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	HAL086008	A. BUILDING: _____ B. WING _____	C 07/17/2025

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TWELVE OAKS	1297 GALAX TRAIL MOUNT AIRY, NC 27030

(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 and the Surry County Department of Social Services (DSS) conducted an annual survey and complaint investigation from 07/15/25 through 07/17/25.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a clean and uncluttered environment for 1 of 29 resident rooms on the special care unit (SCU) related to a soiled shower curtain and a soiled bedside commode. The findings are: Observations during the initial facility tour on 07/15/25 at approximately 9:38am revealed multiple brown and yellow stains on the bedside toilet seat beside a resident's bed in room #51 and multiple brown stains on the shower curtain in the bathroom of resident room #51.	D 079		

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D 079	Continued From page 1 Based on observations and interviews, the resident who resided in room #51 was not interviewable. Attempted interview with the family member of the resident who resided in room #51 on 07/16/25 at 10:03 am but was unsuccessful. Interview with a housekeeper on 07/16/25 at 9:00am revealed: -She cleaned assigned resident rooms once daily unless she was called back to address a specific issue. -She was responsible for cleaning the shower, the curtain, mirrors, floors, windows, trash cans and furniture. -Personal Care Aides (PCAs) were responsible for cleaning bedside toilets, oxygen concentrators and other medical equipment. Interview with a personal care assistant (PCA) on 07/15/25 at 2:50pm revealed: -Housekeeping is responsible for cleaning resident bathrooms. -PCAs are responsible for cleaning resident bedside toilets but there is no set cleaning schedule. -She would clean the bedside toilet by putting the seat into the shower and soaking it in hot, soapy water but she could not recall the last time the bedside toilet was cleaned. -She had not noticed stains on the shower curtain in the bathroom. Interview with a medication aide (MA) on 07/16/25 at 3:00pm revealed she only cleaned resident rooms and/or equipment when housekeeping or PCAs were unavailable.	D 079		

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D 079	Continued From page 2 Interview with the Special Care Unit Coordinator (SCUC) on 07/16/25 at 9:17am revealed: -Housekeeping, PCAs and MAs clean resident rooms and equipment. -There was no set schedule for cleaning. -She expected medical equipment such as oxygen concentrators, tubing, bedside toilets, etc. to be cleaned once or twice per week. Interview with the Administrator on 07/16/25 at 10:15am revealed: -She expected SCU staff members to complete daily tidy tasks and housekeeping to complete a deep cleaning (dusting, mopping, sweeping under bed, etc.) once per week. -Bedside toilets should be cleaned after each use and other medical equipment at least monthly. -No other staff members are responsible for cleaning except housekeeping.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain all plumbing equipment in a safe and operating condition for 1 of 29 resident rooms (#45) on the special care unit (SCU).	D 105		

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D 105	Continued From page 3 The findings are: Observations during the initial tour of the facility on 07/15/25 at approximately 9:25am revealed brown water running in the bathroom sink and shower of room #45 on the special care unit (SCU). Reviews of facility electronic mail (email) correspondence on 07/16/25 revealed: -The facility maintenance director sent an email to the corporate office on 03/31/25 @ 11:42am reporting the bottom had rusted out of one of the hot water tanks on the SCU and attached pictures of the rust that poured out. -A work order was created on 06/10/25 by the corporate office and assigned to an Upkeep Specialist, reporting a hot water tank had been inoperable for 2 weeks and a new circulator was needed on the SCU. -The facility administrator sent 3 emails to the corporate office on 06/10/25, 06/20/25 and 07/08/25 requesting updates on the repair of the water heater. Interview with the resident who resided in room #45 on 07/16/25 at 1:15pm revealed: -She took showers in her bathroom in the evenings, and her water had been warm and clean. -She had no problems with any equipment in her room or bathroom. Attempted telephone interview with a family member of the resident who resided in room #45 on 07/16/25 at 3:42pm but was unsuccessful. Interview with a housekeeper on 07/15/25 at 2:50pm revealed:	D 105		

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-A member of the housekeeping staff cleaned the bathroom in room #45 daily.
-She had not noticed brown water coming from the sink or shower.
-She would report water discoloration to the facility's maintenance director.

Interview with a personal care assistant (PCA) on 07/15/25 at 9:45am revealed:
-The resident who resided in room #45 took showers in her bathroom, usually in the evenings.
-She had not noticed brown water coming from the sink or shower.
-The PCA was responsible for making sure the water is the correct temperature and clean.

Interview with a medication aide (MA) on 07/15/25 at 9:55am revealed:
-She had not noticed brown water in the bathroom of room #45.
-She would report water discoloration to her supervisor and the maintenance director.

Interview with the Special Care Unit Coordinator (SCUC) on 07/15/25 at 10:26am revealed:
-She was made aware of a leak in the ceiling but no other issues with the water supply on the SCU.
-She would contact the maintenance director and the administrator regarding all problems on the unit.

Interview with the maintenance director on 07/16/25 at 9:10am revealed:
-The water in room #45 was brown due to rust and there was only one water heater working on the SCU.
-The working water heater was in the middle of the hallway on the SCU and when hot water ran out, rust came from the bottom of the tank into some of the residents' rooms.

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-A new circulating pump was needed to better distribute water to each room.
-Because room #45 was located at the end of the hallway, it typically experienced discoloration.
-He did not complete a work order but sent an email to the corporate office.

Interview with the county Environmental Health Specialist on 07/17/25 at 9:20am revealed:
-She could not recall her last inspection date at the facility.
-She would only test the water if the facility utilized a well.
-Minerals at the bottom of a hot water tank would not be harmful but if she noticed discolored water, she would advise the facility to have the water tested.
-Her department only tested for bacteria and since rust is not a bacterium, she did not think there were any health concerns.
-The best practice would be for the facility to have the hot water heater replaced.

Interview with Director of Environmental Health on 07/17/25 at 9:40am revealed:
-Brown water could be aesthetically unpleasant and could result in stained clothing, sinks and showers but there was usually no health concerns associated with rust.
-If the facility's water supply contained toxic levels of iron oxide (rust), the water would be sluggish and undrinkable.

Interview with Administrator on 07/15/25 at 12:20pm revealed:
-There was an issue with one of the water heaters on the SCU last week producing brown water in room #73 and a regional maintenance man came to the facility and resolved the issue.
-The facility had issues with water temperatures

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D 105	Continued From page 6 last month after undergoing a county inspection, but the maintenance director corrected the issue. -She reported that repairmen were in the facility on this date to fix the sprinkler system which could potentially affect the water supply. Interview with fire and safety inspectors on 07/15/25 at 12:40pm revealed the fire line and the domestic lines in the facility are separate and their work would never affect water in resident rooms. Second interview with the Administrator on 07/16/25 at 11:43am revealed: -She was made aware of dirty water in resident rooms on 07/07/25 and 07/15/25 only. -Two members of the corporate maintenance team were in the facility on 07/07/25 and they were notified of the issue. -She took no steps to ensure clean water was provided when rust was noticed but notified her corporate office.	D 105		
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 observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 7 sampled residents who had orders for the primary care provider (PCP) to be notified of daily weight gain of 2 pounds or a weekly weight gain of 5 pounds (#1).	D 273		

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D 273	Continued From page 7 Review of Resident #1's current FL2 dated 05/20/25 revealed diagnosis included coronary artery disease, heart failure with reduced ejection fraction, hypoxic respiratory failure, elevated troponin, type 2 diabetes, hypertension, hyperlipidemia, dementia, atrial fibrillation and chronic kidney disease. Review of Resident #1's signed physician's orders dated 05/20/25 revealed there was an order for bumetanide (used to treat fluid retention) 1mg take 2 tablets (2mg) twice daily; call provider with weight gain of 2 pounds in a day or 5 pounds in a week. Review of Resident #1's electronic medication administration record (eMAR) for July 2025 for 07/01/25 through 07/14/25 revealed there was an entry for bumetanide 1mg take 2 tablets (2mg) twice daily; call provider with weight gain of 2 pounds in a day or 5 pounds in a week. Review of Resident #1's weight summary record for 07/01/25 through 07/17/25 revealed: -There was documentation on 07/02/25 at 8:22am his weight was 170.4 pounds (it was flagged as an error). -There was documentation on 07/03/25 at 11:03am his weight was 248.2 pounds. -There was documentation on 07/04/25 at 5:14pm his weight was 246.2 pounds. -There was documentation on 07/08/25 at 10:19am his weight was 243.4 pounds. -There was documentation on 07/13/25 at 12:14pm his weight was 250.6 pounds. -There was documentation on 07/17/25 at 9:05am his weight was 249.6 pounds. -There were no weights documented on 07/01/25, 07/05/25-07/07/25, 07/09/25-07/12/25 and	D 273		

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D 273	Continued From page 8 07/14/25-07/16/25. Record reviews for Resident #1 revealed there was no documentation of contact with the PCP on 07/13/25 for a weight gain 7.2 pounds in a week. Interview with Resident #1 on 07/16/25 at 12:30pm revealed: -Staff had not weighed him every day. -According to his physician, staff were supposed to weigh him every day. -Staff had not weighed him this morning. Interview with Resident #1's PCP on 07/17/25 at 12:30pm revealed: -Resident #1 was ordered bumetanide related to his congestive heart failure. -She had not been notified of Resident #1's weekly weight gain of 7.2 pounds from 07/08/25 through 07/13/25. -She would have Resident #1's weight rechecked and ordered labs to determine if his bumetanide should be adjusted if facility would have notified her of Resident #1's weight gain. -She expected the facility staff to contact her about Resident #1's weight fluctuation of 5 pounds or more weekly to accurately adjust his bumetanide. -She expected the facility staff to follow her orders for Resident #1. Interview with a medication aide (MA) on 07/16/25 at 12:37pm revealed: -She documented the resident's vitals in a notebook when she administered medications. -Staff were supposed to contact Resident #1's PCP when his weight was more than 5 pounds. -She had notified Resident #1's PCP about his weight fluctuations but was unsure of the date.	D 273		

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D 273	Continued From page 9 Interview with the same MA on 07/17/25 at 10:40am revealed: -She had not documented Resident #1's weight in her notebook on 07/01/25 but she documented his other vitals. -She had documented Resident #1's weight in her notebook on 07/02/25 as 248 pounds not 170.4 which she entered on his vitals report. -She was not aware of Resident #1's weight gain of 7.2 pounds from 07/08/25 through 07/13/25 because she had not worked the medication cart for Resident #1 from 07/05/25 through 07/12/25 and 07/14/25 through 07/16/25. -If no weight was documented for the previous day, she just weighed Resident #2 and entered the weight in the vitals report. -She could not have compared Resident #1's daily weight If his previous days' weight was not entered by MAs. -She was not aware to review Resident #1's weekly weights and only reviewed his daily weights. Interview with a second MA on 07/16/25 at 12:45pm revealed: -She weighed Resident #1 daily when she worked and wrote his weight down on a piece of paper. -She had to go to a different area in the system to enter Resident #1's weight. -She did not remember to enter Resident #1's weights into the eMAR as it had to be entered under his vitals. -She did not keep a notebook with residents' weight. -She took Resident #1's weight today. -She did not have the paper with Resident #1's weight today as she had thrown it away. -She did not have notepapers which showed Resident #1's daily weight.	D 273		

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D 273	Continued From page 10 Interview with Resident Care Coordinator (RCC) on 07/17/25 at 11:10am revealed: -An MA informed her yesterday (07/16/25) the MA had not documented daily weights for Resident #1. -The MAs were expected to document daily weights on the morning shift. -She was not aware if the MAs had contacted the PCP about Resident #1's weight fluctuations. Second interview with the RCC on 07/17/25 at 4:55pm revealed: -She was not aware that the MAs were not documenting daily weights for Resident #1. -Staff had not informed her Resident #1 had a weight gain of 7.2 pounds from 07/08/2025 through 07/13/2025. -She had not contacted the PCP of the weight gain because she was not aware of it. -She expected the MAs to get clarification with orders. Interview with the Administrator on 07/17/25 at 5:30pm revealed: -She was not aware that Resident #1 had a weight gain of 7.2 pounds from 7/08/25 through 07/13/25 and his weights were not being documented as ordered by the PCP. -She was not aware the MAs had not contacted Resident #1's PCP about his weight gain of 7.2 pounds. -She expected the MAs to contact the PCP with Resident #1's weight gain.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care	D 286		

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D 286	Continued From page 11 Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that residents were provided with non-disposable place settings, including plates, forks, knives, spoons, and cups, during meal service when eating in their rooms. The findings are: Observation of a resident's breakfast meal service on 07/15/22 at 9:22am revealed: -The resident was served breakfast in her room. -The resident had eggs and two pancakes. -The resident had a fork and no other utensils. Observation of the lunch meal service on 07/15/25 at 12:00pm revealed: -There were 8 tables in the dining room. -At one table, 2 of 3 residents did not have a knife -A male resident at this table who did not have a knife and was having difficulty cutting his Salisbury steak with his fork. -At a second table, 1 of 3 residents did not have a knife. -At a third table, 3 of 5 residents did not have a knife. -At a fourth table, 2 of the 4 residents did not	D 286		

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have a knife.
-One of the residents at this table did not have a knife and was picking the piece of salisbury steak up with his fork to take bites.
-At a fifth table, 1 of 4 residents did not have a knife.
-At a sixth table, 4 of 4 residents did not have a knife.
-At the seventh table, 2 of 4 residents did not have a knife.

Observation of the lunch meal service on 07/15/25 at 12:39pm revealed:
-The residents were served ice cream.
-Several residents requested spoons to eat their ice cream.
-Staff members were observed telling the resident they needed to wash some spoons.
-The residents were provided with spoons.
-One resident was provided with a disposable spoon.

Observation of four residents' lunch meal service on 07/15/22 from 12:43pm-12:46pm revealed:
-The residents were served lunch in their rooms.
-The residents had salisbury steak, a baked potato cut in half, turnip greens, and a roll.
-The residents had a fork and no other utensils.
-One of the residents was using her fork and fingers to pull apart the Salisbury steak.

Interview with two residents on 07/15/25 at 12:43pm revealed they were only provided with a fork for their meals.

Interview with a third resident on 07/15/25 at 12:48pm revealed she was usually only provided a fork with her meals.

Observation of the breakfast meal service on

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07/16/25 at 7:37am revealed:
-At one table, 1 of 2 residents did not have a knife
-At a second table, 1 of 3 residents did not have a knife.
-At the third table, 5 of 5 residents did not have a knife.
-A personal care aide (PCA) brought one of the residents a knife.
-At a fourth table, 3 of the 4 residents did not have a knife.
-One of the residents at this table did not have a knife and was using her fingers and her fork to tear off pieces of her ham.
-At a fifth table, 1 of 2 residents did not have a knife.
-At the sixth table, 1 of 4 residents did not have a knife.

Interview with a resident on 07/16/25 at 10:47am revealed:
-The residents were not allowed to have a knife because they might cut someone.
-He picked his meat up and took bites off it.
-Staff members had said they were short on utensils.

Observation of two residents' breakfast meal service on 07/16/25 at 8:20am revealed:
-The residents were served breakfast in their rooms.
-The residents had sausage, hash brown patty, eggs, and fruit.
-The residents had a fork and no other utensils.

Interview with a personal care aide (PCA) on 07/16/25 at 3:19pm revealed:
-The residents who ate in their rooms were usually only provided with a fork.
-The Dietary Manager (DM) knew there was not enough silverware for all the residents to have a

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D 286	Continued From page 14 complete setting. Interview with a medication aide (MA) on 07/16/25 at 3:07pm revealed: -Sometimes the residents "just" had a fork or spoon. -Sometimes the residents used disposable silverware. Interview with the Resident Care Coordinator (RCC) on 07/16/25 at 3:38pm revealed: -She had not paid attention to the silverware served to the residents. -Ideally, the residents should be provided with a fork, a knife, and a spoon. -One day last week, she observed a meal, and most of the residents had knives. -Knives were needed to spread jelly and/or butter as well as to cut up meats. Interview with the DM 07/17/25 at 9:15am revealed: -Every resident should get a complete place setting to include a fork, spoon, and a knife. -A knife was needed even if the resident was on a chopped diet. -There had been an issue with the residents taking the silverware with them to their rooms. -She was ordering 50 more sets of silverware. -She had 95 complete sets of silverware at the end of last week. -She had the PCAs do a room sweep every week to look for missing silverware. -Disposable utensils should only be used in an emergency. Interview with the Administrator on 007/17/25 at 5:15pm revealed: -She expected every resident to be provided with a fork, knife, and spoon during meals.	D 286		

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D 286	Continued From page 15 -She was concerned that some of the residents were provided only with a fork. -She was not aware that the kitchen was low on silverware.	D 286		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 6 sampled residents (#10, #11, #13), including 2 residents who were ordered entire meal chopped (#10, #11) and a resident who was ordered chopped meats (#13). The findings are: 1. Review of Resident #11's current FL2 dated 04/29/25 revealed diagnoses included ischemic stroke, cerebrovascular disease (CVA), failure to thrive in adult, and diabetes mellitus. Review of Resident #11's signed physician's orders dated 03/0325 revealed an order for a regular diet, entire meal chopped. Review of the diet order list in the kitchen on 07/15/25 and 07/17/25 revealed Resident #3 was listed as the entire meal chopped.	D 310		

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D 310	Continued From page 16 Review of the therapeutic menu for mechanical soft chopped lunch meal on 07/15/25 revealed: -The hamburger steak with gravy should be well-cooked and ½ inch diced and the gravy should be thick, so the liquid did not separate from the solids. -The baked potato should have the skin removed. -The potato should be well cooked and cut into ½ inch pieces, mashed or scalloped. -The dinner roll should be well moistened and cut into bite-sized pieces. Observation of the lunch meal on 07/15/25 at 12:51pm revealed: -Resident #11 was served a piece of hamburger steak with gravy that was not chopped, a baked potato that was cut in half, turnip greens, and a dinner roll. -Resident #4 ate 100% of his meat and roll, 75% of his baked potato, and none of his greens. Review of the therapeutic menu for mechanical soft chopped breakfast meal on 07/16/25 revealed: -The ham should be moistened with gravy and diced into ½ inch pieces. -The hash brown patty should be served shredded, not crispy, and in a sauce such as gravy, salsa, or ketchup. Observation of the breakfast meal on 07/16/25 at 7:37am revealed: -Resident #11 was served eggs, a piece of ham, and a hash brown patty. -Resident #11 ate 100% of his egg, ham, and hash brown patty. -The ham was not chopped and was not moistened with gravy. -The hash brown patty was not shredded and was not served with a sauce.	D 310		

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D 310	Continued From page 17 Interview with Resident #11 on 07/17/25 at 10:21am revealed: -He only had "a couple of teeth". -The ham was hard for him to chew. -He did better with soft foods. -He could cut his food up himself when he had a knife, but he did not always have one. -It would help if he were served softer meat. Interview with a medication aide (MA) on 07/16/25 at 3:07pm revealed: -Resident #11 was supposed to be served a chopped diet. -When she helped with meals, Resident #11 was usually served a chopped diet. Interview with Resident #11's primary care provider (PCP) on 07/17/25 at 12:36pm revealed: -Resident #11's entire meal was supposed to be chopped because he had a CVA and his swallowing was affected. -Resident #11 was at risk for aspiration if his meal was not served as ordered. Interview with the Dietary Manager (DM) on 07/17/25 at 9:15am revealed she was not aware Resident #11's meals were not served chopped as ordered. Interview with the Resident Care Coordinator (RCC) on 07/16/25 at 3:38pm revealed: -If there was an x beside the entire meal chopped, that meant the meal should be a mechanical soft diet. -She expected diets to be served as ordered. -If she saw a meal that was served and it was not chopped, she would either cut it up herself or send it back to the kitchen.	D 310		

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D 310	Continued From page 18 Refer to the interview with the DM on 07/17/25 at 9:15am. Refer to the interview with the Administrator on 07/17/25 at 5:15pm. 2. Review of Resident #10's current FL2 dated 07/17/25 revealed: -Diagnoses included hypertension, dementia, and schizoaffective disorder. -There was an order for mechanical soft, chopped meats. Review of Resident #10's signed physician's orders dated 06/27/24 revealed an order for her entire meal to be chopped. Review of the diet order list in the kitchen on 07/15/25 and 07/17/25 revealed Resident #10 was listed as the entire meal chopped. Review of the therapeutic menu for mechanical soft chopped lunch meal on 07/15/25 revealed: -The hamburger steak with gravy should be well-cooked and ½ inch diced and the gravy should be thick, so the liquid did not separate from the solids. -The baked potato should have the skin removed. -The potato should be well cooked and cut into ½ inch pieces, mashed or scalloped. -The dinner roll should be well moistened and cut into bite-sized pieces. Observation of the lunch meal on 07/15/25 at 12:43pm revealed: -Resident #10 was served a piece of hamburger steak with gravy that was not chopped, a baked potato that was cut in half, turnip greens, and a dinner roll. -Resident #10 ate 100% of her meal.	D 310		

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D 310	Continued From page 19 Review of the therapeutic menu for mechanical soft chopped breakfast meal on 07/16/25 revealed: -The ham should be moistened with gravy and diced into ½ inch pieces. -The hash brown patty should be served shredded, not crispy, and in a sauce such as gravy, salsa, or ketchup. Observation of the breakfast meal on 07/16/25 at 8:22am revealed: -Resident #10 was served eggs, a piece of ham, and a hash brown patty. -Resident #10 ate 100 % of her egg, ham, and hash brown patty. -The ham was not chopped and was not moistened with gravy. -The hash brown patty was not shredded and was not served with a sauce. Interview with Resident #10 on 07/17/25 at 8:34am revealed: -She did not have any swallowing problems. -She said it was easier to eat her meals when she had a knife to cut the meat up. Interview with a medication aide (MA) on 07/16/25 at 3:07pm revealed: -Resident #10 was supposed to be served a chopped diet. -She did not deliver meals on 07/15/25 or 07/16/25. Interview with a personal care aide (PCA) on 07/16/25 at 3:19pm revealed: -Resident #10 was supposed to be served a chopped diet. -She could not recall if she delivered Resident #10's lunch meal on 07/15/25.	D 310		

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D 310	Continued From page 20 -She did not deliver Resident #10's breakfast meal today, 07/16/25. Interview with Resident #10's primary care provider (PCP) on 07/17/25 at 12:36pm revealed: -Resident #10's entire meal was supposed to be chopped. -She did not know why Resident #10 was on a chopped diet because that was the diet the resident was ordered when she became her PCP. -She expected Resident #10's diet to be served as ordered. Interview with the Dietary Manager (DM) on 07/17/25 at 9:15am revealed she was not aware Resident #10's meals were not served chopped as ordered. Interview with the Resident Care Coordinator (RCC) on 07/16/25 at 3:38pm revealed: -If there was an x beside the entire meal chopped, that meant the meal should be a mechanical soft diet. -She expected diets to be served as ordered. -If she saw a meal that was served and it was not chopped, she would either cut it up herself or send it back to the kitchen. Refer to the interview with the DM on 07/17/25 at 9:15am. Refer to the interview with the Administrator on 07/17/25 at 5:15pm. _____ Interview with the DM on 07/17/25 at 9:15am revealed: -She expected diets to be served as ordered. -She did not know if the issue was from the kitchen and the plate not being prepared correctly, or if, when the plate was served, the	D 310		

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resident was served the wrong plate.
-She had monitored diets being served before, and the diets were usually served as ordered.

Interview with the Administrator on 07/17/25 at 5:15pm revealed:
-She did not know resident meals were not served as ordered until after it happened.
-The dietary staff and the care staff, PCAs/MAs, were responsible for ensuring the residents' diets were served as ordered.
-She expected diets to be served as ordered.
3. Review of Resident #13's current FL2 dated 04/29/25 revealed diagnoses included dementia, hypertension (HTN), diabetes, cerebrovascular accident (CVA), and obesity.

Review of Resident #13's signed physician's orders dated 04/15/25 revealed an order for a regular diet with chopped meats.

Review of the diet order list in the kitchen on 07/15/25 and 07/17/25 revealed Resident #3 was listed as a regular diet with chopped meats.

Review of the therapeutic menu for mechanical soft chopped lunch meal on 07/15/25 revealed the hamburger steak with gravy should be well-cooked and ½ inch diced and the gravy should be thick, so the liquid did not separate from the solids.

Observation of the lunch meal on 07/15/25 at 12:45pm revealed:
-Resident #13 was served a piece of hamburger steak with gravy that was not chopped, a baked potato that was cut in half, turnip greens, and a dinner roll.
-Resident #13 ate 100% of his meat and roll, 50% of his baked potato and his greens.

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D 310	Continued From page 22 Review of the therapeutic menu for mechanical soft chopped breakfast meal on 07/16/25 revealed the ham should be moistened with gravy and diced into ½ inch pieces. Observation of the breakfast meal on 07/16/25 at 7:55am revealed: -Resident #13 was served scrambled eggs, a piece of ham, and a hash brown patty. -Resident #13 ate 100% of his egg, ham, and hash brown patty. -The ham was not chopped and was not moistened with gravy. Based on record reviews and interviews, it was determined Resident #13 was not interviewable. Attempted telephone interview with Resident #13's power of attorney (POA) was unsuccessful. Interview with Resident #13's primary care provider (PCP) on 07/17/25 at 12:36pm revealed: -She was not aware Resident #13 was on a regular diet with chopped meats. -She expected Resident #13's meal to be served as ordered. Interview with the Dietary Manager (DM) on 07/17/25 at 9:15am revealed she was not aware Resident #13's meats were not served chopped as ordered. Interview with a personal care aide (PCA) on 07/16/25 at 8:10am revealed: -She was aware Resident #13 was to be served chopped meat at every meal. -She was not aware Resident #13 was not served chopped meat on 07/15/25 for the lunch meal service and on 07/16/25 for the breakfast meal	D 310		

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service because she had not served him at either meal.
-Resident #13 should have chopped meat for every meal.

Interview with another PCA on 07/16/25 at 8:20am revealed:
-She was not aware Resident #13 was to be served chopped meat at every meal.
-She was not aware Resident #13 was not served chopped meat on 07/15/25 for the lunch meal service because she had not served him during the lunch meal.
-She was aware Resident #13 was not served chopped meat on 07/16/25 for the breakfast meal service but she was not aware he should be served chopped meat.

Interview with a medication aide (MA) on 07/16/25 at 8:30am revealed:
-Resident #13 was supposed to be served chopped meat but meats were not usually chopped when PCAs and MAs brought the dining cart from the kitchen.
-When she helped with meals, Resident #13 was usually served a chopped diet.
-She was not aware Resident #13 was not served chopped meat on 07/15/25 for the lunch meal service and on 07/16/25 for the breakfast meal service.

Interview with the Special Care Unit Coordinator (SCUC) on 07/16/25 at 8:45am revealed:
-She knew Resident #13 was to be served chopped meat at every meal.
-She was not aware Resident #13 was not served chopped meat on 07/15/25 for the lunch meal service and on 07/16/25 for the breakfast meal service.
-If PCAs and MAs saw a meal that was served

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D 310	Continued From page 24 and it was not chopped, they should either cut it up or send it back to the kitchen. -She expected diets to be served as ordered. Refer to the interview with the DM on 07/17/25 at 9:15am. Refer to the interview with the Administrator on 07/17/25 at 5:15pm. _____ Interview with the DM on 07/17/25 at 9:15am revealed: -She expected diets to be served as ordered. -She did not know if the issue was from the kitchen and the plate not being prepared correctly, or if, when the plate was served, the resident was served the wrong plate. -She had monitored diets being served before, and the diets were usually served as ordered. Interview with the Administrator on 07/17/25 at 5:15pm revealed: -She did not know resident meals were not served as ordered until after it happened. -The dietary staff and the care staff, PCAs/MAs, were responsible for ensuring the residents' diets were served as ordered. -She expected diets to be served as ordered.	D 310		
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	D 358		

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D 358	Continued From page 25 (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 4 of 7 sampled residents (#2, #4, #5, #6) related to a stool softener and laxative combination used to treat constipation (#2); a basal insulin used to treat hyperglycemia and a medication used to treat depression (#5); two medications used to treat constipation (#4); and a resident who had sliding scale insulin orders who had no documentation of how many units of insulin were administered (#6). The findings are: 1. Review of Resident #2's current FL2 dated 09/23/24 revealed diagnoses included heart failure, failure to thrive, and acute hypoxic respiratory failure. Review of Resident #2's signed physician's order dated 06/18/25 revealed there was an order for sennosides-docusate sodium (used to treat constipation) 8.6-50mg take one tablet twice daily. Review of Resident #2's signed physician's order dated 06/23/25 revealed there was an order to increase sennosides-docusate sodium 8.6-50mg to two tablets twice daily. Review of Resident #2's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for sennosides-docusate	D 358		

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sodium 8.6-50mg tablet take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation sennosides-docusate sodium take one tablet twice daily was administered on 06/18/25 and 06/19/25.
-There was no documentation sennosides-docusate sodium was administered from 06/20/25 to 06/30/25.
-There was no entry for sennosides-docusate sodium 8.6-50mg tablet take two tablets twice daily.

Review of Resident #2's physician's order dated 07/12/25 revealed:
-There was a note under the findings section, "Patient reports constipation and abdominal pain."
-There was an order to discontinue sennosides-docusate sodium 8.6mg-50mg two tablets twice daily.
-There was an order for sennosides-docusate sodium 8.6mg-50mg take 3 tablets twice daily.
-There was an order for bisacodyl suppository 10mg insert 1 suppository rectally once daily as needed (PRN) if no bowel movement for three days.
-There was a return fax message from the pharmacy, "Please note the patient is currently taking sennosides-docusate sodium 1 tablet twice daily not two tablets twice daily."
-The order was signed by a hospice nurse from Resident #2's hospice agency.

Review of Resident #2's facility progress note dated 07/13/25 revealed:
-Resident #2's hospice agency was called by a medication aide (MA) for an enema.
-Resident #2 had the enema and had a bowel movement.

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Review of Resident #2's July 2025 eMAR from 07/01/25 to 07/16/25 revealed:
-There was an entry for sennosides-docusate sodium 8.6-50mg tablet take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no entry for sennosides-docusate sodium 8.6-50mg tablet take two tablets twice daily.
-There was no documentation sennosides-docusate sodium one tablet twice daily was administered from 07/01/25 to 07/13/25.
-There was documentation sennosides-docusate sodium take one tablet twice daily was administered on 07/14/25 and 07/15/25 at 8:00am.
-There was an entry for sennosides-docusate sodium 8.6-50mg tablet take three tablets twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation sennosides-docusate sodium 8.6-50mg take three tablets twice daily was administered on 07/15/25 at 8:00pm and 07/16/25 at 8:00am.

Observation of the medications on hand for Resident #2 on 07/17/25 at 12:48pm revealed:
-There was a multiple medication dose pack dispensed on 07/14/25 containing sennosides-docusate sodium 8.6-50mg take one tablet twice daily to be administered for the week of 07/17/25 to 07/23/25.
-The sennosides-docusate sodium 8.6-50mg take one tablet twice daily was highlighted in orange on the multiple dose pack with documentation of a medication order dose change.
-There was a medication card dispensed on 07/14/25 with 15 of 20 doses remaining for sennosides-docusate sodium 8.6-50mg take

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three tablets twice daily available for administration.
-There was no multiple medication dose pack containing sennosides-docusate sodium 8.6-50mg take two tablets twice daily on the medication cart.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/17/25 at 12:05pm revealed:
-Resident #2 had a current order on file for sennosides-docusate sodium 8.6-50mg take one tablet twice daily.
-Sennosides-docusate sodium 8.6-50mg take one tablet twice daily was dispensed as part of a weekly multiple medication dose pack on 06/18/25, 06/23/25, 06/30/25, 07/07/25 and 07/14/25.
-There was no dispensing history for sennosides-docusate sodium 8.6-50mg take two tablets twice daily.
-A medication card for sennosides-docusate sodium 8.6-50mg take three tablets twice daily was dispensed on 07/14/25.
-Sennosides-docusate sodium was a stool softener and laxative combination.
-Constipation was a potential side effect if sennosides-docusate sodium was not administered as ordered by a provider.

Interview with Resident #2 on 07/17/25 at 3:25pm revealed:
-She was constipated for about a month until she had an enema on 07/13/25 administered by a hospice nurse.
-She had tried to go to the restroom and could not have a bowel movement.
-It was painful not being able to go to the restroom and she was sore.
-She felt more anxious because she had been

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unable to use the restroom and felt as if she could not function.
-Staff administered her medications but she did not know which medication she was taking.

Telephone interview with a Registered Nurse (RN) from Resident #2's hospice agency on 07/17/25 at 4:00pm revealed:
-Hospice nurses visited Resident #2 one or two times weekly.
-If Resident #2's sennosides-docusate sodium was not administered as ordered by the hospice provider, it could have caused Resident #2's constipation.
-Sennosides-docusate sodium was prescribed as a bowel regimen for constipation.

Interview with a MA on 07/17/25 at 12:30pm revealed:
-Resident #2 was administered sennosides-docusate sodium take one tablet twice daily until the order was changed to three tablets twice daily on 07/12/25.
-Resident #2's sennosides-docusate sodium was part of a multiple medication dose package and was dispensed to the facility weekly.
-Sennosides-docusate sodium take one tablet twice daily was highlighted on the multiple medication dose package as an order change on the medication cart.
-Resident #2 had an enema on 07/13/25 administered by the hospice nurse.

Interview with the Resident Care Coordinator (RCC) on 07/17/25 at 4:55pm revealed:
-She did not know Resident #2's sennosides-docusate sodium order changed from one tablet twice daily to two tablets twice daily on 06/23/25.
-She did not know Resident #2 was administered

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sennosides-docusate sodium 8.6-50mg one tablet twice daily instead of the ordered dose of two tablets twice daily from 06/23/25 to 07/12/25.
-She did not know Resident #2 had been constipated for the last few weeks and had an enema on 07/13/25 until Monday, 07/14/25.

Interview with the Administrator on 07/17/25 at 5:30pm revealed:
-She did not know Resident #2's sennosides-docusate sodium order changed from one tablet twice daily to two tablets twice daily on 06/23/25.
-She did not know Resident #2 was administered sennosides-docusate sodium 8.6-50mg one tablet twice daily instead of the ordered dose of two tablets twice daily from 06/23/25 to 07/12/25.
-She did not know Resident #2 had been constipated for the last few weeks and had an enema on 07/13/25.

Refer to the interview with the RCC on 07/17/25 at 4:55pm.

Refer to the interview with the Administrator on 07/17/25 at 5:30pm.

2. Review of Resident #5's current FL2 dated 10/28/24 revealed diagnoses included diabetes mellitus with hypoglycemia and hypokalemia.

a. Review of Resident #5's signed physician order dated 06/05/25 revealed there was an order for insulin glargine (used to treat hyperglycemia) 100 units/ml inject 10 units subcutaneously in the morning.

Review of Resident #5's lab results dated 04/15/25 revealed a hemoglobin A1C (a blood test that measures average blood sugar levels

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D 358	Continued From page 31 over the past 2-3 months) value of 7.8%. Review of Resident #5's lab results dated 06/24/25 revealed a hemoglobin A1C value of 7.2%. Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed: -There was no entry for insulin glargine 100 unit/ml, inject 10 units subcutaneously in the morning. -There was no documentation insulin glargine 10 units was administered from 06/05/25 to 06/30/25. -Resident #5's finger stick blood sugar (FSBS) ranged from 86-286. Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/16/25 revealed: -There was no entry for insulin glargine 100 unit/ml, inject 10 units subcutaneously in the morning. -There was no documentation insulin glargine 10 units was administered from 07/01/25 to 07/16/25. -Resident #5's FSBS ranged from 87-416. Observation of the medications on hand for Resident #5 on 07/17/25 at 12:25pm revealed: -There was a 3ml insulin glargine pen labeled inject 10 units subcutaneously every morning; inject 30 units subcutaneously at bedtime available for administration. -The 3ml insulin glargine pen was dispensed on 06/13/25 and opened on 07/10/25. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/17/25 at 12:05pm revealed:	D 358		

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-Resident #5 had a current order on file for insulin glargine inject 10 units in the morning and 30 units at bedtime.
-Insulin glargine was dispensed on 06/13/25 for a quantity of 12mL, or four 3mL insulin pens which was a 30-day supply if 40 units of insulin glargine were administered daily.
-Insulin glargine was also dispensed on 04/26/25 and 05/16/25.
-The insulin glargine orders were dispensed as one order but they should show up on the eMAR separately for administration purposes.

Interview with Resident #5 on 07/17/25 at 3:33pm revealed:
-Staff administered his medications.
-He was only administered insulin at night and was not administered insulin in the morning.

Interview with Resident #5's primary care provider (PCP) on 07/17/25 at 1:03pm revealed:
-She was not aware Resident #5 was not being administered insulin glargine 10 units in the morning.
-Resident #5 should have been administered 10 units of insulin glargine in the morning as ordered.
-A potential side effect of Resident #5 not being administered the 10 units of insulin glargine was hyperglycemia (elevated blood sugar).
-She expected provider orders to be followed as she wrote them.

Interview with a medication aide (MA) on 07/17/25 at 12:30pm revealed:
-Resident #5 was not administered 10 units of insulin glargine in the morning because the medication order did not populate on the eMAR.
-She had not administered insulin glargine to Resident #5 in the morning.

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D 358	Continued From page 33 Interview with the Resident Care Coordinator (RCC) on 07/17/25 at 4:55pm revealed: -She did not know Resident #5 had an order for insulin glargine 10 units in the morning until 07/17/25. -Insulin glargine was not populating on the eMAR for MAs to administer in the morning. -She expected the MAs to administer medication as ordered, including insulin glargine. Interview with the Administrator on 07/17/25 at 5:30pm revealed: -She did not know Resident #5 had an order for insulin glargine 10 units in the morning. -She expected the MAs to administer medications timely and as ordered, including insulin glargine. b. Review of Resident #5's current FL2 dated 09/23/24 revealed: -There was an order for sertraline (used to treat depression) 100mg take 1 tablet daily with 50mg to equal 150mg. -There was an order for sertraline 50mg take 1 tablet daily with 100mg to equal 150mg. Review of Resident #5's signed physician's orders dated 07/13/25 revealed: -There was an order to discontinue sertraline 150mg daily. -There was an order for sertraline 100mg daily. Review of Resident #5's July 2025 electronic medication administration record (eMAR) from 07/01/25 to 07/16/25 revealed: -There was an entry for sertraline 100mg take 1 tablet daily with 50mg to equal 150mg scheduled for administration at 8:00am. -There was an entry for sertraline 50mg take 1 tablet daily with 100mg to equal 150mg	D 358		

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scheduled for administration at 8:00am.
-There was documentation sertraline 100mg (to equal 150mg) was administered from 07/01/25 to 07/16/25.
-There was documentation sertraline 50mg (to equal 150mg) was administered from 07/01/25 to 07/16/25.

Observation of the medications on hand for Resident #5 on 07/17/25 at 12:48pm revealed:
-There was a multiple medication dose pack dispensed on 07/14/25 with a start date of 07/17/25 containing sertraline 100mg with 6 of 7 tablets remaining.
-There was a multiple medication dose pack dispensed on 07/14/25 with a start date of 07/17/25 containing sertraline 50mg with 6 of 7 tablets remaining.

Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 07/17/25 at 4:04pm unsuccessful.

Telephone interview with Resident #5's psychiatric provider on 07/17/25 at 3:53pm revealed:
-She did not know Resident #5's sertraline was not decreased from 150mg daily to 100mg daily per the order from 07/13/25.
-She decreased the sertraline from 150mg to 100mg daily as a gradual dose reduction.
-There was no potential outcome or side effect for Resident #5.

Interview with the Resident Care Coordinator (RCC) on 07/17/25 at 4:55pm revealed:
-She did not know Resident #5's sertraline was decreased from 150mg to 100mg daily on 07/13/25.
-She expected the MAs to administer medications

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D 358	Continued From page 35 as ordered, including Resident #5's sertraline. Interview with the Administrator on 07/17/25 at 5:30pm revealed: -She did not know Resident #5's sertraline was decreased from 150mg to 100mg daily on 07/13/25. -The MAs were responsible to administer medications as ordered by the provider. Refer to the interview with the RCC on 07/17/25 at 4:55pm. Refer to the interview with the Administrator on 07/17/25 at 5:30pm. 3. Review of Resident #6's current FL2 dated 10/06/24 revealed: -Diagnoses included dementia, chronic kidney disease, Alzheimer's disease, depression, gastroesophageal reflux disease, abnormal gait, muscle weakness, anemia, diabetes. -She was constantly confused. -There was an order for Finger Stick Blood Sugar (FSBS) twice daily. Review of Resident #6's physician orders dated 05/15/25, 06/15/25, and 07/15/25 revealed an order for insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject insulin subcutaneously per sliding scale at bedtime; inject 4 units if blood glucose (BG) 251-300; inject 6 units if BG 301-350; inject 8 units if BG 351-400; inject 10 units if BG 401-450; notify provider if BG greater than 450; at bedtime. Review of Resident #6's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS twice daily.	D 358		

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-There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject insulin subcutaneously per sliding scale at bedtime; inject 4 units if BG 251-300; inject 6 units if BG 301-350; inject 8 units if BG 351-400; inject 10 units if BG 401-450; notify provider if BG greater than 450; at bedtime; 08:00pm.
-There was no space in the eMAR to document the number of insulin units administered.
-There was documentation that sliding scale insulin coverage was administered on 10 occasions from 05/01/25-05/31/25, but the number of units administered was not documented.

Review of Resident #6's electronic vitals signs report for May 2025 revealed:
-There were FSBS readings documented, but the number of units administered was not documented.
-Examples are as follows:
-The FSBS reading on 05/08/25 was 332; 6 units of insulin aspart should have been administered.
-The FSBS reading on 05/11/25 was 385; 8 units of insulin aspart should have been administered.
-The FSBS reading on 05/27/25 was 432; 10 units of insulin aspart should have been administered.

Review of Resident #6's June 2025 eMAR revealed:
-There was an entry to check FSBS twice daily.
-There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject insulin subcutaneously per sliding scale at bedtime; inject 4 units if BG 251-300; inject 6 units if BG 301-350; inject 8 units if BG 351-400; inject 10 units if BG 401-450; notify provider if BG greater than 450; at bedtime; 08:00pm.
-There was no space in the eMAR to document

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the number of insulin units administered.
-There was documentation that sliding scale insulin coverage was administered on 19 occasions from 06/01/25-06/30/25, but the number of units administered was not documented.

Review of Resident #6's electronic vitals signs report for June 2025 revealed:
-There were FSBS readings documented, but the number of units administered was not documented.
-Examples are as follows:
-The FSBS reading on 06/04/25 was 302; 6 units of insulin aspart should have been administered.
-The FSBS reading on 06/12/25 was 369; 8 units of insulin aspart should have been administered.
-The FSBS reading on 06/14/25 was 372; 8 units of insulin aspart should have been administered.
-The FSBS reading on 06/15/25 was 331; 6 units of insulin aspart should have been administered.
-The FSBS reading on 06/20/25 was 421; 10 units of insulin aspart should have been administered.

Review of Resident #6's July 2025 eMAR from 07/01/25 to 07/15/25 revealed:
-There was an entry to check FSBS twice daily.
-There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject insulin subcutaneously per sliding scale at bedtime; inject 4 units if BG 251-300; inject 6 units if BG 301-350; inject 8 units if BG 351-400; inject 10 units if BG 401-450; notify provider if BG greater than 450; at bedtime; 08:00pm.
-There was no space in the eMAR to document the number of insulin units administered.
-There was documentation that sliding scale insulin coverage was administered on 8 occasions from 07/01/25-07/15/25, but the

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number of units administered was not documented.

Review of Resident #6's electronic vitals signs report dated 07/01/25-07/15/25 revealed:
-There were eight FSBS readings documented, which did not require sliding scale insulin coverage.
-Examples are as follows:
-The FSBS reading on 07/03/25 was 227; no insulin should have been administered.
-The FSBS reading on 07/06/25 was 199; no insulin should have been administered.
-The FSBS reading on 07/08/25 was 240; no insulin should have been administered.

Observation of medications on hand for Resident #6 on 07/17/25 at 8:50 am revealed there was one insulin aspart U-100 pen that had been opened on 07/15/25.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Telephone interview with the facility's contracted pharmacy on 7/17/25 at 11:55am revealed:
-Pharmacy staff added orders onto the facility's eMARs, but facility staff could make changes.
-The last 3 dispense dates for insulin apart were 02/04/25, 04/25/25 and 06/07/25.
-One pen (3mL/200units) was dispensed on each date and expired 28 days after opening.
-The current order on file at the pharmacy matched the sliding scale order on the resident's physician orders.

Interview with Resident #6's primary care provider (PCP) on 07/17/25 at 12:35pm revealed:
-She was unaware that Resident #6's insulin units

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being administered were not being documented on the eMAR
-She expected staff to document the number of units of insulin administered per order.
-If facility staff did not administer the sliding scale coverage correctly, there was the potential for either hypoglycemia or hyperglycemia.

Interview with medication aide (MA) on 07/16/25 at 4:25pm revealed:
-Resident #6's eMAR prompted her to administer insulin based on the resident's FSBS reading.
-There was no option in the eMAR system that allowed her to enter the number of insulin units administered for Resident #6.
-She was unable to document the number of insulin units administered for Resident #6 anywhere in the electronic medical record.

Interview with the MA Supervisor on 07/16/25 at 4:45pm revealed:
-She was unsure of who was responsible for entering orders onto the eMAR.
-She reported there was no option in the eMAR system that allowed staff to enter the number of insulin units administered to Resident #6 when sliding scale coverage was required.
-Staff were unable to document the number of insulin units administered for Resident #6 anywhere in the electronic medical record.

Interview with Special Care Unit Coordinator (SCUC) on 07/17/25 at 9:15am revealed:
-The facility's contracted pharmacy staff entered orders into the residents' eMAR.
-The MAs were responsible for auditing eMARs for accuracy of orders.
-The MA Supervisor was responsible for checking that entries were correct and complete.
-All eMAR notes and exceptions were listed on

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Resident #6's printed eMARs.
-She was not aware that Resident #6's insulin units being administered were not entered onto the eMARs.
-She expected MAs to document the number of insulin units administered to residents as ordered.

Interview with the Administrator on 07/17/25 at 10:20am revealed:
-The facility's contracted pharmacy was responsible for entering orders and sliding scale coverage onto eMARs.
-The MA Supervisor was responsible for checking that entries were correct and complete.
-She was not aware that Resident # 6's insulin units being administered were not entered onto the eMARs.
-She expected MAs to document the number of insulin units administered to residents as ordered.

Refer to the interview with the Administrator on 07/17/25 at 5:30pm.

4. Review of Resident #4's current FL2 dated 09/17/24 revealed diagnoses included cerebrovascular accident (CVA), embolic stroke, and hypertension.

a. Review of Resident #4's primary care provider's (PCP) after-visit summary dated 07/14/25 revealed:
-Resident #4 was seen for complaints of bloating.
-Resident #4 reported she had been bloated for the past 2-3 days.
-Resident #4 was uncertain if she was fully emptying her bowels.
-Resident #4 was experiencing excessive flatulence.
-Resident #4's past medical history included constipation.

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-The plan was to administer senna plus (a stimulant laxative used to treat constipation) for three days to address bloating and then resume use as needed.
-The new order was to give 1 tablet of sennosides-docusate Na 8.6-50mg tablet for 3 days, then resume 1 tablet as needed for constipation.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) from 07/14/25-07/17/25 revealed:
-There was an entry for senna plus 8.6-50mg take one tablet daily as needed for constipation.
-There was no other entry for senna plus.
-There was no documentation senna plus was administered from 07/14/25-07/17/25.

Observation of Resident #4's medications on hand on 07/15/25 at 2:58pm and 07/17/25 at 3:06pm revealed:
-There was a punch card for senna plus 8.6-50mg dispensed on 03/10/25 with the directions to administer daily as needed for constipation.
-There were 10 of 10 tablets remaining on the punch card.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/17/25 at 11:53am revealed:
-Resident #4 had an order for senna plus 8.6-50mg take one tablet daily as needed, dated 03/10/25.
-Senna plus had been dispensed on 03/10/25.
-There was no record of an order dated 07/14/25 for senna for Resident #4.
-Senna plus was a stimulant/stool softener, and if it was not administered as ordered, the resident could experience constipation.

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D 358	Continued From page 42 Interview with Resident #4's PCP on 07/17/25 at 12:36pm revealed: -She saw Resident #4 on 07/14/25 for bloating. -She was not sure Resident #4's bowels were emptying, which could cause bloating. -She ordered senna for Resident #4 for a few days to see how the resident was doing. -If Resident #4's senna was not administered as ordered, the resident's bloating may not resolve. Interview with Resident #4 on 07/15/25 at 4:10pm revealed: -She talked to her PCP about bloating "earlier this week". -She did not know the PCP had ordered senna for her to take for 3 days and then prn as needed. -She had not been administered senna that she knew of, and she had not asked for senna. -She was still bloated. -She had problems with constipation all her life. -She had a small bowel movement yesterday, 07/14/25. Interview with Resident #4 on 07/16/25 at 11:52am revealed: -She still had not been administered the senna that she knew of, and she had not asked for senna. -She was still feeling bloated. -She had not had a bowel movement today, 07/16/25. Interview with a medication aide (MA) on 07/17/25 at 2:59pm revealed: -The MAs were responsible for processing new orders. -When new orders were received, the order was scanned to the pharmacy. -The order would be dated when it was sent to	D 358		

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the pharmacy.
-The order would then be placed in a file until it was delivered to the facility, and then the order would be filed.
-She did not see the order for Resident #4's senna dated 07/14/25.
-She did not see a copy to show the order had been stamped when scanned to the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 07/17/25 at 3:14pm revealed:
-The MAs were responsible for reviewing the PCP's after-visit summary.
-The PCP usually left a form to show new orders for that visit.
-The MA should have reviewed Resident #4's PCP's after-visit summary and processed the orders.

Interview with the Administrator on 07/17/25 at 5:30pm revealed:
-She had proof Resident #4's senna order had been faxed to the pharmacy.
-The MAs should have followed up with the pharmacy until the medication was delivered.
-If the medication had not been delivered within 48 hours, she would expect the MAs to notify her.
-She was not notified there was an issue with Resident #4's senna until today, 07/17/25.

Refer to the interview with the RCC on 07/17/25 at 4:55pm.

Refer to the interview with the Administrator on 07/17/25 at 5:30pm.

b. Review of Resident #4's signed physician's orders dated 12/04/24 revealed an order for miralax 17gm in 8 ounces of fluid daily at 8:00am.

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D 358	Continued From page 44 Review of Resident #4's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation miralax was administered at 8:00am from 05/01/25-05/03/25 and 05/05/25-05/31/25. -There was an exception documented on 05/04/25 as refused. Review of Resident #4's June 2025 eMAR revealed: -There was an entry for miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation miralax was administered at 8:00am from 06/01/25-06/07/25 and 06/09/25-06/30/25. -There was an exception documented on 06/08/25 as not administered due to the resident having diarrhea. Review of Resident #4's July 2025 eMAR from 07/01/25-07/17/25 revealed: -There was an entry for miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation miralax was administered at 8:00am from 07/01/25-07/17/25. Observation of Resident #4's medications on hand on 07/15/25 at 2:58pm revealed: -There was a bottle of miralax dispensed on 09/21/24; the bottle had not been opened. -There was a bottle of miralax dispensed on 12/16/24 -The bottle contained 510 grams of miralax, and the bottle was one-fourth full.	D 358		

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D 358	Continued From page 45 Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/16/25 at 4:08pm revealed: -Resident #4 was dispensed a large bottle (510 grams) of miralax on 10/22/24, 12/16/24, 01/13/25 and 03/10/25. -Each bottle of miralax would have lasted for 30 days if the resident had been administered 17 grams daily as ordered. -If miralax was not administered as ordered, the resident could experience constipation. Interview with Resident #4's PCP on 07/17/25 at 12:36pm revealed: -Resident #4 was ordered miralax to treat constipation. -If Resident #4's miralax was not administered as ordered, the resident's bloating would not be resolved. Interview with Resident #4 on 07/15/25 at 4:10pm revealed: -She had problems with constipation all of her life. -Last week, she did not recall the date, she had not had a bowel movement for a few days, and she asked the MA if she was getting her miralax, and the MA told her no. -She told the MA she was supposed to be getting miralax every day. Interview with a MA on 07/17/25 at 2:59pm revealed: -Resident #4's miralax was to be administered daily. -She recalled Resident #4 had complained of constipation, but she could not recall when. -She administered Resident #4's miralax when she worked. -She did not know why there was extra miralax on	D 358		

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D 358	Continued From page 46 hand. Interview with the RCC on 07/17/25 at 3:14pm revealed: -She was not aware Resident #4 had more miralax on hand than should be based on dispensing. -She would have to look to see if the resident had possibly been administered miralax from another resident's bottle. Interview with the Administrator on 07/17/25 at 5:30pm revealed: -She expected medications to be administered on time and as ordered. -She did not know Resident #4's miralax had not been administered as ordered. Refer to the interview with the RCC on 07/17/25 at 4:55pm. Refer to the interview with the Administrator on 07/17/25 at 5:30pm. _____ Interview with the RCC on 07/17/25 4:55pm at revealed she and the MAs were expected to complete medication audits weekly, comparing physician orders and comparing them to the eMAR. Interview with the Administrator on 07/17/25 at 5:30pm revealed: -The MAs were responsible for completing eMAR to medication cart audits. -She did not know when the last medication cart audit was completed. -She expected the MAs to administer medications timely and as ordered by the provider. _____ The facility failed to ensure medications were	D 358		

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D 358	Continued From page 47 administered as ordered for a resident who was ordered a stool softener and laxative combination, resulting in constipation, pain, and anxiety (#2). Another resident, who had a history of diabetes mellitus and was ordered a basal insulin, was not administered his morning dose of insulin for 41 consecutive days and had a finger stick blood sugar (FSBS) range of 86-416 (#5); and a third resident was not administered a medication used to treat and prevent constipation as ordered and the resident experienced difficulty with bloating because her bowels had not completely emptied. The resident was then ordered a stool softener/laxative, and the medication was not administered (#4); and a resident who had a history of diabetes and was ordered a sliding scale insulin order which was not documented consistently, placing the resident at risk for hyperglycemia or hypoglycemia (#6). This failure was detrimental to the health and safety and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/17/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 31, 2025.	D 358		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following	D 375		

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D 375	Continued From page 48 requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 2 of 2 sampled residents (#8, #9) had a physician's order to self-administer eye drops and a topical cream (#8) and a nebulizer treatment (#9). The findings are: Review of the facility's undated resident self-management policy revealed: -Any Resident who desired to self-manage his\her medication must first successfully complete the self-administration assessment completed by the Resident Care Coordinator (RCC) or designee. -The Administrator should approve all self-management of medications. -The completed assessment for medication self-management would be filed in the resident's chart with the resident's assessment once the resident had satisfactorily passed the evaluation. -The RCC or designee would ensure there was a physician's order in place that indicated the resident was able to store and self-administer his or her medications. -Residents who self-administered their medications were required to have specific	D 375		

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instructions for the administration of prescription medications printed on the medication label.
-A reevaluation of the resident's ability to safely self-administer their medications would be conducted quarterly or sooner if indicated by a change in status.
-Residents with a diagnosis of memory impairment would not be permitted to self-manage their medications.

1. Review of Resident #8's current FL2 dated 10/26/24 revealed:
-Diagnoses included heart disease, hyperlipidemia, and gastroesophageal reflux disease.
-Resident #8 had limited sight.

a. Review of Resident #8's current FL2 dated 10/26/24 revealed:
-There was an order for flurometholone (FML) forte (a steroid eye drop used to treat inflammation), to instill one drop in both eyes four times daily.
-There was no order for Resident #8 to self-administer the FML forte eye drops.

Review of Resident #8's July 2025 electronic medication administration record (eMAR) for 07//01/25-07/16/25 revealed:
-There was an entry for FML forte eye drops, instill one drop in both eyes four times a day with a scheduled administration time of 7:00am, 11:00am, 3:00pm, and 7:00pm.
-There was documentation that Resident #8's FML forte eye drops were documented as administered four times daily from 07/01/25-07/15/25 and at 7:00am, 11:00am, and 3:00pm on 07/16/25.
-There was no entry that the medication could be kept at the bedside and self-administered by

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D 375	Continued From page 50 Resident #8. Observation of Resident #8's room on 07/16/25 at 11:40am revealed: -Resident #8 had a bottle of FML forte eye drops in the top drawer of the table beside his chair. -The bottle of FML forte did not have a pharmacy label. Review of Resident #8's record on 07/16/25 revealed there was no self-administration evaluation available for review. Interview with Resident #8 on 07/16/25 at 11:43am revealed: -He used eye drops 3-4 times per day. -He did not have any other bottles of eye drops in his room. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/25 at 4:08pm revealed: -A bottle of FML forte was dispensed on 04/10/25 with the directions to administer 1 drop in both eyes four times per day. -He did not see an order for the medication to be kept at the bedside. Interview with Resident #8's primary care provider (PCP) on 07/17/25 at 12:36pm revealed: -Resident #8 was alert and could use his eye drops himself. -Resident #8 had complained about having to wait for staff to administer his medications. -She thought she had written an order for Resident #8 to keep his eye drops at his bedside. Interview with a medication aide (MA) on 07/16/25 at 11:35am revealed -Resident #8 kept his eye drops at the bedside.	D 375		

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-She was told it was okay.
-She was not sure why there was no order on the eMAR for Resident #8 to keep the eye drops at the bedside.

Interview with a second MA on 07/16/25 at 3:07pm revealed:
-She knew Resident #8 had eye drops in his room.
-She was told Resident #8 had eye drops in his room.
-At one time, Resident #8 had an order to keep the eye drops at his bedside.

Interview with the RCC on 07/16/25 at 3:38pm revealed she thought Resident #8 had an order to keep his eye drops at his bedside.

Interview with the Administrator on 07/17/25 at 5:15pm revealed:
-She was not aware that Resident #8 had medication in his room.
-Resident #8 did not have a self-assessment to administer his medication that she could locate.

Refer to the interview with the Administrator on 07/17/25 at 5:15pm.

b. Review of Resident #8's current FL2 dated 10/26/24 revealed no order for clotrimazole-bethamethasone cream a (topical medication combining an antifungal (clotrimazole) and a corticosteroid (betamethasone).

Review of Resident #8's July 2025 eMAR for 07//01/25-07/16/25 revealed:
-There was an entry for clotrimazole-bethamethasone cream twice daily with a scheduled administration time of 8:00am and 8:00pm; can keep at bedside.

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-There was documentation that Resident #8's clotrimazole-bethamethasone cream was documented as administered twice daily from 07/01/25-07/15/25 and at 8:00am on 07/17/25.
-There was no entry that the medication could be kept at the bedside and self-administered by Resident #8.

Observation of Resident #8's room on 07/16/25 at 11:40 a.m. revealed a box labeled for clotrimazole-bethamethasone cream with directions to apply topically twice daily, with a dispensed date of 06/24/25; the tube had been used.

Interview with Resident #8 on 07/16/25 at 10:47am revealed:
-He used the cream for itching.
-He had issues with itching for months, which he used the cream on.
-He did not use the cream every day, but did use it 3 times per week.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/25 at 4:08pm revealed Resident #8's order for clotrimazole-bethamethasone was entered as the medication may be kept in the room; the medication was not dispensed by their pharmacy.

Telephone interview with a pharmacist from Resident #8's pharmacy on 07/17/25 at 11:30am revealed:
-An order was received for Resident #8's clotrimazole-bethamethasone cream on 06/24/25.
-There was no order that the medication could be kept at the bedside.
-If the medication was not used enough, the fungus would not be resolved.
-If the medication was used too much, because

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWELVE OAKS	1297 GALAX TRAIL MOUNT AIRY, NC 27030

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the medication contained a steroid, the skin could thin.

Interview with a medication aide (MA) on 07/16/25 at 11:35am revealed Resident #8 had an order to keep his antifungal cream in his room.

Interview with Resident #8's PCP on 07/17/25 at 12:36pm revealed:
-Resident #8 was alert and could apply his cream himself.
-Resident #8 had complained about having to wait for staff to administer his medications.
-She thought she had written an order for Resident #8 to keep his cream at his bedside.

Interview with the facility's nurse on 07/16/25 at 4:34pm revealed:
-She had not completed a self-administration assessment on Resident #8.
-Resident #8 was legally blind.
-She did not think Resident #8 should administer his medications because of his limited vision.

Interview with the Administrator on 07/17/25 at 5:15pm revealed:
-She was not aware that Resident #8 had medication in his room.
-Resident #8 did not have a self-assessment to administer his medication that she could locate.

Refer to the interview with the Administrator on 07/17/25 at 5:15pm.

2. Review of Resident #9's current FL2 dated 05/27/25 revealed:
-There was a diagnosis of chronic respiratory failure with hypoxia.
-There was an order for ipratropium-albuterol (a combination medication that helps open the

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airways to improve breathing) to administer 1 vial every four hours.

Review of Resident #9's July 2025 electronic medication administration record (eMAR) for 07//01/25-07/16/25 revealed:
-There was an entry for ipratropium-albuterol to administer 1 vial every four hours with a scheduled administration time of 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-There was documentation Resident #9's ipratropium-albuterol was administered every 4 hours daily on 07/01/25-07/16/25 with exceptions on 07/03/25 at 2:00am and on 07/16/25 at 10:00am and 2:00pm.

Observation of Resident #9's bedside table on 07/15/25 at 9:31 revealed an individual vial of medication lying on her bedside table.

Observation of Resident #9 on 07/15/25 at 9:31 revealed Resident #9 picked up the vial, broke off the end, and emptied the contents into her nebulizer machine.

Interview with Resident #9 on 07/15/25 at 9:31am revealed she did her own nebulizer treatments.

Observation of Resident #9 on 07/16/25 at 12:11pm revealed Resident #9 took a vial, broke off the end, and emptied the contents into her nebulizer machine.

Interview with Resident #9 on 07/16/25 at 12:11pm revealed:
-She had 2 nebulizer treatments today, 07/16/25.
-This was the 3rd nebulizer treatment today, 07/16/25.
-It was hard for her to walk up the hall to ask for

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her medications when she was already short of breath.
-She was given a vial of nebulizer treatment to do her treatment when she wanted to.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/25 at 4:08pm revealed:

Telephone with Resident #9's hospice nurse on 07/17/25 at 12:24pm revealed:
-Resident #9 could hold the nebulizer when doing breathing treatments.
-Resident #9's nebulizer medication should not be left in her room.

Interview with a personal care aide (PCA) on 07/16/25 at 3:19pm revealed she had not seen any vials of medication in Resident #9's room.

Interview with a medication aide (MA) on 07/16/25 at 11:35am revealed Resident #9 did not have any medications she kept at the bedside.

Interview with a second MA on 07/16/25 at 3:07pm revealed:
-When she administered Resident #9's medication, she put the vial of medication in the nebulizer; she went back later to ensure the resident had inhaled the medication.
-She did not leave a vial of medication in Resident #9's room.
-She had found a vial of medication in Resident #9's room on 05/29/25 that had been left by a previous shift.
-She notified the Resident Care Coordinator (RCC) that she had seen the vial in the resident's room.

Interview with the RCC on 07/16/25 at 3:38pm

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D 375	Continued From page 56 revealed: -She did not think Resident #9 had an order to keep the nebulizer medication at the bedside. -She expected the MAs to open the vial, put it in the nebulizer, and turn the nebulizer machine on. -She was not aware that a vial had been left in Resident #9's room. -She expected the MAs to watch Resident #9 take her nebulizer treatments. Interview with the facility's nurse on 07/16/25 at 4:34pm revealed: -She had not completed a self-administration assessment on Resident #9. -Resident #9 took a lot of medications that could affect her ability to self-administer her medications, and therefore, she did not think the resident should administer her nebulizer treatments. Interview with the Administrator on 07/17/25 at 5:15pm revealed: -The MAs could put Resident #9's medication in her nebulizer, and she could then hold the nebulizer to inhale the medication, but should not leave the medication in her room for her to do independently -The MAs should ensure Resident #9 took all of the nebulizer medication. -If Resident #9 was giving staff a hard time about her nebulizer treatments, she would be expected to be notified. Refer to the interview with the Administrator on 07/17/25 at 5:15pm. _____ Interview with the Administrator on 07/17/25 at 5:15pm revealed: -Residents could self-administer medications after being assessed by the nurse or the RCC.	D 375		

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D 375	Continued From page 57 -The PCP would then write an order for the resident to self-administer the medication.	D 375		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that a resident's medication was stored safely and securely for a resident who required topical pain relief medication (#8). The findings are: Review of the facility's undated resident self-management and storage of medication policy revealed: -The Resident Care Coordinator (RCC) or designee would ensure there was a physician's order in place that indicated the resident was able to store and self-administer his or her medications. -Residents who self-administered their medications were required to have specific instructions for the administration of prescription medications printed on the medication label. -A re-evaluation of the residents' ability to safely store and self-administer their medications would be conducted quarterly. -All medication must be kept in a secure environment that was accessible only to the resident and the staff.	D 377		

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D 377	Continued From page 58 -Locked storage, such as a container, drawer, or cabinet, was maintained in the resident's room to prevent access by other residents. Review of Resident #8's current FL2 dated 10/26/24 revealed: -Diagnoses included heart disease, hyperlipidemia, and gastroesophageal reflux disease. -Resident #8 had limited sight. -There was an order for cooling pain relief (menthol) gel 4%, used once a day on Mondays, Wednesdays, and Fridays. Review of Resident #8's July 2025 electronic medication administration record (eMAR) for 07//01/25-07/17/25 revealed: -There was an entry for cooling pain relief (menthol) gel 4%, used once a day on Mondays, Wednesdays, and Fridays with a scheduled administration time of 6:30pm. -There was documentation that Resident #8's cooling pain relief (menthol) gel 4% was documented as administered on 07/02/25, 07/04/25, 07/07/25, 07/09/25, 07/22/25, and 07/14/25. -There was no entry that the medication could be kept at the bedside. Observation of Resident #8's room on 07/16/25 at 10:49am revealed a 32-ounce bottle of biofreeze, professional, menthol gel; there was no pharmacy label. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/25 at 4:08pm revealed: -Resident #8 had an order for cooling pain relief 4%, which was probably the same as biofreeze, to be used after soaking feet.	D 377		

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-There was no order for the medication to be kept at the bedside.
-Biofreeze had not been dispensed to Resident #8 but had been profiled in the eMAR system.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/17/25 at 11:53am revealed:
-There was no order for Resident #8's biofreeze at the bedside.
-If Resident #8 missed using the biofreeze, the resident could have pain.
-If Resident #8 used too much, the resident could have skin irritation.
-If Resident #8 accidentally got the biofreeze in his eyes, it could cause burning.

Interview with Resident #8's primary care provider (PCP) on 07/17/25 at 12:36pm revealed:
-Resident #8 had complained about having to wait for staff to administer his medications.
-She did not have an issue with Resident #8 keeping the biofreeze at his bedside.

Interview with a medication aide (MA) on 07/16/25 at 3:07pm revealed:
-Resident #8's biofreeze was kept in his room to be used after his shower.
-The staff applied the biofreeze to Resident #8's feet.
-She did not know the biofreeze could not be in his room.

Interview with the RCC on 07/16/25 at 3:38pm revealed:
-The MAs applied the biofreeze after the resident had soaked his feet.
-She did not see an order that the biofreeze could be kept at the bedside.

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D 377	Continued From page 60 Interview with the RCC on 07/17/25 at 11:09am revealed: -Medication that could be kept at the bedside should be in a lock box. -If there was no order to keep the medication at the bedside, the medication should be kept on the medication cart. Interview with the Administrator on 07/17/25 at 5:15pm revealed: -She was not aware Resident #8 had medication in his room. -The MAs should be applying Resident #8's biofreeze and returning the biofreeze to the medication cart.	D 377		