Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL067022	A. BUILDING: ______ B. WING ______	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COTTAGES AT SWANSBORO- COTTAGE I	101 PELICAN CIRCLE SWANSBORO, NC 28584

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 03, 2025.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain verification of physician orders for 1 of 3 sampled residents (#3) related to an order for a medication used to treat hypertension. The findings are: Review of Resident #3's current FL-2 dated 03/26/25 revealed: -Diagnoses included essential hypertension, edema of lower extremity, chronic low back pain and nausea. -There was an order for amlodipine (amlodipine is used to treat high blood pressure) 2.5mg, take one tablet daily as needed for systolic blood pressure greater than 140.	C 315		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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-There was an order for vital signs as needed.
-There was no order for daily blood pressure checks.

Review of Resident #3's signed physicians order sheet dated 03/26/25 revealed:
-There was an order for amlodipine 2.5mg, take one tablet daily as needed for systolic blood pressure greater than 140.
-There was an order for vital signs as needed.
-There was no order for daily blood pressure checks.

Observation of Resident #3's medications on hand on 06/03/25 at 3:25pm revealed there was no amlodipine 2.5mg tablets, available on the medication cart for Resident #3.

Telephone interview with a representative with Resident #3's preferred retail pharmacy on 06/03/25 at 3:53pm revealed:
-Resident #3's amlodipine 2.5mg was last dispensed for a quantity of 90 tablets, to take one daily as needed for systolic blood pressure greater than 140 on 05/03/24.
-Resident #3's prescription for amlodipine 2.5mg expired as it was over a year old.

Interview with Resident #3 on 06/03/25 at 12:35pm revealed:
-She took medication for high blood pressure.
-Staff checked her blood pressure often but she did not think her blood pressure was checked daily.
-She went home with her family frequently.

Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 2.5mg, take

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one tablet once daily as needed for systolic blood pressure greater than 140.
-There was an entry for vital signs as needed.
-There was documentation, Resident #3 was out of the facility, 04/06/25, 04/07/25, 04/11/25, 04/12/25, 04/13/25, 04/14/25, 04/18/25, 04/19/25, 04/20/25, 04/21/25, 04/25/25, 04/26/25, 04/27/25 and 04/28/25.
-Resident #3's vital signs were documented on 04/02/25, 04/09/25, 04/23/25 and 04/31/25.

Review of Resident #3's May 2025 eMAR revealed:
-There was an entry for amlodipine 2.5mg, take one tablet once daily as needed for systolic blood pressure greater than 140.
-There was an entry for vital signs as needed.
-There was documentation, Resident #3 was out of the facility on 05/02/25, 05/03/25, 05/04/25, 05/05/25, 05/09/25, 05/10/25, 05/11/25, 05/12/25, 05/16/25, 05/17/25, 05/18/25, 05/19/25, 05/23/25, 05/24/25, 05/25/25, 05/26/25, 05/30/25, and 05/31/25.
-Resident #3's vital signs were documented on 05/07/25 and 05/14/25.

Review of Resident #3's June 2025 eMAR revealed:
-There was an entry for amlodipine 2.5mg, take one tablet once daily as needed for systolic blood pressure greater than 140.
-There was an entry for vital signs as needed.
-There was documentation, Resident #3 was out of the facility on 06/01/25 and 06/02/25.
-There were no vital signs documented for 06/03/25.

Interview with the medication aide (MA) on 6/03/25 at 3:25pm revealed:
-She thought Resident #3's primary care provider

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C 315	Continued From page 3 (PCP) discontinued amlodipine because it was a PRN (as needed) order and she never used it. -PRN medications did not automatically pop up on the residents' eMAR, you had to look for the PRN orders on the eMAR. -Resident #3's vital signs including her blood pressure were checked weekly. -It did not occur to her that Resident #3 should have daily blood pressure checks to see if the amlodipine was needed. Interview with the facility's Registered Nurse on 06/03/25 at 2:56pm revealed: -The MAs were to review the medication and treatment orders on the residents' eMAR. -The MAs should have notified her if they had a question about a medication or treatment order. -Resident #3's PCP should have been contacted for clarification of her vital sign frequency related to the amlodipine order. Interview with the Administrator on 06/03/25 at 4:50pm revealed the MAs were responsible to review all medication and treatment orders and if there were any questions, they should either notify the facilty's RN or contact the residents' PCP for order clarification. Attempted telephone interview with Resident #3's PCP on 06/03/25 at 3:59pm was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:	C 330		

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(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 observations, interviews, and record review with facility failed to administer medication as ordered to 1 of 3 sampled residents (#3) pertaining to a medication ordered with parameters to treat hypertension.

The findings are:

Review of Resident #3's current FL-2 dated 03/26/25 revealed:
-Diagnoses included essential hypertension, edema of lower extremity, chronic low back pain and nausea.
-There was an order for amlodipine (amlodipine is used to treat high blood pressure) 2.5mg, take one tablet daily as needed for systolic blood pressure greater than 140.
-There was an order for vital signs as needed.

Review of Resident #3's signed physicians order sheet dated 03/26/25 revealed:
-There was an order for amlodipine 2.5mg, take one tablet daily as needed for systolic blood pressure greater than 140.
-There was an order for vital signs as needed.

Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 2.5mg, take one tablet daily as needed for systolic blood pressure greater than 140.
-There was an entry for vital signs as needed.

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-Resident #3's blood pressure was documented as 154/82 on 04/02/25.
-There was no documentation that amlodipine 2.5mg was administered to Resident #3 on 04/02/25.
-Resident #3's blood pressure was documented as 165/86 on 04/09/25.
-There was no documentation that amlodipine 2.5mg was administered to Resident #3 on 04/09/25.
-Resident #3's blood pressure was documented as 155/105 on 04/30/25.
-There was no documentation that amlodipine 2.5mg was administered to Resident #3 on 04/30/25.

Observation of Resident #3's medications on hand on 06/03/25 at 3:25pm revealed there were no amlodipine 2.5mg tablets available on the medication cart for Resident #3.

Telephone interview with a representative from Resident #3's preferred retail pharmacy on 06/03/25 at 3:53pm revealed:
-Resident #3's amlodipine 2.5mg was last dispensed for a quantity of 90 tablets, to take one daily as needed for systolic blood pressure greater than 140 on 05/03/24.
-Resident #3's prescription for amlodipine 2.5mg had expired because it was over a year old.

Interview with the medication aide (MA) on 06/03/25 at 3:25pm revealed:
-She thought the reason there was no amlodipine on the medication cart for Resident #3 was because her primary care provider (PCP) discontinued the medication since it was a PRN (as needed) order and the resident never used it.
-PRN medications did not automatically pop up on the residents' eMAR, she had to look for the

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PRN orders on the eMAR.
-She did not think she had ever administered amlodipine to Resident #3.

Second interview with the MA on 06/03/25 at 4:41pm revealed:
-She was not sure why she did not administer amlodipine to Resident #3 in April 2025 when her systolic blood pressure was over 140.
-She had previously contacted Resident #3's PCP for a discontinuation order for the amlodipine but had to leave a message and never received a phone call back.
-She could not remember exactly when she placed the call to Resident #3's PCP requesting to discontinue her amlodipine order.
-She did not document her attempt to contact Resident #3's PCP by phone.

Interview with the facility's Registered Nurse (RN) on 06/03/25 at 2:56pm revealed:
-The MAs were to review all medication orders on the eMAR.
-If a medication was ordered with parameters, she expected the medication to be administered according to the ordered parameters.
-Resident #3 should have received the amlodipine as ordered when her systolic blood pressure was above 140.

Interview with the Administrator on 06/03/25 at 4:50pm revealed she expected the MAs to administer all scheduled medications and PRN medications to the residents as ordered by the PCP.

Attempted telephone interview with Resident #3's PCP on 06/03/25 at 3:59pm was unsuccessful.