STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023042	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF KINGS MOUNTAIN	1001 PHIFER ROAD KINGS MOUNTAIN, NC 28086

(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 Cleveland County Department of Social Services conducted a annual survey and complaint investigation on 03/19/25 through 03/20/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#1) was tested for tuberculosis (TB) disease in compliance with the control measures for the Commission for Public Health. The findings are: 1.Review of Resident #1's current FL2 dated 02/26/25 revealed diagnoses included diabetes mellitus type 2 (high blood sugar), hypertension (high blood pressure), chronic kidney disease stage 3, and mild cognitive impairment. Review of Resident #1's Resident Register	D 234		

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D 234	Continued From page 1 revealed an admission date of 01/29/24. Review of Resident #1's TB skin testing revealed there was documentation of a TB skin test read as negative on 01/26/24. Review of Resident #1's record revealed there was no documentation of a second TB skin test. Interview with Resident #1 on 03/20/25 at 3:15pm revealed: -She was unsure how long she had lived at the facility. -She remembered getting a TB skin test but did not remember when she received it or if she received more than one TB skin test. -She denied having cough, fever or weight loss since admission to the facility. Interview with the Manager on 03/20/25 at 5:00pm revealed: -She had not been aware Resident #1 did not have a second TB test result in her chart. -She could not find documentation of a second step TB skin test completed for Resident #1. -She expected the Health and Wellness Director (HWD) to ensure the completion and documentation of TB tests for new residents. -The HWD left her position at the facility approximately one month ago. -The Administrator or Manager were responsible to follow up on completion of all required TB tests.	D 234		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 2 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the electronic medication administration record (eMAR) were accurate for 1 of 5 sampled residents (#4) related to the failure to accurately document the administration of a medication used to treat infections and a medication used to treat parasites. Review of Resident #4's current FL-2 dated 09/23/25 revealed: -Diagnosis of dementia, Alzheimer's disease, anxiety, depression and anxiety. -Resident #4 resided in the Special Care Unit.	D 367		

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D 367	Continued From page 3 Review of a Hospice progress note dated 03/07/25 revealed Resident #4 was admitted to Hospice on 12/06/24. a. Review of Resident #4's signed physician order dated 02/21/25 revealed an order for Macrobid (a medication used to treat infections) 100mg take one capsule twice day for seven days. Review of Resident #4's February 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for nitrofurantn (Macrobid) Cap 100mg take one capsule twice daily for seven days. -There was documentation that nitrofurantn 100mg was administered as given on February 02/22/25 through 02/26/25 at 8:00am and 8:00pm, 02/2725 at 8:00pm and 02/28/25 at 8:00am and 8:00pm. -There was documentation that nitrofurantn 100 mg was not administered on 02/27/25 at 8:00am with an exception code as other and additional note written, "this medication was given yesterday (02/26/25), one time dose". Telephone interview with the Lead medication aide(MA)on 03/20/25 at 3:55pm revealed: -She gave the dose of nitrofurantn on 02/27/25 at 8:00am and documented she administered it under the wrong medication. -She meant to document the note under the medication of Ivermectin (a medication to treat parasites) and documented under the wrong medication. -She should have wrote a note explaining there was an error of documenting the nitrofurantin. Telephone interview with the pharmacist at the facility's contracted pharmacy on 03/20/25 at	D 367		

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D 367	Continued From page 4 4:49pm revealed: -The pharmacy dispensed Resident #4's nitrofurantoin 100mg by mouth twice daily for seven days on 02/21/25. -The pharmacy dispensed a total of 14 capsules. -There was no documentation of the facility returning any nitrofurantoin capsules. Refer to interview with the Special Care Coordinator (SCC) on 03/20/25 at 3:20pm. Refer to interview with the Manager on 03/20/25 at 5:10pm. b. Review of Resident #4's signed physician orders revealed there was an order dated 02/25/25 for Ivermectin (a medication used to treat parasites) 3mg, take 3 tablets (9mg) for a one-time dose. Review of Resident #4's February 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ivermectin 3mg, take 3 tablets (9mg) by mouth for 1 dose. -There was documentation that Ivermectin was administered on 02/26/25 through 02/28/25 at 8:00am. -There were no exception codes or notes written regarding the Ivermectin 3mg, 3 tablets for a one-time dose. Telephone interview with the medication aide (MA) on 03/20/25 at 4:26pm revealed: -She confirmed her initials were the same initials entered on the eMAR on 02/26/25 under the entry Ivermectin 3mg, 3 tablets (9mg). -She remembered giving the medication. -She recalled the directions were for a one-time dose.	D 367		

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-She remembered looking up the medication to see what it was used for.
-She recalled there were only three ivermectin tablets, and she gave it all to Resident #4 on 02/26/25.
-She understood the ivermectin order and did not need to clarify it because it read "one time dose".

Telephone interview with the lead MA on 03/20/25 at 3:55pm revealed:
-She was the first shift lead MA and works in the Special Care Unit.
-She confirmed her initials were the same initials entered on the eMAR on 02/27/25 and 02/28/25 under the entry Ivermectin 3mg, 3 tablets (9mg).
-She recalled Resident #4 was to receive three tablets of the Ivermectin for a one-time dose as she was present when the order had been written by the hospice nurse.
-She remembered taking the order out of pending when it was entered on the eMAR by the pharmacy and it was for a one time dose.
-She did not administer the Ivermectin on 02/27/25 and 02/28/25 and remembered writing a note about it.
-She was read the note which was displayed under a different medication (nitrofurantoin) and wrote "this medication was given yesterday (02/26/25), one time dose".
-She thought that must have been a mistake and meant to write it under the Ivermectin entry.
-She recalled on 02/27/25 and 02/28/25 the Ivermectin was displayed on the eMAR as to be administered.
-She remembered calling the pharmacy to put a stop date on the order as there was no stop date and the Ivermectin was still showing to administer on the February 2025 eMAR
-She was not sure why her initials were showing she administered the medication as there was no

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D 367	Continued From page 6	D 367		

medication to administer as there were only three tablets.
-She was able to put in a stop order date but knew she called the pharmacy to enter the stop date of 02/26/25.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 03/20/25 at 3:53pm revealed:
-The pharmacy dispensed Resident #4's Ivermectin 3mg, 3 tabs to equal 9mg, by mouth, one time dose on 02/25/25.
-Resident #4's Ivermectin was dispensed in a sealed pharmacy labeled bag, containing three foil tablets, individually wrapped.
-There was no stop date entered on the eMAR by the pharmacy.
-On 02/28/25, a MA entered a stop date of 02/28/25 on the eMAR.

Refer to interview with the Special Care Coordinator (SCC) on 03/20/25 at 3:20pm.

Refer to interview with the Manager on 03/20/25 at 5:10pm.

_____

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 3:20pm revealed:
-If a resident was on Hospice the Nurse Practitioner or Nurse will hand the order to the lead MA or SCC and they were responsible for faxing the new order to the pharmacy.
-The Pharmacy was responsible for entering the new orders onto the eMAR.
-The SCC or the Lead MA releases the pending order in the eMAR system once it was reviewed.
-Before releasing the order the SCC or the lead MA should compare the order to what was in the

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D 367	Continued From page 7 eMAR system and if everything was ok they should release the order. -He remembered when the order was written but was not able to release orders in February 2025 until he had completed training, so the Lead MA would have released the order for the Ivermectin for Resident #4. -He reviewed Resident #4's February eMAR and thought it was to be given one time and not three times as documented. -He and the corporate nurse review the Medication accuracy report for any red flags daily. -The stop date on the eMAR system showed a stop date of 02/28/25 and it should have read 02/26/25, it would not had shown as a missed medication or pop up as a red flag. -No one had brought this to his attention regarding the order not having a stop date for the Ivermectin for Resident #4. Interview with the Manager on 03/20/25 at 5:10pm revealed: -The SCC and the lead MA need to compare the medication to the order and this should have had a stop date entered on the eMAR. -She expected the MAs to document correctly on the eMAR.	D 367		