STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	R 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(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 a follow-up survey on 07/23/25 and 07/24/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#6) during the 8:00am morning medication pass including a dietary supplement and an inhaler, and for 2 of 6 sampled residents for record review including an opioid (#7) and a vitamin supplement (#4). The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 8:00am medication pass on 07/24/25. 1. Review of Resident #6's current FL2 dated 07/18/25 revealed diagnoses included senile dementia, heart failure, hyperglycemia, and atrial	D 358		

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D 358	Continued From page 1 fibrillation. a. Review of Resident #6's current FL2 dated 07/18/25 revealed there was an order for Breo Ellipta (used to prevent wheezing) 100-25 mcg inhalant aerosol powder (AEPB) inhale 2 puffs into lungs daily. Review of Resident #6's signed physician orders dated 07/16/25 revealed there was an order for Breo Ellipta 100-25 mcg inhalant AEPB inhale 2 puffs into lungs daily (rinse mouth after use). Observation of the morning medication pass on 07/24/25 at 9:00am revealed: -The medication aide (MA) prepared 13 oral medications for administration to Resident #6. -The MA prepared Resident #6's Breo Ellipta inhaler for administration. -The MA administered Resident #6's Breo Ellipta inhaler to Resident #6. -The MA did not prompt Resident #6 to rinse her mouth with water after the Breo Ellipta inhaler was administered. -The MA administered the 13 prepared oral medications to Resident #6. -Resident #6 did not rinse her mouth with water prior to taking her oral medications with water. Observation of Resident #6's medications on hand on 07/24/25 at 8:59am revealed: -There was a Breo Ellipta inhaler dispensed on 06/11/25 available for administration. -The Breo Ellipta inhaler box was opened on 07/24/25. Review of Resident #6's July 2025 electronic medication administration record (eMAR) for 07/24/25 revealed: -There was an entry for Breo Ellipta 100-25	D 358		

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D 358	Continued From page 2	D 358		

inhalant AEPB inhale 2 puffs into lung daily (rinse mouth after use) scheduled for administration at 9:00am.
-There was documentation Breo Ellipta 100-25 inhalant AEPB was administered on 07/24/25.

Telephone interview with resident #6's primary care provider (PCP) on 07/24/25 at 4:37pm revealed:
-She was concerned Resident #6 would develop thrush if she did not rinse her mouth after using her Breo Ellipta inhaler.
-She expected facility staff to administer medications as ordered.

Interview with the MA on 07/24/25 at 2:15pm revealed she did not know Resident #6 was supposed to rinse her mouth after using her Breo Ellipta inhaler.

Interview with the Resident Care Coordinator (RCC) on 07/24/25 at 6:38pm revealed she did not know Resident #6 was administered her Breo Ellipta inhaler without rinsing her mouth after its use.

Interview with the Administrator on 07/24/25 at 7:30pm revealed she did not know Resident #6 was administered her Breo Ellipta inhaler without rinsing her mouth after its use.

Attempted telephone interview with the facility's contracted pharmacy on 07/24/25 at 6:10pm unsuccessful.

Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable.

b. Review of Resident #6's signed physician order

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D 358	Continued From page 3 dated 07/09/25 revealed there was an order to discontinue D-mannose (a dietary supplement) per family request. Observation of the morning medication pass on 07/24/25 at 9:00am revealed: -The MA prepared 13 oral medications for administration to Resident #6, including D-mannose. -The MA administered D-mannose to Resident #6. Observation of Resident #6's medications on hand on 07/24/25 at 8:59am revealed: -There was a D-mannose 500mg take 1 capsule daily medication card dispensed on 07/10/25 available for administration. -There were 27 of 28 D-mannose capsules remaining after the MA prepared the medication for administration. Review of Resident #6's July 2025 eMAR for 07/24/25 revealed: -There was an entry for D-mannose 500mg capsule take 1 capsule daily scheduled for administration at 9:00am. -There was documentation D-mannose was administered on 07/24/25. Telephone interview with Resident #6's PCP on 07/24/25 at 4:37pm revealed: -She was not aware Resident #6 was administered D-mannose on 07/24/25 after it was discontinued. -Resident #6's family member reported Resident #6 experienced an upset stomach after taking D-mannose which was why it was discontinued. Interview with the MA on 07/24/25 at 2:15pm revealed:	D 358		

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D 358	Continued From page 4 -She administered D-mannose to Resident #6 on 07/24/25. -She did not know D-mannose was discontinued for Resident #6. -The facility had just changed to a new eMAR system two days ago. -Today, 07/24/25, was her first full day using the new eMAR system. -The new eMAR system displayed Resident #6's D-mannose as an active order when she administered medications to Resident #6 on 07/24/25. -She went by the eMAR system for administering medications. -Both MAs and the RCC removed discontinued medications from the medication cart. Interview with the RCC on 07/24/25 at 6:38pm revealed: -D-mannose was discontinued for Resident #6. -She did not know Resident #6 was administered D-mannose on 07/24/25 after it was discontinued on 07/09/25. Interview with the Administrator on 07/24/25 at 7:30pm revealed she did not know Resident #6 was administered D-mannose on 07/24/25 after it was discontinued on 07/09/25. Attempted telephone interview with the facility's contracted pharmacy on 07/24/25 at 6:10pm unsuccessful. Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable. Refer to the interview with the medication aide (MA) on 07/24/25 at 2:16pm.	D 358		

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D 358	Continued From page 5 Refer to the interview with the RCC on 07/24/25 at 6:41pm. Refer to the interview with the Administrator on 07/24/25 at 7:31pm. 2. Review of Resident #7's current FL2 dated 05/02/25 revealed diagnoses included heart failure, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of Resident #7's signed physician's orders dated 05/05/25 revealed: -There was an order for morphine (an opioid used to control pain and shortness of breath) 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours (control). -There was an order for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours as needed (PRN) for pain or dyspnea (control). Review of Resident #7's signed physician orders dated 07/18/25 revealed: -There was an order of morphine 20mg/mL concentrate, administer 0.5mL (10mg) every 4 hours for pain and dyspnea. -There was an order for morphine 20mg/mL concentrate, administer 0.5mL (10mg) every 2 hours for breakthrough pain and dyspnea. Review of Resident #7's signed physician order dated 07/22/25 revealed there was an order for morphine 100mg/5mL (20mg/mL) oral solution administer 0.5mL every six hours for pain and dyspnea. Review of Resident #7's May 2025 electronic medication administration record (eMAR) from 05/06/25 to 05/31/25 revealed: -There was an entry for morphine 20mg/mL oral	D 358		

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D 358	Continued From page 6 solution administer 10mg (0.5mL) every 6 hours scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm. -Morphine was not documented as administered on 05/18/25 at 12:00pm and 6:00pm, and 05/25/25 at 12:00pm with documentation the morphine was pending pharmacy delivery. -Morphine was not documented as administered on 05/26/25 at 6:00pm, 05/27/25 at 6:00am, 05/28/25 at 6:00am and 05/29/25 at 6:00am with documentation of resident refusals. -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was a second entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was no documentation any PRN morphine was administered to Resident #7. Review of Resident #7's June 2025 eMAR revealed: -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm. -Morphine was not documented as administered on 06/01/25 at 6:00am with documentation of resident refusal. -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was documentation PRN morphine was administered on 06/09/25 at 10:20am, 06/11/25 at 2:56pm and 06/11/25 at 9:43pm. -There was a second entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was documentation PRN morphine was administered on 06/12/25 at 3:40am.	D 358		

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D 358	Continued From page 7 -There was third entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for breakthrough pain/dyspnea (control). -There was documentation PRN morphine was administered on 06/14/25 at 3:38pm, 06/17/25 at 2:21pm and 06/25/25 at 10:56pm. Review of Resident #7's July 2025 eMAR from 07/01/25 to 07/22/25 revealed: -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours for pain scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm. -Morphine was documented as administered from 07/01/25 to 07/18/25 at 12:00pm; the order entry was discontinued on the eMAR on 07/18/25. Review of Resident #7's Controlled Substance Count Sheets (CSCS) from 05/05/25 to 07/22/25 revealed: -On 05/11/25, there was no scheduled morphine administration signed out at 6:00pm for 1 dose administration. -On 05/12/25, there were no scheduled morphine administrations signed out at 12:00am, 6:00am, 12:00pm, and 6:00pm for a total of 4 dose administrations. -On 05/13/25, there was no scheduled morphine administration signed out at 12:00am. -On 05/18/25, there were no scheduled morphine administrations signed out at 6:00am, 12:00pm and 6:00pm for a total of 3 dose administrations. -On 05/19/25, there was no scheduled morphine administration signed out at 6:00pm. -On 07/02/25, there was no scheduled morphine administration signed out at 12:00am and 6:00am. Observation of Resident #7's medications on hand on 07/24/25 at 2:45pm revealed:	D 358		

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D 358	Continued From page 8 -There were 14 of 20 prefilled morphine 0.5mL syringes dispensed on 07/22/25 available for administration. -There were 18 of 20 prefilled PRN morphine 0.5mL syringes dispensed on 07/17/25 available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/25 at 4:35pm revealed: -They had a continuous prescription for morphine syringes but were only partially filling the prescription for Resident #7. -There was a pharmacy policy to only dispense 20 prefilled morphine syringes (10mL) at a time for hospice residents in long term care settings. -The pharmacy dispensed 20 prefilled morphine syringes (10mL) for Resident #7 which was a 5-day supply on 05/05/25, 05/11/25, 05/19/25, 05/28/25, 06/05/25, 06/12/25, 06/17/25, 06/20/25, 06/25/25, 07/17/25 and 07/22/25. -The pharmacy dispensed 20 prefilled PRN morphine syringes (10mL) for Resident #7 on 05/28/25, 06/12/25, 06/18/25, 06/20/25, 07/02/25, 07/09/25 and 07/17/25. -Resident #7 could have increased pain as a side effect if morphine were not administered as ordered. Interview with Resident #7 on 07/24/25 at 2:08pm revealed: -Staff administered her scheduled morphine 3 or 4 times per day. -She also had PRN morphine available if she had trouble breathing or was feeling out of breath. -She thought staff always administered her morphine and brought her morphine when she needed it. -The hospice nurse visited her about once a week.	D 358		

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D 358	Continued From page 9 Telephone interview with Resident #7's hospice nurse for the primary care provider (PCP) on 07/24/25 at 4:40pm revealed: -She was not aware Resident #7 missed 10 doses of morphine in May 2025 and 2 doses of morphine in July 2025. -The facility did not inform her that morphine was not available for administration. -She did not have access to the eMAR to know when a refill was needed. -During her last visit to the facility on 07/17/25, she asked the medication aide (MA) if the resident needed refills. -The MA informed her that the resident only had four doses of PRN morphine, so she requested a refill on 07/17/25. -The protocol was to enter a medication refill request through an electronic prescription, the PCP would write an order and then transmit the order electronically to the pharmacy. -The facility did not inform her they had difficulties getting Resident #7's morphine from the pharmacy. -Resident #7 was prescribed morphine for shortness of breath and anxiety. -A possible negative outcome of missed doses of morphine was increased shortness of breath and anxiety. Interview with a MA on 07/24/25 at 5:45pm revealed: -She administered morphine to Resident #7 two times. -Resident #7 had not run out of morphine as far as she knew. -Resident #7 had pain of 6/10 at her baseline and was always in pain. -Resident #7 had complained before of shortness of breath and pain.	D 358		

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D 358	Continued From page 10 -Resident #7 sometimes became out of breath when she used her bedside commode and transferred back to her bed. Telephone interview with a second MA on 07/24/25 at 7:00pm revealed: -She had administered morphine to Resident #7. -She was aware of Resident #7 running out of morphine. -She notified the Resident Care Coordinator (RCC) if the medication needed to be refilled. -It was the RCC's responsibility to order medications. -When the scheduled morphine was not available, she would administer Resident #7's PRN morphine. Interview with the RCC on 07/24/25 at 6:38pm revealed: -She knew Resident #7 needed her scheduled morphine. -If Resident #7 was not administered her scheduled morphine, Resident #7 would call the RCC by phone to let her know. -Resident #7 became short of breath about five hours after her last scheduled dose of morphine if she did not receive another scheduled or PRN dose. Interview with the Administrator on 07/24/25 at 7:30pm revealed: -The facility was having issues with getting Resident #7's morphine on time from the pharmacy. -She did not know Resident #7 missed ten doses of scheduled morphine in May 2025 and two doses of scheduled morphine in July 2025. -If a MA administered a narcotic or controlled medication, they should document administration on the eMAR and on the CSCS.	D 358		

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D 358	Continued From page 11 Refer to the interview with the medication aide (MA) on 07/24/25 at 2:16pm. Refer to the interview with the RCC on 07/24/25 at 6:41pm. Refer to the interview with the Administrator on 07/24/25 at 7:31pm. 3. Review of Resident #4's current FL2 dated 07/23/25 revealed diagnoses included Lewy Body dementia, hypertension, and hyperlipidemia. Review of Resident #4's signed physician's order dated 12/30/24 revealed there was an order for vitamin D3 1000 units (25mcg) take 1 tablet daily. Review of Resident #4's signed physician order dated 04/27/25 revealed there was an order to discontinue vitamin D3 1000 units (25mcg) take 1 tablet daily. Observation of Resident #4's medications on hand on 07/24/25 at 8:04am revealed there was a medication card of vitamin D3 1000 units (25mcg) take 1 tablet daily dispensed on 07/14/25 with 17 of 28 tablets remaining available for administration. Review of Resident #4's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 1000 units (25mcg) tablet take 1 tablet daily scheduled for administration at 9:00am. -There was documentation vitamin D3 1000 units was administered after it was discontinued from 05/01/25 to 05/31/25 except for 05/02/25 when Resident #4 refused vitamin D3.	D 358		

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D 358	Continued From page 12 Review of Resident #4's June 2025 eMAR from 06/01/25 to 06/30/25 revealed: -There was an entry for vitamin D3 1000 units (25mcg) tablet take 1 tablet daily scheduled for administration at 9:00am. -There was documentation vitamin D3 1000 units was administered after it was discontinued from 06/01/25 to 06/30/25 except for 06/05/25. Review of Resident #4's July 2025 eMAR from 07/01/25 to 07/22/25 revealed: -There was an entry for vitamin D3 1000 units (25mcg) tablet take 1 tablet daily scheduled for administration at 9:00am. -There was documentation vitamin D3 1000 units was administered after it was discontinued from 07/01/25 to 07/22/25 except for 07/17/25 when Resident #4 refused vitamin D3. Telephone interview with Resident #4's hospice nurse from Resident #4's hospice agency on 07/24/25 at 3:12pm revealed: -She and the hospice provider frequently discontinued non-life saving medications and vitamins when a resident was admitted to hospice. -She did not know Resident #4 was administered vitamin D3 from 05/01/25 to 07/22/25 after vitamin D3 was discontinued on 04/27/25. -There was no harm to the resident being administered vitamin D3 from 05/01/25 to 07/22/25. Interview with the medication aide (MA) on 07/24/25 at 2:15pm revealed: -She administered medications to Resident #4. -She did not know Resident #4's vitamin D3 was discontinued on 04/27/25. -Vitamin D3 was still showing as an active order	D 358		

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	HAL076005	A. BUILDING: _____ B. WING _____	R 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

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D 358	Continued From page 13 on the eMAR and she administered medications according to the eMAR. Interview with the Resident Care Coordinator (RCC) on 07/24/25 at 6:38pm revealed: -She did not know Resident #4 was still being administered vitamin D3 after it was discontinued on 04/27/25. -She thought the order entry for vitamin D3 was not removed from Resident #4's eMAR when the order was discontinued. Interview with the Administrator on 07/24/25 at 7:30pm revealed she did not know Resident #4 was administered vitamin D3 from 05/01/25 to 07/22/25 after vitamin D3 was discontinued on 04/27/25. Attempted telephone interview with the facility's contracted pharmacy on 07/24/25 at 6:10pm unsuccessful. Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable. Refer to the interview with the medication aide (MA) on 07/24/25 at 2:16pm. Refer to the interview with the RCC on 07/24/25 at 6:41pm. Refer to the interview with the Administrator on 07/24/25 at 7:31pm. _____ Interview with the medication aide (MA) on 07/24/25 at 2:16pm revealed: -The Resident Care Coordinator (RCC) faxed new orders and discontinue orders to the pharmacy most of the time.	D 358		

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-Sometimes the MAs would fax orders to the pharmacy.
-The pharmacy placed new medication order entries on the electronic medication administration record (eMAR).
-The RCC checked the eMARs to ensure orders were placed on the eMAR.
-Audits were completed but she did not know how often.

Interview with the RCC on 07/24/25 at 6:41pm revealed:
-She normally faxed or sent medication orders to the pharmacy.
-If she was not at the facility, MAs would fax medication orders.
-Sometimes providers sent an electronic prescription directly to the pharmacy, and she became aware of orders when the medication was sent to the facility.
-The third shift MA completed medication cart audits weekly.
-She thought the last time a medication cart audit was completed was sometime within the last week.

Interview with the Administrator on 07/24/25 at 7:31pm revealed:
-She expected MAs to administer and document medications as ordered and administer medications as they should be administered.
-The third shift MA completed medication cart audits and was supposed to complete them one or two times weekly.
-She did not know the last time an audit was completed.

_____

The facility failed to ensure medications were administered as ordered for 1 of 3 residents during the morning medication pass; a resident

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D 358	Continued From page 15 with an order for a Breo Ellipta inhaler was administered the inhaler without the resident being prompted to rinse their mouth with water after administration, placing the resident at risk for developing thrush, and a dietary supplement was administered to a resident after it was discontinued due to family request, placing the resident as risk for upset stomach (#6). Another resident was ordered an opioid for pain, shortness of breath, and anxiety. Ten doses of morphine were not administered according to the Controlled Substance Count Sheet (CSCS) in May 2025 and two doses were not administered in July 2025, placing the resident at risk for increased shortness of breath and anxiety (#7). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/24/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED September 7, 2025.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by:	D 392		

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D 392	Continued From page 16 Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 6 residents (#7) sampled with an order for a controlled substance used to treat pain and shortness of breath. The findings are: Review of Resident #7's current FL2 dated 05/02/25 revealed diagnoses included heart failure, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of Resident #7's signed physician's orders dated 05/05/25 revealed: -There was an order for morphine (an opioid used to control pain and shortness of breath) 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours (control). -There was an order for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours as needed (PRN) for pain or dyspnea (control). Review of Resident #7's signed physician orders dated 07/18/25 revealed: -There was an order of morphine 20mg/mL concentrate, administer 0.5mL (10mg) every 4 hours for pain and dyspnea. -There was an order for morphine 20mg/mL concentrate, administer 0.5mL (10mg) every 2 hours for breakthrough pain and dyspnea. Review of Resident #7's signed physician order dated 07/22/25 revealed there was an order for morphine 100mg/5mL (20mg/mL) oral solution administer 0.5mL every six hours for pain and dyspnea.	D 392		

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D 392	Continued From page 17 Review of Resident #7's May 2025 electronic medication administration record (eMAR) from 05/06/25 to 05/31/25 revealed: -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm. -Morphine was not documented as administered on 05/18/25 at 12:00pm and 6:00pm, and 05/25/25 at 12:00pm with documentation the morphine was pending pharmacy delivery. -Morphine was not documented as administered on 05/26/25 at 6:00pm, 05/27/25 at 6:00am, 05/28/25 at 6:00am and 05/29/25 at 6:00am with documentation of resident refusals. -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was a second entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was no documentation any PRN morphine was administered to Resident #7. Review of Resident #7's June 2025 eMAR revealed: -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm. -Morphine was not documented as administered on 06/01/25 at 6:00am with documentation of resident refusal. -There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control). -There was documentation PRN morphine was administered on 06/09/25 at 10:20am, 06/11/25 at 2:56pm and 06/11/25 at 9:43pm. -There was a second entry for morphine	D 392		

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20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for pain or dyspnea (control).
-There was documentation PRN morphine was administered on 06/12/25 at 3:40am.
-There was third entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 2 hours PRN for breakthrough pain/dyspnea (control).
-There was documentation PRN morphine was administered on 06/14/25 at 3:38pm, 06/17/25 at 2:21pm and 06/25/25 at 10:56pm.

Review of Resident #7's July 2025 eMAR from 07/01/25 to 07/22/25 revealed:
-There was an entry for morphine 20mg/mL oral solution administer 10mg (0.5mL) every 6 hours for pain scheduled for administration at 12:00am, 6:00am, 12:00pm and 6:00pm.
-Morphine was documented as administered from 07/01/25 to 07/18/25 at 12:00pm; the order entry was discontinued on the eMAR on 07/18/25.

Review of Resident #7's Controlled Substance Count Sheets (CSCS) from 05/05/25 to 07/22/25 revealed:
-There was no scheduled morphine administration signed out on 05/11/25 at 6:00pm, on 05/12/25 at 12:00am, 6:00am, 12:00pm, and 6:00pm, on 05/13/25 at 12:00am, on 05/18/25 at 6:00am, on 05/19/25 at 12:00am, 6:00am, 12:00pm and 6:00pm, on 05/20/25 at 12:00am, on 05/25/25 and 05/26/25 at 6:00am, on 06/12/25 at 6:00am, 12:00pm, and 6:00pm, and on 06/13/25 at 12:00am when administration was documented on the eMAR.
-There was no documentation Resident #7's PRN morphine syringes were used for the scheduled dose on 06/26/25 at 6:00pm, 06/27/25 at 6:00am and 12:00pm, 06/30/25 at 12:00pm and 6:00pm, and 07/01/25 at 12:00am, 6:00am,12:00pm and 6:00pm when administration was documented on

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the eMAR.
-On 07/02/25, there was no scheduled morphine administration signed out at 12:00am and 6:00am when administration was documented on the eMAR.
-There was no documentation Resident #7's PRN morphine syringes were used for the scheduled doses on 07/02/25 at 12:00pm and 6:00pm, 07/03/25 and 07/04/25 at 12:00am, 6:00am, 12:00pm and 6:00pm, 07/05/25 at 12:00am and 6:00am, 07/07/25, 07/08/25 and 07/09/25 at 12:00pm, 07/10/25, 07/11/25 and 07/14/25 at 12:00pm and 6:00pm, and from 12:00pm on 07/15/25 to 6:00am on 07/17/25 when administration was documented on the eMAR.

Observation of Resident #7's medications on hand on 07/24/25 at 2:45pm revealed:
-There were 14 of 20 prefilled morphine 0.5mL syringes dispensed on 07/22/25 available for administration.
-There were 18 of 20 prefilled PRN morphine 0.5mL syringes dispensed on 07/17/25 available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/25 at 4:35pm revealed:
-They had a continuous prescription for morphine syringes but were only partially filling the prescription for Resident #7.
-There was a pharmacy policy to only dispense 20 prefilled morphine syringes (10mL) at a time for hospice residents in long term care settings.
-The pharmacy dispensed 20 prefilled morphine syringes (10mL) for Resident #7 which was a 5-day supply on 05/05/25, 05/11/25, 05/19/25, 05/28/25, 06/05/25, 06/12/25, 06/17/25, 06/20/25, 06/25/25, 07/17/25 and 07/22/25.
-The pharmacy dispensed 20 prefilled PRN

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D 392	Continued From page 20 morphine syringes (10mL) for Resident #7 on 05/28/25, 06/12/25, 06/18/25, 06/20/25, 07/02/25, 07/09/25 and 07/17/25. Interview with Resident #7 on 07/24/25 at 2:08pm revealed: -Staff administered her scheduled morphine 3 or 4 times per day. -She also had PRN morphine available if she had trouble breathing or was feeling out of breath. -She thought staff always administered her morphine and brought her morphine when she needed it. Telephone interview with a medication aide (MA) on 07/24/25 at 7:00pm revealed: -She had administered morphine to Resident #7. -When the scheduled morphine was not available, she would administer Resident #7's PRN morphine. Interview with the Administrator on 07/24/25 at 7:30pm revealed if a MA administered a narcotic or controlled medication, they should document administration on the eMAR and on the CSCS.	D 392		