealed: -She and the SCC completed medication cart audits monthly. -If a resident were out of their medications within 3 days the MAs should notify the SCC or her that the medication had not been delivered and they would notify the pharmacy and alert the primary care provider (PCP) the medication had not been administered. -She expected medications to always be in the facility for the residents. _____ The facility failed to ensure medications were administered as ordered to 1 of 3 residents (#6) observed during the medication pass on 07/29/26 (Resident #6) did not receive 9 of his scheduled medications which included medications used to treat bipolar I disorder, used to lower cholesterol, used to treat heart failure, high blood pressure (hypertension), or hypokalemia (low potassium levels in the blood), used to treat certain types of depression and anxiety, used to treat acid reflux, used to help protect eye health, used to treat allergy symptoms, and used to help absorb calcium and essential for maintaining a healthy immune system to prevent or limit infection. Resident #6 also received enteric coated aspirin that was crushed and could have caused gastric upset and bleeding and to 2 of 5 sampled residents (#2, #4) Resident #2 who was on oxygen who missed 6 doses of a medication used	{D 358}		

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{D 358}	Continued From page 24 for treatment for chronic-obstructive pulmonary disease (COPD) and 8 doses of a medication used to reduce COPD flare-ups, and Resident #4 missed 34 doses of a medication used to reduce high eye pressure which could result in the loss of vision if not treated. These failures resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 28, 2026.	{D 358}		