STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059035	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING	5235 NC 226 SOUTH MARION, NC 28752

(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 McDowell County Department of Social Services completed an annual survey from 03/11/25 to 03/12/25.	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 review and interviews the facility failed to ensure 1 of 5 sampled residents (Resident #4) were tested for tuberculosis (TB) disease in compliance with the control measures for the Commission for Control Measures. The findings are: Review of Resident #4's current FL2 dated 2/13/25 revealed diagnoses including dysphagia, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, anxiety, and history of aspiration.	D 234		

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D 234	Continued From page 1 Review of Resident #4's Resident Register revealed an admission date of 07/17/19. Review of Resident #4's record on 03/11/25 revealed: -There was documentation a TB test was administered on 06/01/14 and had a negative result. -There was no documentation a TB test was administered prior to or after Resident #4's admission on 07/17/19. Interview with the Resident Care Coordinator on 03/12/25 at 11:35am revealed: -Resident #4 received her most recent TB test on 06/01/14 when she resided in an affiliated family care home. -Resident #4 did not receive a TB test prior to and after her admission to current placement on 07/17/19. -Resident #4 may not have received an updated TB test prior to admission because the group home she transferred from, was managed by the same company she was transferred to. -She expected all residents to have at least step 1 TB test prior to admission and step 2 TB test to be administered post admission. Interview with the Administrator on 03/12/25 at 4:00pm revealed: -Resident #4 was admitted in 2018 and he became the Administrator in December 2024 as a new owner. -The RCC and BOM were completing resident record audits and had not completed Resident #4's record yet, so it was not identified as missing. -The RCC/BOM were responsible to make sure that residents had a TB completed before admission and a second one within a year later.	D 234		

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D 234	Continued From page 2 Attempted contact with the responsible party was unsuccessful.	D 234		
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: Type A2 Violation Based on record reviews, and interviews, the facility failed to ensure physician notification for 3 of 5 sampled residents (#1, #2 and #5) related to a medication to treat elevated potassium (#1), fingerstick blood sugars (FSBS) greater than 300 (#2) and an order to hold a medication used to lower cholesterol (#5). The findings are: 1. Review of Resident #1's FL-2 dated 01/09/25 revealed: -Diagnoses included osteomyelitis (a infection of the bone) of the right foot, chronic diabetic foot ulcers of the right foot, right foot neuropathy, schizophrenia and blindness. -There was an order for lokelma (used to lower elevated potassium) 10gm pack mixed with liquid three times a day. Review of Resident #1's signed physician orders dated 01/16/25 revealed an order for lokelma 10gm pack mixed with liquid three times a day.	D 273		

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D 273	Continued From page 3 Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as "unavailable" on 01/20/25, 01/29/25 and 01/30/25 at 7:00am. -The lokelma was documented as "unavailable" on 01/19/25, 01/20/25, 01/25/25 and 01/29/25 at 1:00pm, and documented a "refused" on 03/12/25 at 1:00pm. -The lokelma was documented as "unavailable" on 01/29/25 at 7:00pm. -The lokelma was documented as not administered on 9 of 93 opportunities. -There was no documentation the physician was notified. Review of Resident #1's February 2025 eMAR revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as administered from 02/01/25 to 02/28/25 at 7:00am, 1:00pm and 7:00pm. Review of Resident #1's March 2025 eMAR revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as administered 03/01/25 to 03/10/25 at 7:00am, 1:00pm and 7:00pm. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed:	D 273		

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D 273	Continued From page 4 -Resident #1's admission FL2 dated 01/09/25 was sent to another pharmacy on admission by a case manager at the hospital. -She faxed the FL2 dated 01/09/25 to the facility's pharmacy that same day. -The lokelma required a prior authorization which the pharmacy contacted the physician to obtain. -With the confusion of two pharmacies getting the prescription for lokelma and trying to get the prior authorization the facility was getting refills for three days at a time she did not know that Resident #1 was not administered the lokelma as order and missed some doses. -She did not contact Resident #1's ordering physician or his previous physician about the prior authorization or the about the missed does of lokelma. -On 01/29/24, after receiving many 3-day supplies, she called the pharmacy and received a full 30-day amount of lokelma. Telephone with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 2:53pm revealed: -On 01/09/24, the facility faxed Resident #1's FL2 dated 01/09/25 with an order for lokelma 10gm, mix with liquid three times a day. -On 01/09/25, the pharmacy required a prior authorization and faxed the physician and the facility. -The pharmacy did not receive a signed the prior authorization from the physician. -The pharmacy received a call from the RCC on 01/29/25 about the prior authorization but it was already completed. -It was the responsibility of the facility to check up on the prior authorization, and because the prior authorization was not completed the pharmacy could only completed 3-day doses of the lokelma.	D 273		

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D 273	Continued From page 5 Telephone interview with Resident #1's previous Primary Care Provider (PCP) on 03/12/24 at 10:01am revealed: -She first saw Resident #1 for a new patient visit on 01/06/24. -She ordered labs during the visit and continued Resident #1's lokelma from his FL2 dated 01/09/25. -Resident #1 was prescribed lokelma to treat high potassium in the blood. -On 01/30/25, she saw Resident #1 for a follow up. -She reviewed Resident #1's January 2025 eMAR and noted that he was not given lokelma 8 times due to the facility did not have to lokelma to administer. -She also reviewed his potassium level which was 5.3 milimoles per liter (mmol/L). -A potassium level of 5.3mmol/L was high (normal level 3.5mmol/l - 5.1mmol/l). -The facility staff did not notify her that the lokelma needed a prior authorization after the pharmacy contacted another physician for the prior authorization or that Resident #1 missed any doses. -She was concerned because of Resident #1's history of diabetes and hypertension and now a high potassium level in the blood, Resident #1 was at risk of cardiac arrhythmia (irregular heartbeat). -When potassium levels were high in the blood, the high potassium interfere with the hearts electrical signal causing arrythmias such as ventral fibrillation and ventricle tachycardia (rapid heart rate more than 100 beats per minute) which are life threatening. -Increased levels of potassium in the body can also cause muscle weakness and numbness. -She expected the staff to administer the lokelma as ordered and to notify her with any issues with	D 273		

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D 273	Continued From page 6 not getting the medication. Interview with the Administrator on 03/12/25 at 4:00pm revealed he did not know that the staff did not notify the physician when the lokelma was only being sent for 3 days at a time or that Resident #1 did not receive the dosages as ordered. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am. Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. 2. Review of Resident #2's current FL-2 dated 11/08/24 revealed: -Diagnoses included Type 2 diabetes, ulcers of left foot and toes, stage 2 chronic kidney disease, amputation of right foot and hypertension. -There was an order to check FSBS five times a day and administer insulin Novolin or lispro. -There was an order for lispro Kwikpen/ml, check FSBS three times a day before meals and inject per sliding scale insulin (SSI) for a FSBS 150-169 = 1 unit; 170-189 = 2 units; 190-209 = 3 units; 210-229 = 4 units; 230-249 = 5 units; 250-269 = 6 units; 270-289 = 7 units; 290-300 = 8 units; and FSBS >300 = 9 units and notify the physician. Review of Resident #2's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS five times a day and administer insulin novolin or lispro scheduled at 6:00am, 8:00am, 12:00pm, 4:00pm and 6:00pm.	D 273		

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D 273	Continued From page 7 -There was an entry for lispro Kwikpen/ml, check FSBS three times a day before meals and inject per sliding scale insulin (SSI) for a FSBS 150-169 = 1 unit ; 170-189 = 2 units; 190-209 = 3 units; 210-229 = 4 units; 230-249 = 5 units; 250-269 = 6 units; 270-289 = 7 units; 290-300 = 8 units; and >300 = 9 units and notify the physician, scheduled at 7:00am, 1:00pm and 7:00pm. -On 01/03/25 at 4:00pm, the FSBS was documented as 400, and there was no documentation the physician was notified. -On 01/03/25 at 6:00pm, the FSBS was documented as 400, and there was no documentation the physician was notified. -On 01/03/25 at 7:00pm, the FSBS was documented as 319, and there was no documentation the physician was notified. -On 01/09/25 at 4:00pm, the FSBS was documented as 303, and there was no documentation the physician was notified. -On 01/09/25 at 6:00pm, the FSBS was documented as 303, and there was no documentation the physician was notified. -On 01/14/25 at 7:00pm, the FSBS was documented as 310, and there was no documentation the physician was notified. -On 01/20/25 at 4:00pm, the FSBS was documented as 339, and there was no documentation the physician was notified. -On 01/20/25 at 6:00pm, the FSBS was documented as 339, and there was no documentation the physician was notified. -On 01/21/25 at 7:00pm, the FSBS was documented as 306, and there was no documentation the physician was notified. -On 01/24/25 at 7:00pm, the FSBS was documented as 332, and there was no documentation the physician was notified. -Resident #2's FSBS was >300 on 10 out of 93 opportunities and the physician was not notified.	D 273		

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D 273	Continued From page 8 Review of Resident #2's February 2025 eMAR revealed: -There was an entry to check FSBS five times a day and administer insulin novolin or lispro, scheduled 02/01/25 to 02/14/25 at 6:00am, 8:00am, 12:00pm, 4:00pm and 6:00pm. -There was an entry for lispro Kwikpen 100units/ml, check FSBS three times a day before meals and inject per sliding scale insulin (SSI) for a FSBS 150-169 = 1 unit; 170-189 = 2 units; 190-209 = 3 units; 210-229 = 4 units; 230-249 = 5 units; 250-269 = 6 units; 270-289 = 7 units; 290-300 = 8 units; and >300 = 9 units and notify the physician, scheduled 02/01/25 to 02/14/24 at 7:00am, 1:00pm and 7:00pm. -On 02/07/25 at 4:00pm, the FSBS was documented as 305, and there was no documentation the physician was notified. -On 02/07/25 at 6:00pm, the FSBS was documented as 303, and there was no documentation the physician was notified. -On 02/11/25 at 4:00pm, the FSBS was documented as 420, and there was no documentation the physician was notified. -On 02/11/25 at 7:00pm, the FSBS was documented as 420, and there was no documentation the physician was notified. -An entry for lispro Kwikpen 100units/ml, check FSBS three times a day before meals and inject per sliding scale insulin (SSI) for a FSBS 150-169 = 1 unit; 170-189 = 2 units; 190-209 = 3 units; 210-229 = 4 units; 230-249 = 5 units; 250-269 = 6 units; 270-289 = 7 units; 290-300 = 8 units; and >300 = 9 units and notify the physician, scheduled 02/14/25 to 02/28/24 at 7:00am, 12:00pm and 5:00pm. -Resident #2's FSBS was >300 on 4 out of 84 opportunities and the physician was not notified.	D 273		

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D 273	Continued From page 9 Interview with a second shift MA on 03/11/25 at 4:30pm revealed: -On 01/03/25 at 4:00pm and 6:00pm, she documented a FSBS of 400. -She did not notify the physician as ordered because the physician's office was closed. -She notified the RCC the next day. Interview with another second shift MA on 03/11/25 at 4:30pm. -On 01/09/25 at 4:00pm and 6:00pm, she documented a FSBS of 303. -She did not notify the physician because the physician office was closed and did not have an answering service. -She was not sure if she notified the RCC. Telephone interview with Resident #1's previous Primary Care Provider (PCP) on 03/12/24 at 10:01am revealed: -Resident #2 was last seen at the facility on 01/30/25 when she reviewed his FSBS and found many occasions where his FSBS was greater than 300. -She expected to be notified when the FSBS was above 300 and she was not notified. -Because of Resident #2's current issues with hypertension, he was at risk for complication such as a heart attack and stroke, worsening of his stage 2 kidney disease, and with his ulcerations of his left foot, he was at risk for increased infections and amputation of the left foot due to continued FSBS > 300. -If she had been notified of the FSBS > 300, she would have adjusted his SSI dosages. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed: -The MA were responsible to notify her about Resident #2's FSBS > 300.	D 273		

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D 273	Continued From page 10 -Resident #2's physician was very difficult to get a hold of epically after 5:00pm because the physician did not have an answering service, or answered her phone. -She did not know Resident #2 had FSBS > 300. -If she had known Resident #2's FSBS was > 300, she could have called the physician the next day when the office was open. Interview with the Administrator on 03/12/25 at 4:00pm revealed he did not know Resident #2's physician was not notified for FSBS > 300. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am. Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. 3. Review of Resident #5's current FL2 dated 11/08/24 revealed diagnoses included intellectual disability, developmental delay, major depressive disorder, anxiety, DM II, schizoaffective disorder, bipolar disorder, hypertension, hyperlipidemia, hypothyroidism, hypomagnesium, chronic kidney disease, and hypotension. Review of Resident #2's Resident Register revealed an admission date of 07/25/19. Review of Resident #5's physician order dated 01/31/25 revealed and order to hold simvastatin 20mg (a medication used to lower cholesterol), while taking Paxlovid (a medication to treat COVID-19).	D 273		

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Review of Resident #5's February 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for simvastatin 20mg, one tablet, at bedtime, and administered everyday at 8:00pm.
-There was documentation simvastatin 20mg was administered on 02/01/25-02/28/25.
-There was an entry for Paxlovid 150-100mg, take one nirmatrelvir 150mg tablet and one ritonavir 100mg tablet, beginning 02/01/25 twice daily for five days with stop date 02/05/25.
-There was documentation Paxlovid 150-100mg was administered once on 02/01/25, twice on 02/02/25, twice on 02/03/25, twice on 02/04/25, and twice on 02/05/25.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 11:01am revealed:
-On 01/31/25, the facility faxed over a verbal order for Paxlovid use as directed.
-The pharmacy dispensed Paxlovid 150-100mg, 20 tablets, a 5-day supply on 02/01/25 from a back-up pharmacy.
-The pharmacy faxed a drug interaction notice to the facility on 02/01/25 to hold simvastatin while taking Paxlovid.
-Simvastatin and Paxlovid taken together could cause an increased plasma concentration and pharmacological effects of Paxlovid.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/12/25 at 4:33pm revealed:
-The provider was not notified the simvastatin was not held per the pharmacy's drug interaction notice.
-She informed the RCC and BOM to discontinue the Paxlovid for any pharmacy contraindications

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or hold any medications while taking Paxlovid per the pharmacy's order.
-The facility should have held the simvastatin while giving Paxlovid because of the interactions which the provider was unable to recall.

Interview with a MA on 03/12/25 at 3:07pm revealed:
-She administers medications that are active on the eMAR
-The RCC makes corrections to the eMAR
-The eMAR would show if there is a hold on a medication.
-There was no hold order on the simvastatin.
-She would notify the RCC of any discrepancies on the eMAR

Interview with the RCC on 03/12/25 at 4:00pm revealed:
-She was responsible for obtaining orders from the physician and sending orders to the pharmacy.
-She was responsible for sending drug interaction notices from the pharmacy to the facility provider for any orders.
-She did not receive a faxed drug interaction from the pharmacy to hold Resident #5's simvastatin while taking Paxlovid.
-She did not notify the provider of the drug interaction or make any corrections to the eMAR

Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am.

Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am.

Refer to interview with the Administrator on 03/12/25 at 4:00pm.

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D 273	Continued From page 13 Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed: -The MAs were responsible for reordering a medication when there were 7 doses left and then notifying her if a resident's medication did not arrive the next day from the pharmacy. -The MAs were responsible for notifying her if a resident missed three doses, medication errors or if there was an issue with administering medications as ordered. -She was responsible for notifying the physician of missed medications, medication errors, and medications not administered as ordered. Interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am revealed: -The MAs were responsible for notifying the RCC when a medication was ordered and did not arrive on the second day. -The RCC was responsible for calling the pharmacy to find out what happened. Interview with the Administrator on 03/12/25 at 4:00pm revealed: -The MAs were trained to administer the medications per the physician's orders. -If the medication could not be administered per the order then they were to notify the RCC. -The RCC was responsible for notifying the physician or pharmacy related to the issue. -If the medication was not available, the MA was to reorder the medication. -If the medication was not available on the second day then the MAs were responsible for notifying the RCC. -The RCC was responsible for notifying the physician if there were any issues with missed medications, FSBS > 300, or follow-up with the pharmacy and physician related to prior	D 273		

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D 273	Continued From page 14 authorizations. _____ The facility failed to notify a physician when a resident required a prior authorization approval by their insurance provider prior to paying for a medication to treat elevated potassium levels resulting in the pharmacy dispensing a 3-day supply and missed doses, putting the resident at an increased risk of life threatening cardiac arrhythmia (#1), and a resident who had 14 FSBS > 300 putting him at risk for complication such as a heart attack and stroke, worsening of his stage 2 kidney disease, and with his ulcerations of his left foot, he was at risk for increased infections and amputation of the left foot (#2). This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/12/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 17, 2025.	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 supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 15 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 5 sampled residents (Resident #4 and #5) were served physician ordered therapeutic diets related to pureed diets with nectar thickened liquids. The findings are: Review of the daily menu for regular diets dated 03/11/25 revealed pork chops, green collards, corn muffin, pinto beans, and cinnamon peaches were being served for lunch. Request for therapeutic diet extension menu for pureed diets was not provided prior to exit. 1. Review of Resident #4's current FL2 dated 2/13/25 revealed diagnoses including dysphagia, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, anxiety, and history of aspiration. Review of Resident #4's Resident Register revealed an admission date of 07/17/19. Review of Resident #4's diet order dated 02/13/25 revealed an order for pureed diet with nectar thickened liquids, head turned right, small bites and sips, and to remain upright for 45 minutes after meals. Review of Resident #4's licensed health professional support (LHPS) tasks dated 02/21/25 revealed feeding techniques/thickened liquids, nebulizer and walker/ transfers. Review of Resident #4's care plan dated 02/13/25 revealed dietary restrictions related to puree nectar thickened liquids, assistance with feeding,	D 310		

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head turned right, small bites and sips, remain sitting upright for 45 minutes after meals.

Review of a list of residents on thickened liquid diets posted in the kitchen revealed Resident #4 should be served nectar thickened liquids.

Observation of Resident #4 on 03/11/25 at 12:30pm during the lunch meal revealed:
-She was sitting in a geriatric chair at a dining table with other residents and staff nearby.
-Her lunch consisted of pureed green vegetables, pureed corn muffin, pureed pork chop, pureed pinto beans, thickened sweet tea and a container of vanilla ice cream that was not thickened.
-She was fed herself 100 percent of the ice cream without difficulty, without assistance and without coughing.
Interview with the Primary Care Provider (PCP) on 03/12/25 at 4:27pm revealed:
-Resident #4 was to be served a pureed diet with nectar thickened liquids, head turned right, small bites and sips, and to remain upright for 45 minutes after meals.
-It was not a good idea for Resident #4 to have ice cream since she was on a thickened liquid diet due to increased risk for aspiration and history of pneumonia.
-She expected all liquids to be thickened before being served to residents on thickened liquids, according to physician orders.

Refer to interview with the cook on 3/11/25 at 12:48pm.

Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:03am.

Refer to telephone interview with the cook on 03/12/25 at 4:01pm.

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D 310	Continued From page 17 Refer to telephone interview on 03/12/25 at 1:16pm with the facility's contracted Registered Dietitian. Refer to interview with the Administrator on 03/12/25 at 4:00pm. 2. Review of Resident #6's current FL2 dated 2/13/25 revealed diagnoses including dementia, traumatic brain injury with cerebral contusion, and dysphagia. Review of Resident #6's Resident Register revealed an admission date of 12/03/01. Review of Resident #6's diet order dated 01/30/25 revealed she was to be fed by staff, be served a low sodium, pureed diet with nectar thickened liquids, and shakes with meals. Review of Resident #6's LHPS tasks dated 12/31/24 revealed tasks related to feeding techniques for residents with swallowing problems, use of geriatric chair/ transfers and pureed diet/thickened liquids. Review of Resident #6's care plan dated 01/30/25 revealed dietary restrictions related to low sodium and pureed with nectar thickened liquids. Review of a list of residents on thickened liquid diets posted in the kitchen revealed Resident #6 should be served nectar thickened liquids. Observation of Resident #6 on 03/11/25 at 12:35pm during the lunch meal revealed: -She was sitting in a geriatric wheelchair at the dining table with other residents and was being fed pureed pinto beans, pureed collard greens,	D 310		

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D 310	Continued From page 18 pureed pork chop, nutritional shake (Mighty Shake) and a container of ice cream that was not thickened. -She was fed 100 percent of the ice cream without difficulty and without coughing. Telephone interview with the (PCP) on 03/12/25 at 4:27pm revealed: -Resident #6 was on a pureed diet with nectar thickened liquids. -Resident #6 should not have been fed ice cream due to being a very high-risk for aspiration, poor posture and inability to sit up. -She expected all liquids to be thickened before being served to residents on thickened liquids, according to physician orders. Refer to interview with the cook on 3/11/25 at 12:48pm. Refer to interview with the RCC on 03/12/25 at 9:03am. Refer to telephone interview with the cook on 03/12/25 at 4:01pm. Refer to telephone interview on 03/12/25 at 1:16pm with the facility's contracted Registered Dietitian. Refer to interview with the Administrator on 03/12/25 at 4:00pm. _____ Interview with the cook on 03/11/25 at 12:48pm revealed: -She was responsible for placing food items on resident meal trays, according to their diet orders. -She did not know if the ice cream served to	D 310		

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Resident #4 and Resident #6 at lunch time was appropriate for nectar thickened diets.
-She could not locate the covers to the ice cream that she had already thrown away and there were no other containers of ice cream in the facility.
-She later provided a cover/ lid from the ice cream that was served to Resident #4 and Resident #6 and indicated the ice cream was regular ice cream.

Interview with the RCC on 03/12/25 at 9:03am revealed:
-She was aware Resident #4 and Resident #6 were to be served pureed with thickened liquid diets.
-She was made aware Resident #4 and Resident #6 received regular/ ice cream that was not thickened, with their lunch meal on 03/11/25.
-There was a list posted on an eraser board in the kitchen of Residents (#4 and #6) who received thickened liquids.
-Diet extensions were usually attached to the daily regular menus but could not be located menu file in the kitchen.
-The facility contracted Registered Dietitian planned to resend the diet extensions via email.
-She expected therapeutic diet orders to be followed.

Telephone interview with the cook on 03/12/25 at 4:01pm revealed:
-She normally included the extension diet menus with the daily diet menus for regular diets located in the kitchen and that she may have placed them in the folder located behind the menu binder.
-There was a list posted on an eraser board in the kitchen of Residents (#4 and #6) who received thickened liquids.
-She was running late with lunch and did not have enough time to puree the dessert that was on the

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menu, therefore she placed regular ice cream that had not been thickened, on the Resident #4 and Resident #5's lunch trays.
-She did not usually provide ice cream to residents on thickened liquid diets and that was the first time she placed ice cream on the trays of residents who were on thickened liquid diets.

Telephone interview with the facility's contracted Registered Dietitian (RD) on 03/12/25 revealed:
-She created and supplied diet menus and diet extensions to the facility by emailing them to the food provider's sales representative, who in turn forwards the menus and extensions to the facility's RCC.
-She was familiar with the regular lunch menu that was to be served on 03/11/25 (revealed pork chops, green collards, corn muffin, pinto beans, and cinnamon peaches) and ice cream was not on the menu.
-The diet extension menu would have included all things from the regular menu except those items would be pureed and liquids thickened.
-Ice cream liquefies to thin liquids once it's placed in the mouth and could cause choking or gagging in residents with dysphagia.
-Ice cream could be served to residents on thickened liquid diets if the ice cream was melted then thickened with thickener.
-She expected meals to be served according to the menus provided and therapeutic diet orders.

Interview with the Administrator on 03/12/25 at 4:00pm revealed:
-The cook was responsible for preparing the resident's food per their order.
-The cook was responsible for using the menu for a pureed diet which would have contained the dessert to be served for a nectar thickened diet.
-He did not know that ice cream was served as a

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D 310	Continued From page 21 nectar thickened liquid.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #3 and #5) related to medications used to treat elevated potassium (#1), a urinary tract infection (#3) , and Covid (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 01/09/25 revealed: -Diagnoses included osteomyelitis infection of the bone) of the right foot, chronic diabetic foot ulcers of the right foot, right foot neuropathy, schizophrenia and blindness. -There was an order for lokelma (to treat elevated potassium)10gm pack mixed with liquid three times a day. Review of Resident #1's signed physician orders	D 358		

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D 358	Continued From page 22 dated 01/16/25 revealed an order for lokelma 10gm pack mixed with liquid three times a day. Review of the facility's receipt of Resident #1's medications from home dated 01/09/25 revealed there were 10 packets of lokelma 10gm packets available for administration. Review of Resident #1 lab results dated 01/17/25 revealed his potassium level was 5.3 milimoles per liter mmol/L (normal was 3.5mmol/L-5.1mmol/L). Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as "unavailable" on 01/20/25, 01/29/25 and 01/30/25 at 7:00am. -The lokelma was documented as "unavailable" on 01/19/25, 01/20/25, 01/25/25 and 01/29/25 at 1:00pm, and documented a "refused" on 03/12/25 at 1:00pm. -The lokelma was documented as "unavailable" on 01/29/25 at 7:00pm. -The lokelma was documented as not administered 9 out of 93 opportunities. Telephone with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 2:53pm revealed: -On 01/09/24, the facility faxed Resident #1's FL2 dated 01/09/25 with an order for lokelma 10gm, mix with liquid three times a day. -On 01/09/25, the pharmacy required a prior authorization and faxed the physician and the facility. -It was the responsibility of the facility to check up	D 358		

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on the prior authorization, and because the prior authorization was not completed the pharmacy could only completed 3-day doses of the lokelma until 01/29/25.
-The pharmacy dispensed lokelma 10gm packets, 9 packets, a 3-day supply on 01/09/25 and delivered to the facility lock box on 01/10/25 at 2:05am.
-The pharmacy dispensed lokelma 10gm packets, 9 packets, a 3-day supply on 01/13/25 and delivered to the facility lock box on 01/14/25 at 2:20am.
-The pharmacy did not receive signed physician's order dated 01/16/25 for lokelma 10gm.
-The pharmacy dispensed lokelma 10gm packets, 9 packets, a 3-day supply on 01/20/25 and delivered to the facility lock box on 01/21/25 at 2:57am.
-The pharmacy dispensed lokelma 10gm packets, 9 packets, a 3-day supply on 01/25/25 and delivered to the facility lock box on 01/26/25 at 12:44am.
-Resident #1 required 66 doses of lokelma from 01/10/25 to 01/31/25 and the pharmacy dispensed 36 doses.
-The lokelma was used to decrease the amount of potassium in body and missed doses could cause Resident #1 to experience cardiac arrythmias.

Review of Resident #1's February 2025 eMAR revealed:
-There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25.
-The lokelma was documented as administered 02/01/25 to 02/28/25 at 7:00am, 1:00pm and 7:00pm.

Telephone with a Pharmacist from the facility's

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contracted pharmacy on 03/12/25 at 2:53pm revealed:
-On 01/09/24, the facility faxed Resident #1's FL2 dated 01/09/25 with an order for lokelma 10gm, mix with liquid three times a day.
-The pharmacy dispensed lokelma 10gm packets, 90 packets, a 30-day supply on 01/30/25 and delivered to the facility lock box on 02/01/25 at 1:18am.
-Resident #1 required 84 doses of lokelma from 02/01/25 to 02/28/25 and the pharmacy dispensed 90 doses.

Review of Resident #1's March 2025 eMAR revealed:
-There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm and 7:00pm, with a start date of 01/09/25.
-The lokelma was documented as administered 03/01/25 to 03/10/25 at 7:00am, 1:00pm and 7:00pm.

Telephone with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 2:53pm revealed:
-On 01/09/24, the facility faxed Resident #1's FL2 dated 01/09/25 with an order for lokelma 10gm, mix with liquid three times a day.
-The pharmacy dispensed lokelma 10gm packets, 90 packets, a 30-day supply on 03/04/25 and delivered to the facility lock box on 03/05/25 at 11:29pm.
-Resident #1 required 35 doses of lokelma from 03/01/25 to 03/11/25 at 1:00pm and the pharmacy dispensed 90 doses.
-According to the dispense history, Resident #1 would have been out of the lokelma on 03/02/25 and did not receive lokelma until 03/05/25.
-The lokelma was used to decrease the amount of potassium in body and missed doses could

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D 358	Continued From page 25 cause Resident #1 to experience cardiac arrythmias. Review of Resident #1's medications available for administration on 03/11/25 at 2:30pm revealed: -There was a plastic bag tabled 1 of 2 containing lokelma 10gm packets, with a dispense date of 03/04/25, to be administered at 7:00am, 1:00pm and 7:00pm, with 24 packets left to administer. -There was a plastic bag tabled 2 of 2 containing lokelma 10gm packets, with a dispense date of 03/04/25, to be administered at 7:00am, 1:00pm and 7:00pm, with 50 packets left to administer. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed: -Resident #1's admission FL2 dated 01/09/25 was sent to another pharmacy on admission by a case manager at the hospital. -Resident #1 was admitted to the facility on 01/09/25 with 10 packets of lokelma 10gm. -She faxed the FL2 dated 01/09/25 to the facility's pharmacy that same day. -The lokelma required a prior authorization which the pharmacy contacted the physician to obtain. -With the confusion of two pharmacies getting the prescription for lokelma and trying to get the prior authorization the facility was getting refills for three days at a time she did not know that Resident #1 was not administered the lokelma as order and missed some doses. -On 01/29/24, after receiving many 3-day supplies, she called the pharmacy and received a full 30-day amount of lokelma. Telephone interview with Resident #1's previous Primary Care Provider (PCP) on 03/12/24 at 10:01am revealed: -She first saw Resident #1 for a new patient visit on 01/06/24.	D 358		

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D 358	Continued From page 26 -She ordered labs during the visit and continued Resident #1's lokelma from his FL2 dated 01/09/25. -Resident #1 was prescribed lokelma to treat high potassium in the blood. -On 01/30/25, she saw Resident #1 for a follow up. -She review Resident #1's January 2025 eMAR and noted that he was not given lokelma 8 times due to the facility did not have to lokelma to administer. -She also reviewed his potassium level which was 5.3mmol/L. -A potassium level of 5.3mmol/L was high. -She was concerned because of Resident #1's history of diabetes and hypertension and now a high potassium level in the blood, Resident #1 was at risk of cardiac arrhythmia. -When potassium levels were high in the blood, the high potassium interfere with the hearts electrical signal causing arrythmias such as ventral fibrillation and ventricle tachycardia which are life threatening. -Increased levels of potassium in the body can also cause muscle weakness and numbness. -She expected the staff to administer the lokelma as ordered and to notify her with any issues with not getting the medication. Interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am revealed: -She was not aware that Resident #1 did not get the lokelma as ordered. -On 03/11/25, she called the pharmacy and Resident #1's guardian to find out what happened. -The only medication cart audits performed was by the pharmacy during their pharmacy reviews. -The pharmacy completed a pharmacy review on Resident #1 but did not indicate an issue with the	D 358		

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lokelma.

Interview with the Administrator on 03/12/25 at 4:00pm revealed he did not know that Resident #1 did not receive the lokelma as ordered.

Refer to interview with a second shift MA on 03/11/25 at 4:30pm.

Refer to interview with another second shift MA on 03/11/25 at 4:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am.

Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am.

Refer to interview with the Administrator on 03/12/25 at 4:00pm.

2. Review of Resident #3's current FL-2 dated 01/16/25 revealed a diagnosis of traumatic brain injury with behavioral disturbance, epilepsy, anxiety and manic depression.

Review of Resident #3's hospital discharge summary dated 01/15/25 revealed there was an order for Duricef (cefadroxil) 500mg (used to treat infections), one capsule two times daily for six days.

Review of Resident #'3's physician orders dated 01/20/2025 revealed an order to stop antibiotic and start macrobid (a medication used to treat urinary tract infections) 100mg two times a day for ten days.

Review of Resident #3's January 2025 electronic Medication Administration Record (eMAR)

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D 358	Continued From page 28 revealed: -There was an entry for cefadroxil 500mg take one capsule two times a day for six days. -There was documentation that cefadroxil 500mg was administered as given on 01/16/25 and 01/17/25, at 7:00am and 7:00pm. -There was documentation that cefadroxil 500mg was not administered on 01/18/25 at 7:00am and 7:00pm with a reason code of medication not available -There was documentation that cefadroxil 500mg was not administered on 01/19/25 at 7:00am with a reason code of medication not available. -There was documentation that cefadroxil 500mg was administered as given on 01/19/25 at 7:00pm. -There was documentation that cefadroxil 500mg was not administered on 01/20/25 at 7:00am with a reason code of medication not available. -There was documentation that cefadroxil 500mg was administered as given on 01/20/25 at 7:00pm. Review of a text message exchange from the Residential Care Coordinator (RCC) to the Primary Care Provider (PCP) dated 01/19/25 revealed: "Resident #3 came back from the hospital with a antibiotic for the urinary tract infection, he hasn't gotten it yet because I (RCC) was just notified yesterday evening that It hadn't come, but I (RCC) have medication errors because they (staff) were marking that it was here, can I have a new order? Or do you want another urinalysis done he hasn't complained of any symptoms". -Response from the PCP read "no start it". -Response from the RCC read "Okay". Interview with a first shift medication aide (MA) on 3/12/25 at 11:00am revealed:	D 358		

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-She could not recall any information related to Resident #3's cefadroxil in January 2025.
-They do medication cart audits, but she only works four days a week and was not sure when they it had been done last, but thought it had been a long time since a medication cart audit was completed.
-She thought the Business Office Manager (BOM) was the person responsible for completing the medication cart audits.

Interview with a second shift medication aide (MA) on 03/12/25 at 4:55pm revealed:
-She identified her initials on the January 2025 eMAR for Resident #3 of cefadroxil 500mg documented as administered on 01/19/25 at 7:00pm and 01/20/25 at 7:00pm.
-She did not know why she documented the cefadroxil as administered, and thought it was a mistake that she marked the medication as given.
-She thought she might have been in a hurry, but did not remember that far back and did not remember Resident #3 ever being on an antibiotic.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 8:54am revealed:
-Cefadroxil did not show on Resident #3's profile in January 2025.
- An order for Macrobid 100mg 2 x day for 10 days was received on 01/20/25 and a 10-day supply was delivered on 01/20/25.

Telephone interview with a representative (Quality Assurance Specialist) from the facility's contracted pharmacy on 03/12/25 at 3:10pm revealed:
-The pharmacy would put the orders on the eMAR once they receive the order.

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D 358	Continued From page 30 -They did not enter any orders in January 2025 for cefadroxil on the eMAR for Resident #3. -Cefadroxil was entered manually by the facility on 01/15/25 at 8:55pm and could identify the initials from the staff who entered the order from the facility. Interview with RCC on 03/12/25 at 3:20pm revealed: -She was responsible for faxing any new orders to the pharmacy. -She could not recall why the pharmacy did not receive the order for the cefadroxil and must have forgotten to fax it to them. -She verified she was the one who entered the order for the cefadroxil on the eMAR. -She was not made aware Resident #3 had not been getting cefadroxil until 01/19/25. -She realized the MA's were marking they gave the cefadroxil when it was not here. Telephone interview with the former PCP on 03/12/25 at 4:40pm revealed: -She initially stated she was not notified of the missed doses of cefadroxil but then was informed of the text message and recalled being notified. -The risks of Resident #3 not getting cefadroxil could have resulted in re-hospitalization or sepsis. -She expected all medication orders to be followed. Refer to interview with a second shift MA on 03/11/25 at 4:30pm. Refer to interview with another second shift MA on 03/11/25 at 4:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am.	D 358		

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D 358	Continued From page 31 Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. 3. Review of Resident #5's FL-2 dated 11/08/24 revealed diagnoses included intellectual disability, developmental delay, major depressive disorder, anxiety, DM II, schizoaffective disorder, bipolar disorder, hypertension, hyperlipidemia, hypothyroidism, hypomagnesium, chronic kidney disease, hypotension. a. Review of Resident #5's physician order dated 01/31/25 revealed and order to hold simvastatin 20mg (a medication used to lower cholesterol), while taking Paxlovid (a medication to treat COVID-19). Review of Resident #5's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for simvastatin 20mg every night at 8:00pm, with an original date of 10/09/24. -The simvastatin was documented a administered from 01/01/25 to 01/31/25 at 8:00pm. -There was no documentation the simvastatin was held on 01/31/25. Review of Resident #5's February 2025 eMAR revealed: -There was an entry for simvastatin 20mg every night at 8:00pm, with an original date of 10/09/24. -The simvastatin was documented a administered from 02/01/25 to 02/28/25 at 8:00pm. -There was no documentation the simvastatin was held from 02/01/25 to 02/05/25.	D 358		

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D 358	Continued From page 32 Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 11:01am revealed: -On 01/31/25, the facility faxed over a verbal order for Paxlovid use as directed. -The pharmacy dispensed Paxlovid 150-100mg, 20 tablets, a 5-day supply on 02/01/25 from a back-up pharmacy. -The pharmacy faxed a drug interaction notice to the facility on 02/01/25 to hold simvastatin while taking Paxlovid. -Simvastatin and Paxlovid taken together could cause an increased plasma concentration and pharmacological effects of Paxlovid. Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/12/25 at 4:33pm revealed the facility should have stopped the simvastatin while administering Paxlovid because of the interactions which the provider was unable to recall. Interview with a MA on 03/12/25 at 3:07pm revealed: -The fax machine was in the main office. -The MA didn't have access to the fax machine. -The RCC or business office manager (BOM) received faxes and corrected orders on the eMAR if needed. Interview with the RCC on 03/12/25 at 4:00pm revealed: -The RCC was responsible for obtaining orders from the physician and sending orders to the pharmacy. -The RCC was responsible for sending drug interaction notices from the pharmacy to the facility provider for any orders. b. Review of Resident #5's FL-2 dated 11/08/24	D 358		

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revealed an order for Paxlovid use as directed.

Review of Resident #5's February 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Paxlovid 150-100mg twice a day for five days, at 8:00am and 8:00pm, with a beginning date of 02/01/25 and a stop date of 02/06/25.
-There was no documentation the Paxlovid was administered on 02/01/25 at 8:00am.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/12/25 at 11:01am revealed:
-On 01/31/25, the facility faxed over a verbal order for Paxlovid use as directed.
-The pharmacy dispensed Paxlovid 150-100mg, 20 tablets, a 5-day supply on 02/01/25 from a back-up pharmacy and arrived at the facility in the afternoon on 02/01/25.
-The last dose of Paxlovid would have been on 02/06/25 at 8:00am.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/12/25 at 4:33pm revealed the resident should have received the full dose of medication for treatment to be effective.

Telephone Interview with a medication aide (MA) on 03/12/25 at 3:15pm revealed the MA should contact the supervisor if a resident has medications remaining after the order stop date.

Interview with a second MA on 03/12/25 at 3:07pm revealed:
-She administered medication that were active on the eMAR and the Paxlovid was not active on 02/01/25 at 8:00am and 02/06/25 at 8:00am.

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D 358	Continued From page 34 -She could not recall if any Paxlovid tablets were left because the Paxlovid was not active on the eMAR on 02/06/25 at 8:00am. -The MAs should contact the RCC if a resident has medications remaining after the order stop date. -The RCC should correct orders on the eMAR if needed. Interview with the RCC on 03/12/25 at 4:00pm revealed: -She was responsible for obtaining orders from the physician and sending orders to the pharmacy. -The MAs were responsible for contacting the RCC if there are medications remaining in the pill packs after the discontinue date. -She was responsible for evaluating and addressing possible medication errors. -The pharmacy entered the Paxlovid on the eMAR but because the Paxlovid came from the backup pharmacy, the Paxlovid did not start until 02/01/25 at 8:00pm and there would have been one dose left to be administered on 02/06/25 at 8:00am. -On 02/06/25 at 8:00am, the Paxlovid was not active medication and did not show on the eMAR for the MAs to administer, one dose of Paxlovid was not administered. Refer to interview with a second shift MA on 03/11/25 at 4:30pm. Refer to interview with another second shift MA on 03/11/25 at 4:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am. Refer to interview with the Business Office	D 358		

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D 358	Continued From page 35 Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. _____ Interview with a second shift MA on 03/11/25 at 4:30pm revealed: -She was trained to bring up the resident on the eMAR, pull the medication from the drawer on the medication cart, scan the bubble pack and if the medication matched the order in the eMAR she could then administer the medication to the correct resident. -In January 2025, she administered medication from the medication room and the residents would line up to receive their mediations. -During that time it was very busy and noisy during the medication pass. -Different residents would ask for their medications as she was administering medications to another resident. -She sometimes would not scan the medication but click it as administered and there was no way to know if the medication was there or not. -The MAs did not complete medication cart audits and she was not sure who did. -She would re-order medications if the resident was out and she would let the Resident Care Coordinator (RCC) know when a medication had been out more than two days. -The RCC was responsible for calling the pharmacy to check on a medication that did not come in from the pharmacy. Interview with another second shift MA on 03/11/25 at 4:30pm revealed: -She was trained to scan the residents bubble pack to confirm the right medication, pop the medication into the medication cup, administer	D 358		

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the medication and document that she administered the medication.
-She sometimes documented the medication as being administered without scanning the medication and after all of the medication were administered she would document the medications all at once because it was very busy.
-She did not perform medication cart audits and she did not know who did.
-She would re-order medications when they were out through the computer.
The RCC was responsible for calling the pharmacy if there was an issue with missing medications.

Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed:
-She was responsible for faxing orders to the pharmacy.
-The MAs were responsible for matching the order on the eMAR with the medication, scan the medication which provides a second verification that its the correct medication for the resident, administer the medication and then click the medication as administered.
-The number of scanned medications should match the number of clicked medications.
-The MAs were responsible for reordering a medication when there were 7 doses left and then notifying her if a resident's medication did not arrive the next day from the pharmacy.
-She was not trained to complete medication cart audits because the pharmacy completed them monthly.

Interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am revealed:
-The MAs were responsible for notifying the RCC when a medication was ordered and did not arrive on the second day.

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D 358	Continued From page 37 -The RCC was responsible for calling the pharmacy to find out what happened. -The MAs were responsible for scanning a medication before it was administered to provide a secondary verification that the medication was the correct medication and dosage and then documentation that the medication was administered. -The pharmacy completed quarterly review and she thought a medication cart audit was also performed. -She completed some scan/click percentage rate reports, and knew there was a problem with the MA not scanning a medication before administration which could be the reason for some missed medications. -The RCC was not trained to complete medication cart audits, because the management staff were still in the process of training the RCC on the job duties of a RCC. Interview with the Administrator on 03/12/25 at 4:00pm revealed: -The MAs were trained to administer the medications per the physician's orders. -If the medication could not be administered per the order then they were to notify the RCC. -The RCC was responsible for notifying the physician or pharmacy related to the issue. -The MAs were trained to compare the medication with the order in the eMAR, scan the mediation for second verification, administer the medication and document if the medication was administered and if not then put a reason in the comment section. -If the medication was not available, the MA was to reorder the medication. -If the medication was not available on the second day then the MAs were responsible for notifying the RCC.	D 358		

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D 358	Continued From page 38 -The BOM was responsible for completing eMAR reports to check for missed medication and scan/click percentages. -He was not sure about the audits and how often they were performed. _____ The facility failed to administer a medication to lower Resident #1's potassium resulting in a potassium level of 5.3mmol/L, putting the resident at an increased risk of life threatening cardiac arrhythmia (#1) a resident not receiving 10 does of cefadroxil resulting in a risk of re-hospitalization or sepsis (#3), and a resident not receiving a medication to treat COVID-19 in order for it to be effective. This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/12/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 17, 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;	D 367		

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	HAL059035	A. BUILDING: _____ B. WING _____	03/12/2025

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D 367	Continued From page 39 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 5 sampled residents (#1 and #3) related to the failure to accurately document the administration of a medication used to treat high potassium (#1), and an antibiotic (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 01/09/25 revealed: -Diagnoses included osteomyelitis of the right foot, chronic diabetic foot ulcers of the right foot, right foot neuropathy, schizophrenia and blindness. -An order for lokelma (used to treat elevated potassium) 10gm pack mixed with liquid three times a day. Review of Resident #1's signed physician orders	D 367		

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D 367	Continued From page 40 dated 01/16/25 revealed an order for lokelma 10gm pack mixed with liquid three times a day. Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm, and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as "unavailable" on 01/20/25, 01/29/25 and 01/30/25 at 7:00am. -The lokelma was documented as "unavailable" on 01/19/25, 01/20/25, 01/25/25 and 01/29/25 at 1:00pm, and documented a "refused" on 03/12/25 at 1:00pm. -The lokelma was documented as "unavailable" on 01/29/25 at 7:00pm. Review of Resident #1's February 2025 eMAR revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm, and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as administered 02/01/25 to 02/28/25 at 7:00am, 1:00pm, and 7:00pm. Review of Resident #1's March 2025 eMAR revealed: -There was an entry for lokelma 10gm pack mixed with liquid three times a day, at 7:00am, 1:00pm, and 7:00pm, with a start date of 01/09/25. -The lokelma was documented as administered 03/01/25 to 03/10/25 at 7:00am, 1:00pm, and 7:00pm. Interview with a second shift MA on 03/11/25 at	D 367		

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D 367	Continued From page 41 4:30pm revealed: -In January 2025, she administered Resident #1's medications from the medication room and the residents would line up to receive their mediations. -During that time it was very busy and noisy during the medication pass. -Different residents would ask for their medications as she was administering medications to another resident. -She sometimes would not scan the medication but click it as administered and there was no way to know if the medication was there or not. -She could not say that she administered every medication for Resident #1 that was documented as administered on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed she was not aware the MAs were documenting medications as administered Resident #1's lokelma was not in the building. Refer to interview with a second shift MA on 03/11/25 at 4:30pm. Refer to interview with another second shift MA on 03/11/25 at 4:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am. Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. 2.Review of Resident #3's FL-2 dated 01/16/25 revealed a diagnosis of traumatic brain injury with	D 367		

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behavioral disturbance, epilepsy, anxiety and manic depression.

Review of Resident #3's hospital discharge summary dated 01/15/25 revealed there was an order for Duricef (cefadroxil) (a medication used to treat infections), 500mg one capsule two times daily for six days.

Review of Resident #3's January 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cefadroxil 500mg take one capsule two times a day for six days.
-There was documentation that cefadroxil 500mg was administered as given on 01/16/25 and 01/17/25, at 7:00am and 7:00pm.
-There was documentation that cefadroxil 500mg was not administered on 01/18/25 at 7:00am and 7:00pm with a reason code of medication not available
-There was documentation that cefadroxil 500mg was not administered on 01/19/25 at 7:00am with a reason code of medication not available.
-There was documentation that cefadroxil 500mg was administered as given on 01/19/25 at 7:00pm.
-There was documentation that cefadroxil 500mg was not administered on 01/20/25 at 7:00am with a reason code of medication not available.
-There was documentation that cefadroxil 500mg was administered as given on 01/20/25 at 7:00pm.

Review of a text message exchange from the Residential Care Coordinator (RCC) to the Primary Care Provider (PCP) dated 01/19/25 revealed: "Resident #3 came back from the hospital with an antibiotic for a urinary tract infection, he hasn't gotten it yet because I (RCC)

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was just notified yesterday evening that It hadn't come, but I (RCC) have medication errors because they (staff) were marking that it was here (in the facility)."

Interview with a second shift medication aide (MA) on 03/12/25 at 4:55pm revealed:
-She identified her initials on the eMAR for Resident #3 of cefadroxil 500mg documented as administered on 01/19/25 at 7:00pm and 01/20/25 at 7:00pm.
-She thought it was a mistake that she marked the medication and may have been in a hurry, but did not remember that far back and did not remember Resident #3 ever being on an antibiotic.

Interview with RCC on 03/12/25 at 3:20pm revealed:
-She was responsible for faxing any new orders to the pharmacy.
-She could not recall why the pharmacy did not receive the order for the cefadroxil and must have forgotten to fax it to them.
-She verified her initials, and she was the one who entered the order for the cefadroxil on the eMAR.
-She was not made aware Resident #3 had not been getting cefadroxil until 01/19/25 when one of the MA's told her.
-She communicated in writing to the PCP regarding the missed cefadroxil.
-She expected the MAs to notify her when medication was not available and to document correctly.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/12/25 at 8:54am revealed cefadroxil did not show on Resident #3's profile.

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D 367	Continued From page 44 A second telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 3:10pm revealed: -The pharmacy would put the orders on the eMAR once they receive the order. -They did not enter any orders for cefadroxil on the eMAR for Resident #3. -Cefadroxil was entered manually by the facility on 01/15/25 at 8:55pm and could see the initials from the staff from the facility. Refer to interview with a second shift MA on 03/11/25 at 4:30pm. Refer to interview with another second shift MA on 03/11/25 at 4:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am. Refer to interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am. Refer to interview with the Administrator on 03/12/25 at 4:00pm. _____ Interview with a second shift MA on 03/11/25 at 4:30pm revealed: -She was trained to bring up the resident on the eMAR, pull the medication from the drawer on the medication cart, scan the bubble pack and if the medication matched the order in the eMAR she could then administer the medication to the correct resident. -In January 2025, she administered medication from the medication room and the residents would line up to receive their mediations. -During that time it was very busy and noisy	D 367		

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during the medication pass.
-Different residents would ask for their medications as she was administering medications to another resident.
-She sometimes would not scan the medication but click it as administered and there was no way to know if the medication was there or not.

Interview with another second shift MA on 03/11/25 at 4:30pm revealed:
-She was trained to scan the residents bubble pack to confirm the right medication, pop the medication into the medication cup, administer the medication and document that she administered the medication.
-She sometimes documented the medication as being administered without scanning the medication and after all of the medication were administered she would document the medications all at once because it was very busy.

Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 9:09am revealed:
-The MAs were responsible for matching the order on the eMAR with the medication, scan the medication which provides a second verification that its the correct medication for the resident, administer the medication and then click the medication as administered.
-The BOM was responsible for reviewing the report that included number of scanned medications should match the number of clicked medications.

Interview with the Business Office Manager (BOM) on 03/12/25 at 11:00am revealed:
-The MAs were responsible for scanning a medication before it was administered to provide a secondary verification that the medication was the correct medication and dosage and then

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D 367	Continued From page 46 documentation that the medication was administered. -She completed some scan/click percentage rate reports, and knew there was a problem with the MA not scanning a medication before administration which could be the reason for some missed medications. -The RCC was not trained to complete medication cart audits, because the management staff were still in the process of training the RCC on the job duties of a RCC. Interview with the Administrator on 03/12/25 at 4:00pm revealed: -The MAs were trained to document the medication that was administered. -If a medication was missing the MA was not to document it as administered. -The MAs were trained to compare the medication with the order in the eMAR, scan the mediation for second verification, administer the medication and document if the medication was administered and if not then put a reason in the comment section. -The BOM was responsible for completing eMAR reports to check for missed medication and scan/click percentages. -He was not sure about medication audits and how often they were performed.	D 367		