STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R **04/08/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

(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 a follow-up survey on 04/07/25 and 04/08/25.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 5 sampled residents (#1, #5) with orders for thrombo-embolic deterrent hose (TED). The findings are: 1. Review of Resident #3's current FL-2 dated 03/17/25 revealed diagnoses included Dementia, chronic atrial fibrillation, pulmonary embolism, chronic gout, and gastro esophageal reflux disease. Review of Resident #3's physician order summary report dated 03/05/25 revealed there was an order for anti-embolism knee high closed toe stockings apply every morning to both legs and remove at bedtime. Observation of Resident #3 on 04/07/25 at 12:15pm revealed she did not have on her thrombo-embolic deterrent hose (TED).	{D 276}		

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{D 276}	Continued From page 1 Attempted Interview with Resident #3 on 04/07/25 at 12:15pm revealed resident was not interviewable. Review of Resident #3s April eMAR revealed: -Compression socks were documented as removed at 8:00pm on 04/06/25. -Compression socks were documented as applied at 8:00am on 04/07/25. Interview with a medication aide MA on 04/07/25 at 9:20am revealed: -She worked on the female side of the facility. -Resident #3 had a current order for TED hose. -She wore her TED hose when the MAs applied them. -She usually put Resident #3's TED hose after she administered her medication. -She forgot to apply Resident #3's TED hose on. Refer to interview with the Resident Care Coordinator (RCC) on 04/07/25 at 9:30am. Refer to interview with the Administrator on 04/07/24 at 9:50am. Refer to telephone interview with the primary care provider (PCP) on 04/08/25 at 2:25pm. 2. Review of Resident #5's current FL-2 dated 07/01/24 revealed diagnoses included dementia, muscle weakness, polyneuropathy, thrombocytopenia, and hypothyroidism. Review of Resident #5's physician order summary report dated 03/14/25 revealed there was an order for anti-embolism knee high closed toe stockings apply every morning to both legs and remove at bedtime.	{D 276}		

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{D 276}	Continued From page 2	{D 276}		

Observation of Resident #5 on 04/07/25 at 2:10pm revealed he did not have on her thrombo-embolic deterrent hose (TED).

Attempted Interview with Resident #5 on 04/07/25 at 2:10pm revealed resident was not interviewable.

Review of Resident #5s April eMAR revealed:
-Compression socks were documented as removed at 8:00pm on 04/06/25.
-Compression socks were documented as applied at 8:00am on 04/07/25.

Interview with a second MA on 02/07/25 at 2:20pm revealed:
-She worked on the male side of the facility.
-Resident #5 had a current order for TED hose.
-She usually passed morning medications to all residents, then put Resident #5's TED hose on him.
-She could not find Resident #5's TED hose that morning.

Refer to interview with the Resident Care Coordinator (RCC) on 04/07/25 at 9:30am.

Refer to interview with the Administrator on 04/07/24 at 9:50am.

Refer to telephone interview with the primary care provider (PCP) on 04/08/25 at 2:25pm.

___

Interview with the Resident Care Coordinator (RCC) on 04/07/25 at 2:30pm revealed:
-The home health nurse did not want Resident #3 to wear her TED hose in April because she had bandages on her lower legs.
-She expected the MAs to apply Resident #5's

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{D 276}	Continued From page 3 TED hose every morning and remove every night. -She expected the MAs to inform her if they were not able to apply residents TED hose for any reason. -The MAs were responsible for ensuring resident health care was completed as ordered. -She did not know why Resident #5 did not have her TED hose applied daily. Interview with the Administrator on 04/07/24 at 2:45pm revealed: -She did not think that Resident #3 was currently supposed to be wearing TED hose. She did not know why Resident #5 did not have his TED hose applied daily. -She expected the MAs to implement physician orders. -The MAs were responsible for applying and removing residents TED hose daily. -It was the responsibility of the RCC and herself to ensure health care was being completed for each resident. Telephone interview with the primary care provider (PCP) on 04/08/25 at 10:50am revealed: -Resident #5 had an order for TED hose. -Resident #5 did not always comply when MAs attempted to apply TED hose. -She was not concerned if Resident #5 did not wear his TED hose daily. -Resident #3 frequently got ulcerations and needed her lower legs dressed. -Resident #3 did not need to wear her TED hose when she had dressings on her legs. -She expected the MAs to follow resident orders as prescribed.	{D 276}		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 4 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#1, #2, #5) including inaccurate documentation of a medication used to treat depression and help with sleep (#1), a blood pressure medication (#2), and a thyroid medication (#5). The findings are: 1. Review of Resident #1's current FL-2 dated	D 367		

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03/24/25 revealed:
-Diagnoses included dysphagia, atrial fibrillation, coronary artery diseases involving coronary bypass graft of native artery, chronic heart failure, hypertension, cerebral vascular accident, insulin dependent diabetes mellitus, seizure disorder, and chronic kidney disease IV.
-There was an order for trazodone (used to treat depression) 100mg ½ tablet=50mg by mouth at bedtime.

Review of Resident #1's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for trazodone 100mg at bedtime scheduled for administration at 8:00pm.
-Trazodone 100mg was documented as administered at 8:00pm on 02/01/25 to 02/28/25.
-There was no entry for trazodone 100mg (1/2 tab = 50mg).

Review of Resident #1's March 2025 eMAR revealed:
-There was an entry for trazodone 100mg at bedtime scheduled for administration at 8:00pm.
-Trazodone 100mg was documented as administered at 8:00pm on 03/01/25, 03/02/25, 03/03/25, 03/05/25, 03/07/25, 03/08/25, 03/10/25, 03/13/25, 03/16/25, 03/19/25, 03/24/25 to 03/31/25.
-Trazodone 100mg was documented as not administered with the reason listed as "6" on 03/04/25, 03/06/25, 03/09/25, 03/11/25, 03/12/25, 03/14/25, 03/15/25, 03/17/25, 03/18/25, and 03/20/25 to 03/23/25.
-The exceptions page documented the reason "6" as 'hospitalized'.
-There was an entry for trazodone 100mg take ½ tab = 50mg at bedtime scheduled for administration at 9:00pm.

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-Trazodone 100mg take ½ tab = 50mg was documented as administered on 03/25/25 - 03/31/25 at 9:00pm.

Review of Resident #1's April 2025 eMAR revealed:
-There was an entry for trazodone 100mg at bedtime scheduled for administration at 8:00pm.
-Trazodone 100mg was documented as administered at 8:00pm on 04/01/25 - 04/06/25.
-There was an entry for Trazodone 100mg take ½ tab = 50mg at bedtime scheduled for administration at 9:00pm.
-Trazodone 100mg take ½ tab = 50mg was documented as administered at 9:00pm on 04/01/25 - 04/06/25.

Observation of Resident #1's medications on hand on 04/08/25 at 8:58am revealed:
-There were 24 - halved tablets of Trazodone 100mg (=50mg) on the cart for Resident #1.
-The dispensed date was 04/03/25 and 28 - halved tablets were dispensed.
-There were no 100mg tablets of trazodone noted on the medication cart for Resident #1.

Interview with a medication aide (MA) on 04/08/25 at 10:10am revealed:
-She was not aware of Resident #1 having more than one trazodone order.
-She thought the dosage had changed.
-She scanned the card of the medication when the medication showed up at the times to be administered.
-She would click off the medications after she had administered them to the resident.
-Resident #1 received trazodone at bedtime and she did not work that shift, so she was not sure how the medication "pops" up on the computer to be administered.

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Interview with the Memory Care Coordinator (MCC) on 04/08/25 at 11:01am revealed:
-She had become the MCC in January 2025 and was still learning.
-The pharmacy was responsible for deleting any discontinued medications, as she could not delete them.
-If a resident had more than one medication order for the same medication, she expected the MA to notify her of any discrepancies.
-The MAs were responsible for auditing their medication carts daily.
-She performed cart audits weekly.

Interview with the Administrator on 04/08/25 at 11:09am revealed:
-She expected MAs to document correctly on Resident #1's eMAR that trazodone 50mg was administered as ordered and to notify the MCC or her if there were any other orders for the same medication.
-The MAs should had notified the MCC of the order for the trazodone 100mg remaining to 'pop up' instead of just clicking on it to make it "go away" so they could finish the medication the administration, the MCC would have known to contact the pharmacy to get the discontinued order removed from the eMAR.

Telephone interview with the facility's contracted primary care provider (PCP) on 04/08/25 at 10:45am revealed:
-The pharmacy dispensed medications for residents and they were the ones responsible to make sure the residents received the medications as ordered.
-She was aware of discrepancies in orders for Resident #1 and she addressed this at length in her notes from the 03/31/25 visit.

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-She was not concerned about the inaccuracies on the eMARs as long as the residents received the appropriate dosages of the correct medications.

2. Review of Resident #5's current FL-2 dated 07/01/24 revealed:
-Diagnoses included dementia, hypothyroidism, hypertension, muscle weakness, polyneuropathy, thrombocytopenia, right bundle branch block, and chronic kidney disease III.
-There was an order for levothyroxine 125mcg (used to treat an underactive thyroid - a condition where the thyroid gland does not produce enough thyroid hormone) one tablet daily at least 30 minutes prior to breakfast.

Review of a primary care provider's (PCP's) orders dated 04/01/25 revealed an order to discontinue levothyroxine 125mcg daily and to start levothyroxine 137mcg daily.

Review of Resident #5's April 2025 eMAR revealed:
-There was an entry for levothyroxine 125mcg tablet take one tablet by mouth daily at least 30 minutes before breakfast scheduled at 7:00am.
-Levothyroxine 125mcg tablet scheduled at 7:00am was documented as administered from 04/01/25-04/07/25.
-There was an entry for levothyroxine 137mcg tablet take one tablet by mouth daily scheduled at 9:00am.
-Levothyroxine 137mcg tablet scheduled at 9:00am was documented as administered from 04/01/25-04/07/25.

Observation of Resident #5's medications on hand on 04/08/25 at 8:46am revealed:
-There were 21 tablets of levothyroxine 137mcg

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on the cart for Resident #5.
-The dispensed date was 04/01/25 and 28 tablets were dispensed.
-There were no 125mcg tablets of levothyroxine noted on the medication cart for Resident #5.

Interview with the Memory Care Coordinator (MCC) on 04/08/25 at 11:01am revealed:
-She had become the MCC in January 2025 and was still learning.
-The pharmacy was responsible for deleting any discontinued medications, as she could not delete them.
-If a resident had more than one medication order for the same medication, she expected the MA to notify her of any discrepancies.
-The MAs were responsible for auditing their medication carts daily.
-She performed cart audits weekly.

Interview with the Administrator on 04/08/25 at 11:09am revealed:
-She expected the medication aides (MAs) to document correctly on the resident's eMAR that the medication was administered as ordered and to notify the MCC or her if there were any other orders for the same medication.
-The MAs should have notified the MCC of the "extra" orders for same medication and not just clicking on it to make it "go away" so they could finish the medication the administration, the MCC would have known to contact the pharmacy to get the "extra" order removed from the eMAR.

Telephone interview with the facility's contracted primary care provider (PCP) on 04/08/25 at 10:45am revealed:
-The pharmacy dispensed medications for residents and they were the ones responsible to make sure the residents received the medications

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as ordered.
-She was not concerned about the inaccuracies on the eMARs as long as the residents received the appropriate dosages of the correct medications.

3. Review of Resident #2's current FL-2 dated 03/17/25 revealed:
-Diagnosis included Alzheimer's disease, essential hypertension, chronic obstructive pulmonary disease, and gastro-esophageal reflux disease.
-There was an order for amlodipine besylate 10 mg take one tablet by mouth daily (used to treat high blood pressure).
-There was an order for amlodipine 10 mg take one tablet by mouth daily (used to treat high blood pressure).

Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 10 mg take one tablet by mouth daily at 8:00pm, documented as administered 28 out of 28 days.
-There was an entry for amlodipine besylate 10 mg take one tablet by mouth daily at 9:00pm, documented as administered 28 out of 28 days.

Review of Resident #2's March 2025 eMAR revealed:
-There was an entry for amlodipine 10 mg take one tablet by mouth daily at 8:00pm, documented as administered 31 out of 31 days.
-There was an entry for amlodipine besylate 10 mg take one tablet by mouth daily at 9:00pm, documented as administered 31 out of 31 days.

Review of Resident #2's April 2025 eMAR revealed:

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D 367	Continued From page 11 -There was an entry for amlodipine 10 mg take one tablet by mouth daily at 8:00pm, documented as administered 6 out of 6 days. -There was an entry for amlodipine besylate 10 mg take one tablet by mouth daily at 9:00pm, documented as administered 6 out of 6 days. Observation of Resident #2's medication on hand on 04/08/25 at 10:15am revealed: -There were 23 tablets of amlodipine 10mg on the cart for Resident #2. -The dispense date was 04/03/25. -There were no amlodipine besylate 10mg tablets on the medication cart for Resident #2. Interview with a medication aide (MA) on 04/08/25 at 10:15am revealed: -Resident #2 was only administered amlodipine 10mg once nightly for blood pressure. -She signed off on the eMAR that it was administered at 8:00pm and at 9:00pm because it was listed that way on the eMAR. -She knew that there was an error on the eMAR. -The Resident Care Coordinator (RCC) and Administrator were responsible for ensuring the medications were listed accurately on the eMAR. Interview with the Memory Care Coordinator (MCC) on 04/08/25 at 11:15am revealed: -Resident #2 had only been administered amlodopine 10mg once nightly. -She believed the amlodipine 10mg being listed on the eMAR twice was a pharmacy error. -She did not have the ability to remove any medications from the eMAR. -The MAs should not have been documenting that Resident #2 was being administered amlodipine 10mg at 8:00pm and again at 9:00pm. -The MAs should have informed her of the issue in order to get the eMAR corrected.	D 367		

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-Cart audits were done daily by the MAs and weekly by the RCC.
-She was responsible for ensuring the eMARs were accurate.

Interview with the Administrator on 04/08/25 at 11:30am revealed:
-She was not sure why amlodipine 10mg was listed on the eMAR to be administered at 8:00pm and again at 9:00pm.
-She expected the MAs to get clarification if the eMAR has duplicate medications.
-The MAs did medication cart audits nightly.
-The RCC did medication cart audits weekly.
-The RCC and Administrator were responsible for the accuracy of the eMAR.

Interview with Resident #2's primary care provider (PCP) on 04/08/25 at 10:50am revealed:
-Resident #2 should have been getting only one dose of amlodipine 10 mg for blood pressure.
-She believed it was a inaccuracy on the eMAR.
-The facility had been having problems with the facility getting medications corrected on the eMAR.
-Resident #2's blood pressure had been stable.