STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001141	A. BUILDING: _____ B. WING _____	09/10/2025

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HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 09/09/25 to 09/10/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 5 sampled residents (#2, #3, and #4) had completed the two-step tuberculosis (TB) testing in compliance with the control measures adopted by the Commission for Public Health. The findings are: 1. Review of Resident #3's current FL2 dated 07/06/25 revealed diagnoses included acute respiratory failure, major depressive disorder, type 2 diabetes, and hypertension. Review of Resident #3's Resident Register revealed an admission date of 06/30/24.	D 234		

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Review of Resident #3's record revealed:
-There was documentation that a TB skin test was completed on 06/28/24 and the results were negative.
-There was no documentation that a second TB skin test was completed.

Interview with Resident #3 on 09/10/25 at 10:08am revealed she did not remember if she had a two-step TB skin test completed after being admitted to the facility.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 09/10/25 at 10:51am was unsuccessful.

Attempted telephone interview with a Register Nurse (RN) on 09/10/25 at 10:52am was unsuccessful.

Refer to the interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm.

Refer to the interview with the HWD on 09/10/25 at 3:26pm.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:21pm.

2. Review of Resident #4's current FL2 dated 10/18/24 revealed diagnoses included gastro-esophageal reflux, non-rheumatic mitral, and osteoporosis.

Review of Resident #4's Resident Register revealed an admission date of 03/29/23.

Review of Resident #4's record revealed:
-There was documentation that a TB skin test

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was completed on 02/16/23 and the results were negative.
-There was no documentation that a second TB skin test was completed.

Interview with Resident #4 on 09/10/25 at 10:24am revealed she did not remember if she had a two-step TB skin test completed after being admitted to the facility.

Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 09/10/25 at 10:54am was unsuccessful.

Attempted telephone interview with a Register Nurse (RN) on 09/10/25 at 10:52am was unsuccessful.

Refer to the interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm.

Refer to the interview with the HWD on 09/10/25 at 3:26pm.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:21pm.

3. Review of Resident #2's current FL2 dated 12/13/24 revealed diagnoses included chronic hypotension, presence of cardiac pacemaker, chronic diastolic congestive heart failure (CHF), coronary artery disease, and paroxysmal atrial fibrillation.

Review of Resident #2's Resident Register revealed an admission date of 11/15/24.

Review of Resident #2's record revealed:
-There was documentation that a TB skin test

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was administered on 06/28/24 and the results were negative, but the date the result was read was not documented.
-There was documentation of a negative TB skin test dated 11/05/24, but no documentation specifying when the test was administered or when it was read.

Telephone interview with Resident #2's primary care provider (PCP) on 09/10/25 at 1:15pm revealed she did not have access to Resident #2's TB test results.

Interview with Resident #2 on 09/10/25 at 2:25pm revealed he had TB skin tests completed in the past, but he could not remember if he had any since his admission to the facility in November 2024.

Attempted telephone interview with a Register Nurse (RN) on 09/10/25 at 10:52am was unsuccessful.

Refer to the interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm.

Refer to the interview with the HWD on 09/10/25 at 3:26pm.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:21pm.

_____
Interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm revealed:
-The HWD was responsible for ensuring the two-step TB skin tests were completed.
-The Register Nurse (RN) at the facility completed the two-step TB skin test for the

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D 234	Continued From page 4 residents. Interview with the HWD on 09/10/25 at 3:26pm revealed: -She was responsible for ensuring the two-step TB skin tests were completed. -She was not aware there were residents who did not have a two-step TB test completed after they were admitted to the facility. Interview with the Executive Director (ED) on 09/10/25 at 4:21pm revealed: -The HWD was responsible for ensuring the two-step TB skin tests were completed. -She was not aware there were any residents who had not completed a two-step TB test after the residents were admitted to the facility.	D 234		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be	D 259		

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performed;
(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;
(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;
(5) a dated signature of the assessor upon completion; and
(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 5 sampled residents had a completed care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (#2, #4, and #5).

The findings are:

1. Review of Resident #4's current FL2 dated 10/18/24 revealed:
-Diagnoses included gastro-esophageal reflux,

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nonrheumatic mitral, and osteoporosis.
-Resident #4 was semi-ambulatory.

Review of Resident #4's Resident Register revealed an admission date of 03/29/23.

Review of Resident #4's care plan dated 02/01/25 revealed:
-Resident #4 required supervision from staff with ambulation, bathing, and dressing.
-Resident #4 was independent with eating, toileting, grooming, and transferring.
-Resident #4 utilized a wheelchair.
-The care plan was not signed by Resident #4's Primary Care Physician (PCP).

Refer to the interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm.

Refer to the interview with the HWD on 09/10/25 at 3:26pm.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:21pm.

2. Review of Resident #2's current FL2 dated 12/13/24 revealed diagnoses included chronic hypotension, presence of cardiac pacemaker, chronic diastolic congestive heart failure (CHF), coronary artery disease, and paroxysmal atrial fibrillation.

Review of Resident #2's Resident Register revealed an admission date of 11/15/24.

Review of Resident #2's change in condition care plan dated 06/25/25 revealed:
-Resident #2 required minimal assistance from staff with transfers.

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-Resident #2 required standby supervision from staff with ambulation.
-Resident #2 required physical assistance from staff with bathing and continence management.
-The care plan was not signed by Resident #2's primary care provider (PCP).

Interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm revealed she was not aware that Resident #2's care plan had not been signed.

Interview with the HWD on 09/10/25 at 3:26pm revealed she did not know Resident #2's care plan was not signed.

Interview with the Executive Director (ED) on 09/10/25 at 4:20pm revealed she was not aware Resident #2's care plan was not signed.

Refer to interview with the HWD Assistant on 09/10/25 at 12:20pm.

Refer to interview with the HWD on 09/10/25 at 3:26pm.

Refer to interview with the ED on 09/10/25 at 4:21pm.

3. Review of Resident #5's current FL2 dated 07/29/25 revealed:
-Diagnoses included difficulty walking, muscle weakness, hypothyroidism, and hyperlipidemia.
-Resident #5 was ambulatory.
-Resident #5 was constant disorientated and a wanderer.
-Resident #5 was continent of bowel and bladder.

Review of Resident #5's Resident Register revealed:

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D 259	Continued From page 8 -There was no documented admission date. -The Resident Register was signed on 07/29/25. Review of Resident #4's record revealed there was no care plan available for review. Refer to the interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm. Refer to the interview with the HWD on 09/10/25 at 3:26pm. Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:21pm. _____ Interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:20pm revealed: -She and the HWD were responsible to ensure care plans were completed. -She was not aware there were residents who did not have care plans signed or completed. Interview with the HWD on 09/10/25 at 3:26pm revealed: -She and the HWD Assistant were responsible for ensuring the resident care plans were completed. -She did not know there were resident care plans that were not completed. Interview with the Executive Director (ED) on 09/10/25 at 4:21pm revealed: -The HWD was responsible for ensuring resident care plans were completed. -She was not aware resident care plans were not completed.	D 259		

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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 observation, interviews and record reviews the facility failed to ensure referral and follow up for 1 of 5 sampled residents (#2) who had a referral to podiatry, a blood pressure order with parameters, and medication refusals. The findings are: Review of Resident #2's current FL2 dated 12/13/24 revealed diagnoses included chronic hypotension, presence of cardiac pacemaker, chronic diastolic congestive heart failure (CHF), coronary artery disease, and paroxysmal atrial fibrillation. a. Review of Resident #2's physician's order dated 07/31/25 revealed there was an order for a podiatry referral. Review of Resident #2's record on 09/09/25 revealed there were no podiatry visit notes. Observation of Resident #2's toenails on 09/10/25 at 2:35pm revealed -The toenails were thick and yellow-orange in color on both left and right feet. -The toenails on both great toes were 1 centimeter (cm) thick. -The second toenail on the right foot extended half of a centimeter beyond the toe. -The third toenail on the right foot extended	D 273		

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2/3cm beyond the toe and curved into the second toe.
-The fourth and fifth toenails on the right and left foot extended beyond the toe.
-The second and third toenails on the left foot extended half of a centimeter beyond the end of the toe.
-The skin on his feet was flakey and dry.
-There were no areas of open skin.

Interview with a medication aide (MA) on 09/10/25 at 10:42am revealed:
-She was not aware Resident #2 had not been seen by podiatry.
-She had not seen Resident #2's feet.
-Resident #2 asked her when the podiatrist would be at the facility at least one month ago but had not mentioned podiatry services to her since.

Interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 12:00pm revealed:
-Resident #2 had not been seen by podiatry.
-Either she, the HWD, or the Executive Director (ED) were responsible for ensuring referrals were followed up on.
-She was not aware of any issues with Resident #2's feet.

Telephone interview with a Nurse Practitioner (NP) from Resident #2's primary care provider's (PCP) office on 09/10/25 at 1:15pm revealed:
-She was not aware that Resident #2 had not been seen by podiatry.
-She would have expected the referral to be made as soon as possible because it could take up to three months to be seen by a specialist.

Interview with Resident #2 on 09/10/25 at 2:26pm revealed:

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-He had been begging to see a podiatrist for the previous three months.
-He wanted his toenails cut.
-The MAs did not cut toenails.
-He signed a consent form for podiatry services, but he had not had a visit from podiatry yet.
-He did not have any pain from his toenails being long, but he knew they needed to be cut.

Interview with the ED on 09/10/25 at 4:20pm revealed:
-Resident #2 had a physician's order and a signed consent for podiatry services at the end of June 2025.
-She forwarded the referral information for Resident #2 to podiatry on 06/27/25 and received a response back that there was an issue with insurance and asked the ED for more information.
-She provided the requested information to the podiatry office, but never received a response back to set up an appointment for Resident #2.
-She had forgotten to follow up with podiatry to schedule an appointment for Resident #2.
-She was aware that Resident #2 had not been seen by the podiatrist.
-She would expect the referral to have been completed as soon as possible.

Attempted telephone interview with the podiatry office on 09/10/25 at 3:05pm was unsuccessful.

b. Review of Resident #2's signed physician order dated 06/19/25 revealed there was an order to check vital signs (VS) daily and to report fever >100.4, heart rate (HR) >100 or <50, or blood pressure (BP) >150 or <110.

Review of Resident #2's July 2025 electronic medication administration record (eMAR)

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revealed:
-There was an entry to check VS daily, report fever >100.4, HR >100 or <50, or BP >150 or <110 with a scheduled time of 8:00am.
-Resident #2's BP was documented as less than 110 on 8 of 31 opportunities, with values ranging from 99/62 to 108/82, with examples as follows:
-On 07/01/25, the BP reading was documented as 103/68.
-On 07/13/25, the BP reading was documented as 102/80.
-On 07/19/25, the BP reading was documented as 108/82.
-On 07/25/25, the BP reading was documented as 100/63.
-On 07/27/25, the BP reading was documented as 99/62.

Review of Resident #2's August 2025 eMAR revealed
-There was an entry to check VS daily, report fever >100.4, HR >100 or <50, or BP >150 or <110 with a scheduled time of 8:00am.
-Resident #2's BP was documented as less than 110 on 16 of 31 opportunities, with values ranging from 95/60 to 108/74, with examples as follows:
-On 08/05/25, the BP reading was documented as 100/76.
-On 08/08/25, the BP reading was documented as 106/70.
-On 08/16/25, the BP reading was documented as 95/60.
-On 08/21/25, the BP reading was documented as 104/76.
-On 08/28/25, the BP reading was documented as 106/66.
-On 08/31/25, the BP reading was documented as 108/74.

Review of Resident #2's September 2025 eMAR

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from 09/01/25 through 09/09/25 revealed:
-There was an entry to check VS daily, report fever >100.4, HR >100 or <50, or BP >150 or <110 with a scheduled time of 8:00am.
-Resident #2's BP was documented as less than 110 on 7 of 9 opportunities, with values ranging from 81/66 to 108/74, with examples as follows:
-On 09/01/25, the BP reading was documented as 108/74.
-On 09/03/25, the BP reading was documented as 99/66.
-On 09/05/25, the BP reading was documented as 93/71.
-On 09/06/25, the BP reading was documented as 93/71.
-On 09/07/25, the BP reading was documented as 103/69.
-On 09/08/25, the BP reading was documented as 81/66.
-On 09/09/25, the BP reading was documented as 104/66.

Interview with a MA on 09/10/25 at 10:42am revealed:
-She had checked Resident #2's BP and had the value less than 110 before.
-She did not report any BP reading below 110 to Resident #2's PCP.
-Resident #2 did not complain of symptoms of low blood pressure such as light headedness.
-She was aware that orders should be followed as written.

Interview with a second MA on 09/10/25 at 11:50am revealed:
-She was aware that any BP readings below 110 should be reported to Resident #2's PCP.
-She may have notified the provider in person but did not document the notification.
-Resident #2 did not complain of symptoms of

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low blood pressure.

Telephone interview with an NP from Resident #2's PCP's office on 09/10/25 at 1:15pm revealed:
-There was no documentation the facility notified their office of Resident #2's BP readings that were less than 110.
-She would expect to be notified of the low BP reading so medication adjustments could be made if needed.

Interview with Resident #2 on 09/10/25 at 2:26pm revealed:
-The staff checked his BP every morning.
-His BP had always run low.
-He had no symptoms when his BP was low.

Telephone interview with a third MA on 09/10/25 at 3:20pm revealed:
-She told the HWD about Resident #2's low BP readings but not the PCP.
-Resident #2 did not have any complaints of low blood pressure.

Interview with the HWD on 09/10/25 at 3:27pm revealed:
-She had only been working at the facility for about one week.
-She was not made aware of any BP readings less than 110.
-She expected the MAs to report any BP reading below 110 as ordered.

Interview with ED on 09/10/25 at 4:20pm revealed:
-She was not aware that Resident #2 had BP readings less than 110, or that he had an order to notify his PCP for BP less than 110.
-She expected the MA to notify Resident #2's

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D 273	Continued From page 15 PCP of all BP readings less than 110. c. Review of the Medication Management policy dated 08/01/25 revealed: -Medication refusals were documented on the eMAR. -Staff should notify the HWD, who would interview and assess the resident and notify the PCP. Review of Resident #2's signed physician's orders dated 06/19/25 revealed there was an order for melatonin 5 mg (a medication used to help promote sleep) give 1 tablet at bedtime. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for melatonin 5 mg give one tablet by mouth at bedtime with an administration time of 8:00pm. -There was documentation melatonin was not administered 9 out of 31 opportunities due to the resident refusing. Review of Resident #2's August 2025 eMAR revealed: -There was an entry for melatonin 5mg give one tablet by mouth at bedtime with an administration time of 8:00pm. -There was documentation melatonin was not administered 9 out of 31 opportunities due to the resident refusing. Review of Resident #2's September 2024 eMAR from 09/01/25 through 09/09/25 revealed: -There was an entry for melatonin 5mg give one table by mouth at bedtime with an administration time of 8:00pm. -There was documentation melatonin was not administered 5 out of 8 opportunities due to the	D 273		

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D 273	Continued From page 16 resident refusing. Interview with a MA on 09/10/25 at 11:50am revealed: -Resident #2 refused the melatonin at times. -She thought she had reported the refusals to Resident #2's PCP but did not document the notification. Telephone interview with an NP from Resident #2's PCP's office on 09/10/25 at 1:15pm revealed: -There was no documentation the facility staff notified their office of Resident #2's melatonin refusals. -She would expect there to be notification of the medication refusals so medication order changes could be made. Interview with Resident #2 on 09/10/25 at 2:26pm revealed: -He did not like taking melatonin because it made him groggy the next day. -He did not think the MAs were administering the melatonin to him anymore. Telephone interview with a second MA on 09/10/25 at 3:10pm revealed: -Resident #2 refused his melatonin because he said it made him sleepy all day the following day. -She had never reported Resident #2's melatonin refusals to his PCP. -She was not aware of the facility having a policy for staff to know when the PCP should be contacted about medication refusals. Interview with the HWD on 09/10/25 at 3:27pm revealed: -She had only been working at the facility for about one week.	D 273		

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-It had not been reported to her that Resident #2 was refusing melatonin.
-She expected the MAs to notify her and PCP after 2-3 days of refused medication.
-She had not seen a policy regarding refused medications.

Interview with the ED on 09/10/25 at 4:20pm revealed:
-She was not aware that Resident #2 had refused melatonin.
-Her expectation was after three medication refusals, the MA should notify the HWD and the PCP.
-The HWD should be auditing the eMARs every two to three weeks to check for refused medications.

d. Review of Resident #2's signed physician orders dated 12/13/24 revealed there was an order for hydrocortisone external cream 1% (a topical medication used help prevent itching) apply topically two times a day.

Review of Resident #2's July 2025 eMAR revealed:
-There was an entry for hydrocortisone external cream 1% apply topically two times a day for itching with an administration time of 9:00am and 9:00pm.
-There was documentation hydrocortisone cream was not administered 52 out of 62 opportunities due to the resident refusing.

Review of Resident#2's August 2025 eMAR revealed:
-There was an entry for hydrocortisone external cream 1% apply topically two times a day for itching with an administration time of 9:00am and 9:00pm.

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D 273	Continued From page 18 -There was documentation hydrocortisone cream was not administered 48 out of 62 opportunities due to the resident refusing. Review of Resident #2's September 2025 eMAR from 09/01/25 through 09/09/25 revealed: -There was an entry for hydrocortisone external cream 1% apply topically two times a day for itching with an administration time of 9:00am and 9:00pm. -There was documentation hydrocortisone cream was not administered 12 out of 17 opportunities due to the resident refusing. Interview with a MA on 09/10/25 at 10:42 am revealed: -Resident #2 refused the hydrocortisone cream because the area of skin that had been itchy was cleared up. -She had reported the hydrocortisone cream refusals to the PCP two months ago but did not document the notification. Interview with a second MA on 09/10/25 at 11:50am revealed: -Resident #2 refused the hydrocortisone cream because he did not need it anymore. -She tried to remember to report medication refusals to the PCP in person when she saw her, but she did not document the notification. Telephone interview with an NP from Resident #2's PCP's office on 09/10/25 at 1:15pm revealed: -There was no documentation the facility staff notified their office of Resident #2's refusals of hydrocortisone cream. -She would expect there to be notification of the medication refusals so the medication could be discontinued if it was no longer needed.	D 273		

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D 273	Continued From page 19 Interview with Resident #2 on 09/10/25 at 2:26pm revealed: -Hydrocortisone cream had been ordered to treat an itchy rash that was on his leg months ago. -He refused the hydrocortisone cream because he no longer needed it. Interview with the HWD on 09/10/25 at 3:27pm revealed: -She had only been working at the facility for about one week. -It had not been reported to her that Resident #2 was refusing hydrocortisone cream. -If a resident refused a medication, the MA was responsible for checking the eMAR history to see if that was the first time the medication was refused, or if it had been refused in the days prior. -If a resident refused a medication more than two to three times in a row, the MA should notify her and the resident's PCP so they could re-evaluate if the medication was needed. -She was not aware of the facility having a policy for when to notify the PCP about medication refusals. Interview with the ED on 09/10/25 at 4:20pm revealed: -She was not aware that Resident #2 had been refusing hydrocortisone cream. -Her expectation was for the MA to notify the HWD and the resident's PCP after three medication refusals. -The HWD should be completing a review of the eMARs every two to three weeks to check for refused medications.	D 273		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service	D 292		

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D 292	Continued From page 20 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Review of the Menu Substitution log dated 09/10/25 revealed there were no substitutions documented for the breakfast meal service. Review of the facility's Spring/Summer 2025 menu for the week of 09/07/25 through 09/13/25 revealed the breakfast menu for 09/10/25 was oatmeal, fresh fruit cup, whole toast, scrambled egg, 2 bacon strips, orange juice, 2% milk, and coffee. Observation of the breakfast meal service on 09/10/25 8:00am revealed a resident was served a bowl of cold cereal with milk, 2 small fried eggs,	D 292		

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D 292	Continued From page 21 toast, hot tea, and water. Interview with the Cook on 09/10/25 at 9:15am revealed: -He was responsible for updating the menu substitution log when changes were made to the menu. -He could not recall why he did not update the menu substitution log for 09/10/25. Interview with the Dietary Manager on 09/10/25 at 9:26am revealed: -He was responsible for ensuring the menu substitution log was updated. -The dietary staff were responsible for making changes to the menu substitution log then giving it to him to review. -He was not aware the menu substitution log had not been updated for 09/10/25. Interview with the Executive Director (ED) on 09/10/25 at 9:52am revealed she expected the dietary staff to update the menu substitution logs as required.	D 292		
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, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 4 residents	D 310		

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D 310	Continued From page 22 with a diet order for finger foods (#6). The findings are: Observation of the kitchen on 09/09/25 at 10:32am revealed: -There was a list of residents' photos with a color-coded background to indicate the diets posted in the kitchen. -Resident #6's diet was on a green background, which indicated a finger food diet. -The regular menu for lunch on 09/09/25 was chicken minestrone soup, chicken salad croissant, French fried potatoes, quiche Lorraine, creamed corn, tossed salad, bread pudding, 2% milk, coffee, and tea. -The finger food menu for lunch on 09/09/25 was chicken salad sliders, French fried potatoes, quiche Lorraine tarts, corn fritters, mini banana bread pudding cone, garden salad, 2% milk, coffee, tea. -The regular menu for breakfast on 09/10/25 was oatmeal, fresh fruit cup, whole toast, scrambled egg, 2 bacon strips, orange juice, 2% milk, and coffee. -The finger food menu for breakfast on 09/10/25 was 1x1 baked oatmeal square, fresh grapes, white toast, egg bites, 2 slices of bacon strips, orange juice, 2% milk, and coffee. Review of Resident #6's FL 2 dated 07/10/25 revealed: -Diagnoses included major depressive disorder, gastro-esophageal reflux, hypertension, and dyspnea. -The was a checkmark next to diet but no diet was indicated. Review of Resident #6's diet order dated 06/19/25 revealed an order for finger foods.	D 310		

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D 310	Continued From page 23 Observations of the lunch meal service on 09/09/25 from 12:00pm to 12:42pm revealed: -Resident #6 was served quiche, minestrone soup, bread pudding, water, and tea. -Resident #6 ate 100% of her quiche, minestrone soup, and bread pudding. Observation of the breakfast meal service on 09/10/25 from 7:45am to 8:10am revealed: -Resident #6 was served cold cereal in a bowl, 2 small fried eggs, toast, milk, hot tea, and water. -Resident #6 ate 90% of her cold cereal, 2 small fried eggs, and toast. Telephone interview with resident #6's primary care provider (PCP) on 09/10/25 at 9:14am revealed: -Resident #6 was ordered a finger food diet. -The resident was not able to hold utensils and her diet was downgraded. -She expected the facility to follow the therapeutic diets as ordered. Interview with a PCA on 09/10/25 at 7:31am revealed: -The kitchen staff served the residents' meals. -She watched the residents to ensure the residents were not choking during their meals. Interview with another PCA on 09/10/25 at 7:36am revealed: -The kitchen staff served all of the meals to the residents. -She brought the residents from their bedrooms into the dining room. -She stayed in the dining room to assist residents if they needed help. Interview with the Cook on 09/10/25 at 9:15am	D 310		

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D 310	Continued From page 24 revealed: -He was trained to read and prepare therapeutic diets by the Dietary Manager (DM). -He was unaware the resident's quiche should have been cut into pieces. -He served Resident #6 cold cereal because the resident asked for it. -He did not refer to the therapeutic diet menu for guidance. -He usually served the residents whatever the residents asked for. Interview with the DM on 09/10/25 at 9:26am revealed: -He was responsible for ensuring dietary staff were trained to read and prepare therapeutic diets. -He was not aware Resident #6 was not served the finger food diet as ordered. -He was concerned that the dietary staff were not following the therapeutic diets menu for guidance. Interview with the Health and Wellness Director (HWD) Assistant on 09/10/25 at 9:46am revealed: -She was concerned that a resident could aspirate if not served the correct therapeutic diet. -She expected the dietary staff to serve therapeutic diets as ordered. Interview with the Executive Director (ED) on 09/10/25 at 9:52am revealed she expected the dietary staff to serve therapeutic diets as ordered.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify a medication order for 2 of 5 sampled residents (#1 and #5) related to a medication for tremors (#1) and an anti-anxiety medication (#5).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/26/25 revealed:
-Diagnoses included mild dementia, pancreatic cancer, and diabetes mellitus secondary to pancreatic cancer.
-There was an order for Primidone 100mg (used to treat tremors) at bedtime.

Review of Resident #1's signed physician order's dated 06/19/25 revealed there was an order for Primidone 50mg one tablet at bedtime.

Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Primidone 50mg one tablet at bedtime with a scheduled administration time of 7:00pm.

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D 344	Continued From page 26 -There was documentation that Primidone 50mg was administered each night from 07/01/25 to 07/31/25. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Primidone 50mg one tablet at bedtime with a scheduled administration time of 7:00pm. -There was documentation that Primidone 50mg was administered each night from 08/01/25 to 08/31/25. Review of Resident #1's September 2025 eMAR from 09/01/25 to 09/08/25 revealed: -There was an entry for Primidone 50mg one tablet at bedtime with a scheduled administration time of 7:00pm. -There was documentation that Primidone 50mg was administered each night from 09/01/25 to 09/08/25. Observation of Resident #1's medication on hand on 09/09/25 revealed: -There was a punch card with 8 of 56 Primidone 50mg tablets dispensed on 08/05/25 available for administration. -The prescription label read, "Primidone 50mgs take 2 tablets (100mg) at bedtime for tremors." Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 9:48am revealed: -Resident #1 had an order for Primidone 50mg two tablets at bedtime dated 03/26/25. -The pharmacy did not have an order for Primidone 50mg one tablet at bedtime. -The facility was on cycle fill and the pharmacy prepared a 28-day supply for the residents on cycle fill.	D 344		

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D 344	Continued From page 27 -The pharmacy dispensed 56 tablets of Primidone 50mg on 08/05/25 for Resident #1. Interview with a medication aide (MA) on 09/10/25 at 11:20am revealed: -She had administered Primidone to Resident #1. -She administered Primidone 50mg 2 tablets at bedtime because that was what the pharmacy dispensed. -She had not noticed that the eMAR entry read, "Primidone 50mg one tablet at bedtime." -She had not spoken to anyone about the discrepancy because she had not noticed the discrepancy. -The Health and Wellness Director (HWD), the HWD Assistant, and some of the MAs could enter medication orders into the eMAR. -She had entered orders onto the eMAR, but she did not know who entered the Primidone 50mg one tablet at bedtime order into the eMAR. Interview with a second MA on 09/10/25 at 11:41am revealed: -She administered medications to Resident #1 based on what was dispensed from the pharmacy. -If the pharmacy dispensed two tablets in one blister on the punch card, that was what she administered. -She did not know the eMAR read to give one tablet. -She compared the medication in the medication cart to the entry on the eMAR, but she had not noticed the difference in the instructions for the Primidone. Telephone interview with Resident #1's primary care provider (PCP) on 09/10/25 at 3:30pm revealed: -Resident #1 had an order for Primidone 50mg 2	D 344		

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tablets at bedtime.
-She signed the 6-month order review on 06/19/25 but did not realize the order for Primidone read 50mg one tablet at night.
-She expected the 6-month order review to be accurate when she signed it.
-She had not noticed Resident #1 having any tremors, and the staff had not reported any issues with tremors to her.
-She wanted Resident #1 to continue taking Primidone 50mg 2 tablets at bedtime because it was controlling his tremors.
-No one from the facility had contacted her to clarify the Primidone order.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 2:17pm.

Refer to the interview with the HWD on 09/10/25 at 11:56am.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:35pm.

2. Review of Resident #5's current FL-2 dated 07/29/25 revealed:
-Diagnoses included difficulty walking, hypothyroidism, and hyperlipidemia.
-There was an order for Seroquel 25mg (used to treat anxiety) ½ tablet at bedtime.

Review of Resident #5's signed physician orders dated 08/07/25 revealed:
-There was a diagnosis of dementia with mood disturbances.
-There was an order for Seroquel 25mg ½ tablet at bedtime.

Review of Resident #5's August 2025 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Seroquel 25mg ½ tablet at bedtime for behaviors with a scheduled administration time of 9:00pm
-There was documentation Seroquel 25mg ½ tablet was administered each night from 08/04/25 to 08/31/25.
-There was no documentation that Seroquel 25mg 1/2 tablet was administered from 08/01/25 to 08/03/25; the eMAR was blank.

Review of Resident #5's September 2025 eMAR from 09/01/25 through 09/08/25 revealed:
-There was an entry for Seroquel 25mg ½ tablet at bedtime for behaviors with a scheduled administration time of 9:00pm
-There was documentation Seroquel 25mg ½ tablet was administered each night from 09/01/25 to 09/08/25.

Observation of Resident #5's medication on hand on 09/09/25 at 1:54pm revealed:
-There was a punch card with 8 of 25 Seroquel 25mg tablets dispensed on 08/08/25 available for administration.
-The prescription label read, "Seroquel 25mg take 1 tablet at bedtime for dementia with behaviors."

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 2:17pm revealed:
-Resident #5 had an order for Seroquel 25mg daily dated 07/31/25.
-The order was received from the facility on 08/08/25 and the pharmacy dispensed 25 Seroquel 25mg tablets.

Interview with a medication aide (MA) on 09/10/25 at 11:20am revealed:

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D 344	Continued From page 30 -She had administered Seroquel to Resident #5. -She administered what the pharmacy dispensed which was Seroquel 25mg at bedtime. -She had not noticed that the eMAR entry read, "Seroquel 25mg 1/2 tablet at bedtime." -She had not spoken to anyone about the discrepancy because she had not noticed the discrepancy. -The Health and Wellness Director (HWD), the HWD Assistant, and some of the MAs could enter medication orders into the eMAR. -She had entered orders onto the eMAR, but she did not know who entered the Seroquel 25 mg 1/2 tablet at bedtime order into the eMAR. Interview with a second MA on 09/10/25 at 11:41am revealed: -She administered medications to Resident #5 based on what was dispensed from the pharmacy. -She did not know the eMAR read to give one tablet. -She compared the medication in the medication cart to the entry on the eMAR, but she had not noticed the difference in the instructions of the Seroquel. Telephone interview with Resident #5's Mental Health Provider (MHP) on 09/10/25 at 3:42pm revealed: -Resident #5 had an order for Seroquel 25mg ½ tablet a bedtime. -She had not written an order for Seroquel 25mg daily. -Seroquel was ordered for Resident #5 for behaviors related to her dementia. -She expected medications to be administered as ordered. Refer to the telephone interview with a	D 344		

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representative from the facility's contracted pharmacy on 09/10/25 at 2:17pm.

Refer to the interview with the HWD on 09/10/25 at 11:56am.

Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:35pm.

_____

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 2:17pm revealed:
-The pharmacy accepted FL-2's, electronic prescriptions, and faxed prescriptions as orders.
-The pharmacy received signed 6-month orders from the facility, but the pharmacy did not reconcile the medications listed on the 6-month orders.
-The facility entered all orders into their eMAR system.
-Once the pharmacy received the order, the order would be entered into the pharmacy's computer system for profiling and for dispensing of the medication.

Interview with the HWD on 09/10/25 at 11:56am revealed:
-She started working at the facility last week.
-She was responsible for entering orders into the computer and the eMAR and sending orders to the pharmacy.
-She thought some of the MAs had access to enter orders onto the eMAR but she was not sure.
-She expected the MAs to compare the medications in the medication cart with the entry on the eMAR and if there was a discrepancy the MA should let her know.
-The MAs should be comparing the medication to the eMAR at least 3 times before administering

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D 344	Continued From page 32 the medications. -She expected the MAs to notify the HWD if there were discrepancies with the medication on the medication cart and what was entered on the eMAR. Interview with the Executive Director (ED) on 09/10/25 at 4:35pm revealed: -The MAs should be comparing the medication they were administering to the eMAR. -She expected the MAs to notify the HWD if there was a discrepancy between the medication on the medication cart and the entry on the medication. -The resident should be receiving the medications the PCP ordered.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2 and #5) who each had an order for a supplement. The findings are: 1. Review of Resident #5's current FL-2 dated	D 358		

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07/29/25 revealed:
-Diagnoses included difficulty walking, hypothyroidism, and hyperlipidemia.
-There was an order for vitamin B-12 (a supplement) 1000mcg daily.

Review of Resident #5's after visit summary dated 09/04/25 revealed:
-Resident #5's vitamin B-12 level was high at 1,965pg/ml (normal range for vitamin B-12 was 160-950pg/ml).
-There was an order to discontinue vitamin B-12.

Review of Resident #5's September 2025 electronic administration medication record (eMAR) from 09/01/25 to 09/09/25 revealed:
-There was an entry for vitamin B-12 1000mcg daily with a scheduled administration time of 8:00am.
-There was documentation vitamin B 12 was administered daily from 09/01/25 to 09/09/25.

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 3:58pm revealed:
-Resident #5 had an order for vitamin B-12 1000mcg every day.
-The pharmacy dispensed 28 vitamin B-12 1000mcg tablets for Resident #5 on 08/04/25 and 09/02/25.
-The pharmacy did not have an order to discontinue the vitamin B-12.
-The facility entered the orders onto the eMAR and faxed the order to the pharmacy.
-The pharmacy would enter the order into their computer system to profile the order.

Interview with the medication aide (MA) on 09/10/28 at 11:20am revealed:
-She administered vitamin B-12 to Resident #5.

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-Vitamin B-12 was an active order on the eMAR and the medication was on the medication cart.
-The vitamin B-12 had not discontinued.
-She did not know Resident #5's vitamin B-12 had been discontinued.

Interview with the Primary Care Provider (PCP) on 09/10/25 at 3:30pm revealed:
-She wrote an order to discontinue Resident #5's vitamin B-12 because Resident #5's vitamin B-12 level was elevated and Resident #5 no longer needed the supplementation.
-She expected the facility to follow the orders as written.

Interview with the Health Wellness Director (HWD) on 09/10/25 at 12:27pm revealed:
-She started working at the facility last week.
-She may be responsible for reviewing the PCP's after visit summary but she was not sure.
-The after visit summary needed to be reviewed for orders and faxed to the pharmacy.

Interview with the Executive Director (ED) on 09/10/25 at 4:23pm revealed:
-The HWD was responsible for reviewing the PCP's after visit summaries, making changes on the eMAR as needed and faxing the new orders to the pharmacy.
-She expected all orders to be followed.

Refer to the interview with the ED on 09/10/25 at 4:23pm.

2. Review of Resident #2's current FL2 dated 12/13/24 revealed diagnoses included chronic hypotension, presence of cardiac pacemaker, chronic diastolic congestive heart failure (CHF), coronary artery disease, and paroxysmal atrial fibrillation.

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D 358	Continued From page 35 Review of Resident #2's signed physician's orders dated 11/15/24 revealed there was an order for ergocalciferol 50,000 unit (a vitamin D supplement) give one capsule by mouth once a day every Monday for supplementation. Observation of medications on hand for Resident #2 on 09/09/25 at 4:20pm revealed there was no ergocalciferol 50,000 units capsules available for administration. Review of Resident #2's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ergocalciferol 50,000 units, give one capsule by mouth one time a day every Monday for supplement with a scheduled administration time of 9:00am. -There was documentation that ergocalciferol was not administered 3 out of 4 opportunities with a chart code of O (other/see progress notes). Review of Resident #2's August 2025 eMAR revealed: -There was an entry for ergocalciferol 50,000 units, give one capsule by mouth one time a day every Monday for supplement with a scheduled administration time of 9:00am. -There was documentation that ergocalciferol was not administered 2 out of 4 opportunities with a chart code of O. Review of Resident #2's September 2025 eMAR from 09/01/25 through 09/09/25 revealed: -There was an entry for ergocalciferol 50,000 units, give one capsule by mouth one time a day every Monday for supplement with a scheduled administration time of 9:00am. -There was documentation that ergocalciferol	D 358		

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was not administered 2 out of 2 opportunities with a chart code of O.

Resident #2's progress notes were requested on 09/09/25 and 09/10/25 and were not provided by the survey exit.

Interview with a medication aide (MA) on 09/10/25 at 10:42 am revealed:
-She did not see ergocalciferol on the medication cart and did not remember administering it to Resident #2.
-Any missing medication should be written on a paper form and then faxed to the pharmacy to request a refill.
-She did not request a refill of ergocalciferol for Resident #2 from the pharmacy.

Telephone interview with a Nurse Practitioner (NP) from Resident #2's primary care provider's (PCP) office on 09/10/25 at 1:15pm revealed:
-There was no documentation the facility staff contacted the provider's office regarding ergocalciferol not being administered.
-A blood test to check Resident #2's Vitamin D level was not ordered so she did not know if Resident #2's vitamin D level was low.
-She expected the facility staff to notify the provider if a medication was not administered.

Interview with a representative from the facility's contracted pharmacy on 09/10/25 at 2:15pm revealed:
-Resident #2 did not have an active order in their system for ergocalciferol 50,000 units every Monday, but they did not receive an order to discontinue the medication so she did not know why the pharmacy had discontinued ergocalciferol.
-Ergocalciferol had not been dispensed since

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D 358	Continued From page 37 January 2025. -No refill requests for Resident #2's ergocalciferol had been made. Interview with Resident #2 on 09/10/25 at 2:26pm revealed he did not know if he was getting ergocalciferol. Interview with the Health and Wellness Director (HWD) on 09/10/25 at 3:27pm revealed: -She was not aware that ergocalciferol was not on the medication cart for Resident #2. -She expected the MAs to notify the HWD and PCP when a medication was not available. -Medication refills should be requested from the pharmacy via fax when there were seven days left of the medication remaining. Interview with the Executive Director (ED) on 09/10/25 at 4:20pm revealed: -She was not aware of Resident #2's ergocalciferol not being available for administration. -She did not know why so much time had passed when the ergocalciferol not being available on the medication cart should have been caught during a medication cart audit. -The most recent medication cart audit was completed one week ago. -It was expected that the MA should request refills by calling or faxing the pharmacy before the medication ran out. Refer to the interview with the ED on 09/10/25 at 4:23pm. _____ Interview with the ED on 09/10/25 at 4:23pm revealed: -The HWD was responsible for ensuring medication carts were audited weekly.	D 358		

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D 358	Continued From page 38 -The HWD could delegate the medication cart audit to the MAs. -The staff should compare the medications on the eMAR to the medications on the medication cart. -If there was a discrepancy, the HWD should follow up with the pharmacy or the PCP.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic	D 367		

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medication administration record (eMAR) was accurate for 1 of 5 residents (#5) related to an anti-anxiety medication.

The findings are:

Review of the facility's Medication Management policy dated 08/01/05 revealed the documentation of the administration was completed on the resident's individual medication administration record.

Review of Resident #5's current FL-2 dated 07/29/25 revealed diagnoses included difficulty walking, hypothyroidism, and hyperlipidemia.

Review of Resident #5's signed physician order dated 08/04/25 revealed there was an order for Seroquel 25mg (used for anxiety) ½ tablet every 12 hours as needed (PRN) for combativeness, anxiety, and insomnia.

Review of Resident #5's signed physician orders dated 08/07/25 revealed:
-There was a diagnosis of dementia with mood disturbances.
-There was no order for Seroquel 25mg ½ tablet every 12 hours PRN for combativeness, anxiety, and insomnia.

Review of Resident #5's August 2025 eMAR from 08/04/25 to 08/31/25 revealed:
-There was no entry for Seroquel 25mg ½ tablet every 12 hours PRN combativeness, anxiety, and insomnia.
-There was no documentation Seroquel 25mg ½ tablet every 12 hours PRN was administered.

Review of Resident #5's September 2025 eMAR from 09/01/25 to 09/08/25 revealed:

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D 367	Continued From page 40 -There was no entry for Seroquel 25mg ½ tablet every 12 hours PRN combativeness, anxiety, and insomnia. -There was no documentation Seroquel 25mg ½ tablet every 12 hours PRN was administered. Observation of Resident #5's medication on hand on 09/09/25 at 1:53pm revealed: -There was a punch card with 8 of 30 one-half Seroquel 25mg tablets dispensed on 08/04/25 available for administration. -The prescription label read, "Seroquel 25mg take ½ tablet every 12 hours PRN combativeness, anxiety, and insomnia. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 9:48am revealed: -Resident #5 had an order for Seroquel 25mg take ½ tablet every 12 hours PRN dated 07/31/25. -The pharmacy received the order on 08/04/25 and dispensed 30 ½ tablets of Seroquel 25mg on 08/04/25. Telephone interview with Resident #5's Mental Health Provider (MHP) on 09/10/25 at 3:42pm revealed: -Resident #5 had an order for Seroquel 25mg take ½ tablet at bedtime. -Resident #5 did not have an order through her office for Seroquel 25mg take ½ tablet every 12 hours PRN for combativeness, anxiety, and insomnia on her profile. -She did not know who ordered the PRN dose of Seroquel. Second telephone interview with a representative for the facility's contracted pharmacy on 09/10/25 at 3:58pm revealed:	D 367		

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	HAL001141	A. BUILDING: _____ B. WING _____	09/10/2025

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D 367	Continued From page 41 -The Seroquel PRN order was received from the admitting physician. -The facility staff were responsible for entering all medication orders into the eMAR. -The pharmacy's computer and the facility's eMAR did not transfer information back and forth. -The pharmacy entered orders for profiling and dispensing, the facility should enter the orders into their eMAR for administration. Interview with the medication aide (MA) on 09/10/25 at 11:20am revealed: -She had not administered Seroquel 25mg ½ tablet PRN to Resident #5 because there was no entry on the eMAR. -She had not noticed that Resident #5 had a punch card of Seroquel 25mg ½ tablet with instructions to administer every 12 hours PRN for combativeness, anxiety, and insomnia. Interview with a second MA on 09/10/25 at 11:41am revealed: -She knew Resident #5 had a PRN order for Seroquel. -She had administered the PRN dosage of Seroquel to Resident #5. -She did not realize the Seroquel 25mg ½ tablet PRN was not on the eMAR. Interview with the Health Wellness Director (HWD) on 09/10/25 at 12:27pm revealed: -She started working for the facility last week. -She knew the facility staff entered the orders, but she did not know why this order was not entered onto the eMAR. -The MAs should not administer a medication that was not on the eMAR. -The MA should verify with the HWD that there was an order for the medication before the medication was administered.	D 367		

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D 367	Continued From page 42 Interview with the Executive Director (ED) on 09/10/25 at 4:23pm revealed: -The medication should not have been administered if it was not on the eMAR. -The MA should have verified the order since the medication was on the medication cart and not on the eMAR. -The HWD was responsible for ensuring medication carts were audited weekly. -The HWD could delegate the medication cart audit to the MAs. -The staff should compare the medications on the eMAR to the medications on the medication cart. -If there was a discrepancy, the HWD should follow up with the pharmacy or the PCP.	D 367		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 03/26/25 revealed:	D 406		

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-Diagnoses included mild dementia, pancreatic cancer, and diabetes mellitus secondary to pancreatic cancer.
-There was an order for Primidone 100mg (used to treat tremors) at bedtime.

Review of the quarterly pharmacy medication reviews for Resident #1 dated 05/09/25 and 08/31/25 revealed:
-There was a discrepancy between the entry for Primidone on the electronic medication administration record (eMAR) and the order for Primidone.
-The order read, "Primidone 50mg two tablets (100mg) at bedtime for tremors."
-The eMAR entry read, "Primidone 50mg one tablet daily."
-There was no documentation that the pharmacy medication recommendation had been reviewed by the primary care provider (PCP).

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/25 at 9:48am revealed:
-The pharmacy medication reviews were completed quarterly.
-Resident #1 had an order for Primidone 50mg two tablets at bedtime dated 03/26/25.
-The pharmacy did not have an order for Primidone 50mg one tablet at bedtime.
-The facility entered all orders into their eMAR system.
-Once the pharmacy received the order, the order would be entered into the pharmacy's computer system for profiling and for dispensing of the medication.

Telephone interview with Resident #1's PCP on 09/10/25 at 3:30pm revealed:
-Resident #1 had an order for Primidone 50mg 2

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D 406	Continued From page 44	D 406		

tablets at bedtime.
-She wanted Resident #1 to continue taking Primidone 50mg 2 tablets at bedtime because it was controlling his tremors.
-No one from the facility had given her a copy of the quarterly pharmacy review.

Refer to the interview with the Health and Wellness Director (HWD) on 09/10/25 at 3:30pm.

Refer to the interview with the Executive Director on 09/10/25 at 4:20pm.
2. Review of Resident #2's current FL2 dated 12/13/24 revealed diagnoses included chronic hypotension, presence of cardiac pacemaker, chronic diastolic congestive heart failure (CHF), coronary artery disease, and paroxysmal atrial fibrillation.

Review of a quarterly pharmacy drug review for Resident #2 dated 05/09/25 revealed:
-According to pharmacy records, Resident #2 was receiving levothyroxine 100 mcg tablets take one tablet by mouth once daily, but the entry on the electronic medication administration record (eMAR) was for levothyroxine 50mcg, take two tablets once daily.
-There was a recommendation that the eMAR should match the medication strength and quantity being administered.

Review of Resident #2's July, August, and September 2025 eMAR revealed there was an entry for levothyroxine 50 mcg capsules take two tablets by mouth daily in the morning.

Telephone interview with a representative from Resident #2's pharmacy on 09/10/25 at 2:20pm revealed according to their records Resident #2 was receiving levothyroxine 100 mcg tables take

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D 406	Continued From page 45 one tablet by mouth daily. Refer to the interview with the Health and Wellness Director (HWD) on 09/10/25 at 3:30pm. Refer to the interview with the Executive Director (ED) on 09/10/25 at 4:20pm. _____ Interview with the Health and Wellness Director (HWD) on 09/10/25 at 3:30pm revealed: -She was responsible for reviewing the quarterly pharmacy reviews for recommendations or requested follow-up. -If the pharmacy staff had a recommendation, she was responsible for giving that recommendation to the resident's primary care provider (PCP). -If new orders were received from the PCP based on the pharmacist's recommendation, she was responsible for processing those new orders. -She was not aware of any residents having recommendations that were not followed up on. Interview with the Executive Director (ED) on 09/10/25 at 4:20pm revealed: -The HWD received the quarterly pharmacy reviews and was responsible for reviewing them and following up on any recommendations. -She was not aware there were residents who had recommendations on their pharmacy reviews that had not been addressed.	D 406		