STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL012041	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCALPINE ADULT CARE	3806 KATHY ROAD MORGANTON, NC 28655

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D 000	Initial Comments The Adult Care Licensure Section conducted an anuual survey and complaint investigation from April 1, 2025 to April 2, 2025.	D 000	Integrity McAlpine will continue to focus on ensuring that we maintain good practices to ensure quality of care for all our residents.	
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the ceilings were kept in good repair in resident's room (#4) and in the kitchen. The finding are: 1. Observation of Room #4 on 04/01/25 at 9:47am revealed: -There were 4 residents' beds in the room. -Bed #1 when you walked into the room was to	D 074	10A NCAC 13F .0306 (a) (1) Housekeeping and Furnishings The facility will ensure that walls, ceilings, and floors or floor coverings are clean, safe, and functional. The facilities maintenance technician has made repairs to the kitchen ceiling as well as Room #4 as identified in the statement of deficiency. As observed at the time of the survey, the facility was in the process of obtaining quotes to correct facility roofing issues. Roofing Company corrected areas needing resurfaced on May 5, 2025. Maintenance technicians will do monthly inspections on ceilings to ensure they are safe and functional. Completed: May 5, 2025	

Faheemah Jones "reviewed and acknowledged" 5/20/25

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D 074	Continued From page 1 the left with the headboard against the left side wall. -Bed #2 was to the right along the right side of the room wall. -Bed #3 and #4 were pushed all the way against the back wall on the left side. -There were 10 wet bath towels on the floor in between bed #1, to the left of #2 and up to bed #3. -Along with the 10 wet towels there was a 5-gallon round bucket, a 5-gallon square bucket and 2 large clear plastic containers with water covering the bottoms of the containers and water actively dripping from the ceiling. -There were 4 large rectangle ceiling tiles removed and there were numerous brown stains on the ceiling above the missing ceiling times. -There was a large skylight above the end of bed #1 with water actively dripping from it. -Bed #1 and #3's were placed on plastic round risers to keep them off of the floor. -The flooring was discolored in areas where the buckets and towels were and along the wall on the left side where bed #2 and #3 were previously located. Interview with a resident who resided in room #4 on 04/01/25 at 9:48am revealed: -The ceilings were leaking since last year and were worse when the hurricane hit. -There was standing water in the floor until the staff came in the room and placed towels and buckets to catch the water. -All of the residents' beds were moved along the walls of the room so they would not get wet. -The staff put plastic risers under two of the bed posts so they would not get wet. -Two of the residents in the room moved out and he did not move because he did not like who he was going to have to room with.	D 074		

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D 074	Continued From page 2 Interview with another resident who resided in room #4 on 04/01/25 at 9:53am revealed: -The ceiling had been leaking since he was admitted here, about 8 years. -Every time it rained hard the staff would have to mop up the water, put down towels and buckets. -On 03/31/25, water puddle on the floor and the beds were moved. -The maintenance man took down ceiling tiles in the room and staff put towels and buckets on the floor to catch the water that was leaking from the ceiling. Review of a work order dated 12/17/24 revealed: -On 12/17/24, staff notified the Administrative Assistant about the ceiling tiles leaking in room #4 over bed #3. -On 12/17/24, the work order was faxed to the Business Office Manager (BOM). -There was no documentation that the work order was completed. Review of a work order dated 03/26/25 revealed: -On 03/26/25, staff reported the ceiling tiles were leaking and coming off in room #4. -On 03/26/25, the work order was faxed to the BOM. -There was no documentation that the work order was completed. Review of a work order dated 03/26/25 revealed: -On 03/26/25, staff reported the ceiling tiles were leaking and coming off in the kitchen /mop room. -On 03/26/25, the work order was faxed to the BOM. -There was no documentation that the work order was completed. Refer to interview with the Administrative	D 074		

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D 074	Continued From page 3 Assistant on 04/02/025 at 9:45am. Refer to interview with the BOM on 04/02/25 at 9:58am. Refer to interview with the Operations Manager on 04/02/25 at 11:00am. Refer to a telephone interview with the Administrator/Maintenance Director on 04/02/25 at 10:30am. 2. Observation of the kitchen on 04/01/25 at 12:45pm revealed: -There was a leak in the ceiling between the ice machine and a stainless-steel table. -There was water dripping on the stainless-steel table, and no food was present. A second observation of the kitchen on 04/02/25 at 11:51am revealed: -There was a leak in the ceiling between the ice machine and a stainless-steel table. -There was water dripping on the left side of the stainless-steel table and on the floor between the ice machine, and no food was present. -There was a bucket placed on the floor to catch the drips from the ceiling. -The 5-gallon bucket was half full. Review of a work order dated 03/26/25 revealed: -On 03/26/25, staff reported the ceiling tiles were leaking and coming off in the kitchen /mop room. -On 03/26/25, the work order was faxed to the BOM. -There was no documentation that the work order was completed. Interview with the Dietary Manager on 04/02/25 at 11:53am revealed:	D 074		

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D 074	Continued From page 4 -She was not sure how long the ceiling had been leaking but new if was over a week. -She knew that someone was coming today 04/02/25 to fix it. Interview with the Manager on 04/02/25 at 6:15pm revealed: -The leak had just started with the rain today 04/02/25. -She was not aware of any other previous leaks in the kitchen. Refer to interview with the Administrative Assistant on 04/02/025 at 9:45am. Refer to interview with the BOM on 04/02/25 at 9:58am. Refer to interview with the Operations Manager on 04/02/25 at 11:00am. Refer to a telephone interview with the Administrator/Maintenance Director on 04/02/25 at 10:30am. --- Interview with the Administrative Assistant on 04/02/025 at 9:45am revealed: -The staff were responsible to notify him about any issues with the facility and he would fill out a work order. -Once he completed the work order, he was responsible to fax the work order to the Business Office Manager (BOM). -The BOM was responsible to give the work order to the Maintenance Technician/Maintenance Director for approval. -Once the work order was approved by the Maintenance Director, the Maintenance Director would give the BOM permission to release the	D 074		

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D 074	Continued From page 5 company credit card for the Maintenance Technician to get the required supplies or call an outside agency to come and give a quote. -Once a work order was completed the Maintenance Technician was responsible for signing off on the work order as completed. -He did not have a work order dated 12/17/24 or 03/26/25 signed off as completed. Interview with the BOM on 04/02/25 at 9:58am revealed: -She received all work orders faxed over by the Administrative Assistant and placed them in the mailbox for the Maintenance Director. -The Maintenance Technician would pick them up and fix the issues. -The Maintenance director was responsible to notify her when the Maintenance Technician needed to get supplies with the company credit card and to notify any outside agency to access the situation and give a quote on what needed fixing. -The 12/16/24 and 03/26/25 work orders for room #4 and the kitchen were given to the Maintenance Technician. -The roof was replaced about 2012. -The roof had been leaking for about a year or so. -The Maintenance Director had someone come out to the facility and give a quote to repair the roof about a month ago. Interview with the Operations Manager on 04/02/25 at 11:00am revealed: -She did know about room #4 ceiling leaking in December 2024 and March 2025 as well as the kitchen ceiling leaking in March 2025. -The Administrator/Maintenance Director had patched the room several times. -There were 2 quotes completed on the roof since March 2025.	D 074		

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D 074	Continued From page 6 -There were no empty room available in the facility but there were empty beds but two of the four residents in room #4 did not want to move. -The staff placed buckets and towels down to catch the water leaking from the ceiling. Telephone interview with the Administrator/Maintenance Director on 04/02/25 at 10:30am revealed: -The roof had been leaking off and on since December 2024. -The roof was patched several times but would start leaking again in other areas. -He received the 12/16/24 and the 03/26/25 work orders. -On 03/18/25, he received a quote for the room membrane replacement and sent the quote to the corporate office for approval and now needs to get another quote and send it to corporate as well. -The Operations Manager asked the residents in room #4 would like to move to a different room and was told no. -There were no empty rooms just empty beds.	D 074		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure follow-up with a physician for 1 of 5 sampled residents (#2) related to a medication used to treat schizoaffective disorder.	D 273	10A NCAC 13F .0902 (b) Health Care The facility will ensure that referral and follow-up will meet the routine and acute health care needs of the residents. All orders will be documented on a "order log" and will be followed by a two-person check process until completion. This process will include ensuring that all orders are sent to the pharmacy, correctly added to the residents' MAR, and any other directives documented in an order. All injection orders will also be documented in an injection Log for the Licensed Health Professional, who administers the injections to document in, as well as the residents MAR.	

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D 273	Continued From page 7 The findings are: Review of Resident #2's current FL-2 dated 01/23/25 revealed: -Diagnoses of chronic obstructive pulmonary disease, asthma, anemia, fatigue and high blood pressure. -There was an order for Invega Trinza (a medication to treat schizoaffective disorder) 819mg/2.625ml inject 819mg every 90days. Review of Resident #2's signed Primary Care Provider (PCP) orders dated 01/23/25 revealed there was an order for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. Review of Resident #2's care plan dated 01/02/25 revealed: -Resident #2 received an Invega Trinza every three months, Resident #2 was not always medication compliant." -The Care plan was signed by the Assessor who was the Residential Care Coordinator (RCC) on 01/02/25. Review of Resident #2's signed Licensed Health Professional Support dated 02/12/25 revealed under LHPS personal care tasks provided included intramuscular injections by "psych" (psychiatrist). Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time.	D 273	The Resident Care Coordinator and Medication Technicians will attend an In-Service on the process of the order log and the and the importance of the two-person check process to ensure the completion of all orders on May 9, 2025. To ensure ongoing compliance, the following monitoring process has been put into place. The Resident Care Coordinator and/or Designee will review the "order log" daily to ensure the order log process is being followed. The Operational Manager and/or Designee will review all order logs monthly to ensure compliance and the completion of all orders. Completed: May 9, 2025	

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D 273	Continued From page 8 -There was no documentation Invega Trinza 819mg/2.625ml was administered. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time. -There was no documentation Invega Trinza 819mg/2.625ml was administered. Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen. -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time. -There was no documentation Invega Trinza 819mg/2.625ml was administered. Observations of Resident #2's medications on hand on 04/02/25 at 3:09pm revealed the Invega Trinza injection was not available to be administered. Interview with the medication aide (MA) on 04/02/25 at 3:09pm revealed: -The Invega Trinza was not kept on the cart because it was ordered PRN. -She did not remember the last time Resident #2 received the injection of Invega Trinza. -There was a book kept in the medication room for all Residents who received injections. -The Nurse who gave the injection would document in the book.	D 273		

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D 273	Continued From page 9 Review of the facility's Injection notebook revealed: -The form included columns with the Residents name, date, site/procedure and nurse signature. -There was no column to indicate what injection was given. -Resident #2's name was documented in the book with a date beginning 01/05/23 through 07/22/24, for a total of 8 injections. -The last signature on 07/22/24 was from the pharmacy representative. Interview with the RCC on 04/02/25 at 3:12pm revealed: -Resident #2 only got an Invega injection as needed. -She did not recall Resident #2 ever receiving an Invega Injection. -Hospice would give the medication injection when needed. Telephone interview with a representative with the facility' s hospice provider for Resident #3's on 04/02/25 at 10:48am revealed: -Resident #3 was not on hospice but received palliative care. -Palliative Care did not complete any injections. A second interview was completed with the RCC on 04/02/25 at 06:30pm revealed: -She was responsible for notification to the psychiatric provider and the PCP. -The psychiatric provider had not asked about it when he had seen Resident #2. -She was unaware Resident #2 was taking the Invega Trinza injection. -She did not think that it was on the eMAR. Telephone interview with a representative from	D 273		

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D 273	Continued From page 10 the facility's contracted pharmacy on 04/02/25 at 03:13pm revealed: -They received Resident #2's with physician orders on 03/22/24 and on 01/30/2025 for Invega Trinza 819mg/2.625ml inject 819mg every 90 days plus 7 days. -They dispensed Invega Trinza 819mg/2.625ml 03/22/24 and 06/04/24. -Invega Trinza was enter on the eMAR as a PRN medication for re-order purposes only as the facility would need to schedule the injection with an outside provider to give the medication, as the medication would be ordered every 90 days. Telephone interview with the facility's contracted pharmacy consultant on 04/02/25 at 05:11pm revealed: -She was a certified immunizing pharmacist. -She was responsible for the pharmacy reviews for the facility which are completed on a quarterly basis. -Her last review was on 01/28/25. -When she conducted her medication review, she would review the eMAR and would ask if home health was giving the injections. -She knew that Resident #2 was followed by a Mental Health Provider (MHP) and a PCP. -She gave Resident #2 the Invega Trinza injection on 07/22/24 and remembered that the injection was present on the medication cart and Resident #2 was willing to receive the medication, so she had given it as it was within the scheduled timeframe. Interview with the Operations Manager on 04/02/25 at 06:15pm revealed: -The RCC was responsible for reviewing all medication orders. -Medication cart audits should have been completed to ensure the medication was	D 273		

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D 273	Continued From page 11 available for administration. -There should have been follow up with Resident #2's PCP and or the MHP to inform them the medication had not been given. Telephone interview with the facility's contracted PCP on 04/02/25 at 04:42pm revealed: -Resident #2 was to receive the Invega Trinza injection every 90days and it should not be given on an as needed basis. -Resident #2 was receiving the Invega Trinza injection due to her schizoaffective disorder. -He expected the order to be given as prescribed every 90 days. -He was not made aware that Resident #2 had not received her injection of Invega Trinza since 07/22/24. -Resident #2 could have had an increase in behaviors by not receiving the Invega Trinza injection. -Resident #2's MHP should be made aware of the failure to follow the scheduled administration of the Invega Trinza injection. Attempted telephone interview with Resident #2's MHP on 04/02/25 at 04:24pm was unsuccessful.	D 273		
D 346	10A NCAC 13F .1002(c) Medication Orders 10A NCAC 13F .1002 Medication Orders (c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) oute of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated	D 346	10A NCAC 13f .1002 (c) Medication Orders The facility will ensure that all medication orders shall be complete and include the following: Medication name Strength of medication Dosage of medication to be administered Route of administration Specific directions of use: including frequency	

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D 346	Continued From page 12 indication for use. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure a medication that was prescribed to be administered as needed included an indication for use and the correct dosage amount for 1 of 5 residents related to an order for oxygen (Resident #2). The findings are: 1. Review of Resident #2's current FL-2 dated 01/24/25 revealed: -Diagnoses of chronic obstructive pulmonary disease, asthma, anemia, fatigue and high blood pressure. -There was an order for oxygen 3 liters per minute via nasal cannula (NC) daily at bedtime and as needed with no indication of when it was to be administered. -There were no additional orders for Resident #2 for oxygen included under medications. Review of Resident #2's signed primary care provider (PCP) orders dated 01/23/25 revealed: -There was no order for oxygen. -There was no order to check Resident #2's oxygen level. Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed:	D 346	of administration If ordered on an as needed basis, a stated indication for use All orders will be documented on a "order log" and will be followed by a two-person check process until completion. This process will include ensuring that all orders are sent to the pharmacy, added to the residents' MAR, and any other directives documented in an order. Any orders found not to be complete or need verification will be sent to the appropriate licensed health care provider for clarification. All oxygen orders will be on the resident's medication administration record and be monitored by the medication technicians. The Resident Care Coordinator and Medication Technicians will attend an In-Service on the order log process for ensuring the completion of all orders and a review of this area of rule, May 9, 2025. All staff will attend an In-Service on "Oxygen", May 9, 2025. To ensure ongoing compliance, the following monitoring process has been put into place. The Resident Care Coordinator and/or Designee will review the "order log" daily to ensure the order log process is being followed. The Operational Manager and/or Designee will review all order logs monthly to ensure compliance and the completion of all orders. Completed: May 9, 2025	

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D 346	Continued From page 13 -There was no entry for oxygen. -There were no vitals recorded for oxygen saturation levels. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was no entry for oxygen. -There were no vitals recorded for oxygen saturation levels. Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed: -There was no entry for oxygen. -There were no vitals recorded for oxygen saturation levels. Observation of Resident #2's room on 04/01/25 at 9:00am during the initial tour revealed: -Resident #2 was in her bed in room #2. -Her eyes were closed, and she was wearing her oxygen via NC at 4 liters -Interview with Resident #2 on 04/02/25 at 10:38am revealed: -Resident #2 was lying on her bed and she was wearing her oxygen via NC at 4 liters. -Resident #2 said it was supposed to be at 4 liters and not 3 liters as her Primary Care Provider (PCP) told her that but could not remember when. Interview with the first shift Supervisor in Charge (SIC) on 04/01/25 at 4:10pm revealed: -Resident #2 had been wearing oxygen for several years. -She was on 3 liters of oxygen via NC at bedtime and as needed. -Resident #2 will put on her oxygen after coming in from smoking and increase the oxygen to 4	D 346		

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D 346	Continued From page 14 liters after coming in from smoking. -The pharmacy puts all medication orders on the eMAR, but they had never put oxygen on the eMAR. -She had never been told to monitor the amounts of oxygen a Resident was wearing. -The personal care aides (PCA's) monitor Residents on oxygen every night between 11:00pm and 12:00am and document it in an oxygen notebook if the resident is wearing oxygen, but not the amount of the oxygen to be delivered via the oxygen concentrator. -If after three times a resident refused, she or the RCC would call the PCP. Interview with the Residential Care Coordinator on 04/01/25 at 4:13pm revealed: -The medication aides (MA) were not responsible for monitoring the oxygen. -The PCA's were responsible for looking at the number of liters that the oxygen concentrator is set to and whether the resident is wearing the oxygen at night or on an as needed basis. -Resident #2 had her oxygen saturation levels checked monthly or if she had problems breathing. Review of the facility's oxygen notebook for the dates of 03/06/25 through 04/01/25 revealed: -The form was titled oxygen sheets and had a column for date, time, off/on, comments and staff initials. -Resident #2's name was written at the top and it was documented "on" for wearing her oxygen at 11:00pm 03/06/25 through 04/01/25. -There were no documented notes. -The staff signed their initials after each entry. Interview with the Residential Care Coordinator on 04/02/25 at 06:30pm revealed:	D 346		

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D 346	Continued From page 15 -The PCA's should monitor if a Resident was wearing their oxygen. -The PCA's were aware of each resident's oxygen orders and should let the MA know if the concentrator was not set correctly. -The MA could turn the oxygen back down to the prescribed PCP order. -We should let Resident #2 know not to turn the oxygen level up. Telephone interview with a representative from the facility's contracted pharmacy on 04/01/25 at 12:57pm revealed they do not put oxygen orders on the eMAR. Interview with the Manager on 04/02/25 at 06:15pm revealed the RCC and MAs were responsible for checking the PCP orders and monitor they are being as ordered and administered correctly. Telephone interview with the facility's contracted primary care provider on 04/02/25 at 01:21pm revealed: -Resident #3 had an oxygen order for 3 liters per minute via nasal cannula daily at bedtime and as needed during the day. -He had treated Resident #2 for the last couple of years and knew she did turn her oxygen up to 4 liters after she had been smoking. -He would expect the staff to monitor the oxygen levels. -There were no risks if Resident #2 was wearing 4 liters of oxygen.	D 346		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358	10A NCAC 13F .1004 (a) Medication Administration The facility will ensure that the preparation and administration of medication, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioners which are maintained in	

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D 358	Continued From page 16 (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: Based on observation, record review and interviews, the facility failed to administer medications as ordered for 3 of 5 sampled residents (#1, #5 and #2) related to a medication used to treat high blood pressure (#1), to treat fever (#5) and a medication used to treat schizophrenia (#2). The findings are: 1. Review of Resident #1's recent FL2 dated 01/23/25 revealed diagnoses of dementia, generalized anxiety disorder and seizure disorder. Review of Resident #1's signed physician's order dated 01/24/25 revealed an order for amlodipine (used to treat high blood pressure) 5mg every day and to hold for a systolic blood pressure < 110 or mean arterial pressure (MAP is the average blood pressure in the arteries) < 70. Review of Resident #1's February 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 5mg every day and to hold for a systolic blood pressure < 110 or mean artial pressure (MAP)< 70, with a start date of 01/06/25. -The amlodipine was administered 02/01/25 to 02/08/25 and 02/10/25 to 02/27/25 at 8:00am and	D 358	the resident record: and (2) rules in this section and the facility's policies and procedures. All orders will be documented on a "order log" and will be followed by a two-person check process until completion. This process will include ensuring that all orders are sent to the pharmacy, added to the residents' MAR, and any other directives documented in an order. All orders will be checked when documenting on the order log for correct indications for the use of the medication. The facility will see that all orders needing drop-down boxes for vital readings will be placed on the medication administration record. All medication technicians will attend an In-Service with licensed professionals from facilities contracted pharmacy on Medication Administration, May 15, 2025. All medication technicians will be required to run the exception report, missed meds, and summary of each medication pass, review, correct any issues, then turn into the Resident Care Coordinator. To ensure ongoing compliance, the following monitoring process has been put into place. The Resident Care Coordinator and/or Designee will review the "order log" daily to ensure the order log process is being followed. The Operational Manager and/or Designee will review all order logs monthly to ensure compliance and the completion of all orders. The Resident Care Coordinator and/or Designee will observe each medication technician performing a medication pass at least monthly for compliance. Completed: May 15, 2025	

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D 358	Continued From page 17 there was no documentation a blood pressure was obtained prior to administration. Review of Resident #1's March 2025 eMAR revealed: -There was an entry for amlodipine 5mg every day and to hold for a systolic blood pressure < 110 or MAP < 70, with a start date of 01/06/25. -The amlodipine was administered 03/01/25 to 03/31/25 at 8:00am and there was no documentation a blood pressure was obtained prior to administration. Review of Resident #1's April 1, 2025 eMAR revealed: -There was an entry for amlodipine 5mg every day and to hold for a systolic blood pressure < 110 or MAP < 70, with a start date of 01/06/25. -The amlodipine was administered 04/01/25 at 8:00am and there was no documentation a blood pressure was obtained prior to administration. Interview with a medication aide (MA) on 04/01/25 at 3:43pm revealed: -When she worked, she administered Resident #1's amlodipine without checking the blood pressure first. -She did not know she was supposed to. -The MAs were supposed to identify the resident, scan the mediation bubble packs and administer if there was no issue with the scan. -She did not look at the order in the eMAR or on the bubble pack because scanning the bubble pack was to match the physician's order. Interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm revealed she did not know the MA were administering amlodipine without checking the blood pressure.	D 358		

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D 358	Continued From page 18 Interview with another MA on 04/02/25 at 6:30am revealed: -She administered Resident #1's amlodipine without checking the blood pressure first. -She did not know she was supposed to check Resident #1's blood pressure because she scanned the bubble pack and administered the medications if the scanner did not throw and error. Interview with the Operations Manager on 04/02/25 at 12:10am revealed she did not know the MAs were not checking Resident #1's blood pressure firt to make sure it was of to administer the amlodipine. Refer to interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm. Refer to interview with the Operations Manager on 04/02/25 at 12:10am. 2. Review of Resident #5's recent FL2 dated 02/13/25 revealed: -Diagnoses of hypertension, schizophrenia, depression, and chronic obstructive pulmonary disease. -There was an order for acetaminophen 325mg, every 6 hours as needed for fever only, Review of Resident #5's Feburary 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen 325mg, every 6 hours as needed for fever only, with a start date of 04/01/22. -On 02/01/25 at 9:45am, acetaminophen 650mg was documented as administered for pain. -On 02/03/25 at 9:47am, acetaminophen 650mg was documented as administered for pain.	D 358		

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D 358	Continued From page 19 -On 02/04/25 at 11:35am, acetaminophen 650mg was documented as administered for pain. -On 02/05/25 at 9:31am, acetaminophen 650mg was documented as administered for pain. -On 02/09/25 at 9:50am, acetaminophen 650mg was documented as administered for pain. -On 02/10/25 at 3:42pm, acetaminophen 650mg was documented as administered for pain. -On 02/13/25 at 9:49am, acetaminophen 650mg was documented as administered for pain. -On 02/14/25 at 10:09am, acetaminophen 650mg was documented as administered for pain. -On 02/15/25 at 9:59am, acetaminophen 650mg was documented as administered for pain. -On 02/16/25 at 9:10am, acetaminophen 650mg was documented as administered for headache. -On 02/20/25 at 7:28am, acetaminophen 650mg was documented as administered for pain. -On 02/22/25 at 8:52am, acetaminophen 650mg was documented as administered for pain. -On 02/23/25 at 9:35am, acetaminophen 650mg was documented as administered for pain. -On 02/26/25 at 7:06am, acetaminophen 650mg was documented as administered for pain. -On 02/27/25 at 8:11am, acetaminophen 650mg was documented as administered for pain. -On 02/28/25 at 8:04am, acetaminophen 650mg was documented as administered for pain. -The acetaminophen was documented as administered 16 times in Feburary for pain/headache instead of for fever. Review of Resident #5's March 2025 eMAR revealed: -There was an entry for acetaminophen 325mg, every 6 hours as needed for fever only, with a start date of 04/01/22. -On 03/04/25 at 10:33am, acetaminophen 650mg was documented as administered for pain. -On 03/08/25 at 8:34am, acetaminophen 650mg	D 358		

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D 358	Continued From page 20 was documented as administered for pain. -On 03/10/25 at 8:42am, acetaminophen 650mg was documented as administered for pain. -On 03/17/25 at 7:28am, acetaminophen 650mg was documented as administered for pain. -On 03/21/25 at 8:42am, acetaminophen 650mg was documented as administered for pain. -On 03/22/25 at 9:20am, acetaminophen 650mg was documented as administered for pain. -On 03/23/25 at 7:21am, acetaminophen 650mg was documented as administered for pain. -On 03/25/25 at 11:28am, acetaminophen 650mg was documented as administered for pain. -On 03/26/25 at 9:07am, acetaminophen 650mg was documented as administered for pain. -On 03/27/25 at 8:33am, acetaminophen 650mg was documented as administered for pain. -On 03/28/25 at 8:34am, acetaminophen 650mg was documented as administered for pain. -On 03/30/25 at 9:31am, acetaminophen 650mg was documented as administered for pain. -On 03/31/25 at 7:46am, acetaminophen 650mg was documented as administered for pain. -The acetaminophen was documented as administered 13 times in March for pain instead of for fever. Review of Resident #5's April 1, 2025 eMAR revealed: -There was an entry for acetaminophen 325mg, every 6 hours as needed for fever only, with a start date of 04/01/22. -On 04/01/25 at 8:37am, acetaminophen 650mg was documented as administered for pain. -The acetaminophen was documented as administered 1 time in April for pain instead of for fever. Interview with a medication aide (MA) on 04/01/25 at 3:43pm revaeled:	D 358		

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D 358	Continued From page 21 -In Feburary and March 2025, she administered Resident #5's acetamophin for pain instead of for fever because she did not see the order was for fever only. -The MAs were supposed to identify the resident, scan the mediation bubble packs and administer if there was no isuue with the scan. -She did not look at the order in the eMAR or on the bubble pack because scanning the bubble pack was to match the physician's order. -She did not look at the eMAR or the bubble pack. Interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm reveale she did not know the MA were administering acetaminophen for pain instead of for fever per the physician's order. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/02/25 at 12:44pm revealed: -There was an escript order dated 04/01/22 for acetaminophen 325mg, administer 2 tablets (650mg) every 6 hours as needed for fever only. -There was no discontinue order received in Resident #5's pharmacy record. Telephone interview with the facility's contracted primary care provider on 04/02/25 at 4:42pm revealed: -On 04/01/22, he wrote a PRN order for acetaminophen 325mg, administer 2 tablets (650mg) every 6 hours as needed for fever only because Resident #5 was already on medication from pain hydrocodone/APAP 7.5mg/325mg, three times a day. -He wrote the acetaminophen 325mg every 6 hours for fever so that Resident #5 did not exceed the daily amount of acetaminophen which	D 358		

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D 358	Continued From page 22 was 3000mg a day to prevent acetaminophen toxicity. -Resident #5 did not receive more than 2000mg of acetaminophen a day. Interview with the Operations Manager on 04/02/25 at 12:10am revealed she did not know the MAs were administering acetaminophe for pain instead of for fever. Refer to interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm. Refer to interview with the Operations Manager on 04/02/25 at 12:10am. 3. Review of Resident #2's current FL-2 dated 01/23/25 revealed: -Diagnoses of chronic obstructive pulmonary disease, asthma, anemia, fatigue and high blood pressure. -There was an order for Invega Trinza (a medication to treat schizoaffective disorder) 819mg/2.625ml inject 819mg every 90days. Review of Resident #2's signed Primary Care Provider (PCP) orders dated 01/23/25 revealed there was an order for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. Review of Resident #2's care plan dated 01/02/25 revealed: -Resident #2 received an Invega Trinza every three months, Resident #2 was not always medication compliant." -The Care plan was signed by the Assessor who was the Residential Care Coordinator (RCC) on 01/02/25.	D 358		

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D 358	Continued From page 23 Review of Resident #2's signed Licensed Health Professional Support dated 02/12/25 revealed under LHPS personal care tasks provided included intramuscular injections by "psych" (psychiatrist). Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time. -There was no documentation Invega Trinza 819mg/2.625ml was administered. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time. -There was no documentation Invega Trinza 819mg/2.625ml was administered. Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen. -There was an entry for Invega Trinza 819mg/2.625ml inject 819mg every 90days plus 7 days for diagnosis of schizoaffective disorder. -There was an entry as needed (PRN) under the scheduled time. -There was no documentation Invega Trinza 819mg/2.625ml was administered.	D 358		

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D 358	Continued From page 24 Review of the facility's Injection notebook revealed: -The form included columns with the Residents name, date, site/procedure and nurse signature. -There was no column to indicate what injection was given. -Resident #2's name was documented in the book with a date beginning 01/05/23 through 07/22/24, for a total of 8 injections. -The last signature on 07/22/24 was from the pharmacy representative. Observations of Resident #2's medications on hand on 04/02/25 at 3:09pm revealed the Invega Trinza injection was not available to be administered. Interview with the medication aide (MA) on 04/02/25 at 3:09pm revealed: -The Invega Trinza was not kept on the cart because it was ordered PRN. -She did not remember the last time Resident #2 received the injection of Invega Trinza. -There was a book kept in the medication room for all Residents who received injections. -The Nurse who gave the injection would document in the book. Interview with the RCC on 04/02/25 at 3:12pm revealed: -Resident #2 only got an Invega injection as needed. -She did not recall Resident #2 ever receiving an Invega Injection. -Hospice would give the medication injection when needed. Telephone interview with a representative with the facility' s hospice provider for Resident #3's on 04/02/25 at 10:48am revealed:	D 358		

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D 358	Continued From page 25 -Resident #3 was not on hospice but received palliative care. -Palliative Care did not complete any injections. A second interview was completed with the RCC on 04/02/25 at 06:30pm revealed: -She was responsible for notification to the psychiatric provider and the PCP. -The psychiatric provider had not asked about it when he had seen Resident #2. -She was unaware Resident #2 was taking the Invega Trinza injection. -She did not think that it was on the eMAR. Telephone interview with a representative from the facility's contracted pharmacy on 04/02/25 at 03:13pm revealed: -They received Resident #2's with physician orders on 03/22/24 and on 01/30/2025 for Invega Trinza 819mg/2.625ml inject 819mg every 90 days plus 7 days. -They dispensed Invega Trinza 819mg/2.625ml 03/22/24 and 06/04/24. -Invega Trinza was enter on the eMAR as a PRN medication for re-order purposes only as the facility would need to schedule the injection with an outside provider to give the medication, as the medication would be ordered every 90 days. Telephone interview with the facility's contracted pharmacy consultant on 04/02/25 at 05:11pm revealed: -She was a certified immunizing pharmacist. -She was responsible for the pharmacy reviews for the facility which are completed on a quarterly basis. -Her last review was on 01/28/25. -When she conducted her medication review, she would review the eMAR and would ask if home health was giving the injections.	D 358		

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D 358	Continued From page 26 -She knew that Resident #2 was followed by a Mental Health Provider (MHP) and a PCP. -She gave Resident #2 the Invega Trinza injection on 07/22/24 and remembered that the injection was present on the medication cart and Resident #2 was willing to receive the medication, so she had given it as it was within the scheduled timeframe. Interview with the Operations Manager on 04/02/25 at 06:15pm revealed: -The RCC was responsible for reviewing all medication orders. -Medication cart audits should have been completed to ensure the medication was available for administration. -There should have been follow up with Resident #2's PCP and or the MHP to inform them the medication had not been given. Telephone interview with the facility's contracted PCP on 04/02/25 at 04:42pm revealed: -Resident #2 was to receive the Invega Trinza injection every 90days and it should not be given on an as needed basis. -Resident #2 was receiving the Invega Trinza injection due to her schizoaffective disorder. -He expected the order to be given as prescribed every 90 days. -He was not made aware that Resident #2 had not received her injection of Invega Trinza since 07/22/24. -Resident #2 could have had an increase in behaviors by not receiving the Invega Trinza injection. -Resident #2's MHP should be made aware of the failure to follow the scheduled administration of the Invega Trinza injection. Attempted telephone interview with Resident #2's	D 358		

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D 358	Continued From page 27 MHP on 04/02/25 at 04:24pm was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm. Refer to interview with the Operations Manager on 04/02/25 at 12:10am. --- Interview with the Resident Care Coordinator (RCC) on 04/01/25 at 3:55pm revealed the MA's were responsible for looking at the eMAR order, and match that with the bubble pack as the first verification and then scan the bubble pack as the second verification. Interview with the Operations Manager on 04/02/25 at 12:10am revealed the MAs were trained to identify the resident, check the order in the eMAR with the bubble pack and make sure they match (1st) verification and then scan the bubble pack to make sure it matched the order in the eMAR (2nd) verification.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	10A NCAC 13F .1004 (j) Medication Administration The facility will ensure that the residents' medication administration record (MAR) will be accurate and include all the requirements in (j) (1-8) of rule area Medication Administration. All orders will be documented on a "order log" and will be followed by a two-person check process until completion. This process will include ensuring that all orders are sent to the pharmacy, added to the residents' MAR, and any other directives documented in an order.	

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D 367	Continued From page 28 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 interviews and record reviews the facility failed to ensure the electronic Medication Administration Record (eMAR) was accurat for 1 of 5 sampled residents (Resident #2) related to an order for oxygen. The findings are: Review of Resident #2's current FL-2 dated 01/24/25 revealed: -Diagnoses of chronic obstructive pulmonary disease, asthma, anemia, fatigue and high blood pressure. -Under respiration section on the FL-2 included oxygen 3 liters per minute via nasal cannula (NC) daily at bedtime and as needed. -There was no additional order for oxygen included under medications. Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen.	D 367	To ensure ongoing compliance, the following monitoring process has been put into place. The Resident Care Coordinator and/or Designee will review the "order log" daily to ensure the order log process is being followed. The Operational Manager and/or Designee will review all order logs monthly to ensure compliance and the completion of all orders. All medication technicians will attend an In-Service with licensed professionals from facilities contracted pharmacy on Medication Administration, May 15, 2025. All medication technicians will be required to run the exception report, missed meds, and summary of each medication pass, review, and correct any issues, then turn into the Resident Care Coordinator to review and correct any issues the medication technicians could not resolve. Operation Manager to review all reports weekly. Completed: May 15, 2025	

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D 367	Continued From page 29 Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen. Observation of Resident #2's room on 04/01/25 at 9:00am during the initial tour revealed: -Resident #2 was in her bed in room #2. -Her eyes were closed, and she was wearing her oxygen via NC at 4 liters -Interview with Resident #2 on 04/02/25 at 10:38am revealed: -Resident #2 was lying on her bed and she was wearing her oxygen via Nc at 4 liters. -Resident #2 said it was supposed to be at 4 liters and not three liters as her Primary Care Provider (PCP) told her that but could not remember when. Interview with the first shift Supervisor in Charge (SIC) on 04/01/25 at 4:10pm revealed: -Resident #2 had been wearing oxygen for several years. -She was on 3 liters of oxygen via nasal canula at bedtime and as needed. -Resident #2 will put on her oxygen after coming in from smoking and increase the oxygen to 4 liters after coming in from smoking. -The pharmacy puts all medication orders on the eMAR but they had never put oxygen on the eMAR. -She had never been told to monitor the amounts of oxygen a Resident was wearing. -The personal care aides (PCA's) monitor every night between 11:00pm and 12:00am and document it in an oxygen notebook. -They document if the resident is wearing oxygen, but not the amount of oxygen the Resident is wearing. -If after three times a resident refused to wear her	D 367		

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D 367	Continued From page 30 oxygen, she or the RCC would call the PCP. Interview with the Residential Care Coordinator on 04/02/25 at 06:30pm revealed: -She was not aware oxygen should be on the eMAR. -The PCA's should document if the resident is wearing her oxygen and the amount of oxygen her nasal canula is set to. -The PCA's are aware of each resident's oxygen orders. Telephone interview with a representative from the facility's contracted pharmacy on 04/01/25 at 12:57pm revealed they do not put oxygen orders on the eMAR. Interview with the Operations Manager on 04/02/25 at 06:15pm revealed: -The oxygen had never been on the eMAR and was unaware it should be on the eMAR. -She expected the oxygen to be monitored and documented on the eMAR.	D 367		