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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on May 20, 2025 through May 22, 2025.	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: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (MA) passed the written MA examination within 60 days of completion of the MA skills checklist. The findings are: Review of Staff B's personnel record revealed: -Staff B's hire date was 02/05/25. -There was documentation Staff B completed 15 hour medication aide training on 02/05/25. -Staff B completed the medication aide (MA) skills checklist on 02/17/25. -There was no documentation Staff B had taken and passed the written MA examination within 60 days of completing the MA skills checklist. Review of a resident's electronic medication	D 125		

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administration record (eMAR) for April 2025 revealed Staff B documented the administration of medication on 04/19/25-04/20/25, 04/23/25-04/24/25, 04/28/25 and on 04/29/25.

Review of a resident's eMAR for May 2025 revealed Staff B documented the administration of medication on 05/02/25-05/04/25, 05/08/25, 05/13/25-05/14/25 and on 05/17/25-05/18/25.

Interview with the Resident Care Coordinator (RCC) on 05/22/25 at 1:49pm revealed:
-She was responsible for ensuring new medication aides (MAs) successfully completed the medication aide exam with 60 days but she thought the 60 days began after all training was completed.
-She thought Staff B completed training at the end of March 2025 or beginning of April 2025.
-Staff B took the medication aide exam on 05/19/25 but was unsuccessful and was rescheduled for 05/29/25.
-It was important for MAs to be qualified to administer medications to ensure they knew what they were doing.

Interview with the Administrator on 05/22/25 at 12:57pm revealed:
-Staff B took her medication aide exam on 05/19/25 but was unsuccessful and was rescheduled to retake the exam on 05/29/25.
-The RCC was responsible for scheduling and should know when the 60 days was up for new MAs.
-She thought Staff B was within her 60 days and has continued to administer medications to residents.
-Staff B continued to work on the floor as a personal care aide after she completed the clinical skills check validation and thought the 60

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D 125	Continued From page 2 days began from the time she started administering medications but she did not know what date that was. Attempted telephone interview with Staff B on 05/22/25 at 12:45pm and 1:26pm were unsuccessful.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure follow-up to meet the acute health care needs of 1 of 5 sampled residents (#3) related to failing to inform the primary care provider (PCP) of multiple refusals of insulin and failing to report elevated fingerstick blood sugars (FSBSs) (#3). The findings are: Review of the facility's Medication Administration policy dated November 2018 included: -If a resident refuses medication, document the refusal on the medication administration record (MAR), research the refusals for the possibility of dry mouth, resident reluctance, development of swallowing difficulty. -Notification of physician/provider for persistent refusals. Review of the facility's Missed or Refused Medication policy dated September 2011	D 273		

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revealed:
-No resident can be forced to take any medication.
-Steps will be taken to avoid missed or refused doses of medication per the medication policy.
-Missed/refused medications are documented in the resident's medication administration record (MAR) and the provider, responsible party/guardian, is notified and documented.
-The medication aide (MA) and/or the Resident Care Coordinator (RCC) notifies the prescribing provider of the missed/refused medications immediately using the medication notification form after 3 consecutive refusals unless the medications are related to diabetic, coumadin, and seizures disorders.
-The RCC evaluates the resident refusals and contacts the physician and responsible party if the resident is continually refusing a medication(s) and documents the communication on the Care Coordinator Meeting progress note.

Review of the facility's Residents Receiving Diabetic Medications/Treatments policy date September 2021 included:
-Residents receiving medication/treatments for diabetic care will be monitored according to the Physician orders.
-The MA will notify the RCC of any refusals and/or abnormal results.
-The Care Coordinator will review any refusals and/or abnormal blood sugar readings and notify the provider.

Review of Resident #3's current FL-2 dated 03/12/25 revealed:
-Diagnoses included type 2 diabetes, atrial fibrillation, anxiety, hypertension and obstructive sleep apnea.
-There was an order for Novolog 70/30 (Novolog

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70/30 is a mixture of intermediate and rapid acting insulin used to treat elevated blood sugars) per sliding scale at every morning and at 8:00pm.
-There was a clarification of order attached to Resident #3 's FL2 for Fiasp FlexTouch (Fiasp is a rapid acting insulin used to treat elevated blood sugar) U-100 twice daily per sliding scale, if finger stick blood sugar (FSBS) 149 or below give 20 units, if FSBS is 150 - 250 give 25 units, if FSBS is greater than 250 give 30 units.
-There were no parameters listed for the primary care provider (PCP) notification of FSBSs.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 03/18/25.

Review of Resident #3's signed physicians order sheet dated 04/22/25 revealed:
-There was an order for Fiasp Flex touch U-100 per sliding scale, if FSBS 0-149 give 20 units, if FSBS 150-250 give 25 units, if FSBS greater than 250 give 30 units twice daily at 8:00am and 8:00pm.
-There were no parameters listed for PCP notification of FSBSs.

Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Fiasp FlexTouch U-100 insulin pen, administer per sliding scale, if FSBS is 0-149, give 20 units, if FSBS is 150 to 250 give 25 units, if FSBS is greater than 250 give 30 units, twice a day, scheduled at 8:00am and 8:00pm.
-There were no parameters listed for PCP notification of FSBSs.
-Fiasp FlexTouch was documented as refused on 03/22/25, 03/27/25 and 03/29/25 at 8:00am.

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D 273	Continued From page 5 -FSBS was documented as 339, with 30 units of Fiasp administered on 03/21/25 at 8:00pm. -FSBS was documented as 321 with 30 units of Fiasp administered on 03/27/25 at 8:00pm. -FSBS was documented as 309 with 30 units of Fiasp administered on 03/28/25 at 8:00am. -FSBS was documented as 336 with 30 units of Fiasp administered on 03/28/25 at 8:00pm. -FSBS was documented as 435 with 30 units of Fiasp administered on 03/30/25 at 8:00am. -FSBS was documented as 315 with 30 units of Fiasp administered on 03/30/25 at 8:00pm. -FSBS was documented as 416 with 30 units of Fiasp administered on 03/31/25 at 8:00pm. Review of Resident #3's electronic progress notes revealed: -There was no documentation of primary care physician (PCP) notification of Resident #3's Fiasp Flex Touch refusal on 03/22/25 and 03/27/25. -There was an entry by the medication aide (MA) of PCP notification of Resident #3's Fiasp refusal on 03/29/25 at 8:53am and Resident #3's responsible party was notified of the Fiasp refusal as well. -There was no documentation of PCP notification of elevated FSBSs. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for Fiasp FlexTouch U-100 insulin pen, administer per sliding scale, if FSBS is 0-149, give 20 units, if FSBS is 150 to 250 give 25 units, if FSBS is greater than 250 give 30 units, twice a day, scheduled at 8:00am and 8:00pm dated 04/01/25 through 04/22/25. -Fiasp FlexTouch was documented as refused on 04/06/25, 04/07/25, 04/13/25, 04/14/25, and 04/21/25 at 8:00am.	D 273		

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-Fiasp FlexTouch was documented as refused on 04/15/25, 04/16/25 and 04/17/25 at 8:00pm.
-There were no parameters listed for PCP notification of FSBSs.
-There was a second entry for Fiasp FlexTouch U-100 insulin pen, administer per sliding scale, if FSBS is 0-149, give 20 units, if FSBS is 150 to 250 give 25 units, if FSBS is greater than 250 give 30 units, twice a day, scheduled at 8:00am and 5:00pm dated 04/23/25 through 04/30/25.
-There were no parameters listed for PCP notification of FSBS.
-Fiasp FlexTouch was documented as refused on 04/24/25, and 04/25/25 at 8:00am.
-Fiasp FlexTouch was documented as refused on 04/25/25, 04/26/25, 04/27/25, and 04/30/25 at 5:00pm.
-FSBS was documented as 312 with 30 units of Fiasp administered on 04/04/25 at 8:00pm.
-FSBS was documented as 350 with 30 units of Fiasp administered on 04/06/25 at 8:00pm.
-FSBS was documented as 310 with 30 units of Fiasp administered on 04/07/25 at 8:00pm.
-FSBS was documented as 313 with 30 units of Fiasp administered on 04/10/25 at 8:00pm.
-FSBS was documented as 300 with 30 units of Fiasp administered on 04/11/25 at 8:00pm.
-FSBS was documented as 300 with 30 units of Fiasp administered on 04/14/25 at 8:00pm.

Review of Resident #3's electronic progress notes revealed there were no entries for April 2025.

Review of Resident #3's May 2025 eMAR revealed:
-There was an entry for Fiasp FlexTouch U-100 insulin pen, administer per sliding scale, if FSBS is 0-149, give 20 units, if FSBS is 150 to 250 give 25 units, if FSBS is greater than 250 give 30

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units, twice a day, with breakfast and evening meal, scheduled at 7:00am and 4:30pm.
-There were no parameters listed for PCP notification of FSBS.
-Fiasp FlexTouch was documented as refused on 05/02/25, 05/15/25, 05/16/25, 05/17/25, 05/19/25, and 05/20/25 at 7:00am.
-Fiasp FlexTouch was documented as refused on 05/01/25 at 4:30pm.
-FSBS was documented as 301 with 30 units of Fiasp administered on 05/10/25 at 4:30pm.
-FSBS was documented as 315 with 30 units of Fiasp administered on 05/17/25 at 4:30pm.
-FSBS was documented as 321 with 30 units of Fiasp administered on 05/19/25 at 4:30pm.

Review of Resident #3's electronic progress notes revealed:
-There was an entry on 05/05/25 at 10:40am that Resident #3's Responsible Party was notified regarding his insulin refusals.
-There was no documentation of PCP notification of his insulin refusals.
-There was no documentation of PCP notification of elevated FSBSs.

Interview with Resident #3 on 05/22/25 at 8:00am revealed:
-He had been treated for diabetes since 1995.
-He was on a sliding scale insulin.
-He was also on a long-acting insulin as well.
-He did not refuse his insulin.
-If his blood sugar was less than 150, he told staff that he did not want his sliding scale insulin because he did not want his blood sugar to bottom out.
-He had a continuous glucose monitor and he kept an eye on his blood sugar levels.
-His blood sugars ran on the high side.
-He felt sluggish if his blood sugar was too high or

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too low.
-He thought his blood sugars had been pretty good.

Interview with the medication aide (MA) on 05/21/25 at 7:11am revealed:
-If a resident refused their medications, the refusal was documented on the resident's eMAR,
-If the resident refused 3 consecutive times, the resident's PCP was notified by either fax or phone.
-The MAs or the RCC were responsible for notifying the PCP of the residents' medication refusals.
-He had notified Resident #3's PCP previously about Resident #3 refusing his insulin.
-Resident #3 went out to see his PCP and his PCP's office was very difficult to get in touch with.
-Resident #3 usually refused his morning dose of sliding scale insulin,
-When Resident #3 refused his insulin, he would try to talk him into taking it.

Second interview with the MA 0n 05/21/25 at 1:47pm revealed:
-He thought he had contacted Resident #3's PCP in the past about elevated FSBSs but was not certain.
-There were no parameters to contact the PCP for Resident #3's FSBSs.

Interview with the Resident Care Coordinator (RCC) on 05/22/25 at 8:14am revealed:
-The MAs documented on the eMAR if a resident refused their medications.
-After 3 consecutive refusals, the resident's PCP was to be notified of the refusals.
-She or the MAs were responsible for notifying the residents' PCP of medication refusals.
-Resident #3 was fairly new to the facility and if

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he thought his blood sugars were too low, he would refuse his sliding scale insulin.
-She attempted to contact Resident #3's PCP about his refusals and few weeks ago.
-Resident #3's PCP was difficult to get in touch with, and she had left a message and never received a call back.
-She thought she followed up with a 2nd phone call to Resident #3's PCP either the same day or the following day but again had to leave a message.
-She did not document the phone call to Resident #3's PCP because she did not receive a response back.
-A resident's PCP should be contacted if their FSBS were outside of the parameters.
-Resident #3 did not have parameters for his FSBSs and it had not occurred to her to contact the PCP for FSBS parameters.
-She considered a FSBS of 400 or more to be high and Resident #3's PCP should have been contacted for a FSBS of 400 or above.

Second interview with the RCC on 05/22/25 at 1:34pm revealed:
-She did not have care coordinator meeting progress notes for Resident #3 regarding his medication refusals.
-She was not aware of the part of the Missed or Refused Medication policy that noted, the RCC evaluates the resident refusals and contacts the physician and responsible party if the resident was continually refusing a medication(s) and documents the communication on the Care Coordinator Meeting progress note.
-She thought it was mid-April 2025 when she tried to contact Resident #3's PCP about his refusals.
-She first contacted Resident #3's endocrinology office about his sliding scale insulin refusals but was told by the endocrine office that Resident#3's

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insulin was being handled by his PCP since Resident #3's endocrinologist was out of the office on leave.
-She contacted Resident #3's PCP by phone about his sliding scale insulin refusals but did not document the attempts because she had to leave messages.
-She should have followed up with Resident #3's PCP about his sliding insulin refusals when she did not receive a response back.
-She did not have a process in place to follow up or document phone calls made to the residents' PCP in the electronic progress notes.
-She did not perform audits of the residents' eMARs.
-The MAs had not notified her of Resident #3's elevated FSBSs above 250 or above 350.
-Usually, the nurse that performed the Licensed Health Professional Tasks (LHPS) would notify her to request parameters for FSBSs for the residents, if they were not already in place.
-It did not occur to her to contact Resident #3's PCP for parameters for his FSBSs.

Interview with the Administrator on 05/22/25 at 2:16pm revealed:
-Previously the residents' PCP was to be notified when a resident had 3 consecutive medication refusals.
-She thought the corporate office had recently changed the refusal policy for the PCP to be notified after one medication or treatment refusal.
-The MAs or the RCC were responsible for contacting the residents' PCP of medication refusals.
-It was ideal for the PCP to be notified via fax instead of phone.
-She expected all contacts and contact attempts with the PCP on the residents' behalf to be documented.

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-She knew that Resident #3 left the facility often for appointments and outings and thought the MAs often documented Resident #3's sliding scale insulin as "resident refused" instead of "resident unavailable".
-All residents receiving FSBSs should have parameters for PCP notification.
-She thought the parameters for FSBSs was to notify the PCP if the FSBS was less than 60 or greater than 300.
-If a resident did not have FSBS parameters, there was risk the resident could experience a diabetic coma caused from either the FSBS being too low or too high.
-The RCC did not perform eMAR audits.
-All residents had vital sign sheets that included FSBSs if ordered.
-The RCC was responsible for reviewing each residents' vital signs including the FSBSs sheet monthly.

Interview with the medical assistant at Resident #3's PCP's office on 05/22/25 at 8:57am revealed:
-His initial appointment was on 03/12/25 and his next appointment was on 06/24/25.
-Their office was managing Resident #3's sliding scale and long-acting insulin until his upcoming appointment with a new endocrinologist.
-There was no documentation that the facility had contacted their office regarding Resident #3's refusals of sliding scale insulin.
-There was no documentation the facility had called to notify of elevated FSBSs for Resident #3 or to request FSBS parameters.

Interview with a medical assistant at Resident #3's previous endocrinology office on 05/22/25 at 9:20am revealed:
-Resident #3 was last seen at their office on

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11/26/24.
-Resident #3 did not have a follow-up appointment there, his PCP was now managing his diabetes and insulin.
-Resident #3 had an order for Fiasp Insulin, if FSBS less than 150, give 20 units, if FSBS 150 to 250, give 25 units, if FSBS greater than 250, give 30 units in the morning and in the evening.
-There were no parameters listed, except the resident was told to call if he felt "weird" after receiving his insulin.
-There was no documentation, the facility had contacted their office regarding parameters for Resident #3's FSBS or regarding elevated FSBSs for Resident #3.

Interview with Resident #3's previous endocrinologist on 05/22/25 at 10:49am revealed:
-She treated Resident #3 for type 2 diabetes requiring insulin.
-She last saw Resident #3 on 11/26/24.
-Resident #3 was prescribed Fiasp sliding scale, to take 20 units for FSBS less than 150, take 25 units for FSBS of 150 to 250, and 30 units for FSBS greater than 250.
-She never provided FSBS parameters for Resident #3.
-She was never contacted regarding parameters for Resident #3.
-She was never contacted regarding sliding scale insulin refusals for Resident #3.
-Resident #3's FSBSs consistently ran high, and she was not really concerned about his elevated FSBSs in the 300s and 400s as this has been a pattern for him.
-She really had no concerns about the long-term effects of elevated blood sugars in someone his age, she would be more concerned about the long-term effects in someone in their 30s or 40s.
-Resident #3 was insulin resistant and when she

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D 273	Continued From page 13 saw him in November 2024, his HgbA1C was 9.5% (the normal range for HgbA1C is below 5.7%). -She would have expected to be contacted about his refusals of the sliding scale insulin to possibly explore why he was refusing and to explore other options. Attempted telephone interview with Resident #3's responsible party on 05/22/25 at 8:32am was unsuccessful. Attempted telephone interview with Resident #3's PCP on 05/22/25 at 8:57am was unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents related to weekly blood pressure checks (#2). The findings are: Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses included atherosclerotic heart disease, hypothyroidism, pulmonary nodule and	D 276		

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malignant neoplasm of the pancreas.
-There was an order to check Resident #2's blood pressure weekly.

Review of Resident #2's Resident Register revealed he was admitted to the facility on 11/25/24.

Review of Resident #2's clarification order dated 12/02/24 revealed:
-There was documentation Resident #2 was admitted on 11/25/24 and a review and clarification of medications was requested.
-17 medications were listed for review and clarification by the primary care provider (PCP) .
-There was documented response from the PCP for each medication.
-There was no documentation requesting review and clarification of blood pressure monitoring frequency sent to the PCP.

Review of Resident #2's electronic medication administration record (eMAR) for March 2025 revealed:
-There was an entry for monthly vital signs to be obtained on the 15th of the month.
-There was documentation Resident #2's pulse, respirations, blood pressure and weight were obtained on the 7:00am-3:00pm shift of 03/15/25.
-There was no entry for weekly blood pressure checks to be obtained.

Review of Resident #2's eMAR for April 2025 revealed:
-There was an entry for monthly vital signs to be obtained on the 15th of the month.
-There was documentation Resident #2's pulse, respirations, blood pressure and weight were obtained on the 7:00am-3:00pm shift of 04/15/25.
-There was no entry for weekly blood pressure

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checks to be obtained.

Review of Resident #2's eMAR for May 2025 revealed:
-There was an entry for monthly vital signs to be obtained on the 15th of the month.
-There was documentation Resident #2's pulse, respirations, blood pressure and weight were obtained on the 7:00am-3:00pm shift of 05/15/25.
-There was no entry for weekly blood pressure checks to be obtained.

Interview with Resident #2 on 05/21/25 at 10:14am revealed:
-His blood pressure was taken monthly.
-He had heart disease but did not have problems with high or low blood pressure.

Telephone interview with the medical assistant for Resident #2's primary care provider (PCP) on 05/22/25 at 9:27am revealed Resident #2 had some low blood pressure readings in the past and the the PCP ordered weekly blood pressure checks in order to monitor.

Interview with a medication aide on 05/21/25 at 10:11am revealed:
-Resident #2 was on routine monthly vital sign checks and his blood pressure was not checked weekly.
-When an order for increased blood pressure monitoring was ordered by a provider, the order was entered into to eMAR to alert staff to take the blood pressure.

Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 2:20pm revealed:
-Resident #2's blood pressure was taken monthly.
-There was no order for Resident #2 to resume

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D 276	Continued From page 16 routine monthly blood pressure monitoring after the FL-2 dated 11/12/24. Second interview with the RCC on 05/22/25 at 1:49pm revealed: -FL-2 forms for newly admitted residents were supposed to be clarified by the provider. -The clarification form dated 12/02/24 listed medications and gave providers the opportunity to continue or discontinue each medication. -There was no area on the clarification form to address blood pressure/vital signs but they could write it on the form if they chose. -She assumed vital signs for Resident #2 would be routine because the provider did not address vital signs on the medication clarification form but she assumed wrong. Interview with the Administrator on 05/22/25 at 12:57pm revealed: -The RCC was responsible for clarifying all orders on the FL-2 when a resident was admitted to the facility and ensuring all orders are implemented. -Resident #2's blood pressure should have been obtained weekly as ordered.	D 276		
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.	D 358		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#3) pertaining to a sleep aid.

The findings are:

Review of the facility's medication administration policy dated 11/18 included:
-Prior to removing the medication package/container from the medication cart/drawer, check the medication administration record (MAR) for the order.
-Prior to removing the medication from the container, check the label against the order on the MAR.
-Identify the resident before administering the medication (e.g. photo plus verbal confirmation of last name, photo and confirmation by family member, etc.
-After administration, return to cart, replace medication container (if multi-dose and doses remain) and document administration in the MAR, and controlled substance sign out record, if indicated.

Review of Resident #3's current FL-2 dated 03/12/25 revealed:
-Diagnoses included type 2 diabetes, atrial fibrillation, anxiety, hypertension and obstructive sleep apnea.
-There was an order for eszopiclone (eszopiclone is a Schedule IV drug used to treat insomnia) 3mg, take one tablet at bedtime.

Review of Resident #3's physician order sheet dated 04/22/25 revealed there was an order for eszopiclone 3mg, take one tablet at bedtime for sleep.

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D 358	Continued From page 18 Observation of Resident #3's medications on hand on 05/21/25 at 2:03pm revealed there was a bubble card of eszopiclone 3mg, to take 1 tablet at bedtime, dispensed for a quantity of 30 tablets on 05/16/25, with 30 tablets remaining. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for eszopiclone 3mg, take one tablet at bedtime scheduled for administration at 8:00pm. -Eszopiclone 3mg was documented as administered at 8:00pm on 05/01/25 through 05/16/25. -Eszopiclone 3mg was documented as "X" at 8:00pm on 05/17/25 and 05/18/25 with no exception. -Eszopiclone 3mg was documented as administered at 8:00pm on 05/19/25 and 05/20/25. Review of Resident #3 electronic controlled substance log (eCSL) on 05/21/25 at 2:40pm revealed: -There was an entry for eszopiclone 3mg on 05/17/25 an amount of 30 tablets was received for a total amount of 33 tablets. -There was no entry eszopiclone 3mg was removed from the medication cart for administration on 05/17/25. -There was no entry eszopiclone 3mg was removed from the medication cart for administration on 05/18/25. -There was an entry on 05/19/25 and 05/20/25 that eszopiclone 3mg was signed out and administered. -There was a balance of 31 eszopiclone tablets on 05/20/25 at 2:40pm.	D 358		

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-There was a discrepancy of one tablet of eszopiclone, with the eCSL showing a balance of 31, and there were 30 remaining eszopiclone tablets found to be on hand and available for Resident #3.

Review of Resident #3's progress notes revealed there were no entries for 05/17/25 or 05/18/25.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/21/25 at 3:24pm revealed:
-Eszopiclone 3mg was dispensed for Resident #3 on 03/19/25 for a quantity of 30 tablets for a 30-day supply.
-Eszopiclone 3mg was dispensed for Resident #3 on 04/12/25 for a quantity of 30 tablets for a 30-day supply.
-Eszopiclone 3mg was last dispensed for Resident #3 on 05/16/25 for a quantity of 30 tablets for a 30-day supply.

Telephone interview with a medication aide (MA) on 05/21/25 at 4:18pm revealed:
-She worked as the MA on the 3:00pm to 11:00pm shift on 05/17/25 and 05/18/25.
-She administered eszopiclone 3mg to Resident #3 at 8:00pm on both 05/17/25 and 05/18/25.
-She was certain she had documented administration of Resident #3's eszopiclone 3mg on both the eMAR and the eCSL.
-She was not sure why there was no documentation on the eMAR and eCSL that she administered eszopiclone to Resident #3 on 05/17/25 and 05/18/25.

Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 4:11pm revealed:
-A new bubble package of 30 eszopiclone 3mg tablets for Resident #3 was entered as received

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D 358	Continued From page 20 on his eCSL on 05/17/25. -When the MA entered Resident #3's 30 tablets of eszopiclone 3mg received in the eCSL on 05/17/25, the eMAR system saw this as a new order and cancelled the existing entry for eszopiclone 3mg and created a new order for eszopiclone 3mg. -She was the only one that could approve new orders in the eMAR system, and she was not at the facility on 05/17/25 and 05/18/25 returned on Monday 05/19/25 and approved the order. -There was no way the MA could document on the eMAR or eCSL on 05/17/25 and 05/18/25 that eszopiclone 3mg was administered to Resident #3. -The MA should have notified her that she was unable to document administration of Resident #3's eszopiclone on his eMAR and eCSL. -The MA should have documented on Resident 3's electronic progress notes that eszopiclone was administered to Resident #3 when she was unable to document on the eMAR or eCSL. Interview with the Administrator on 05/22/25 at 2:26pm revealed: -Medications should always be documented as administered or not administered. -When the MA was unable to document on the eMAR and eCSL, she should have contacted the pharmacy or the RCC. -When the MA was unable to document on the eMAR and eCSL, she should have documented in the residents' progress notes. Attempted telephone interview with Resident #3's PCP on 05/22/25 at 8:57am was unsuccessful.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances	D 392		

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D 392	Continued From page 21 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: Based on observations, interviews, and record reviews, the facility failed to ensure records that accurately reconciled the receipt and administration of controlled substances for 1 of 3 residents (#3) sampled with orders for a controlled substance used to treat insomnia. The findings are: Review of the facility's medication administration policy dated 11/18 included: -Prior to removing the medication package/container from the medication cart/drawer, check the medication administration record (MAR) for the order. -Prior to removing the medication from the container, check the label against the order on the MAR. -Identify the resident before administering the medication (e.g. photo plus verbal confirmation of last name, photo and confirmation by family member, etc. -After administration, return to cart, replace medication container (if multi-dose and doses remain) and document administration in the MAR, and controlled substance sign out record, if indicated. Review of the facility's controlled substance policy dated 11/18 included:	D 392		

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-Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility, in accordance with federal and states laws and regulations.
-Accurate accountability of the inventory of all controlled drugs is maintained at all times.
-When a controlled substance is administered, the licensed staff member administering the medication immediately enters the following information on the accountability record and the MAR, date and time of administration (MAR, accountability record), amount administered (accountability record), remaining quantity (accountability record), and the initial's of the staff member administering the dose, completed after the medication is actually administered (MAR, accountability record).

Review of Resident #3's current FL-2 dated 03/12/25 revealed:
-Diagnoses included type 2 diabetes, atrial fibrillation, anxiety, hypertension and obstructive sleep apnea.
-There was an order for eszopiclone (eszopiclone is a scheduled IV drug used to treat insomnia) 3mg, take one tablet at bedtime.

Review of Resident #3's physician order sheet dated 04/22/25 revealed there was an order for eszopiclone 3mg, take one tablet at bedtime for sleep.

Observation of Resident #3's medications on hand on 05/21/25 at 1:47pm revealed there was a bubble card of eszopiclone 3mg, to take 1 tablet at bedtime, dispensed for a quantity of 30 tablets on 05/16/25, with 30 tablets remaining.

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D 392	Continued From page 23 Review of Resident #3's electronic controlled substance log (eCSL) on 05/21/25 at 2:40pm revealed there was a balance of 31 tablets of eszopiclone 3mg. Review of Resident #3's progress notes revealed there were no entries for 05/17/25 or 05/18/25. Interview with a medication aide (MA) on 05/21/25 at 2:41pm revealed there was no additional eszopiclone on the medication cart for Resident #3. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/21/25 at 3:24pm revealed: -Eszopiclone 3mg was dispensed for Resident #3 on 03/19/25 for a quantity of 30 tablets for a 30-day supply. -Eszopiclone 3mg was dispensed for Resident #3 on 04/12/25 for a quantity of 30 tablets for a 30-day supply. -Eszopiclone 3mg was last dispensed for Resident #3 on 05/16/25 for a quantity of 30 tablets for a 30-day supply. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for eszopiclone 3mg, take one tablet at bedtime scheduled for administration at 8:00pm. -Eszopiclone 3mg was documented as administered at 8:00pm on 05/01/25 through 05/16/25. -Eszopiclone 3mg was documented as "X" at 8:00pm on 05/17/25 and 05/18/25 with no exception documented. -Eszopiclone 3mg was documented as administered at 8:00pm on 05/19/25 and 05/20/25.	D 392		

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D 392	Continued From page 24 Review of Resident #3's eCSL for eszopiclone for May 2025 revealed: -There was an entry on 05/01/25 through 05/16/25 that eszopiclone was signed out and administered. -There was a balance of 3 eszopiclone 3 mg tablets on 05/16/25. -There was an entry on 05/17/25 at 12:12pm that 30 tablets of eszopiclone 3mg were received for a balance of 33 tablets. -There was no documentation on 05/17/25 and 05/18/25 that eszopiclone was removed from the medication cart and administered. -There was an entry on 05/19/25 at 8:58am that 33 tablets of eszopiclone 3mg were returned for a balance of 0 tablets. -There was an entry on 05/19/25 at 8:58am that 33 tablets of eszopiclone 3mg were received for a balance of 33 tablets. -There was an entry on 05/19/25 and 05/20/25 that eszopiclone 3mg was signed out and administered. -There was a balance of 31 eszopiclone tablets on 05/20/25 at 2:40pm. -There was a discrepancy of one tablet of eszopiclone, with the eCSL showing a balance of 31, and there were 30 remaining eszopiclone tablets found to be on hand and available for Resident #3. Telephone interview with a medication aide (MA) on 05/21/25 at 4:18pm revealed: -She worked as the MA on the 3:00pm to 11:00pm shift on 05/17/25 and 05/18/25. -She administered eszopiclone 3mg to Resident #3 at 8:00pm on both 05/17/25 and 05/18/25. -She was certain she had documented the administration of Resident #3's eszopiclone 3mg on the eCSL.	D 392		

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D 392	Continued From page 25 -She was not sure why there was no documentation on the eCSL that she administered eszopiclone to Resident #3 on 05/17/25 and 05/18/25. Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 4:11pm revealed: -A new bubble package of 30 eszopiclone 3mg tablets for Resident #3 was entered as received on his eCSL on 05/17/25. -When the MA entered Resident #3's 30 tablets of eszopiclone 3mg received in the eCSL on 05/17/25, the eMAR system saw this as a new order and cancelled the existing order for eszopiclone 3mg and created a new order for eszopiclone 3mg. -The MA that worked on 05/17/25 and 05/18/25 probably administered Resident #3's eszopiclone but was unable to document in the eCSL due to the order being cancelled. -There was no way the MA could document on the eMAR or eCSL on 05/17/25 and 05/18/25 that eszopiclone 3mg was administered to Resident #3. -When she returned to the facility on 05/19/25 she documented Resident #3's 33 remaining eszopiclone tablets as returned and then documented the 33 eszopiclone tablets as received and approved the order. -She felt it was possible that she entered the received amount of Resident #3's eszopiclone on 05/19/25 incorrectly. -The MA should have notified her that she was unable to document the administration of Resident #3's eszopiclone on his eCSL. -The MA should have documented on Resident 3's electronic progress notes that eszopiclone was administered to Resident #3 when she was unable to document on the eCSL.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL069002	A. BUILDING: _____ B. WING _____	R 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF PAMLICO	22 MAGNOLIA WAY GRANTSBORO, NC 28529

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D 392	Continued From page 26 Second interview with the RCC on 05/22/25 at 1:54pm revealed: -On 05/19/25, when she re-entered the amount of eszopiclone received for Resident #3 on the eCSL, she felt she must have entered the amount incorrectly. -She did not check the medication cart to see how many tablets of eszopiclone were available for Resident #3. -It was important that the eCSL be accurate to ensure the residents received their medications. Interview with the Administrator on 05/22/25 at 2:26pm revealed: -Controlled medications should always be signed out on the eCSL. -When the MA was unable to document on the eCSL, she should have contacted the pharmacy or the RCC. -When the MA was unable to document on the eCSL, she should have documented in the residents' progress notes. -She expected the eCSL to be accurate to reflect the eCSL balance should match the medication on hand to ensure the residents received their medications as ordered. .	D 392		