STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 05/28/25 to 05/29/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed practitioner for 1 of 3 residents (#7) observed during the 8:00am medication pass on 05/29/25 related to a medication used to treat shortness of breath and for 1 of 5 sampled residents (#2) related to a medication used to treat shortness of breath and a vitamin used to reduce the progression of age-related macular degeneration. The findings are: 1. The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 12:00pm medication pass on 05/28/25 and 8:00am medication pass on 05/29/25. Review of Resident #7's current FL2 dated	D 358		

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D 358	Continued From page 1 01/16/25 revealed: -Diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, and dysphagia. -There was an order for budesonide (used to decrease the inflammation of the airways in the lungs) inhale contents 1 unit dose vial via nebulizer twice daily. Review of Resident #7's primary care provider's (PCP) order dated 02/10/25 revealed budesonide 0.5mg/2ml inhale contents 1 unit dose vial via nebulizer twice daily. Observation of the morning medication pass on 05/29/25 at 7:47am revealed: -The medication aide (MA) prepared seven oral medications for administration to Resident #6 from a multidose package as she compared the medications displayed on the electronic medication administration record (eMAR). -There was an entry on the eMAR for budesonide 0.5mg/2ml 1 unit dose vial via nebulizer. -There was no budesonide 0.5mg/2ml on the medication cart for Resident #7. -The MA looked for the budesonide 0.5mg/2ml in the storage of overstock medications and there was none available for Resident #7. -At 7:55am, the MA administered seven oral medications to Resident #7 and documented administration on the May 2025 eMAR. -The MA documented budesonide 0.5mg/2ml not administered due to "on hold until received from pharmacy." Interview with the MA on 05/29/25 at 7:51am revealed: -Resident #7's budesonide 0.5mg/2ml was not available for administration. -She sent a refill request to the facility's	D 358		

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D 358	Continued From page 2	D 358		

contracted pharmacy for Resident #7's budesonide 0.5mg/2ml through the eMAR on 05/29/25.
-She would call the facility's contracted pharmacy to find out when the budesonide 0.5mg/2ml would be delivered to the facility.
-She would obtain a hold order from Resident #7's primary care provider (PCP) to hold the budesonide 0.5mg/2ml until a new supply arrived from the pharmacy.

Review of Resident #7's March 2025 eMAR revealed:
-There was an entry for budesonide 0.5mg/2ml inhale contents 1 unit dose vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.
-The budesonide 0.5mg/2ml was documented as administered as ordered from 03/01/25-03/31/25.

Review of Resident #7's April 2025 eMAR revealed:
-There was an entry for budesonide 0.5mg/2ml inhale contents 1 unit dose vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.
-The budesonide 0.5mg/2ml was documented as administered for 59 occurrences out of 60 opportunities from 04/01/25-04/30/25.
-On 04/07/25, the budesonide 0.5mg/2ml was documented as not administered due to waiting on pharmacy.

Review of Resident #7's May 2025 eMAR revealed:
-There was an entry for budesonide 0.5mg/2ml inhale contents 1 unit dose vial via nebulizer twice daily scheduled at 8:00am and 8:00pm.
-The budesonide 0.5mg/2ml was documented as administered for 52 occurrences out of 57 opportunities from 05/01/25-05/29/25 at 8:00am.

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	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

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CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

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D 358	Continued From page 3 Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 9:09am revealed Resident #7's family member provided Resident #7's budesonide nebulizer treatments. Telephone interview with Resident #7's family member on 05/29/25 at 9:12am revealed: -The facility was responsible for obtaining all of Resident #7's medications from their contracted pharmacy. -There were no medications he was supposed to obtain for Resident #7 that he had been made aware of. -The family did supply a "partial box" with a "couple packages" of budesonide 0.5mg/2ml when Resident #7 was admitted to the facility in January 2025. -The amount of budesonide provided was not enough to "supply until now." -No one from the facility had contacted him about Resident #7 being out of the budesonide nebulizer treatments. Interview with Resident #7 on 05/29/25 at 9:25am revealed: -She had not received the budesonide in a "couple days". -She had chronic obstructive pulmonary disease (a progressive lung disease characterized by air-flow limitation and difficulty breathing) and emphysema (a chronic progressive lung disease characterized by the destruction and enlargement of the air sacs in the lungs). -The budesonide made it "easier to breath." -Her chest felt like she was "not getting enough air" when she did not receive the budesonide. -She had to breath through her mouth instead of her nose to "get enough oxygen." -The MAs told her the budesonide had been reordered from the pharmacy.	D 358		

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D 358	Continued From page 4 -She did not know if the delay in the delivery of the budesonide was due to the pharmacy or an issue with the manufacturer. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 11:20am revealed: -There was a current order for Resident #7 for budesonide 0.5mg/2ml 1 unit dose vial via nebulizer twice daily dated 05/09/25. -The pharmacy received a resupply request for the budesonide 0.5mg/2ml on 05/28/25. -The budesonide would be delivered to the facility "tomorrow" (05/30/25) unless the facility asked them to refill the medication through their local backup pharmacy. -The pharmacy dispensed budesonide 0.5mg/2ml in a quantity of 60mls or 30 vials equaling a 15-day supply as ordered for Resident #7 on 02/11/25, 03/03/25, 04/15/25, and on 05/09/25. Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 1:16pm revealed: -She did not know there was no budesonide available for administration for Resident #7. -Medication cart audits were conducted weekly for all the residents by the night shift supervisor. -Resident #7's budesonide had to be reordered by the facility and was not on auto-fill with the pharmacy. -She received a prior authorization request from the facility's contracted pharmacy for Resident #7's budesonide 0.5mg/2ml on 05/28/25 or 05/27/25. -Resident #7's PCP signed the prior authorization request on 05/28/25. -If she had known the budesonide was out, she would have obtained a hold order for it on 05/27/25 until a supply of the medication could be obtained.	D 358		

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D 358	Continued From page 5 Telephone interview with Resident #7's PCP on 05/29/25 at 2:43pm revealed: -Resident #7 was ordered budesonide nebulizer treatments to treat chronic obstructive pulmonary disease and emphysema. -Resident #7 could "potentially" experience increased difficulty breathing and shortness of breath when she did not receive the budesonide nebulizer treatments as ordered. -She became aware Resident #7 needed a refill of budesonide on 05/28/25. -She signed the prior authorization for refill of the budesonide on 05/28/25. Interview with the Administrator on 05/29/25 at 1:55pm revealed: -The RCC made her aware Resident #7's budesonide was not available on 05/28/25. -They informed Resident #7's PCP on 05/28/25 and obtained a diagnosis and signature from the PCP for the prior authorization document to submit to Resident #7's insurance. -On 05/28/25, they spoke with Resident #7 concerning the cost to refill the budesonide and Resident #7 was unable to pay for the refill. -The RCC should have obtained a hold order on 05/28/25 for the budesonide from Resident #7's PCP when she received the prior authorization request from the contracted pharmacy. -The PCP's prior authorization allowed for substituting a less expensive medication if it was available from the pharmacy. 2. Review of Resident #2's current FL2 dated 10/23/24 revealed diagnoses included essential hypertension, chronic obstructive pulmonary disease, and coronary artery dissection. a. Review of Resident #2's primary care	D 358		

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	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

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D 358	Continued From page 6	D 358		

provider's (PCP) order dated 02/24/25 revealed Symbicort (used for long-term management of chronic obstructive pulmonary disease) 160-4.5mcg/actuation inhale two puffs twice daily.

Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5mcg/actuation two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort 160-4.5mcg was documented as administered 59 occurrences out 62 opportunities.
-On 03/04/25 at 8:00am and 8:00pm, the Symbicort was documented as not administered due to waiting on pharmacy.
-On 03/05/25 at 8:00am, the Symbicort was documented as not administered due to waiting on pharmacy.

Review of Resident #2's April 2025 eMAR revealed:
-There was an entry for Symbicort 160-4.5mcg/actuation two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort 160-4.5mcg was documented as administered 57 occurrences out 59 opportunities.
-On 04/07/25 at 8:00am and 8:00pm, the Symbicort was documented as not administered due to waiting on pharmacy.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry for Symbicort 160-4.5mcg/actuation two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort 160-4.5mcg was documented as administered 54 occurrences out 55

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	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

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D 358	Continued From page 7	D 358		

opportunities.
-On 05/09/25 at 8:00am, the Symbicort was documented as not administered due to waiting on pharmacy.

Interview with a medication aide (MA) on 05/29/25 at 10:25am revealed:
-She documented administering medications to Resident #2 on the mornings of 03/04/25 and 03/05/24.
-She did not administer Symbicort to Resident #2 on 03/04/25 at 8:00am and on 03/05/25 at 8:00am because the Symbicort was not available to administer.
-If a medication was not available on the medication cart, she always checked to see if the medication was in the overstock storage area in the facility.
-On 03/04/25, after checking overstock storage for the Symbicort, she would have sent a resupply request to the pharmacy for the medication.
-Any medication requested from the facility's contracted pharmacy via the resupply option in the eMAR would usually arrive the next day from the pharmacy.
-On 03/05/25, she would have called the facility's contracted pharmacy to find out when the Symbicort would be delivered.
-She communicated any medications that were not available on medication pass to the Resident Care Coordinator (RCC) and Administrator during their daily morning meetings.

Interview with the RCC on 05/29/25 at 1:16pm revealed:
-Medication cart audits were done weekly on all residents.
-The MAs would check to make sure all medications were available during the cart audits.
-She did not know why the Symbicort was not

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	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

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D 358	Continued From page 8	D 358		

available for administration on 03/04/25, 03/05/25, 04/07/25, and 05/09/25.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/29/25 at 11:20am revealed:
-Resident #2 had a current order dated 02/24/25 for Symbicort 160-4.5mcg/actuation two puffs twice daily.
-The Symbicort 160-4.5mcg 1 box a 30 day supply was dispensed for Resident #2 on 01/31/25, 03/04/25, 04/07/25, and 05/09/25.

Telephone interview with Resident #2's PCP on 05/29/25 at 2:43pm revealed:
-She ordered Symbicort for Resident #2 to treat chronic obstructive pulmonary disease.
-Resident #2 could "potentially" experience shortness of breath and breathing difficulties when the resident did not receive the Symbicort as ordered.

Interview with the Administrator on 05/29/25 at 1:55 revealed:
-She was not aware Resident #2 had missed some doses of Symbicort.
-She did not know why the Symbicort was not available for administration.
-The RCC or MAs should have gotten a hold order for the Symbicort until they received the medication from the pharmacy.

b. Review of Resident #2's primary care provider's (PCP) order dated 02/24/25 revealed Preservision AREDS2 (a vitamin supplement used to reduce the risk of vision loss progression in people with age-related macular degeneration) 250-90-40-1mg one capsule twice daily.

Review of Resident #2's PCP order dated

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	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 9 04/11/25 revealed discontinue Preservision AREDS2. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Preservision AREDS2 250-90-40-1mg one capsule twice daily scheduled at 8:00am and 8:00pm. -The Preservision AREDS2 was documented as administered as ordered from 03/01/25-03/31/25. Review of Resident #2's April 2025 eMAR revealed: -There was an entry for Preservision AREDS2 250-90-40-1mg one capsule twice daily scheduled at 8:00am and 8:00pm. -The Preservision AREDS2 was documented as administered twice daily from 04/01/25-04/30/25. Review of Resident #2's May 2025 eMAR revealed: -There was an entry for Preservision AREDS2 250-90-40-1mg one capsule twice daily scheduled at 8:00am and 8:00pm. -The Preservision AREDS2 was documented as administered twice daily from 05/01/25-05/28/25. Observation of Resident #2's available medications on 05/28/25 at 2:51pm revealed Preservision AREDS2 was in the morning and night oral medication multidose packages for 05/29/25-06/02/25. Telephone interview with the facility's contracted pharmacy on 05/28/25 at 3:16pm revealed: -Resident #2's Preservision AREDS2 order was still active in their system. -They had not received an order to discontinue the Preservision AREDS2.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

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D 358	Continued From page 10 Interview with Resident #2's PCP on 05/29/25 at 2:43pm revealed: -She was made aware by the facility staff on 05/28/25 that Resident #2 continued to receive Preservision AREDS2 after the order to discontinue the medication on 04/11/25. -She told the staff to discontinue the Preservision AREDS2 on 05/28/25. Interview with the Administrator on 05/29/25 at 1:55pm revealed: -The Resident Care Coordinator (RCC) was responsible for following up on discontinued medication orders. -The RCC was supposed to fax the discontinuation order to the pharmacy. -There were multiple medications discontinued on the order written by Resident #2's PCP on 04/11/25. -The pharmacy missed the order to discontinue the Preservision AREDS2 on the 04/11/25 order. -The RCC should have followed up with the pharmacy when all of the medication discontinue orders written on 04/11/25 did not show up as discontinued in the eMAR. _____ The facility failure to administer budesonide to Resident #7 as ordered increased the risk of breathing difficulties and shortness of breath. This failure was detrimental to the health, safety, and welfare of Resident #7 and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 05/29/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 13,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088014	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

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D 358	Continued From page 11 2025.	D 358		