STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(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 an annual and follow up survey on 02/06/25 and 02/07/25.	D 000		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure observation of the resident actually taking the medication was completed by the medication aide (MA) prior to documenting on the Medication Administration Record (MAR) for 1 of 4 sampled residents (#4). The findings are: Review of the facility's Medication Management policy dated 05/11/22 revealed: -Under Distributing Medication, all medication is to be distributed according to the prescriber's orders. -It is the responsibility of the person distributing the medication to make sure the resident has taken the medication. -Under Basic Guidelines for Medication Services, the resident should be observed taking the	D 366		

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medication.
-Medication should never be left on the table or nightstand for the resident to take later.
-After distributing medication, the MAR should be initialed and signed by the person distributing the medication; indicate the appropriate date and time, and/or what happened if resident did not take the medication.

Review of Resident #4's current FL-2 dated 05/06/24 revealed diagnoses included cerebrovascular accident (CVA), aphasia and right arm weakness.

Review of Resident #4's physician's order sheet dated 09/03/24 revealed:
-There was an order for Acetaminophen 325mg Take 2 tablets twice a day at 8:00am and 8:00pm. (Acetaminophen is used to treat pain.)
-There was an order for Aspirin low dose delayed release 81mg Take 1 tablet every day at 8:00am. (Aspirin is used to lower the risks of heart attack, stroke, or blood clot.)
-There was an order for Famotidine 40mg Take 1 tablet every day at 8:00am. (Famotidine is used to treat indigestion.)
-There was an order for Hydrochlorothiazide 12.5mg Take 1 tablet every morning at 8:00am. (Hydrochlorothiazide is used to treat high blood pressure as well as to reduce swelling related to heart, kidney, or liver disease.)
-There was an order for Oxybutynin Chloride 5mg Take 1 tablet twice a day at 7:00am and 8:00pm. (Oxybutynin is used to treat overactive bladder.)
-There was an order for Vitamin B12 500mcg Take 1 tablet once per day at 7:00am. (Vitamin B12 is used to treat a Vitamin B12 deficiency.)
-There was an order for Vitamin B6 100mg Take 1 tablet every morning at 8:00am. (Vitamin B6 is used to treat Vitamin B6 deficiency.)

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D 366	Continued From page 2 -There was an order for Vitamin D3 25mcg Take 1 tablet every day at 8:00am. (Vitamin D3 is used to treat Vitamin D3 deficiency.) Review of a physician's order dated 01/21/25 revealed there was an order for Sertraline HCL 50mg Take 2 tablets in the morning. (Sertraline is used to treat depression, obsessive compulsive disorder, and post-traumatic stress disorder.) Review of Resident #4's February 2025 electronic medication administration records (eMAR) revealed: -There was a printed entry for Acetaminophen 325mg Take 2 tablets twice a day scheduled for administration at 8:00am and 8:00pm daily. There was documentation for administration of the 8:00am scheduled dose for 02/06/25. -There was a printed entry for Aspirin low dose delayed release 81mg Take 1 tablet every day scheduled for administration at 8:00am. There was documentation for administration of the 8:00am scheduled dose for 02/06/25. -There was a printed entry for Famotidine 40mg Take 1 tablet every day scheduled for administration at 8:00am. There was documentation for administration of the 8:00am scheduled dose for 02/06/25. -There was a printed entry for Hydrochlorothiazide 12.5mg Take 1 tablet every morning scheduled for administration at 8:00am. There was documentation for administration of the 8:00am scheduled dose for 02/06/25. -There was a printed entry for Oxybutynin Chloride 5mg Take 1 tablet twice a day scheduled for administration at 7:00am and 8:00pm. There was documentation for administration of the 8:00am scheduled dose for 02/06/25. -There was a printed entry for Sertraline HCL 50mg Take 1 tablet once per day scheduled for	D 366		

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administration at 9:00am. There was documentation for administration of the 9:00am scheduled dose for 02/06/25.
-There was a printed entry for Vitamin B12 500mcg Take 1 tablet once per day scheduled for administration at 7:00am. There was documentation for administration of the 7:00am scheduled dose for 02/06/25.
-There was a printed entry for Vitamin B6 100mg Take 1 tablet every morning scheduled for administration at 8:00am. There was documentation for administration of the 8:00am scheduled dose for 02/06/25.
-There was a printed entry for Vitamin D3 25mcg Take 1 tablet every day scheduled for administration at 8:00am. There was documentation for administration of the 8:00am scheduled dose for 02/06/25.

Observations of Resident #4's room on 02/06/25 at 9:02am revealed:
-There was a small clear cup with 10 pills in it sitting on the television (TV) stand in front of the TV.
-There was a clear cup filled with water sitting on the TV stand in front of the TV, next to the small clear cup of pills.
-Resident #4 took the medications at 9:04am, after being asked about the medication by the Surveyor.

Interview with the medication aide (MA) on 02/06/25 at 9:08am and 4:52pm revealed:
-She had been an MA for 7 months.
-She usually worked from 7:00pm to 7:00am but was filling in for someone today (02/06/25).
-She was the MA that administered medication to Resident #4 this morning.
-She gave Resident #4 his medication between 7:30am and 7:45am.

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-She watched him take some of the medication, but she was not sure which ones he took.
-Resident #4 poured half of the medication in his mouth and drank some water and started pouring the other half of the medication as she left.
-She did not watch Resident #4 swallow all the medication.
-The process for administering medication at other facilities was that she was supposed to watch the resident take the medication and the resident was supposed to hand everything (the pill cup and water cup) back to her.
-At this facility, she had been told by another MA that the residents were all assisted living residents so she could just sit the medication in the room and the resident would take the medication.
-She usually watched the residents take the medication and got the medication cup back from them.
-Her concern with not watching Resident #4 take the medication was the risk of him not taking the medication.
-She was not aware Resident #4 did not take all of the medication.
-The medications that had been put in Resident #4's cup was Acetaminophen, Aspirin, Famotidine, Hydrochlorothiazide, Oxybutynin, Sertraline, Vitamin B12, Vitamin B6, and Vitamin D3.
-When completing the eMAR, she was supposed to go to each medication and sign off after she saw Resident #4 take the medication.
-She thought Resident #4 was going to take and had taken the medication.
-She should have waited to see him take the medication before documenting that the medication had been administered.

Interview with the facility's Registered Nurse (RN)

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D 366	Continued From page 5 on 02/06/25 at 9:26am and 4:32pm revealed: -The MA was responsible for administering medication to the residents. -The MA pulled the medication up on the computer and compared the medication to what was on the screen. -The water and the medication were given to the resident. -The MA watched the resident take the medication. -The MA takes the medication cup from the resident or the resident throws the cup in the trash. -The medication was documented on the eMAR as administered after each medication was observed as taken. -She was not aware Resident #4 was not observed taking his medication. -She was not aware Resident #4's medication was left in his room. -The MA should have stayed and watched him take the medication. -Her concern with Resident #4 not observed taking the medication was the risk of him not taking the medication. -Resident #4 did not have a self-administration order. Interview with the facility's RN on 02/07/25 at 12:54pm and 1:15pm revealed: -Residents were not allowed to have medication in their rooms. -She did not know why the medications were left in Resident #4's room. -She expected the MA to watch the resident take the medication before walking out of the room. Interview with the Administrator on 02/07/25 at 1:51pm revealed: -The MA was supposed to use the eMAR to	D 366		

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D 366	Continued From page 6 identify the resident. -The medications were to be pulled once the MA reached the resident's room. -The medications were supposed to be given to the resident in a cup. -The MA was supposed to make sure the medication had been taken before documenting on the eMAR that the medication had been administered. -The MA should have watched Resident #4 take the medication. -The concern was that the MA did not make sure Resident #4 took the medication. -She was concerned about whether Resident #4 would have remembered to take the medication. -The medication should not have been left unsecured. -She was not aware the medication was left in Resident #4's room. -She did not know why the medication was left in Resident #4's room. -MA's were trained when hired on medication administration. Based on observation, interviews and record reviews it was determined that Resident #4 was not interviewable. Attempted interview with Resident #4's primary care provider (PCP) on 02/06/25 at 4:16pm and 02/07/25 at 10:38am was unsuccessful.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 7 (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 4 sampled residents (#2) pertaining to a topical skin and scalp medication documented as administered twice daily but was ordered and administered three times per week. The findings are: Review of the facility's Medication Management policy dated 05/11/22 revealed: -Under the Administration of Medication heading, documentation is required to include medication name and dosage, time taken or the resident's inability or refusal to take the medication according to the prescription.	D 367		

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D 367	Continued From page 8 -Observe whether the medication was taken but do not force the resident to take the medication. -Under the Daily Medication Records heading, the company utilizes a medication record for all residents included in the community's medication assistance program. -The medication record requires staff notation and signature of medications distributed on its chart with date, time taken, refused or medication errors like missed dose identified. -The General Manager is responsible for routine monitoring of the record to ensure full and timely compliance with the requirements of staff completion each time medication is indicated. -The record will include name of the resident, known allergies, name and phone number of the health care provider, name, strength, and specific instructions for the medication. -A chart for staff who provide assistance or administration to record, initials, time and date when medications are taken, refused or a medication error is identified. -The staff providing the assistance or administration of medications are to update the medication administration record (MAR) each time the medication is offered or taken. -Under the Basic Guidelines for Medication Services heading included medications should be distributed based on the provider's orders. -The resident should be observed actually taking the medication. -After distributing medication, the MAR should be initialed and signed by the person distributing the medication. Review of Resident #2's current FL-2 dated 05/10/24 revealed diagnoses included hypertension, hyperlipidemia, frequent falls, avascular necrosis of the hip, pulmonary embolism and cognitive decline.	D 367		

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D 367	Continued From page 9 Review of Resident #2's signed physicians order sheet dated 05/10/24 revealed an order for clobetasol propionate external solution 0.05% (clobetasol propionate solution is used to treat certain skin and scalp conditions, such as psoriasis, dermatitis, and rash), apply to scalp three times per week for maintenance. Review of Resident #2's signed physicians order sheet dated 08/30/24 revealed an order for clobetasol propionate external solution 0.05%, apply to scalp three times per week for maintenance. Observation of Resident #2's medications on hand on 02/06/25 at 4:54pm revealed there was a 50 milliliter (ml) bottle of clobetasol propionate solution 0.05% dispensed on 10/14/24 labeled with the resident's name and instructions to apply to scalp 3 times per week for maintenance. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/25 at 8:51am revealed clobetasol propionate solution 0.05% was dispensed for Resident #2 on 10/14/24 for a 50 ml bottle with the instructions to apply to scalp three times a week for maintenance. Review of Resident #2's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for clobetasol propionate external solution 0.05%, apply to scalp three times a week for maintenance, scheduled at 9:00am and 9:00pm daily. -Clobetasol propionate external solution 0.05% was documented as administered at 9:00am on 12/01/24 through 12/31/24.	D 367		

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D 367	Continued From page 10 -Clobetasol propionate external solution 0.05% was documented as administered at 9:00pm on 12/01/24 through 12/13/24. -Clobetasol propionate external solution 0.05% was documented as not administered at 9:00pm on 12/14/24, with the exception documented as "Resident Refused". -Clobetasol propionate external solution 0.05% was documented as administered at 9:00pm on 12/15/24 through 12/31/24. Review of Resident #2's January 2025 eMAR revealed: -There was an entry for clobetasol propionate external solution 0.05%, apply to scalp three times a week for maintenance, scheduled at 9:00am and 9:00pm daily. -Clobetasol propionate external solution 0.05% was documented as administered at 9:00am on 01/01/25 through 01/30/25. -Clobetasol propionate external solution 0.05% was documented as administered at 9:00pm on 01/01/25 through 01/30/25. -Clobetasol propionate external solution 0.05% was documented not administered on 01/31/25 at 9:00am and 9:00pm with the exception documented as discontinued. Interview with Resident #2 on 02/07/25 at 1:40pm revealed: -He used clobetasol for dry skin. -He did not use clobetasol daily. -He was not sure how often he used clobetasol, he would let the medication aide (MA) know when he needed it, and they would give it to him. Interview with an MA on 02/06/25 at 4:45pm revealed the MAs were to document on the eMAR after observing a resident take or use their medications.	D 367		

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D 367	Continued From page 11 Interview with a second MA on 02/07/25 at 9:49am revealed: -The MAs should only document on the eMAR after observing a resident take or use a medication. -Resident #2 did not receive clobetasol propionate twice daily as documented on his December 2024 and January 2025 eMAR. -Resident #2 received clobetasol three times per week, when Resident #2 needed the clobetasol, she put the solution in a medication cup and gave it to him to apply. -She was not sure why Resident #2's December 2024 and January 2025 eMAR had clobetasol propionate solution scheduled for twice daily instead of three times a week. -She had not noticed then that Resident #2's clobetasol order did not match the eMAR entry. -When a medication popped up on the eMAR, the MAs checked it off. -She and the other MAs had checked Resident #2's clobetasol as administered twice per day because it popped on the eMAR. -The MAs or the facility's Registered Nurse (RN) approved orders on the eMAR system. -She should have noticed that Resident #2's clobetasol entry did not match the order. -Resident #2's clobetasol entry had been corrected on his February 2025 eMAR after the pharmacist with the facility's contracted pharmacy conducted their periodic review. Interview with the facility's RN on 02/07/25 at 12:55pm revealed: -The MAs should only document on the eMAR after a medication was administered. -She and the MAs approved orders. -She used to do monthly eMAR reviews but stopped in August 2024 because the MAs did a	D 367		

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monthly medication cart audit when the batch-filled medications came from the facility's contracted pharmacy.
-The MAs had not notified her that Resident #2's clobetasol entry on the eMAR did not match the order.
-The MAs should not have documented that clobetasol was administered twice daily and should have notified her that Resident #2's clobetasol entry on the eMAR did not match the clobetasol order.
-Resident #2's clobetasol order on his February 2025 eMAR had been corrected after the pharmacist with the facility's contracted pharmacy conducted the 90-day review.

Interview with the Administrator on 02/07/25 at 1:45pm revealed:
-The MAs were to document on the eMAR only after a medication was administered.
-The facility's RN was responsible for reviewing and approving all orders on the eMAR.
-The facility also has a regional RN that reviewed the eMARs daily for gaps and omissions.
-The facility's RN reviewed all of the residents' eMARs and orders about every 3 months, reviewing about 10 resident records per month.
-The MAs did a monthly medication cart audit when the batch filled medications came in, that included making sure medications were available for administration, checking for expired medications and comparing the eMAR to the medication labels.
-The MAs or the RN should have noticed that Resident #2's clobetasol entry on the eMAR did not match the clobetasol order.

Telephone interview with the certified medical assistant (CMA) at Resident #2's primary care physician's (PCP) on 02/07/25 at 9:19am

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	HAL025041	A. BUILDING: _____ B. WING _____	R 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(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 13 revealed the PCP last ordered clobetasol propionate for Resident #2 on 07/23/24 but it was now managed by the resident's dermatologist. Attempted telephone interview with Resident #2's Dermatologist on 02/07/25 at 9:29am was unsuccessful.	D 367		