STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025046	A. BUILDING: _____ B. WING _____	R 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE INDIGO AT NEW BERN	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(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 Craven County Department of Social Services conducted a follow-up survey on 09/24/25 through 09/26/25.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 5 sampled residents (#1, #2) related to failing to obtain an x-ray that was ordered by a provider (#1) and failing to notify the provider of blood sugars greater than 400. The findings are: 1. Review of Resident #1's current FL-2 dated 06/25/25 revealed: -Diagnoses included dementia, gastroesophageal reflux disease (GERD) and atrial fibrillation. -Resident #1 was semi-ambulatory and constantly disoriented. Review of Resident #1's accident and injury report dated 09/18/25 revealed: -There was an injury of unknown origin in which Resident #1 was found to have bruising on the top of her left foot and toes while she was being assisted to bed. -There was bruising to the bottom of her right foot and swelling of her right ankle. -There was documentation Resident #1's primary	{D 273}		

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{D 273}	Continued From page 1	{D 273}		

care provider was notified at 9:43pm.

Review of a teletriage report regarding Resident #1 dated 09/18/25 revealed:
-There was an order to obtain a STAT x-ray of the right foot and ankle due to bruising and swelling ordered at 9:45pm.
-There was a clarification that the left foot, complete views, were to be x-rayed as well at 9:47pm.

Review of Resident #1's record revealed there were no results for x-rays completed on 09/18/25 through 09/21/25.

Review of Resident #1's after visit summary from the local emergency department (ED) dated 09/22/25 revealed:
-She was seen by providers for a fall.
-There was a x-ray completed of the left foot due to trauma with no acute findings for fracture.
-There was no documentation an x-ray of the right foot was performed.

Review of Resident #1's physician's order dated 09/25/25 revealed there was a clarification order to discontinue the right foot and ankle x-ray.

Telephone interview with the on-call provider for Resident #1 on 09/26/25 at 1:54pm revealed:
-A STAT order meant it was to be completed as soon as possible.
-Resident #1 could have been sent to the local ED for the x-ray if there was a true concern but the x-ray may have just been precautionary to confirm no major injury , however Resident #1's PCP was not available and she was not the provider that ordered the x-ray and could not give definative reason for the x-ray.
-The facility did not have the x-rays completed

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{D 273}	Continued From page 2	{D 273}		

before Resident #1 was sent out to the hospital on 09/22/25.

Interview with a medication aide on 09/26/25 at 3:45pm revealed:
-She was on duty on 09/19/25 and the previous MA reported to her that an x-ray was ordered and not completed.
-No one came to complete the x-rays ordered for Resident #1 during her shift.
-She reported off the information to the next shift but did not notify management.
-It sometimes took days for radiology to come out to the facility.

Interview with the Administrator on 09/26/25 at 3:37pm revealed:
-STAT orders were usually completed within 24 hours but goal is for the same day it is ordered.
-The MAs should have notified her and followed up when x-ray did not come to the facility during their shift.
-She was not aware the x-rays were not completed as ordered.

2.Review of Resident #2's current FL-2 dated 02/19/25 revealed:
-Diagnoses included diabetes, coronary artery disease and peripheral vascular disease.
-There was an order to check blood sugar levels four times each day at meals and bedtime.

Review of Resident #2's physician's order dated 07/30/25 revealed:
-There was an order to check blood sugar levels four times a day.
-There were instructions to call the provider if the blood sugar was over 400 or less than 60.

Review of Resident #2's electronic medication

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{D 273}	Continued From page 3 administration record (eMAR) for September 2025 revealed: -There was an electronic entry for blood sugars to be checked four times each day at meals and bedtime and scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation Resident #2's blood sugar was 424 at 8:00am and 404 at 5:00pm on 09/09/25. -There was documentation Resident #2's blood sugar was 414 at 12:00pm on 09/15/25. Telephone interview with Resident #2's primary care provider on 09/26/25 at 1:54pm revealed: -There was no notification of blood sugars greater than 400 for Resident #2 on 09/09/25 and 09/15/25. -Notification was important monitor and adjust insulin doses. -Increased blood sugar levels increased the risk of organ damage. Interview with the Administrator on 09/25/25 at 1:55pm revealed: -Medication Aides were resposible for notifying providers with blood sugars were outside of parameters. -MAs could make notifications through text service and she was emailed the notification to providers in the system. -There was not notification of blood sugars greater than 400 for Resident #2	{D 273}		
{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	{D 310}		

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{D 310}	Continued From page 4 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 a therapeutic diet was served as ordered for 1 of 4 sampled resident (#6) who had a physician's order for a mechanical soft diet with no added salt (#6). The findings are: Review of Resident #6's current FL-2 dated 03/26/25 revealed: -Diagnosis included severe onset alzheimer's disease. -She was constantly disoriented. Review of an undated resident diet list posted in the special care unit (SCU) on 09/26/25 at revealed: -There were 52 residents listed. -22 names were marked through with a pen and "expired" was documented in the comments section for each name. -6 names were marked through with a pen and "moved" was documented in the comments section for each name. -Resident #6 was not listed on the posted diet list. Review of the resident diet list posted in the kitchen on 09/25/25 revealed Resident #6 was listed as a regular diet with a mechanical soft consistency. Review of Resident #6's diet order dated 03/26/25 revealed she was to be served a regular, no added salt diet with a mechanical soft consistency.	{D 310}		

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{D 310}	Continued From page 5 Review of the breakfast menu dated 09/25/25 revealed bagel, cream cheese, yogurt, fresh fruit and juice were to be served. Review of the diet extention menu for the breakfast meal dated 09/25/25 revealed the bagel shoud be served soft, bite sized and moistened. Observation of the breakfast meal service on 09/25/25 revealed: -Resident #6 was served 2 toasted bagel halves, cream cheese and cup of yogurt at 7:54am. -A care aide for hospice broke the bagel into bite size pieces and began feeding Resident #6. Interview with the hospice aide on 09/25/25 at 8:16am revealed: -She came to assist with Resident #6 2 days per week. -She assisted with feeding to help the facility staff. -Resident #6 was always served a regular consistency. -She did not know what diet Resident #6 was prescribed. -She had not noticed Resident #6 coughing or choking during meals. Interview with a medication aide (MA) on 09/25/25 at 7:57am revealed Resident #6 was on a regular diet. Interview with Resident #6's hospice nurse on 09/25/25 at 2:14pm revealed: -Resident #6 was ordered a mechanical soft diet for risk of aspiration due to a history of seizure like activity. -Not being served a mechanical soft diet increased her risk of choking and aspiration.	{D 310}		

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{D 310}	Continued From page 6 Interview with the cook on 09/25/25 at 8:03am revealed: -She did not look at the posted diet list in the kitchen. -The staff in the SCU told her Resident #6 was on a regular diet. Second interview with the cook on 09/25/25 at 1:39pm revealed: -She worked as a cook at the facility for 8 years. -She took a class to learn how to prepare modified texture diets. -A mechanical soft diet was ordered when a person had difficulty swallow and could choke easily. -She thought Resident #6 was deceased. -She should have looked at the diet list posted in the kitchen to ensure appropriate diet is served to each resident. Interview with the Kitchen Manager on 09/25/25 revealed: -Resident #6 was on a mechanical soft diet. -Bagels were not mechanically soft and should not be served to Resident #6. -The cook was responsible for ensuring the appropriate consistency was served to residents on a modified texture diet. Interview with the Assistant Administrator on 09/26/25 at 10:54am revealed: -The Kitchen Manager was responsible for ensuring an updated diet list is available in the kitchen and SCU. -She provided the Kitchen Manager with diet orders for newly admitted residents and updated orders when diets changed. -Staff in the SCU should know what diet is ordered for each resident. -Resident #6 had trouble swallowing in the past	{D 310}		

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{D 310}	Continued From page 7 but has improved however she was at risk of choking or aspirating if she was not served the appropriate diet texture. Interview with the Administrator on 09/26/25 at 3:37pm revealed: -Resident #6's mechanical soft diet was ordered when hospice was put into place. -There was no process to ensure the Kitchen Manager posted updated diet lists in the SCU. -The Kitchen Manager was responsible for ensuring the cooks and the staff had access to accurate therapeutic diet list. -She expected cooks to refer to the diet list when plating food for each resident.	{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 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 physician's order for 1 of 5 sampled residents to include the frequency of application of a toe spacer. (#5).	{D 344}		

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{D 344}	Continued From page 8 The findings are: Review of Resident #5's current FL2 dated 05/09/25 revealed: -Diagnoses included hyperlipidemia, anxiety, and atherosclerotic disease. -She was intermittently confused. Review of Resident #5's podiatry provider progress notes dated 07/17/25 revealed: -Under physical exam, the resident had a hammertoe of the right great toe with pressure on the second toe, with no redness present. -Under additional orders, a toe spacer was recommended between the right great toe and the second toe. -A silicone toe sleeve could be used to reduce friction and pressure if the spacer was not tolerated. Review of Resident #5's physician order dated 07/17/25 revealed: -A toe spacer was recommended for between the right great toe and the second toe. -A silicone toe sleeve could be used to reduce friction and pressure if the spacer was not tolerated. Review of Resident #5's July 2025 electronic medication administration (eMAR) revealed there was no entry for a toe spacer. Review of Resident #5's August 2025 eMAR revealed: -There was an entry for a toe spacer between the right great toe and second toe, silicone toe sleeve can also be used to reduce friction if spacer is not tolerated scheduled as needed (PRN) with a start date of 08/01/25.	{D 344}		

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{D 344}	Continued From page 9 -There was no documentation that a toe spacer was applied to Resident #5 on 08/01/25 through 08/31/25. Review of Resident #5 September 2025 eMAR revealed: -There was an entry for a toe spacer between the right great toe and second toe, silicone toe sleeve can also be used to reduce friction if spacer is not tolerated scheduled as needed (PRN) with a start date of 08/01/25. -There was no documentation that a toe spacer was applied to Resident #5 on 09/01/25 through 09/24/25. Observations of the medication cart on 09/25/25 at 11:11am revealed there was not a toe spacer on the medication cart for Resident #5. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 09/26/25 at 3:17pm revealed: -An order was received for Resident #5 to have a toe spacer to use between the right great toe and second toe on 07/25/25 at 11:04am and they placed it on the resident's eMAR. -A toe spacer was not dispensed for Resident #5 and she was not sure why the toe spacer was not dispensed. Observation of Resident #5 on 09/25/25 at 8:52am revealed she did not have a toe spacer in place on her right foot. Interview with Resident #5 on 09/25/25 at 8:52am revealed: -Her right great toe caused calluses on the second toe. -She saw a provider last week about her feet. -She moisturized her feet with lotion after her	{D 344}		

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{D 344}	Continued From page 10	{D 344}		

showers.
-Staff had never offered her a toe spacer.
-She was not aware a toe spacer had been ordered for her.
-She had never used a toe spacer for her toes but thought it was a good idea.

Interview with a medication aide (MA) on 09/25/25 at 7:31am revealed:
-The MAs faxed orders to the pharmacy then gave the orders to the Resident Care Coordinator (RCC) or Registered Nurse (RN).
-The RCC and RN were no longer at the facility and the Assistant Administrator (AA) or the Administrator currently received orders after they were faxed to the pharmacy.
-Previously the RCC or the RN approved all the orders for the residents.
-Currently the AA or the Administrator approved all orders for the residents.
-If there were questions or if an order needed clarification, that was previously handled by the RCC or the RN but was now handled mainly by the AA or the Administrator.

Interview with a second MA on 09/25/25 at 11:11am revealed:
-There was no toe spacer on the medication cart for Resident #5.
-She thought she had seen a toe spacer for Resident #5 in the past but was not certain.
-She had never applied a toe spacer to Resident #5.

Interview with a third MA on 09/25/25 at 3:31pm revealed:
-The MAs or the Resident Care Coordinator (RCC) were responsible for ordering medications.
-The MAs faxed orders to the pharmacy then gave the orders to the RCC.

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-The RCC was no longer at the facility, so the orders were now given to either Assistant Administrator (AA) or the Administrator.
-If there was a question about an order the RCC contacted the provider for clarification, since there was no RCC, the AA or the Administrator contacted the provider if there were questions about orders for the residents.
-She had never seen a toe spacer for Resident #5.
-She had never applied a toe spacer to Resident #5.
-She was not aware of an order for a toe spacer for Resident #5.
-The toe spacer order for Resident #5 was a PRN so it would not pop up on her eMAR.

Interview with the AA on 09/26/25 at 12:10pm revealed:
-She was not aware there was an order for a toe spacer for Resident #5.
-She had never seen the order for the toe spacer for Resident #5 until today.
-The MAs faxed orders to the pharmacy and then gave the orders to either the RCC or the RN.
-The RCC or RN were responsible to review and approve all orders after the orders were entered onto the eMAR system.
-The RCC or RN should have reviewed Resident #5's order for a toe spacer and contacted the provider to clarify whether her toe spacer was to be used daily or as needed.
-The RCC and RN were no longer at the facility, and it was currently her or the Administrator's responsibility to review and get clarification of the residents' orders if needed.

Interview with the Administrator on 09/26/25 at 3:59pm revealed:
-The RCC or the RN were responsible for

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{D 344}	Continued From page 12 reviewing and approving all orders. -The RCC should have reviewed Resident #5's order for a toe spacer and contacted the provider to clarify if the toe spacer was to be used daily or as needed. -The RCC and RN were no longer at the facility and currently it was the responsibility of the AA or herself to review and approve orders for the residents. Interview with Resident #5's podiatry provider on 09/25/25 at 10:58am revealed: -She saw Resident #5 for nail trimmings and treated for her for hammer toe (hammertoes are bends in the toe joints that make them point up instead of lying flat). -She recommended a toe spacer for Resident #5 to keep the toes from rubbing. -Without the toe spacer, it was possible that Resident #5's toes could rub together and cause a wound. -She was not sure who was responsible for providing the toe spacer for Resident #5. -The toe spacer for Resident #5 was to be used daily and not as needed. -Resident #5 still needed the toe spacer and she was not aware that a toe spacer had not been provided for Resident #5. -She expected Resident #5 to be provided with a toe spacer to be used daily. -The facility had not contacted her to clarify whether the to spacer was to be used daily or as needed.	{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	{D 358}		

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preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to administer medications as ordered to 3 of 5 sampled residents, (#1, #4, #5) to include medications used to treat bacterial infections, shortness of breath and inflammation (#5), medications used to treat anxiety and mild to moderate pain (#4), and medications used to treat hypertension, and medication used to treat and prevent blood clots (#1).

The findings are:

Review of the facility's Medication Administration policy effective/revised date of 12/01/24 revealed:
-Medication management is done on a scheduled basis for residents who have delegated administration, according to their service plan and physician's orders.
-If a resident is medication managed, medications (prescription and non-prescription) and treatment ordered shall have an order in the resident record for approved medication staff to assist with.
-The residents medication administration record (MAR) accuracy is of utmost importance and shall include the resident's name, the name of the medication/treatment order, the strength and dose or quantity of medication administered, the instructions for administration/treatment, the

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reason for the medication or treatment as needed and documenting the resulting effect, the date and time of administration, document any omission of medications or treatments and the reason including refusals, the name and initials of the person administering the medication or treatment (initials shall have a record of the employees name), if the preparation order differs from the staff that delivers, documentation shall accompany each part, documentation of the order shall occur following the delivery of the care service and observing the resident actually took the medication/treatment completion, this is done prior to exiting the resident's location and assisting another resident.
-Orders shall be followed by verifying the order with each medication three times and completed within the hour before or one hour after the ordered time.
-Completing is verifying the medication was taken or treatment was completed, and documentation completed following verification.
-Medication errors, unavailability of a medication, resident refusal of medication, any adverse reactions shall be documented and notification to provider to accompany as applicable.
-Medications shall be administered and documented per order.
-If a medication is missed and not given, this should be reported to the nurse/Administrator and will be entered as a medication error/incident report.

1. Review of Resident #5's current FL2 dated 05/09/25 revealed:
-Diagnoses included hyperlipidemia, anxiety, and atherosclerotic disease.
-She was intermittently confused.

a. Review of Resident #5's emergency

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department (ED) after visit summary dated 07/18/25 revealed:
-Resident #5's reason for visit was documented as dizziness, cough, and fever.
-Resident #5's diagnosis was bronchitis.
-There was an order to start taking azithromycin (azithromycin is an antibiotic used to treat bacterial infections) 250mg, take 2 tablets daily for one day, then 1 tablet daily for 4 days, start taking on 07/18/25.

Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for azithromycin 250mg, take two tablets (500mg) on day 1 for infection scheduled at 8:00am with a start date of 07/20/25.
-There was a dash only and no initials in the space for azithromycin 250mg, take two tablets (500mg) on day 1 for infection, scheduled at 8:00am on 07/20/25.
-There was no documentation that azithromycin 250mg, two tablets were administered at 8:00am on 07/20/25.
-There was a second entry for azithromycin 250mg, take one tablet daily on days 2 through 5 for infection, scheduled at 8:00am with a start date of 07/21/25.
-Azithromycin 250mg, one tablet daily on days 2 through 5 was documented as administered at 8:00am on 07/21/25 through 07/24/25.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/26/25 at 3:17pm revealed:
-An order was received for Resident #5 for azithromycin 250mg, take 2 tablets on day 1 and take one tablet on days 2 through 5 on 07/18/25 at 10:23pm.

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-Azithromycin 250mg tablets to take 2 tablets on day 1 and one tablet on days 2 through was sent to the facility on 07/19/25 to start on 07/20/25 for a quantity of 6 tablets.
-If the complete dose of azithromycin was not administered, Resident #5 could have experienced a secondary infection.
-There were no azithromycin tablets returned to the pharmacy for Resident #5.

Interview with Resident #5 on 09/25/25 at 8:52am revealed:
-She remembered having a cough and clogged nostrils in July.
-She was given antibiotics and steroids and thought it took her a while to get better.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/26/25 at 12:25pm was unsuccessful.

Telephone interview with the on-call PCP for the facility on 09/26/25 at 2:13pm revealed:
-She was familiar with Resident #5.
-Resident #5 was prescribed azithromycin from the ED on 07/18/25 to treat a respiratory illness.
-Azithromycin had a long half-life, meaning that it remained active in the body for an extended period and worked past the date of dose completion.
-She had no concerns that Resident #5 missed the loading dose of azithromycin.

Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am.

Refer to interview with a second MA on 09/25/25 at 3:31pm.

Refer to interview with the Assistant Administrator

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{D 358}	Continued From page 17 (AA) on 09/26/25 at 11:06am. Refer to interview with the Administrator on 09/26/25 at 3:59pm. b. Review of Resident #5's emergency department (ED) after visit summary dated 07/18/25 revealed: -Resident #5's reason for visit was documented as dizziness, cough, and fever. -Resident #5's diagnosis was bronchitis. -There was an order to start taking prednisone (prednisone is a corticosteroid medication used to treat various conditions including asthma, allergies, inflammation, and breathing disorders) 20mg, take 2 tablets in the morning for 5 days. Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for prednisone 20mg, take 2 tablets (40mg) in the morning for 5 days for inflammation, scheduled at 8:00am with a start date of 07/20/25 and an end date of 07/24/25. -There was a dash only and no initials in the space for prednisone 20mg, take two tablets (40mg) in the morning for 5 days for inflammation, scheduled at 8:00am on 07/20/25. -There was no documentation that prednisone 20mg, two tablets were administered at 8:00am on 07/20/25. -There was documentation that prednisone 20mg, take 2 tablets (40mg) in the morning for 5 days was administered at 8:00am in 07/21/25 through 07/24/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/26/25 at 3:17pm revealed: -An order was received for Resident #5	{D 358}		

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prednisone 20mg, take 2 tablets daily in the morning for 5 days on 07/18/25 at 10:23pm.
-Prednisone 20mg tablets, take 2 tablets daily in the morning for 5 days was sent to the facility on 07/19/25 to start on 07/20/25 for a quantity of 10 tablets.
-If the complete dose of prednisone was not administered, Resident #5 could have experienced shortness of breath.

Interview with Resident #5 on 09/25/25 at 8:52am revealed:
-She remembered having a cough and clogged nostrils in July.
-She was given antibiotics and steroids and thought it took her a while to get better.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/26/25 at 12:25pm was unsuccessful.

Telephone interview with the on-call PCP for the facility on 09/26/25 at 2:13pm revealed:
-She was familiar with Resident #5.
-Resident #5 was prescribed prednisone from the ED on 07/18/25 to treat bronchitis (bronchitis is an inflammatory disease of the respiratory system).
-Prednisone helps treat inflammation of the lungs associated with bronchitis, and not receiving the full dose of prednisone could cause Resident #5 to experience shortness of breath and or coughing.

Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am.

Refer to interview with a second MA on 09/25/25 at 3:31pm.

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{D 358}	Continued From page 19 Refer to interview with the Assistant Administrator on 09/26/25 at 11:06am. Refer to interview with the Administrator on 09/26/25 at 3:59pm. _____ Interview with a medication aide (MA) on 09/25/25 at 7:31am revealed: -The MAs always documented on the eMAR if a medication was or was not administered. -There should never be blanks on the eMAR. -If a medication was not administered to a resident, a reason should always be documented. Interview with a second MA on 09/25/25 at 3:31pm revealed: -If medications were not available for a resident, it was usually because they were waiting on the pharmacy to deliver it. -If an order was received before 3:00pm, the pharmacy would deliver the medication that evening or night for the medication to start the following morning. Interview with the Assistant Administrator (AA) on 09/26/25 at 11:06am revealed: -The Resident Care Coordinator (RCC) or the Registered Nurse (RN) were responsible to review the residents' eMARs daily for omissions or missed doses of medications. -The facility no longer had an RCC or RN and she or the Administrator were responsible to review the residents eMARs daily for omissions and refusals, the corporate RN was trying to assist her and the Administrator with the eMAR reviews. -The RCC was here in July 2025 and should have caught Resident #5's missed initial dose of azithromycin and prednisone. -There should never be blanks on the eMARs.	{D 358}		

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{D 358}	Continued From page 20 Interview with Administrator on 09/26/25 at 3:59pm revealed: -Resident #5 went to the ED in July 2025 and was treated for pneumonia. -The residents' eMAR should never be blank. -Resident #5's missed dose of azithromycin and prednisone should have been caught by the previous RCC per the daily eMAR review. -Resident #5 should have received the full dose of azithromycin and prednisone as ordered. c. Review of Resident #5's signed physicians order sheet dated 07/30/25 revealed an order for albuterol HFA 90mcg (albuterol is used to treat or prevent bronchospasm, which is the tightening or narrowing of the airways in the lungs, it helps open the air passages to make breathing easier), inhale 2 puffs every 4 hours as needed. Review of Resident #5's primary care provider (PCP) progress note dated 07/30/25 revealed an order for albuterol HFA 90mcg/ actuation aerosol inhaler, inhale 1 puff twice a day for 7 days for wheezing. Review of Resident #5's handwritten order sheet signed and dated by her PCP on 07/30/25 revealed an order for albuterol HFA 90mcg inhaler, inhale one puff twice daily for 7 days for wheezing. Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol HFA 90mcg inhaler, inhale 2 puffs every 4 hours as needed for shortness of breath or wheezing. -Albuterol HFA 90mcg inhaler, inhale 2 puffs every 4 hours as needed for shortness of breath or wheezing was not documented as	{D 358}		

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administered on 07/30/25 or 07/31/25.
-There was a second entry for albuterol HFA 90mcg, inhalation aerosol solution, inhale 1 puff twice daily for 7 days for wheezing scheduled at 8:00pm only with a start date of 07/31/25.
-Albuterol HFA 90mcg inhaler, inhale 1 puff twice daily for 7 days was documented as administered at 8:00pm on 07/31/25.

Review of Resident #5's August 2025 eMAR revealed:
-There was an entry for albuterol HFA 90mcg inhaler, inhale 2 puffs every 4 hours as needed for shortness of breath or wheezing.
-Albuterol HFA 90mcg inhaler, inhale 2 puffs every 4 hours as needed for shortness of breath or wheezing was not documented as administered on 08/01/25 through 08/31/25.
-There was no entry for albuterol HFA 90mcg, inhalation aerosol solution, inhale 1 puff twice daily for 7 days for wheezing.

Observations of Resident #5's medications on hand on 09/24/25 at 3:46pm revealed:
-There was pharmacy labeled box for albuterol HFA 90mcg, 200 metered inhalations, inhale 2 puffs every 4 hours as needed for shortness of breath or wheezing that contained one albuterol inhaler that had 202 doses remaining on the dose counter with a dispense date of 05/14/25.
-There was a second pharmacy labeled box for albuterol HFA 90mcg, 200 metered inhalations, inhale 1 puff twice daily for 7 days for wheezing that contained one albuterol inhaler that had 200 doses remaining on the dose counter with a dispense date of 07/30/25.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/26/25 at 3:17pm revealed:

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{D 358}	Continued From page 22 -An order was received for Resident #5 for albuterol HFA 90mcg, inhale one puff twice daily for 7 days on 07/30/25 at 12:21pm. -Albuterol HFA 90mcg, inhale 1 puff twice daily for 7 days was dispensed on 07/30/25 to start on 07/31/25 for 1 inhaler that contained 200 doses. -Some manufacturers included doses in addition to the 200 inhalations to allow for priming of the inhaler. -If Resident #5 did not receive her albuterol as ordered, she could experience shortness of breath and difficulty breathing. Interview with Resident #5 on 09/25/25 at 8:52am revealed: -She remembered having a cough and clogged nostrils in July. -She was given antibiotics and steroids and thought it took her a while to get better. -She had never used an albuterol inhaler that she knew of. Interview with a medication aide (MA) on 09/24/25 at 3:46pm revealed: -Resident #5 had an as needed order for the albuterol inhaler but she never requested it. -She was not aware that Resident #5 ever had a scheduled order for the albuterol inhaler. Interview with a second MA on 09/25/25 at 3:31pm revealed: -Resident #5 had an albuterol inhaler on the medication cart to be used as needed but she had never administered albuterol to Resident #5. -She was not aware that Resident #5 had a second albuterol inhaler on the medication cart with instructions to use twice daily for 7 days. -She did not know why albuterol had not been administered to Resident #5 when it was ordered as a scheduled dose.	{D 358}		

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{D 358}	Continued From page 23 Interview with the Assistant Administrator (AA) on 09/26/25 at 11:52am revealed: -The MAs faxed orders to the pharmacy. -After the MA faxed the orders to the pharmacy, the orders were given to the RCC or the RN. -The Resident Care Coordinator (RCC) or the Registered Nurse (RN) were responsible to approve all orders. -Medication orders were not approved until the medications arrived at the facility. -The RCC or the RN were responsible to add start and stop dates for medications that were ordered short term. -The RCC or the RN were responsible for daily eMAR audits or reviews. -The RCC and RN were no longer at the facility. -She and the Administrator were now responsible for daily eMAR audits, and the corporate RN tried to help with the daily eMAR audits as well. -She did not know why Resident #5's scheduled albuterol did not appear on her August 2025 eMAR. Interview with the Administrator on 09/26/25 at 3:59pm revealed: -The RCC or the RN were responsible to approve all orders for the residents. -The pharmacy, RCC or the RN, could add start and stop dates to short term medications. -Resident #5 had pneumonia back in July and her condition had worsened, and medications were re-ordered. -She did not know why Resident #5's scheduled albuterol fell off the August 2025 eMAR. -It was possible that the wrong stop date was mistakenly entered for Resident #5's scheduled albuterol when her order was approved. -Resident #5 should have received her scheduled albuterol as ordered.	{D 358}		

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{D 358}	Continued From page 24 Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/26/25 at 12:25pm was unsuccessful. Telephone interview with the on-call PCP for the facility on 09/26/25 at 2:13pm revealed: -She was familiar with Resident #5. -Resident #5 was prescribed scheduled albuterol on 07/30/25 per her PCP to treat bronchial irritation and inflammation. -Not having albuterol could cause Resident #5 to worsening symptoms such as wheezing and shortness of breath. -The facility was responsible to make sure the residents' medications were available and administered as ordered. 2. Review of Resident #4's current FL-2 dated 02/19/25 revealed diagnoses included dementia, anxiety and peripheral vascular disease. a. Review of Resident #4's physician's order dated 09/15/25 revealed there was an order for lorazepam 0.5mg at 2:00pm daily. (Lorazepam is a medication used to treat anxiety and agitation.) Review of Resident #4's hospice comprehensive assessment and plan of care update report dated 09/16/25 revealed: -Resident #4 had increased restlessness and required extensive redirection for safety which escalated to a fall over this past weekend. -The hospice nurse discussed Resident #4's	{D 358}		

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"considerable restlessness and fear for safety" with family with agreement to add a dose of lorazepam at 2:00pm in hopes of decreasing afternoon agitation.
-There was an order to add lorazepam 0.5mg at 2:00pm daily with a start date of 09/15/25.

Review of Resident #4's September 2025 eMAR revealed there was no entry for lorazepam 0.5mg to be administered each day at 2:00pm.

Observation of medications on hand for Resident #4 on 09/25/25 at 3:30pm revealed there was no lorazepam 0.5mg labeled to be administered each day at 2:00pm available for administration.

Observation of Resident #4 on 09/24/25 at 3:50pm revealed:
-She was sitting in a gerichair in the common room of the special care unit (SCU).
-She was agitated, made multiple attempts to get up from the chair and required redirection from staff.

Interview with a medication aide (MA) on 09/25/25 at 3:36pm revealed Resident #4 was not administered lorazepam 0.5mg each day at 2:00pm because it was not on the eMAR.

Interview with Resident #4's family member on 09/24/25 at 10:56am revealed:
-Resident #4 had been increasingly agitated and had fallen.
-Lorazepam 0.5mg was prescribed to help with Resident #4's restlessness in the afternoon because Resident #4 would try to get up alone and thought it may help to decrease the risk of falls.

Interview with Resident #4's hospice nurse on

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(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 358}	Continued From page 26 09/24/25 at 11:10am revealed Resident #4 last fell on 09/14/25. Second interview Resident #4's hospice nurse on 09/25/25 at 2:14pm revealed: -Resident #4 was prescribed lorazepam 0.5mg to be administered each day at 2:00pm on 09/15/25 to decrease restlessness and agitation which had led to falls. -If Resident #4 did not receive the lorazepam 0.5mg at 2pm, she would continue to be agitated and this increased the risk of her falling. -Medications should be in the facility and available for administration within 24 hours of being ordered. Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed: -They received an order dated 09/15/25 for Resident #4 to be administered lorazepam 0.5mg each day at 2:00pm on 09/25/25 from Resident #4's primary care provider (PCP. -They required a hard copy prescription which was sent as an eScript on 09/26/25. -Lorazepam 0.5mg had not been dispensed until 09/26/25 but was boxed and ready to be sent to the facility to be available for the next scheduled dose. Interview with the Assistant Administrator on 09/26/25 at 10:54am revealed: -She was not aware hospice comprehensive assessment and plan of care update reports contained physician's orders. -Resident #4's comprehensive assessment and plan of care update reports were not sent to the facility the same day of the hospice visit and may be 2 weeks or a month before they were received.	{D 358}		

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{D 358}	Continued From page 27 -She was not aware of any process in which the comprehensive assessment and plan of care update reports were reviewed once they were received. -Hospice was responsible for sending physician's orders to the pharmacy and were supposed to send the order to the facility as well. Interview with the Administrator on 09/25/25 at 4:05pm revealed: -She was aware physicians orders were written in the hospice comprehensive assessment and plan of care update reports. -She did not review the hospice comprehensive assessment and plan of care update reports. -She did not review the reports for physicians orders because hospice was responsible for sending the orders to pharmacy. -She was not aware Resident #4 had an order for lorazepam 0.5mg to be administered at 2:00pm each day until that morning (09/25/25) so no one had followed-up to ensure the medication was on the eMAR and administered as ordered. Refer to interview with the Assistant Administrator on 09/26/25 at 11:06am. Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am. Refer to interview with a second MA on 09/25/25 at 3:31pm. b. Review of Resident #4's physician's order dated 07/31/25 revealed acetaminophen extra strength, 2 tablets (1000mg) was to be administered every 8 hours for 5 days for acute pain. (Acetaminophen is a medication used to treat pain.)	{D 358}		

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{D 358}	Continued From page 28 Review of Resident #4's July 2025 electronic medication administration (eMAR) record revealed: -There was an entry for acetaminophen extra strength, 2 tablets (1000mg) to be administered every 8 hours for 5 days and scheduled for 6:00am, 2:00pm and 10:00pm. -There was no documentation acetaminophen extra strength, 2 tablets (1000mg) was administered at 6:00am, 2:00pm or 10:00pm on 07/31/25. Review of Resident #4's August 2025 eMAR revealed: -There was an entry for acetaminophen extra strength, 2 tablets (1000mg) to be administered every 8 hours for 5 days and scheduled for 6:00am, 2:00pm and 10:00pm. -There was no documentation acetaminophen extra strength, 2 tablets (1000mg) was administered at 6:00am on 08/01/25 through 08/04/25. -There was documentation acetaminophen extra strength, 2 tablets (1000mg) was administered at 2:00pm on 08/02/25 through 08/04/25. -There was no documentation acetaminophen extra strength, 2 tablets (1000mg) was administered at 2:00pm on 08/01/25. -There was no documentation acetaminophen extra strength, 2 tablets (1000mg) was administered at 10:00pm on 08/01/25 through 08/04/25. -There was no documentation 12 of 15 scheduled doses of acetaminophen extra strength, 2 tablets (1000mg) were administered to Resident #4 from 07/31/25 through 08/04/25. Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed:	{D 358}		

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{D 358}	Continued From page 29	{D 358}		

-An order for acetaminophen extra strength, 2 tablets (1000mg) to be administered every 8 hours for 5 days was called in to the pharmacy by Resident #4's hospice provider on 07/31/25.
-A quantity of 30 acetaminophen extra strength (500mg) tablets were dispensed on 07/31/25 for a 5 day supply.
-No acetaminophen extra strength (500mg) tablets were returned to the pharmacy.
-Resident #4's pain would not be well controlled if she was not administered the medication as prescribed.

Interview Resident #4's hospice nurse on 09/25/25 at 2:14pm revealed:
-Resident #4 has a fall and was prescribed a scheduled course of acetaminophen extra strength, 2 tablets (1000mg) to be administered every 8 hours for 5 days.
-She expected acetaminophen extra strength, 2 tablets (1000mg) to be administered every 8 hours along with ibuprofen 800mg to control pain related to a recent fall.
-Resident #4 would continue to experience pain if the medication was not administered as prescribed.

Refer to interview with the Assistant Administrator on 09/26/25 at 10.54am and 11:06am.

Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am.

Refer to interview with a second MA on 09/25/25 at 3:31pm.

c. Review of Resident #4's physician's order dated 07/31/25 revealed ibuprofen 800mg was to be administered every 8 hours for 5 days for acute pain. (Ibuprofen is an anti-inflammatory

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{D 358}	Continued From page 30 medication used to treat pain.) Review of Resident #4's July 2025 electronic medication administration (eMAR) record revealed: -There was an entry for ibuprofen 800mg to be administered every 8 hours for 5 days and scheduled for 6:00am, 2:00pm and 10:00pm. -There was no documentation ibuprofen 800mg was administered on 07/31/25 at 6:00am, 2:00pm or 10:00pm. Review of Resident #4's August 2025 eMAR revealed: -There was an entry for ibuprofen 800mg to be administered every 8 hours for 5 days and scheduled for 6:00am, 2:00pm and 10:00pm. -There was no documentation ibuprofen 800mg was administered at 6:00am on 08/01/25 through 08/04/25. -There was documentation ibuprofen 800mg was administered at 2:00pm on 08/02/25 through 08/04/25. -There was no documentation ibuprofen 800mg was administered at 2:00pm on 08/01/25. -There was no documentation ibuprofen 800mg was administered at 10:00pm on 08/01/25 through 08/04/25. -There was no documentation 12 of 15 scheduled doses of ibuprofen 800mg were administered to Resident #4 from 07/31/25 through 08/04/25. Telephone interview with the pharmacist for the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed: -An order for ibuprofen 800mg to be administered every 8 hours for 5 days was called in to the pharmacy by Resident #4's hospice provider on 07/31/25. -A quantity of 15 ibuprofen 800mg tablets were	{D 358}		

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{D 358}	Continued From page 31 dispensed on 07/31/25 for a 5 day supply. -No ibuprofen 800mg tablets were returned to the pharmacy. -Resident #4's pain would not be well controlled if she was not administered the medication as prescribed. Interview Resident #4's hospice nurse on 09/25/25 at 2:14pm revealed: -Resident #4 has a fall and was prescribed a scheduled course of ibuprofen 800mg to be administered every 8 hours for 5 days. -She expected ibuprofen to be administered every 8 hours along with acetaminophen extra strength, 2 tablets (1000mg) to control pain related to a recent fall. -Resident #4 would continue to experience pain if the medication was not administered as prescribed. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with the Assistant Administrator on 09/26/25 at 10:54am and 11:06am. Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am. Refer to interview with a second MA on 09/25/25 at 3:31pm. _____ Interview with the Assistant Administrator on 09/26/25 at 10:54am revealed: -She thought staff may not have administered the 10:00pm and the 6:00am doses of acetaminophen extra strength, 2 tablets (1000mg) and the ibuprofen 800mg because Resident #4 may have been asleep.	{D 358}		

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{D 358}	Continued From page 32 -Medication aides could administer medications 1 hour before and up to 1 hour after the scheduled dose. -Resident #4 was up for breakfast by 7:00am and awake for the 6:00am doses of acetaminophen extra strength, 2 tablets (1000mg) and the ibuprofen 800mg that were ordered. -Staff should have tried to wake her up for the 10:00pm doses of acetaminophen extra strength, 2 tablets (1000mg) and the ibuprofen 800mg that were ordered. -She was not aware Resident #4 had not received acetaminophen extra strength, 2 tablets (1000mg) and the ibuprofen 800mg as ordered Interview with a medication aide (MA) on 09/25/25 at 7:31am revealed: -The MAs always documented on the eMAR if a medication was or was not administered. -There should never be blanks on the eMAR. -If a medication was not administered to a resident, a reason was always documented. Interview with a second MA on 09/25/25 at 3:31pm revealed: -If medications were not available for a resident, it was usually because they were waiting on the pharmacy to deliver it. -If an order was received before 3:00pm, the pharmacy would deliver the medication that evening or night for the medication to start the following morning. 3. Review of Resident #1's current FL-2 dated 06/25/25 revealed: -Diagnoses included dementia, gastroesophageal reflux disease (GERD) and atrial fibrillation. -Resident #1 was semi-ambulatory and constantly disoriented.	{D 358}		

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{D 358}	Continued From page 33 Review of an email correspondence dated 08/18/25 revealed: -The Administrator emailed Resident #1's primary care provider (PCP) at 9:49am informing the PCP that Resident #1's medications were not received from pharmacy because the pharmacy needed signed physician's orders. -The Administrator requested signed orders to be sent back at the PCP's earliest convenience. Review of an email correspondence dated 08/19/25 revealed: -The Administrator emailed Resident #1's primary care provider (PCP) at 10:27am informing the PCP that Resident #1's medications were not received from pharmacy because the physician's orders they received were not signed. -The Administrator asked the PCP if orders could be signed and sent back that day (08/19/25). Review of an email correspondence dated 08/28/25 revealed Resident #1's PCP at 8:20am revealed the PCP stated Resident #1's medications were sent by eScript to the pharmacy and the physicians order form had been signed. a.Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for valsartan 40mg to be administered each day. (Valsartan is a medication used to treat high blood pressure.) Review of Resident #1's physicians order dated 08/27/25 revealed valsartan was to be discontinued. Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:	{D 358}		

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-There was an electronic entry for valsartan 40mg to be administered each day and scheduled for 8:00am.
-There was documentation valsartan 40mg was administered on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/30/25.
-There was documentation valsartan 40mg was not administered on 08/18/25 through 08/21/25and on 08/25/25 because the medication was not available.
-There was documentation valsartan 40mg was not administered on 08/26/25 with no reason for omission documented.

Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed:
-Valsartan 40 mg was used to control blood pressure.
-Not being administered the valsartan 40 mg could cause blood pressure to increase which increased the risk of stroke for Resident #1.

b. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for Eliquis 5 mg to be administered twice daily. (Eliquis is a blood thinning medications used to prevent blood clots for people with atrial fibrillation.)

Review of Resident #1's physicians order dated 08/27/25 revealed Eliquis was to be discontinued.

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for Eliquis 5 mg to be administered twice daily and scheduled for 8:00am and 8:00pm.
-There was documentation Eliquis 5mg was

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administered at 8:00am and 8:00pm on 08/01/25 through 08/17/25.
-There was documentation Eliquis 5mg was not administered at 8:00am on 08/18/25 through 08/21/25 and on 08/25/25 through 08/27/25.
-There was documentation Eliquis 5mg was not administered at 8:00am on 08/18/25, 08/21/25, and on 08/27/25 because the medication was not available.
-There was no reason for omission documented for 08/19/25 through 08/20/25 and 08/25/25 through 08/26/25 at 8:00am.
-There was documentation Eliquis 5mg was administered at 8:00pm on 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25 through 08/29/25.
-There was no reason for the omission of administration documented for 08/23/25 and on 08/26/25 through 08/27/25.

Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed :
-Eliquis 5mg was used to prevent the blood from clotting due to atrial fibrillation.
-Not being administered the Eliquis 5mg could aggravate atrial fibrillation leading to blood clots, stroke or heart failure.

c. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for metoprolol 25mg to be administered twice daily. (Metoprolol is a medication used to treat high blood pressure.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for metoprolol 25mg to be administered twice daily and

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scheduled for 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered at 8:00am and 8:00pm on 08/01/25 through 08/17/25 and on 08/29/25 through 08/31/25.
-There was documentation metoprolol 25mg was not administered at 8:00am on 08/18/25 through 08/20/25 and on 08/25/25 through 08/28/25.
-There was documentation the medication was not administered because the medication was not available on 08/18/25 through 08/20/25, on 08/25/25 and on 08/27/25 thorough 08/28/25 at 8:00am.
-There was no reason for omission of administration documented for 08/26/25 at 8:00am.
-There was documentation metoprolol 25mg was administered at 8:00pm on 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25 through 08/31/25.
-There was no reason for the omission of administration documented for 08/23/25 and on 08/26/25 through 08/27/25.

Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed metoprolol 25mg was available for administration.

Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed:
-Metoprolol 25mg was used to control blood pressure.
-Not being administered the metoprolol 25mg could cause blood pressure to increase which increased the risk of stroke for Resident #1.

d. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for potassium chloride 20mEq to be administered

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each day. (Potassium chloride is used to treat low potassium levels in the blood. Potassium is essential for heart and muscle function.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for potassium chloride 20mEq to be administered each day at scheduled for 8:00am.
-There was documentation potassium chloride 20mEq was administered each day on 08/01/25 through 08/17/25 and on 08/20/25 through 08/31/25.
-There was documentation potassium chloride 20mEq was not administered on 08/18/25 through 08/19/25 because the medication was not available.

Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed potassium chloride 20mEq was available for administration.

e. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for Amiodarone 100mg to be administered each day. (Amiodarone is an anti-arrhythmic medication used to treat atrial fibrillation.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for Amiodarone 100mg to be administered each day and scheduled for 8:00am.
-There was documentation Amiodarone 100mg was administered on 08/01/25, 08/03/25, on 08/05/25 through 08/17/25, and on 08/19/25 through 08/31/25.

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{D 358}	Continued From page 38 -There was documentation Amiodarone 100mg was not administered on 08/02/25, 08/04/25 and on 08/18/25 because the medication was not available. Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed Amiodarone 100mg was available for administration. Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed: -Amiodarone 100mg was used to treat atrial fibrillation. -Not being administered Amiodarone 100mg increased the risk of stroke for Resident #1. f. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for ferrous sulfate 325mg to be administered each day. (Ferrous Sulfate is an iron supplement used to treat and prevent anemia and support the body's production of hemoglobin.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for ferrous sulfate 325mg to be administered each day and scheduled for 8:00am. -There was documentation ferrous sulfate 325mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/25/25 and on 08/29/25 through 08/31/25. -There was documentation ferrous sulfate 325mg was not administered on 08/18/25 through 08/21/25 and on 08/27/25 through 08/28/25 because the medication was not available. -There was documentation ferrous sulfate 325mg	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE INDIGO AT NEW BERN	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(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 358}	Continued From page 39 was not administered on 08/26/25 with no reason documented for the omission of administration. Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed ferrous sulfate 325mg was available for administration. Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed ferrous sulfate 325mg and could cause Resident #1 to feel tired and weak if the medication was not administered. g. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for risperidone 0.5mg to be administered each day. (Risperidone is a medication used to treat mental health disorders by regulating mood, thoughts and behaviors.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for risperidone 0.5mg to be administered each day and scheduled for 8:00am. -There was documentation risperidone 0.5mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25. -There was documentation risperidone 0.5mg was not administered on 08/18/25 through 08/21/25, 08/25/25, and on 08/27/25 through 08/28/25 because the medication was not available. -There was documentation risperidone 0.5mg was not administered on 08/26/25 with no reason documented for the omission of administration.	{D 358}		

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{D 358}	Continued From page 40 Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed risperidone 0.5mg was available for administration. Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed: -Risperidone 0.5mg was prescribed to treat Resident #1's hallucinations and agitation. -Symptoms would not be well controlled if medication is not administered as prescribed. h. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for sertraline 50mg, 1 and 1/2 tablet (75mg) to be administered each day. (Sertraline is a medication used to treat depressed mood.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for sertraline 50mg, 1 and 1/2 tablet (75mg) to be administered each day and scheduled for 8:00am. -There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg) was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25. -There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg) was not administered on 08/18/25 through 08/21/25, 08/25/25, and on 08/27/25 through 08/28/25 because the medication was not available. -There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg) was not administered on 08/26/25 with no reason documented for the omission of administration.	{D 358}		

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{D 358}	Continued From page 41 Observation of #1's medications on hand for administration on 09/25/25 at 3:20pm revealed sertraline 50mg,1 and 1/2 tablet (75mg) was available for administration. Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed : -Sertraline 50mg, 1 and 1/2 tablet (75mg) was prescribed to treat hallucinations and agitation. -Symptoms would not be well controlled if medication was not administered as prescribed. i. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for omeprazole DR 20mg to be administered each day. (Omeprazole is medication used to treat GERD by decreasing acid production in the stomach.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for omeprazole DR 20mg be administered each day and scheduled for 8:00am. -There was documentation omeprazole DR 20mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25. -There was documentation omeprazole DR 200mg not administered on 08/18/25 through 08/21/25, 08/25/25, and on 08/27/25 through 08/28/25 because the medication was not available. -There was documentation omeprazole DR 20mg was not administered on 08/26/25 with no reason documented for the omission of administration. Observation of #1's medications on hand for	{D 358}		

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{D 358}	Continued From page 42	{D 358}		

administration on 09/25/25 at 3:20pm revealed omeprazole DR 20mg was available for administration.

Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed omeprazole was ordered to treat GERD and Resident #1 could experience indigestion if omeprazole was not administered as ordered.

Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 4:12pm revealed:
-Resident #1 was dispensed medications on batch cycle fill in July 2025 that should have run out on 08/16/25. (Dispense date unknown)
-Resident #1 was not on batch cycle fill in August 2025 because the facility told them the family would be providing her medications.
-Several of Resident #1's medications were not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25.
-Resident #1's medications were dispensed on 08/29/25 for administration and has since been placed on cycle fill.

Interview with the Administrator on 09/26/25 at 9:15am revealed:
-She remembered Resident #1 being out of medications for a time in August due to physician's orders needing to be signed.
-She was not sure how long Resident #1 was out of some of her medications.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Refer to interview with the Assistant Administrator on 09/26/25 at 10:54am and 11:06am.

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{D 358}	Continued From page 43 Refer to interview with a medication aide (MA) on 09/25/25 at 7:31am. Refer to interview with a second MA on 09/25/25 at 3:31pm. _____ Interview with a medication aide (MA) on 09/25/25 at 7:31am revealed: -The MAs always documented on the eMAR if a medication was or was not administered. -There should never be blanks on the eMAR. -If a medication was not administered to a resident, a reason was always documented. Interview with a second MA on 09/25/25 at 3:31pm revealed: -If medications were not available for a resident, it was usually because they were waiting on the pharmacy to deliver it. -If an order was received before 3:00pm, the pharmacy would deliver the medication that evening or night for the medication to start the following morning. Interview with the Assistant Administrator on 09/26/25 at 11:06am revealed: -The Resident Care Coordinator (RCC) or the Registered Nurse (RN) were responsible to review the residents' eMARs daily for omissions or missed doses of medications. -The facility no longer had an RCC or RN and she or the Administrator were responsible to review the residents eMARs daily for omissions and refusals; the corporate RN was trying to assist her and the Administrator with the eMAR reviews. -There should never be blanks on the eMARs. _____ The facility failed to administer medications as ordered to 3 of 5 residents sampled. (#1, #4, #5).	{D 358}		

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{D 358}	Continued From page 44 Resident #5 missed a loading dose of an antibiotic, 1 dose of an oral steroid, and 13 doses of a bronchodialator inhaler prescribed for a respiratory illness which placed her at risk for continued infection, bronchial irritation and shortness of breath. Failing to administer Resident #4's medications placed Resident #4 at increased risk of falls due to failing to control her agitation and restlessness;failing to administer medications used to treat hypertension and prevent blood clots for 11 days placed Resident #1 at risk for a blood clot that could lead to a stroke or pulmonary embolism. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2025.	{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	{D 367}		

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#3, #5, #1) including documentation for a medication to treat bacterial infections (#3, #5), a medication used to treat inflammation (#5) and medications used to treat high blood pressure, atrial fibrillation, gastroesophageal reflux disease (GERD) and mental health symptoms (#1).

The findings are:

Review of the facility's Medication Administration policy effective/revised date of 12/01/24 revealed:
-The residents medication administration record (MAR) accuracy is of utmost importance and shall include the resident's name, the name of the medication/treatment order, the strength and dose or quantity of medication administered, the instructions for administration/treatment, the reason for the medication or treatment as needed and documenting the resulting effect, the date and time of administration, document any

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omission of medications or treatments and the reason including refusals, the name and initials of the person administering the medication or treatment (initials shall have a record of the employees name), if the preparation order differs from the staff that delivers, documentation shall accompany each part, documentation of the order shall occur following the delivery of the care service and observing the resident actually took the medication/treatment completion, this is done prior to exiting the resident's location and assisting another resident.
-Orders shall be followed by verifying the order with each medication three times and completed within the hour before or one hour after the ordered time.
-Completing is verifying the medication was taken or treatment was completed, and documentation completed following verification.
-Medication errors, unavailability of a medication, resident refusal of medication, any adverse reactions shall be documented and notification to provider to accompany as applicable.
-Medications shall be administered and documented per order.
-If a medication is missed and not given, this should be reported to the nurse/Administrator and will be entered as a medication error/incident report.

1. Review of Resident #5's current FL2 dated 05/09/25 revealed:
-Diagnoses included hyperlipidemia, anxiety, and atherosclerotic disease.
-She was intermittently confused.

Review of Resident #5's primary care provider (PCP) progress note dated 07/30/25 revealed an order to start prednisone (prednisone is a corticosteroid medication used to treat various

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{D 367}	Continued From page 47 conditions including asthma, allergies, inflammation, and breathing disorders) 20mg, take one tablet twice daily for 5 days. Review of Resident #5's handwritten order sheet signed and dated by her PCP on 07/30/25 revealed an order for prednisone 20mg, take one tablet twice daily for 5 days. Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for prednisone 20mg, take one tablet twice daily for 5 days for inflammation, scheduled at 8:00pm only, with a start date of 07/31/25. -Prednisone 20mg, take one tablet twice daily for 5 days was documented as administered at 8:00pm on 07/31/25. Review of Resident #5's August 2025 eMAR revealed: -There was an entry for prednisone 20mg, take one tablet twice daily for 5 days, scheduled at 8:00am and 8:00pm, with a start date of 07/31/25. -Prednisone 20mg was documented as administered at 8:00am on 08/01/25 through 08/04/25. -Prednisone 20mg was documented as not administered at 8:00am on 08/05/25, with the exception documented as "not on cart". -Prednisone 20mg was documented as administered at 8:00am on 08/06/25. -Prednisone 20mg was documented as not administered at 8:00am on 08/07/25, with the exception documented as "med is finished". -Prednisone 20mg was documented as not administered at 8:00am on 08/08/25 and on 08/09/25, with the exception documented as "not on cart".	{D 367}		

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-Prednisone 20mg was documented as not administered at 8:00am on 08/10/25 with the exception documented as "not on cart".
-Prednisone 20mg was documented as not administered at 8:00am on 08/11/25, with the exception documented as "finished medication".
-Prednisone 20mg was documented as not administered at 8:00am on 08/12/25, with the exception documented as "not on cart".
-Prednisone 20mg was documented as not administered at 8:00am on 08/13/25, with the exception documented as "med is finished".
-Prednisone 20mg was documented as not administered at 8:00am on 08/14/25, with the exception documented as "charted in error".
-Prednisone 20mg was documented as not administered at 8:00am on 08/15/25, with the exception documented as "medication complete".
-Prednisone 20mg was documented as not administered at 8:00am on 08/16/25, with the exception documented as "drug not available" and "NOC".
-Prednisone 20mg was documented as administered at 8:00am on 08/17/25.
-Prednisone 20mg was documented as not administered at 8:00am on 08/17/25, with the exception documented as "drug not available" and "NOC".
-Prednisone 20mg was documented as administered at 8:00pm on 08/01/25 through 08/08/25.
-Prednisone 20mg was documented as not administered at 8:00pm on 08/09/25, with the exception documented as "all tablets were taken".
-Prednisone 20mg was documented as not administered at 8:00pm on 08/10/25, with no exception documented.
-Prednisone 20mg was documented as not administered at 8:00pm on 08/11/25, with the exception documented as "prescription is

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finished".
-Prednisone 20mg was documented as administered at 8:00pm on 08/12/25.
-Prednisone 20mg was documented as not administered at 8:00pm on 08/13/25, with the exception documented as "five days is up".
-Prednisone 20mg was documented as administered at 8:00pm on 08/14/25 and 08/15/25.
-Prednisone 20mg was documented as not administered at 8:00pm on 08/16/25, with the exception documented as "not in cart".
-Prednisone 20mg was documented as administered at 8:00pm on 08/17/25.
-Prednisone 20mg was documented as administered on 18 occasions from 08/01/25 through 08/17/25.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 09/26/25 at 3:17pm revealed:
-An order was received for Resident #5 to take prednisone 20mg twice daily for 5 days on 07/30/25 at 12:21pm.
-Prednisone 20mg, take one tablet twice daily for 5 days was dispensed to the facility for Resident #5 for 10 tablets to start on 07/31/25 at 8:00am and to end at 8:00pm on 08/04/25.

Telephone interview with the on-call PCP for the facility on 09/26/25 at 2:13pm revealed:
-She was familiar with Resident #5.
-Resident #5 was prescribed prednisone on 07/30/25 treat bronchitis.
-Prednisone was prescribed for Resident #5 for 5 days only and should have been administered for 5 days only.
-The side effects from extended use of prednisone included irritability, stomach irritation, sleep interruption and suppression of the immune

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{D 367}	Continued From page 50 system. Refer to interview with a medication aide (MA) on 09/24/25 at 3:49pm. Refer to interview with a second MA on 09/25/25 at 7:31am. Refer to interview with a third MA on 09/25/25 at 3:31pm. Refer to interview with the Assistant Administrator on 09/26/25 at 10:35 AM. Refer to interview with the Administrator on 09/26/25 at 3:59pm. 2. Review of Resident #3's current FL2 dated 07/22/25 revealed: -Diagnoses included chronic kidney disease, hypertensive heart and chronic kidney disease without heart failure, atrial fibrillation, and polyneuropathy. -He was intermittently disoriented. Review of Resident #3's emergency department (ED) after visit summary dated 08/06/25 revealed: -The reason for the visit was "illness". -The diagnoses were urinary tract infection and somnolence. -There was an order to start cefuroxime (an antibiotic used to treat bacterial infections) 500mg, two times a day for seven days. Review of Resident #3's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for cefuroxime 500mg, take on tablet two times a day for seven days, scheduled at 8:00am and 8:00pm with a start	{D 367}		

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THE INDIGO AT NEW BERN	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(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
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date of 08/08/25.
-Cefuroxime 500mg was documented as administered at 8:00am on 08/09/25 through 08/15/25.
-Cefuroxime 500mg was documented as not administered at 8:00am on 08/16/25, with the exception documented as "NOC" (not on cart).
-Cefuroxime 500mg was documented as administered at 8:00am on 08/17/25.
-Cefuroxime 500mg was documented as not administered at 8:00am on 08/18/25, with the exception documented as "NOC".
-Cefuroxime 500mg was documented as administered at 8:00pm on 08/08/25 through 08/17/25.
-Cefuroxime 500mg was documented as administered on 8 occasions at 8:00am on 08/09/25 through 08/17/25.
-Cefuroxime 500mg was documented as administered on 10 occasions at 8:00pm on 08/08/25 through 08/17/25.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 09/26/25 at 2:51pm revealed:
-An order was received for Resident #3 for cefuroxime 500mg to take one tablet twice daily for 7 days on 08/07/25 at 6:30am.
-Cefuroxime 500mg was dispensed for Resident #3 to take a tablet twice daily for seven days on 08/07/25 to start 08/08/25 for a quantity of 14 tablets.

Interview with the Resident #3's hospice Registered Nurse on 09/25/25 at 2:25pm revealed Resident #3's eMAR should be documented accurately to ensure he received his medications as ordered.

Refer to interview with a medication aide (MA) on

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{D 367}	Continued From page 52 09/24/25 at 3:49pm. Refer to interview with a second MA on 09/25/25 at 7:31am. Refer to interview with a third MA on 09/25/25 at 3:31pm. Refer to interview with the Assistant Administrator on 09/26/25 at 10:35 AM. Refer to interview with the Administrator on 09/26/25 at 3:59pm. 3. Review of Resident #1's current FL-2 dated 06/25/25 revealed: -Diagnoses included dementia, gastroesophageal reflux disease (GERD) and atrial fibrillation. -Resident #1 was semi-ambulatory and constantly disoriented. Review of an email correspondence dated 08/18/25 revealed: -The Administrator emailed Resident #1's primary care provider (PCP) at 9:49am informing the PCP that Resident #1's medications were not received from pharmacy because the pharmacy needed signed physician's orders. -The Administrator requested signed orders to be sent back at the PCP's earliest convenience. Review of an email correspondence dated 08/19/25 revealed: -The Administrator emailed Resident #1's primary care provider (PCP) at 10:27am informing the PCP that Resident #1's medications were not received from pharmacy because the pharmacy was needing signed physician's orders were not signed. -The Administrator asked the PCP if orders could be signed and sent back that day (08/19/25).	{D 367}		

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{D 367}	Continued From page 53 Review of an email correspondence dated 08/28/25 revealed Resident #1's PCP at 8:20am revealed the PCP stated Resident #1's medications were sent be eScript to the pharmacy and signed the physicians order form. a.Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for valsartan 40mg to be administered each day. (Valsartan is a medication used to treat high blood pressure.) Review of Resident #1's physicians order dated 08/27/25 revealed valsartan was to be discontinued. Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for valsartan 40mg to be administered each day and scheduled for 8:00am. -There was documentation valsartan 40mg was administered on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/30/25. -There was documentation valsartan 40mg was not administered on 08/18/25 through 08/21/25, on 08/25/25 and on 08/27/258 through 08/28/25 because the medication was not available. -There was documentation valsartan 40mg was not administered on 08/26/25 with no reason for omission documented. -There was documentation valsartan 40 mg was not administered on 08/31/25 because the medication had been discontinued. Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at	{D 367}		

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{D 367}	Continued From page 54 2:50pm revealed Valsartan 40mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/22/25 through 08/24/25. b. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for Eliquis 5 mg to be administered twice daily. (Eliquis is a blood thinning medications used to prevent blood clots for people with atrial fibrillation.) Review of Resident #1's physicians order dated 08/27/25 revealed Eliquis was to be discontinued. Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for Eliquis 5 mg to be administered twice daily and scheduled for 8:00am and 8:00pm. -There was documentation Eliquis 5mg was administered at 8:00am and 8:00pm on 08/01/25 through 08/17/25. -There was documentation Eliquis 5mg was not administered at 8:00am on 08/18/25 through 08/21/25 and on 08/25/25 through 08/28/25 because the medication was not available on 08/18/25, 08/21/25, and on 08/27/25 through 08/28/25. -There was no reason for omission documented for 08/19/25 through 08/20/25 and 08/25/25 through 08/26/25 at 8:00am. -There was documentation was administered at 8:00pm on 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25 through 08/29/25. -There was no reason for the omission of administration documented for 08/23/25 and on 08/26/25 through 08/27/25. -There was documentation the medication was	{D 367}		

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discontinued at 8:00pm on 08/30/25 and at 8:00am and 8:00pm on 08/31/25.
-There was documentation Eliquis 5mg was not administered on 08/31/25 because the medication had been discontinued.

Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed Eliquis 5mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25

c. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for metoprolol 25mg to be administered twice daily. (Metoprolol is a medication used to treat high blood pressure.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for metoprolol 25mg to be administered twice daily and scheduled for 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered at 8:00am and 8:00pm on 08/01/25 through 08/17/25 and on 08/29/25 through 08/31/25.
-There was documentation metoprolol 25mg was not administered at 8:00am on 08/18/25 through 08/20/25 and on 08/25/25 through 08/28/25.
-There was documentation the medication was not administered because the medication was not available on 08/18/25 through 08/20/25, on 08/25/25 and on 08/27/25 thorough 08/28/25 at 8:00am.
-There was no reason for omission of administration documented for 08/26/25 at

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{D 367}	Continued From page 56 8:00am. -There was documentation metoprolol 25mg was administered at 8:00pm on 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25 through 08/31/25. -There was no reason for the omission of administration documented for 08/23/25 and on 08/26/25 through 08/27/25. Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed metoprolol 25mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/18/25 through 08/22/25, 08/24/25 through 08/25/25 and on 08/28/25. d. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for potassium chloride 20mEq to be administered each day. (Potassium chloride is used to treat low potassium levels in the blood. Potassium is essential for heart and muscle function.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for potassium chloride 20mEq to be administered each day at scheduled for 8:00am. -There was documentation potassium chloride 20mEq was administered each day on 08/01/25 through 08/17/25 and on 08/20/25 through 08/31/25. -There was documentation potassium chloride 20mEq was not administered on 08/18/25 through 08/19/25 because the medication was not available. Telephone interview with the pharmacist with the	{D 367}		

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facility's contracted pharmacy on 09/26/25 at 2:50pm revealed potassium chloride 20mEq was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/20/25 through 08/28/25.

e. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for Amiodarone 100mg to be administered each day. (Amiodarone is an anti-arrhythmic medication used to treat atrial fibrillation.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for Amiodarone 100mg to be administered each day and scheduled for 8:00am.
-There was documentation Amiodarone 100mg was administered on 08/01/25, 08/03/25, on 08/05/25 through 08/17/25, and on 08/19/25 through 08/31/25.
-There was documentation Amiodarone 100mg was not administered on 08/02/25, 08/04/25 and on 08/18/25 because the medication was not available.

Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed Amiodarone 100mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/19/25 through 08/28/25.

f. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for ferrous sulfate 325mg to be administered each day. (Ferrous Sulfate is an iron supplement used to treat and prevent anemia and support the body's

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{D 367}	Continued From page 58 production of hemoglobin.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for ferrous sulfate 325mg to be administered each day and scheduled for 8:00am. -There was documentation ferrous sulfate 325mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/25/25 and on 08/29/25 through 08/31/25. -There was documentation ferrous sulfate 325mg was not administered on 08/18/25 through 08/21/25 and on 08/27/25 through 08/28/25 because the mediation was not available. -There was documentation ferrous sulfate 325mg was not administered on 08/26/25 with no reason documented for the omission of administration. Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed ferrous sulfate 325mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/22/25 through 08/25/25. g. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for risperidone 0.5mg to be administered each day. (Risperidone is a medication used to treat mental health disorders by regulating mood, thoughts and behaviors.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for risperidone 0.5mg to be administered each day and scheduled for 8:00am.	{D 367}		

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{D 367}	Continued From page 59 -There was documentation risperidone 0.5mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25. -There was documentation risperidone 0.5mg was not administered on 08/18/25 through 08/21/25, 08/25/25, and on 08/27/25 through 08/28/25 because the medication was not available. -There was documentation risperidone 0.5mg was not administered on 08/26/25 with no reason documented for the omission of administration. Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed risperidone 0.5mg was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/22/25 through 08/24/25. h. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for sertraline 50mg, 1 and 1/2 tablet (75mg) to be administered each day. (Sertraline is a medication used to treat depressed mood.) Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was an electronic entry for sertraline 50mg, 1 and 1/2 tablet (75mg) be administered each day and scheduled for 8:00am. -There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg) was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25. -There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg)was not administered on 08/18/25 through 08/21/25, 08/25/25, and on	{D 367}		

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08/27/25 through 08/28/25 because the medication was not available.
-There was documentation sertraline 50mg, 1 and 1/2 tablet (75mg) was not administered on 08/26/25 with no reason documented for the omission of administration.

Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed sertraline 50mg, 1 and 1/2 tablet (75mg) was not dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25 and could not have been administered on 08/22/25 through 08/24/25.

i. Review of Resident #1's current FL-2 dated 06/25/25 revealed there was an order for omeprazole DR 20mg to be administered each day. (Omeprazole is medication used to treat GERD by decreasing acid production in the stomach.)

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an electronic entry for omeprazole DR 20mg be administered each day and scheduled for 8:00am.
-There was documentation omeprazole DR 20mg was administered each day on 08/01/25 through 08/17/25, on 08/22/25 through 08/24/25 and on 08/29/25 through 08/31/25.
-There was documentation omeprazole DR 200mg not administered on 08/18/25 through 08/21/25, 08/25/25, and on 08/27/25 through 08/28/25 because the medication was not available.
-There was documentation omeprazole DR 20mg was not administered on 08/26/25 with no reason documented for the omission of administration.

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{D 367}	Continued From page 61 Telephone interview with the on-call provider for Resident #1's PCP on 09/26/25 at 1:54pm revealed a refill request was sent to the pharmacy on 08/29/25 as requested by the facility. Telephone interview with the pharmacist with the facility's contracted pharmacy on 09/26/25 at 2:50pm revealed: -Resident #1 was not on batch cycle fill in August 2025. -No medications were dispensed on 08/13/25 with other cycle fill to start administration on 08/17/25. -Sertraline 50mg, 1 and 1/2 tablet (75mg) could not have been administered on 08/22/25 through 08/24/25. -Resident #1's medications were dispensed on 08/29/25 for administration and has since been placed on cycle fill. Interview with the Administrator on 09/26/25 at 9:15am revealed: -She remembered Resident #1 being out of medications for a time in August due to physician's orders needing to be signed. -She was not sure how long Resident #1 was out of some of her medications. Refer to interview with a medication aide (MA) on 09/24/25 at 3:49pm. Refer to interview with a second MA on 09/25/25 at 7:31am. Refer to interview with a third MA on 09/25/25 at 3:31pm. Refer to interview with the Assistant Administrator on 09/26/25 at 10:35 AM.	{D 367}		

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{D 367}	Continued From page 62 Refer to interview with the Administrator on 09/26/25 at 3:59pm. _____ Interview with a medication aide (MA) on 09/24/25 at 3:49pm revealed: -There was no schedule for medication cart audits. -She tried to do medication cart audits when she worked nights. -Medication cart audits consisted of printing the resident's eMAR and the eMAR was compared to the resident's medications on the medication cart. -Medication cart audits consisted of making sure medications were available for the residents, looking for expired or discontinued medications and making sure the eMAR matched the medication label. -She thought she had performed a medication cart audit four times since she started employment in June 2025. Interview with a second MA on 09/25/25 at 7:31am revealed: -The MAs always reviewed the eMAR entry and compared the eMAR entry to the medication labels. -If a resident did not receive their medications, there was always to be a reason why documented on the eMAR. -Medications were never to be documented as administered if they were not available. Interview with a third MA on 09/25/25 at 3:31pm revealed: -Usually if medications were not administered it was because either the resident refused or waiting on the pharmacy to send. -She always documented a reason a medication was not administered.	{D 367}		

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THE INDIGO AT NEW BERN	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

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{D 367}	Continued From page 63 -She never documented medication as administered if it was not available. Interview with the Assistant Administrator on 09/26/25 at 10:35am revealed: -The facility's Registered Nurse (RN) or the Resident Care Coordinator (RCC) were responsible to review the residents' eMAR for accuracy. -The RN or the RCC reviewed and approved orders. -The RN or the RCC could add start and stop dates to the residents' orders. -The RN and RCC were no longer employed by the facility and it was up to her or the Administrator to review the residents' eMAR. -Medications should never be documented as administered when they were not available. -Medications that were ordered short term should always have a start and stop date. Interview with the Administrator on 09/26/25 at 3:59pm revealed: -The RN or the RCC were responsible for reviewing the residents' eMARs daily. -If the pharmacy did not add a start and stop date to a resident's eMAR for a short-term medication, the RN or the RCC could add a start and stop date. -The RN and RCC were no longer at the facility, and she or the Assistant Administrator were currently responsible to review the residents' eMARs. -She expected the MAs to read the residents' orders and to notify her or the Assistant Administrator if there was any question about the medication order or if medication was not available. -The MAs were never to document administration of a medication that was not available.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025046	A. BUILDING: _____ B. WING _____	R 09/26/2025

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D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass on 09/24/25 by the medication aide observed who failed to clean and sanitize scissors used to pierce a medication to administer to a resident. The findings are: Review of the facility's Medication Administration policy effective/revised date of 12/01/24 revealed medication and treatment administration shall always be accompanied by a sanitary environment, following infection control and prevention of cross-contamination. Review of Resident #3's current FL2 dated 07/22/25 revealed: -Diagnoses included chronic kidney disease, hypertensive heart and chronic kidney disease without heart failure, atrial fibrillation, and polyneuropathy. -He was intermittently disoriented. -There was an order for Colace (Colace is the brand name for docusate which is a stool softener used to treat mild constipation)100mg capsule, take one twice daily.	D 371		

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D 371	Continued From page 65 Review of Resident #3's signed physicians order sheet dated 08/13/25 revealed an order for docusate 100mg softgel capsule, take one capsule two times a day for constipation. Review of Resident #3 September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for docusate 100mg softgel capsule, take one capsule two times per day for constipation scheduled at 9:00am and 9:00pm. -Docusate 100mg softgel capsules were documented as administered at 9:00am on 09/01/25 through 09/24/25. -Docusate 100mg softgel capsules were documented as administered at 9:00pm on 09/01/25 through 09/23/25. Observation of the morning medication pass on 09/24/25 revealed: -The medication aid (MA) pulled a bubble card of docusate 100mg softgel capsules for Resident #3 from the medication cart at 8:18am. -She also pulled an individual serving size of applesauce from the medication cart. -She donned a pair of gloves and retrieved a pair of scissors from the bottom drawer of the medication cart. -She did not clean the scissors. -She popped the docusate 100mg softgel capsule for Resident #3 into her gloved hand and used the uncleaned scissors to snip the end of the docusate softgel capsule. -She squirted the contents of Resident #3's docusate 100mg softgel capsule into the applesauce. -She did not clean the scissors and returned the scissors to the bottom drawer of the medication cart.	D 371		

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D 371	Continued From page 66	D 371		

-She took the applesauce containing the contents of the docusate 100mg softgel capsule into Resident #3's room and administered it to Resident #3 with a spoon at 8:20am.
-She returned to the medication cart and removed the gloves and used hand sanitizer on her hands.

Interview with the MA on 09/25/25 at 11:11am revealed:
-Resident #3 had some difficulty swallowing.
-She knew Resident #3's docusate softgel capsule could not be crushed.
-She thought Resident #3's hospice nurse told her that she could cut his docusate softgel capsule and administer the contents in applesauce or pudding.
-The scissors kept on the medication cart were not solely for Resident #3.
-She occasionally cleaned the scissors after she cut Resident #3's docusate softgel capsule.
-It had not occurred to her to clean the scissors prior to cutting Resident #3's docusate softgel capsule.

Interview with a second MA on 09/25/25 at 3:54pm she administered Resident #3's docusate softgel capsule by placing the whole capsule into pudding.

Interview with the Assistant Administrator (AA) on 09/26/25 at 11:33am:
-Staff should have contacted Resident #3's hospice provider for different form of the docusate if the resident had difficulty swallowing it.
-If the docusate capsule was to be pierced, she expected the MA to properly clean and sanitize whatever tool they were using before and after use to prevent the spread of bacteria.

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D 371	Continued From page 67 Interview with the Administrator on 09/26/25 at 3:59pm revealed: -She thought possibly a different hospice nurse had advised the medication staff they could empty the contents of Resident #3's docusate into applesauce for administration. -She expected the MAs to always follow standard procedure related to infection control and hand hygiene. -Using unclean and un-sanitized scissors to pierce a resident's medication could lead to contamination of the medication. Interview with the Registered Nurse (RN) from Resident #3's hospice provider on 09/25/25 at 2:25pm revealed: -She had not instructed the medication staff to cut Resident #3's docusate softgel capsule and administer the contents in applesauce. -Staff should have let her know that Resident #3 could not swallow the docusate softgel capsule, so she could change the medication form. -She supposed it would be acceptable to pierce Resident #3's docusate softgel capsule and empty the contents into either applesauce or pudding if properly cleaned and sanitized scissors were used but it was not ideal. -There was concern for cross-contamination by using un-sanitized scissors to pierce Resident #3's docusate softgel capsule.	D 371		