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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 05/14/25 through 05/16/25.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 2 of 5 sampled residents (#1,and #2) who resided in a Special Care Unit (SCU) related to both residents eloping from the facility (#1 and #2) and one resident (#2), who ambulated with a wheelchair, being found outside the SCU, on her knees, and was sent to a local emergency department (ED) for evaluation. The findings are: Observation during the initial tour on 05/14/25 at 9:05am revealed: -The facility had both an assisted living (AL) and Special Care Unit (SCU). -The SCU was located at the back of the facility.	D 270		

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-There were double doors located on the left side of the SCU sitting area that led outside to a secured courtyard.
-On the left side of the SCU, beyond the secured courtyard, there was a metal door marked with an overhead illuminated exit sign.
-The metal door had a magnetic locking device located at the top of the door that secured the door.
-There was a keypad identified by a medication aide (MA) that was used for de-activating the magnetic locking device.
-The metal door had an audible sounding device when activated by pushing on the door.
-The magnetic locking device deactivated after 15 seconds of constant pressure enabling exit in an emergency situation.
-The audible alarm sounded continuously until deactivated by the keypad.
-The metal door led into a 8 feet by 10 feet room with another exit door to the exterior of the building and adjourning the AL patio area.
-The outermost exit door had an audible device that sounded but reset itself after a short period of time when the door was closed.

Observation of the SCU on 05/14/25 at 9:35am revealed:
-Staff performed an operational test on the exit doors located within the SCU.
-The exit door alarm and keypad board were operating correctly.

Review of an accident/incident report dated 05/13/25 revealed:
-Two residents eloped from SCU.
-A [named] resident followed another [name] resident out. They got out our back door."
-A [named] resident pushed on the fire (exit) door until it opened."

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-Both residents went out to the AL courtyard.
-One resident had a fall and was sent to the local hospital ED for evaluation.

Review of the facility's policy for exit alarms dated 04/01/97 and revised in September 2021 revealed:
-Once an alarm sounded, staff must go to the doors that had been opened to investigate the situation.
-Staff must redirect any resident who was near the door away from the exit.
-Staff should also view the immediate area outside the door to locate any other residents who may have exited undetected.
-Staff should escort any such resident who had exited back inside the community.
-Staff should conduct a head count which is defined as the visual inspection, face-to-face observation, and counting of residents.

Interview with the Resident Care Coordinator (RCC) on 05/14/25 at 9:50am revealed:
-She worked in the AL dining room for the dinner meal service of 05/13/25 during the elopement incident.
-At 5:35pm, she and a personal care aide (PCA) observed two SCU residents outside of the AL dining room window at the edge of the AL patio courtyard.
-She went outside the AL to assist with returning the two residents to the SCU.
-One resident was standing in the mulch area where another resident was on the ground on her knees at the edge of the AL patio area outside the SCU.
-No SCU staff were present.
-The RCC instructed the PCA to stay with both residents while the RCC reported the situation to the MA and PCA in the SCU.

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-The PCA in the SCU was assisting a resident with personal care and the MA in the SCU was providing supervision in the SCU dining room when the RCC entered the SCU.
-The RCC informed the MA and the PCA that two SCU residents were found at the AL patio area outside the SCU.
-The RCC, the Health and Wellness Director (HWD), and the MA from the SCU redirected both residents through the SCU exit door.

Observation of the area identified by the RCC where the 2 SCU residents were seen outside the SCU on 05/14/25 at 10:00am revealed:
-The location was 15 feet from the rear exit door of the SCU.
-The ground from the SCU to the location had patches of grass and was soft.
-There was a mulch area located 20 feet from the rear exit door of the SCU and adjoined the patio area for the AL unit.
-The AL patio area and the mulch area were visible from the dining area of the AL.

1. Review of Resident #2's current FL2 dated 11/21/24 revealed:
-Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychiatric disturbance, mood disturbance and anxiety; generalized muscle weakness and unspecified fall (subsequent encounter).
-The resident was intermittently disoriented.
-She was non-ambulatory.
-She was incontinent to bowel and bladder.
-There was no documentation for wandering behaviors.
-The resident required assistance with bathing and dressing.
-The resident's level of care was Special Care

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D 270	Continued From page 4 Unit (SCU). Review of Resident #2's assessment and care plan dated 10/25/24 and 04/29/25 revealed: -She was ambulatory and used a manual wheelchair as a mobility aid. -She wandered and received medication for mental illness/behaviors. -She required total assistance with dressing, toileting, personal hygiene and bathing, -She required extensive assistance by staff with grooming. -She required limited assistance by staff with transferring. Review of Resident #2's Accident/Incident report dated 05/13/25 revealed: -The type of incident was elopement. -On 05/13/25 at 5:45pm, Resident #2 was observed in the assisted living (AL) courtyard. -The resident had bruising and redness on both knees. -Emergency Management Services (EMS) was called and the resident was transported to the local hospital emergency department (ED). Review of a second Accident/Incident report for Resident #2's dated 05/13/25 revealed: -The type of incident was fall, unwitnessed. -On 05/13/25 at 5:45pm, Resident #2 was observed in the AL courtyard by a personal care aide (PCA). -The resident had bruising and redness on both knees. -EMS was called and the resident was transported to the local hospital ED. Review of Resident #2's progress notes revealed: -On 05/13/25 at 8:11pm, a MA noted Resident #2 was taken outside by another resident.	D 270		

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-There was no time documented when the resident was found outside the facility.
-On 05/13/25 at 9:00pm, the Health and Wellness Director (HWD) documented Resident #2 was seen by staff at 5:45pm in the AL courtyard outside the SCU where the resident resided.
-The resident was last seen at 5:15pm in the dining room sitting with another resident.
-Resident #2 was assessed for injuries, both knees were bruised.
-Resident #2 was sent to the ED for evaluation.
-On 05/14/25 at 1:03am, Resident #2 returned from the ED at 1:00am with an ED report revealing ankle an x-ray fine and a chest x-ray with no injury.
-She had a urinary tract infection (UTI) and was ordered an antibiotic.

Review of Resident #2's ED after visit summary dated on 05/13/25 at 11:57pm revealed:
-There was no documented time of arrival.
-Resident #2's visit was for a fall.
-Diagnoses included fall, initial encounter and acute UTI with hematuria (blood in urine).
-Resident #2 had a Computed Tomography (CT) scan of the head, an x-ray of right and left ankles, a chest x-ray, and a urinalysis performed.
-Resident #2 was ordered cephalexin (used to tract infection) 500mg 4 times a day for 7 days.

Observations of Resident #2 on 05/14/25 and 05/15/25 at various times revealed:
-On 05/14/25 at 11:59am, Resident #2 was in the SCU sitting area in a manual wheelchair.
-On 05/14/25 at 3:00pm, Resident #2 was propelling herself in her wheelchair from the sitting area toward the dining room.
-On 05/15/25 at 11:30am, Resident #2 was propelling herself in her wheelchair in the sitting area

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D 270	Continued From page 6 Interview with a personal care aide (PCA) on 05/14/25 at 4:10pm revealed: -She routinely worked second shift (3pm-11pm) in the SCU. -She worked in the SCU on second shift on 05/13/25. -Resident #2 had activated the door alarms at the rear exit and the front main exit a few times by pushing on the door. -Resident #2 activated the door alarm and waited for staff to come to the door. -Resident #2 was easily redirected. -Resident #2 occasionally conversed with other residents. -The PCA felt Resident #2 was capable of asking another resident to assist her with exiting the SCU. -On 05/13/25 at 5:35pm, staff from the AL informed her Resident #2 (and another resident from the SCU) were found at the patio area outside the SCU. -She was not aware Resident #2 had left the SCU until the AL staff informed her. Interview with a medication aide (MA) on 05/14/25 at 4:35pm revealed: -She routinely worked as a MA for second shift (3:00pm to 11:00pm) and assisted as a PCA on other shifts as needed. -She worked in the SCU on second shift on 05/13/25. -She had never seen Resident #2 activate the exit door alarm on her shift. -On 05/13/25 at 5:30pm, the SCU rear exit door's alarm sounded and she responded to the door. -She deactivated the alarm but did not open the door to check outside for a possible elopement per facility procedure because a resident who sometimes activated the alarm was standing	D 270		

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close to the door.
-She started a head count per facility policy.
-On 05/13/25 at 5:35pm, the Resident Care Coordinator (RCC) from the AL informed her Resident #2 (and another resident from the SCU) were found at the AL patio area outside the SCU.
-She was not aware Resident #2 had left the SCU until the RCC informed her.
-She went outside the SCU to assist with returning Resident #2 to the SCU.
-Resident #2 was on the ground on her knees at the AL patio area outside the SCU.
-Resident #2 was wearing a night gown so it was easy to see her knees.
-Resident #2's knees had dirt on them and were red.
-The MA called 911 for evaluation by EMS.

Interview with Resident #2's primary care provider (PCP) on 05/15/25 at 10:30am revealed:
-Resident #2 was limited in mental status due to her diagnosis of vascular dementia.
-Resident #2 was not verbal and unable to communicate well.
-She had never observed Resident #2 exhibiting exit seeking behaviors.
-The facility had no documentation for, or information related to, Resident #2 exhibiting exit seeking behaviors.
-The facility staff emailed her on 05/13/25 at 8:31pm to inform her Resident #2 was being sent out because she fell to her knees in the dirt and the knees were red.
-The PCP did not know Resident #2 had eloped from the SCU and fell outside the SCU.
-She thought she fell in the enclosed SCU patio.
-Residents were in the SCU because of diminished mental capacity and should have increased supervision.
-She would have expected the facility to inform

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her that Resident #2 was injured after she eloped from the facility's SCU to the facility's AL patio.
-She would expect the facility to follow their protocols and if an exit door alarm was activated in the SCU, staff should check outside for possible elopement.

Interview with a second PCA 05/15/25 at 2:20pm revealed:
-There were no residents identified to be on additional supervision in the SCU prior to 05/13/25.
-Resident #2 was in a wheelchair for her mobility.
-She had not seen Resident #2 go to an exit door and try to get out.
-She never reset the exit door alarm because Resident #2 had tried to exit.
-There was a resident who was recently admitted that tried to push Resident #2 around the SCU in her wheelchair.
-Resident #2 had episodes of crying at random, but the PCA had never seen her hanging out near the exit doors (front or back).

Interview with a second MA on 05/15/25 at 2:55pm revealed:
-There were no residents identified to be on additional supervision in the SCU prior to 05/13/25.
-Additional supervision would include visually locating a resident more often than other residents.
-Resident #2 never tried to elope from the SCU on her shift, she just cried a lot.
-There was another resident who pushed Resident #2 around the SCU in her wheelchair a lot.

Interview with a third MA on 05/15/25 at 3:10pm revealed:

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-There were no residents identified as needing increased supervision prior to the elopement on 05/13/25.
-Resident #2 had set off the exit door alarm in the past but had never eloped from the facility prior to 05/13/25.
-She had training on identifying an elopement but not sure of the exact date.
-If the exit door alarm sounded, staff were to reset the alarm, check outside for any residents outside the SCU, and do a resident head count to ensure all residents were accounted for.
-The facility conducted monthly elopement drills for SCU and AL units.

Telephone interview with Resident #2's Power of Attorney (POA) on 05/16/25 at 9:45am revealed:
-The facility notified her on 05/13/25 around dinner time, maybe 6:45pm to 7:00pm, that Resident #2 was being sent to the hospital for evaluation.
-She was told Resident #2 had an altercation with another resident, was pushed down, and was being sent to the hospital for evaluation.
-She was led to believe the altercation happened outside the SCU, in the secure patio area.
-She was not told Resident #2 had eloped from the SCU without the staff's knowledge.
-Resident #2 getting out of the SCU without staff knowledge was a problem for her because the SCU was supposed to provide extra supervision due to her dementia diagnosis.

Interview with Resident #2's mental health provider (MHP) on 05/16/25 at 10:00am revealed:
-Resident #2 had no prior reported incidents or documentation related to exhibiting exit seeking behaviors.
-Resident #2 was treated with medication for other mental disorders but not for exit seeking

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behavior.
-She would have expected to be notified of an elopement but not for transport to the hospital for evaluation after a fall.
-The PCP would be notified about the fall requiring hospital evaluation.

Telephone interview with a third PCA on 05/16/25 at 3:40pm revealed:
-On 05/13/25 at 5:30pm, she was working as second shift PCA in the AL unit.
-She and the RCC observed Resident #2 and another resident outside the SCU.
-Resident #2 was a resident of the SCU but was observed on the ground on her knees with a second resident behind Resident #2's wheelchair and holding the handles.
-The residents were between the patio of the AL unit and the rear exit door of the SCU.
-She stayed with the residents while the RCC went to the SCU unit for help.
-Resident #2 tried to get up from her knees.
-Resident #2 was upset and asked if they could explain what happened.
-Resident #2 "had no clue what was going on".
-The RCC returned from the SCU with the MA and Administrator, and both residents were returned to the SCU.
-She returned to the AL and resumed the duties that she was scheduled to do.

Interview with the HWD on 05/16/25 at 3:50pm revealed:
-She left the facility at 5:00pm on 05/13/25.
-She received a telephone call and returned to the facility around 6:40pm on 05/13/25.
-The Administrator returned to the facility, and had the MA call EMS for Resident #2.
-Resident #2 and anther resident eloped for the SCU through the an exit door.

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-On 05/13/25 at 5:35pm, the exit alarm activated but the MA reset the alarm when she observed a resident, who had often pressed on the door activating the alarm, close to the alarming door.
-The MA started a resident head count per normal procedures but did not check outside the SCU for possible elopement per procedure.
-On 05/13/25 at about the same time, the RCC saw the residents, including Resident #2, through the AL dining room windows between the SCU and the edge of the AL outdoor patio.
-Immediately the RCC called a PCA from the AL unit to assist her and watch the residents while she alerted the MA working in the SCU.
-She had observed Resident #2 on 05/13/25 during the day ambulating around the living room of the SCU and to her room on her own.
-Resident #2 did not appear to be exit seeking during her observation.
-Resident #2 returned from the local hospital ED on 05/14/25 at 1:00am with an order for an antibiotic for a UTI.

Interview with the Administrator on 05/16/25 at 4:30pm revealed:
-She was Operations Specialist with the corporation but was filling the vacant Administrator position until replacement was hired.
-She left the facility for the day on 05/13/25 around 5:30pm.
-She received a call while on her way home to return to the facility related to 2 residents found outside the SCU without staff knowledge and Resident #2 was found on her knees which were dirty and red.
-The Administrator returned to the facility at 6:20pm to assist with caring for the two residents who were found outside the SCU.
-Resident #2 had injuries to her knees and was

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transported by EMS to a local hospital for evaluation for possible injury from the fall.
-The second shift MA in the SCU was assigned to contact Resident #2's POA, notify Resident #2's PCP, and ensure the facility's accident/incident forms were completed.
-She did not consider Resident #2 to be exit-seeking prior to the incident on 05/13/25, or to have activated the door alarms on the SCU exit doors by pushing on the doors.

Refer to the interview with the Sales Manager on 05/15/25 at 3:47pm.

Refer to the interview with the Administrator on 05/16/25 at 4:30pm.
2. Review of Resident #1's current FL2 dated 04/30/25 revealed:
-Diagnoses included dementia, anxiety, depression, insomnia, and cholesterol.
-The resident was constantly disoriented.
-She was ambulatory.
-There was no documentation for wandering behaviors.
-The resident required assistance with bathing and dressing.
-The resident's level of care was documented as Special Care Unit (SCU).

Review of Resident #1's personal service assessment dated 04/29/25 revealed:
-She was ambulatory and required no assistive devices.
-She had memory loss.
-She required assistance with bathing and dressing.

Review of Resident #1 care plan revealed there was no care plan available for review.

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Review of Resident #1's Resident Register dated 05/01/25 revealed:
-She required direction due to significant memory loss.
-She required assistance with bathing.

Review of Resident #1's Accident/Incident report dated 05/13/25 revealed:
-The incident was reported by a personal care aide (PCA) from the assisted living (AL).
-The incident was on 05/13/25 at 5:45pm and the time reported within the SCU was 6:05pm.
-Resident #1 had eloped with no injuries.

Review of Resident #1's facility's progress notes revealed:
-On 05/13/25 at 7:18pm, the Administrator documented Resident #1 was seen by staff at 5:45pm in the AL courtyard outside the SCU where the resident resided.
-The resident was last seen at 5:15pm in the dining room sitting with another resident.
-Resident #1 was assessed for injuries and none were noted.
-On 05/14/25 at 2:49pm, the medication aide (MA) documented Resident #1 had a sitter all day and still tried to go to the door.

Observation of Resident #1 on 05/14/25 at 9:15am revealed:
-The resident was independent in ambulation.
-The resident was sitting in the living room initially and then was ambulatory through the SCU hallways.
-The resident had a sitter with her and did not attempt to go to the exit doors in the SCU.

Interview with a PCA on 05/14/25 at 3:45pm revealed:
-Resident #1 would come to the front main exit

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and ask staff to open the door but was easily redirected.
-Resident #1 often conversed with other residents and tried to push another resident around the SCU in her wheelchair.
-On 05/13/25 at 5:30pm, the SCU rear exit door alarm sounded and the MA responded to the door alarm.
-The PCA was assisting another resident with personal care and heard the door alarm silenced while she was in the resident's room.
-On 05/13/25 at 5:35pm, staff from the AL informed her Resident #1 (and another resident from the SCU) were found at the AL patio area outside the SCU.
-She was not aware Resident #1 had left the SCU until the AL staff informed her because she thought the MA had checked for residents outside of the exit door.

Interview with a MA on 05/14/25 at 4:20pm revealed:
-She had been employed at the facility for more than 2 years and had been an MA since December 2024.
-She routinely worked as an MA for second shift (3:00pm to 11:00pm) and assisted as a PCA on other shifts as needed.
-She worked in the SCU on second shift on 05/13/25.
-She had never seen Resident #1 activate the exit door alarm on her shift.
-On 05/13/25 at 5:30pm, the SCU rear exit door alarm sounded and she responded to the door alarm.
-She deactivated the alarm but did not open the door to check outside for a possible elopement per facility policy because a resident who sometimes activated the alarm was standing close to the door.

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-She started a head count of the SCU residents per facility policy.
-On 05/13/25 at 5:35pm, the Resident Care Coordinator (RCC) from the AL informed her Resident #1 (and another resident from the SCU) were found at the AL patio area outside the SCU.
-She was not aware Resident #1 had left the SCU until the RCC informed her.
-She went outside the SCU to assist with returning Resident #1 to the SCU.

Interview with Resident #1's Power of Attorney (POA) on 05/15/25 at 10:00am revealed:
-The Administrator contacted him on the evening of 05/13/25 about Resident #1's elopement incident but he could not recall the time the facility contacted him.
-Resident #1 had an isolated wandering incident within the last 6 months prior to her admission on 05/07/25 to the SCU at the facility.

Interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm revealed:
-Resident #1 was admitted to the facility on 05/07/25.
-The facility contacted him about Resident #1's elopement incident through fax correspondence on the evening of 05/13/25.
-The PCP was not aware of any previous exit-seeking or wandering history related to Resident #1's dementia.

Interview with a second PCA on 05/15/25 at 2:20pm revealed:
-She had never seen Resident #1 activate the exit door alarm on her shift except for a couple times when she was first admitted to the SCU on 05/07/25.
-Resident #1 was always happy and attempted to help everyone in the SCU.

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D 270	Continued From page 16 -There were no residents identified to be on additional supervision in the SCU prior to 05/13/25. Interview with second MA on 05/15/25 at 2:55pm revealed: -She worked in the SCU on 1st shift (7:00am-3:00pm). -She had never seen Resident #1 activate the exit door alarm on her shift. -Residents in the SCU on 1st shift were usually left active and wandered around the hallways less. -There were no residents identified to be on additional supervision in the SCU prior to 05/13/25. Interview with a third MA on 05/15/25 at 3:10pm revealed: -She worked 2-3 days a week in the SCU on 1st shift (7:00am-3:00pm) and had not worked on 05/13/25. -She had seen Resident #1 activate the exit doors and then Resident #1 would walk away from the exit doors because of the alarm. -The MAs were required to document instances of activating door alarms through alert charting in the residents' progress notes. -There were no residents identified to be on additional supervision in the SCU prior to 05/13/25. Telephone interview with a third PCA on 05/16/25 at 3:40pm revealed: -She worked in the SCU previously and never had issues with Resident #1 tampering with exit doors. -She had worked in the AL dining room for the dinner meal service of 05/13/25 during the elopement incident.	D 270		

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-She and the RCC observed Resident #1 and another SCU resident outside of the AL dining room window at the edge of the AL patio courtyard.
-The residents were between the patio of the AL and the rear exit door of the SCU.
-The RCC instructed the third PCA to stay with Resident #1 and another SCU resident while the RCC reported the situation to the MA and PCA in the SCU.
-She went outside the AL to provide supervision for Resident #1 and the other SCU resident.
-Resident #1 was standing in the mulch area uninjured where another resident was on the ground on her knees at the edge of the AL patio area outside the SCU.
-She returned to the AL dining room to complete dining assistance for the evening meal service with the AL residents when the RCC, the Administrator, and the MA from the SCU redirected Resident #1 and the other resident back into the facility.

Interview with the RCC on 05/16/25 at 11:55am revealed she did not consider Resident #1 to be exit-seeking prior to the incident on 05/13/25 or to have activated the door alarms on SCU exit doors by pushing on the doors.

Interview with the Health and Wellness Director (HWD) on 05/16/25 at 3:55pm revealed:
-She received a telephone call and returned to the facility around 6:40pm on 05/13/25.
-The HWD was told 2 residents eloped from the SCU through the back exit door.
-The Administrator returned to the facility, and made sure Emergency Management Services (EMS) was called for Resident #1.
-On 05/13/25 at 5:35pm, the exit alarm activated but the MA reset the alarm when she observed a

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resident, who had often pressed on the door activating the alarm, close to the alarming door.
-The MA started a resident head count per normal procedures but did not check outside the SCU for possible elopement per procedure.
-On 05/13/25 at about the same time, the RCC saw the residents, including Resident #1, through the AL dining room glass doors between the SCU and the edge of the AL outdoor patio.
-Immediately the RCC called a PCA from the AL unit to assist her and watch the residents while she alerted the MA working in the SCU.
-Both residents were sitting calmly in the SCU living room with Resident #1 talking to the SCU staff.
-She did not consider Resident #1 to be exit-seeking prior to the incident on 05/13/25, or to have activated the door alarms on SCU exit doors by pushing on the doors.

Interview with the Administrator on 05/16/25 at 4:30pm revealed:
-She was Operations Specialist with the corporation but was filling the vacant Administrator position until replacement was hired.
-She left the facility at 5:00pm on 05/13/25.
-She received a telephone call and returned to the facility on 05/13/25 because 2 residents had eloped from the SCU to the AL courtyard without staff knowledge.
-The Administrator returned to the facility at 6:20pm to assist with caring for the 2 SCU residents who were found outside the SCU.
-Resident #1 had no injuries but the Administrator notified Resident #1's POA of the elopement incident on 05/13/25.
-The second shift MA in the SCU was assigned to notify Resident #1's PCP and ensure the facility's accident/incident forms were completed.

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D 270	Continued From page 19 -She did not consider Resident #1 to be exit-seeking prior to the incident on 05/13/25, or to have activated the door alarms on SCU exit doors by pushing on the doors. Refer to the interview with the Sales Manager on 05/15/25 at 3:47pm. Refer to the interview with the Administrator on 05/16/25 at 4:30pm. _____ Interview with the Sales Manager on 05/15/25 at 3:47pm revealed: -She was in the facility at the time of the elopement on 05/13/25. -A PCA in the AL notified her at 5:50pm on 05/13/25 that 2 residents that resided in the SCU had eloped from the SCU and were found at the AL patio area outside the SCU exit door. -The PCA told the her one resident was standing behind the wheelchair of another resident that was found on her knees in the mulch area of the AL patio. -She proceeded to the AL patio area where the 2 residents who resided in the SCU were located. -She observed both residents to be calm, and both residents showed confusion about being in the AL patio area. -She noticed the resident found in the mulch area had red and muddy knees and the other resident appeared uninjured. -She telephoned the Administrator and the HWD who had left the facility for the day. -She had the MA and the PCA from the SCU to complete a headcount for the SCU residents to ensure all were accounted for. -She advised the MA to call EMS for one of the residents since the resident's knees were muddy and red from being down on the ground in the mulch area of the AL patio.	D 270		

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D 270	Continued From page 20 -The residents were redirected back into the SCU by the MA from the SCU, the RCC, and the Administrator. -She did not consider either resident to be exit-seeking prior to the incident on 05/13/25, or to have activated the door alarms on SCU exit doors by pushing on the doors. Interview with the Administrator on 05/16/25 at 4:30pm revealed: -She was made aware the MA and the PCA working in the SCU had not checked outside the SCU exit doors to determine if residents had eloped from the building after an exit door alarm had been activated on 05/13/25.. -She had trained SCU staff on elopement drills and door alarm response, which included deactivating the alarm and checking the exterior of the SCU for possible resident elopement, monthly since she came to the facility on 03/17/25. -She expected staff to respond to door alarms according to the facility policy for activated exit alarms and follow steps to locate residents in the event of an elopement. _____ The facility failed to provide supervision for 2 of 5 sampled residents (#1 and #2), who resided in the SCU, resulting in a resident (#2), who had a diagnosis of vascular dementia and was intermittently disoriented, eloping from the facility, falling to her knees, and being taken to a local hospital emergency department. Another resident (#1), who had a diagnosis of dementia and was constantly disoriented, was observed standing outside the facility unsupervised placing the resident at risk for elopement. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation.	D 270		

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D 270	Continued From page 21 The facility provided a plan of protection in accordance with G.S. 131D-34 on May 16, 2025 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 16, 2025.	D 270		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 19 of 22 assisted living (AL) residents in addition to other beverages. The findings are: Observation of the lunch meal service on 05/14/25 for the AL dining room between 12:00pm and 12:30pm revealed: -There were 22 residents present for the lunch meal service. -Beverages available included milk, tea, coffee, and water.	D 306		

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D 306	Continued From page 22 -The beverages were served by the personal care aides (PCA). -Four residents were served water and all the other residents were served other beverages. -No other residents were served water. Observation of the breakfast meal service on 05/15/25 for the AL dining room between 7:57am and 9:00am revealed: -There were 22 residents present for the breakfast meal service. -Beverages available included milk, tea, coffee, and water. -The beverages were served by a PCA. -Three residents were served water and all the other residents were served other beverages. -No other residents were served water. Interview with a resident on 05/15/25 at 10:40am revealed: -Staff sometimes served him water with meals. -He would drink water with each meal if it was served to him. Interview with a second resident on 05/15/25 at 2:35pm revealed: -She liked to drink water and staff served her water with every meal. -She asked for water if staff did not serve her water with each meal. Interview with a PCA on 05/15/25 at 10:52am revealed: -She assisted in the AL dining room during meals and PCAs normally served beverages. -She knew what the residents normally liked to drink, so she normally served residents the same beverages. -She knew which residents sometimes wanted a different beverage.	D 306		

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D 306	Continued From page 23 -A lot of the residents would not drink water if they were served it so she was not sure if she should serve water to each resident. -She did not know water should have been served to all residents with each meal. Interview with the Dietary Manager (DM) on 05/15/25 at 2:45pm revealed: -Beverages were served by the PCAs at every meal and sometimes the managers would help serve beverages. -Water was always available as a beverage for the AL residents. -He did not know water was not served with the lunch meal service on 05/14/25 for 18 residents or with the breakfast meal service on 05/15/25 for 19 residents. -He did not know water should have been served daily to all AL residents with each meal. Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 12:34pm revealed: -PCAs normally served beverages in the AL dining room. -She did not know water was not served with the lunch meal service on 05/14/25 for 18 residents or with the breakfast meal service on 05/15/25 for 19 residents until 05/15/25. -She knew water must be served to all residents with each meal. -PCAs should make sure all residents were served water with each meal. Interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:20pm revealed: -She did not know water was not served with the lunch meal service on 05/14/25 for 18 residents or with the breakfast meal service on 05/15/25 for 19 residents. -PCAs normally served beverages in the AL	D 306		

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D 306	Continued From page 24 dining room. -She knew water must be served to all residents with each meal. -PCAs were responsible to ensure all residents were served water with each meal. Interview with the Administrator on 05/16/25 at 4:50pm revealed: -She did not know water was not served with the lunch meal service on 05/14/25 for 18 residents or with the breakfast meal service on 05/15/25 for 19 residents. -PCAs and medication aides (MA) normally served beverages in the AL dining room. -She knew water must be served to all residents with each meal. -PCAs and MAs were responsible to ensure all residents were served water with each meal. -She expected all residents to be served water with each meal.	D 306		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication orders were maintained in the residents' records for 1 of 5 sampled residents (#1) related to orders for vitamin supplements.	D 345		

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D 345	Continued From page 25 The findings are: Review of Resident #1's current FL2 dated 04/30/25 revealed: -Diagnoses included dementia, anxiety, depression, insomnia, and cholesterol. -There was no order for Centrum Woman vitamin supplement (used to support cognition and memory). -There was no order for Ferrous Sulfate vitamin supplement (used to support cognition and memory). -There was no order for Vitamin B12 vitamin supplement (used to support the immune system). 1. Review of Resident #1's May 2025 electronic medication administration record (eMARs) from 05/07/25 to 05/14/25 revealed there was an entry for Centrum Woman 1 tablet one time a day with documentation of administration from 05/13/25 and 05/14/25 at 8:00am. Review of Resident #1's record revealed there was no physicians order for Centrum Woman vitamin supplement. Observation of Resident #1's medications on hand on 05/15/25 at 10:18am revealed there was a bottle of Centrum Woman tablets available for administration. Refer to interview with Resident #1's Power of Attorney (POA) on 05/15/25 at 10:00am. Refer to interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm. Refer to interview with a pharmacist at facility's contracted pharmacy on 05/16/25 at 9:03am.	D 345		

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D 345	Continued From page 26 Refer to interview with a medication aide (MA) on 05/15/25 at 10:38am. Refer to interview with a second MA on 05/16/25 at 3:10pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to interview with the Health and Wellness Director (HWD) on 05/16/25 at 3:55pm. Refer to interview with the Administrator on 05/16/25 at 4:30pm. 2. Review of Resident #1's May 2025 electronic medication administration record (eMARs) from 05/07/25 to 05/14/25 revealed there was an entry for Ferrous Sulfate 325mg 1 tablet one time a day with documentation of administration from 05/13/25 and 05/14/25 at 8:00am. Review of Resident #1's record revealed there was no physician order for a Ferrous Sulfate supplement. Observation of Resident #1's medications on hand on 05/15/25 at 10:18am revealed there was a bottle of Ferrous Sulfate 325mg tablets available for administration. Refer to interview with Resident #1's Power of Attorney (POA) on 05/15/25 at 10:00am. Refer to interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm. Refer to interview with a pharmacist at facility's contracted pharmacy on 05/16/25 at 9:03am.	D 345		

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D 345	Continued From page 27 Refer to interview with a medication aide (MA) on 05/15/25 at 10:38am. Refer to interview with a second MA on 05/16/25 at 3:10pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to interview with the Health and Wellness Director (HWD) on 05/16/25 at 3:55pm. Refer to interview with the Administrator on 05/16/25 at 4:30pm. 3. Review of Resident #1's May 2025 electronic medication administration record (eMARs) from 05/07/25 to 05/14/25 revealed there was an entry for Vitamin B12 one tablet one time a day with documentation of administration from 05/13/25 and 05/14/25 at 8:00am. Review of Resident #1's record revealed there was no physician order for a Vitamin B12 supplement. Observation of Resident #1's medications on hand on 05/15/25 at 10:18am revealed there was a bottle of Vitamin B12 tablets available for administration. Refer to interview with Resident #1's Power of Attorney (POA) on 05/15/25 at 10:00am. Refer to interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm. Refer to interview with a pharmacist at facility's contracted pharmacy on 05/16/25 at 9:03am.	D 345		

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D 345	Continued From page 28 Refer to interview with a medication aide (MA) on 05/15/25 at 10:38am. Refer to interview with a second MA on 05/16/25 at 3:10pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to interview with the Health and Wellness Director (HWD) on 05/16/25 at 3:55pm. Refer to interview with the Administrator on 05/16/25 at 4:30pm. _____ Interview with Resident #1's Power of Attorney (POA) on 05/15/25 at 10:00am revealed: -He had brought the bottles of vitamin supplements to the facility for the MAs to put in the medication cart. -The facility had not informed him Resident #1's vitamin supplements would need physician's order. Interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm revealed: -Resident #1 was admitted to the facility on 05/07/25. -He had not ordered a multi-vitamin, iron supplement, or vitamin B12 for Resident #1 since her admission on 05/07/25. -The facility had not communicated with him about needing orders for Resident #1's vitamin supplements. -He expected the facility to communicate with him about new orders for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/16/25 at	D 345		

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9:03am revealed:
-There was no current order on file for Centrum Woman, Ferrous Sulfate, and Vitamin B12 supplements.
-The pharmacy is not responsible for updating the eMAR for the facility.
-The pharmacy expects the facility to provide new orders for the pharmacy to have current orders on file.

Interview with a medication aide (MA) from the SCU on 05/15/25 at 10:38am revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She had administered Resident #1's Centrum Woman, Ferrous Sulfate, and Vitamin B12 at 8:00am when she worked as an MA on first shift.
-She was not aware there were no physicians orders for the the Centrum Woman, Ferrous Sulfate, and Vitamin B12 for Resident #1.
-The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for verifying physician orders and updating the eMAR.

Interview with a second MA on 05/16/25 at 3:10pm revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She had not administered Resident #1's Centrum Woman, Ferrous Sulfate, and Vitamin B12 at 8:00am because she usually worked as an MA on second shift.
-She was not aware there were no physicians orders for the the Centrum Woman, Ferrous Sulfate, and Vitamin B12 for Resident #1.
-The RCC and the HWD were responsible for verifying physician orders and updating the eMAR.

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Interview with the RCC on 05/16/25 at 11:55am revealed:
-She knew Resident #1 had vitamin supplements on the medication cart, but she assumed all the vitamin supplements available for Resident #1 on her eMAR had physicians' orders.
-MAs had not talked to her about any of Resident #1's vitamin supplements.
-The RCC and the HWD were responsible for auditing eMARs and performing card audits weekly but she had been unavailable due to working as an MA and a PCA.

Interview with the HWD on 05/16/25 at 3:50pm revealed:
-She did not know there were medications available for Resident #1 on the medication that were not on Resident #1's eMAR with no orders.
-MAs had not talked to her about any vitamin supplements.
-The HWD and RCC were responsible for conducting medication cart audits weekly but the HWD had just started the HWD position 05/13/25.
-She or the MAs were responsible for clarifying medications/vitamin supplements with Resident #1's PCP.

Interview with the Administrator on 05/16/25 at 4:30pm revealed:
-She did not know there were supplements on the medication cart that were on Resident #1's eMAR with no orders.
-MAs should have contacted Resident #1's PCP to clarify whether Resident #1 should have been administered the vitamin supplements and to obtain orders for the supplements.
-MAs should have let the RCC and HWD know about the vitamin supplements.
-When Resident #1's family brought in the vitamin

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D 345	Continued From page 31 supplements for Resident #1, the MA should not have accepted the vitamin supplements and should not have put the supplements on the medication cart before clarifying them with Resident #1's PCP. -The RCC and HWD were responsible for conducting medication cart audits weekly and verifying physicians' orders.	D 345		
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 observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed practitioner for 3 of 3 residents (# 6, #7, and #8) observed during the 8:00am medication pass on 05/14/25 related to a medication to treat elevated blood pressure (#6); a topical ointment for knee pain (#7); a medication for anxiety and a vitamin supplement (#8) and 4 of 5 sampled residents for record review (#1, #2, #3 and #4) including 2 medications for memory loss (#1), an antibiotic to treat a urinary tract infection (#2), a medication to treat mental health disorders (#3), and a medication to treat hypertension (#4).	D 358		

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D 358	Continued From page 32 The findings are: Review of the facility's general guidelines for medication administration dated 11/2011 and updated 03/2025 revealed: -Trained and/or licensed associates may administer or assist the resident with medication management or medication administration per physician/health care provider (HCP) order and as per state regulation. -Trained and/or licensed associates were to follow the medication label, pharmacy, and manufacturer directions of each medication ordered, and document administration on the electronic medication administration record (eMAR) after observing the resident take the medication. -Medication or treatment directions on the physician/HCP order and pharmacy label should correlate with the medication or treatment directions on the eMAR. Review of the facility's medication and treatment availability policy dated 2/2003 and last revised 08/2022 revealed: -All currently ordered medications should be available for the resident. -The community was responsible for obtaining newly ordered medication or refills for medications and treatment orders, unless agreed upon with the resident, family, or legally responsible party in accordance with Pharmacy Services Agreement Addendum to the Residency Agreement. 1. The medication error rate was 12% as evidenced by the observation of 4 errors out of 31 opportunities during the 8:00am medication pass on 05/14/25.	D 358		

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D 358	Continued From page 33 a. Review of Resident #6's current FL2 dated 09/03/24 revealed: -Diagnoses included unspecified dementia with behavioral disturbances and essential (primary) hypertension. -Resident #6's level of care was special care unit (SCU). -There was an order for amlodipine (used to treat hypertension or elevated blood pressure) 5 mg once daily. Review of Resident #6's physician order dated 03/31/25 revealed amlodipine 5mg one time a day was ordered with 6 refills indicated. Observation of the morning medication pass on 05/15/25 at 8:35am revealed: -The medication aide (MA) prepared 7 oral medications for administration to Resident #6 from medications packaged in bubble cards, as she compared the medications displayed on eMAR. -There was no amlodipine 5mg listed on the eMAR in the resident's appointed space on the medication cart. -The MA looked in the medication slot on the medication cart and in the storage of overstock for residents on the medication cart but had no amlodipine 5mg to administer to Resident #6. -At 8:42am, the MA administered the 7 prepared oral medications with water and documented administration on the May 2025 eMAR. -The MA documented amlodipine 5mg not administered due to medication/treatment not available. Observation of Resident #6's medication on hand for administration on 05/15/25 at 8:40am revealed there was no amlodipine 5mg available for	D 358		

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D 358	Continued From page 34 administration. Interview with the MA on 05/15/25 at 8:45am revealed: -She searched the medication cart for Resident #6's amlodipine 5mg but she could not locate the medication in the space designated for Resident #6's medication or in the bottom drawer of the medication cart reserved for residents' reordered or overstock medications. -The computer reorder status displayed the amlodipine 5mg was reordered from the contracted pharmacy on 05/02/25 and should be available unless the contracted pharmacy needed a new order. -If the contracted pharmacy needed a new order, the pharmacy sent a copy of the refill request to the facility for contacting the resident's primary care provider (PCP) for refills. -The MAs were supposed to reorder residents' medication when the supply was down to 5-7 days remaining. -The MAs were responsible to check with the contracted pharmacy on the status of the requested refill of a medication if the MA administered the last dose in the bubble pack and there was no additional medication in the overstock area. -She did not work on 05/14/25 when the last dose of Resident #6's amlodipine 5mg was documented for administration. -She would have to check with the contracted pharmacy to request Resident #6's amlodipine be sent to the facility in the afternoon (5:00pm or 6:00pm) daily delivery but it would be outside the 1 hour before or 2 hour after scheduled time of administration. Review of Resident #6's May 2025 eMAR from 05/01/25 to 05/15/25 at 10:00am revealed:	D 358		

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-There was an entry for amlodipine 5mg one tablet one time a day related to essential hypertension scheduled for administration at 8:00am daily.
-Amlodipine 5mg was documented daily at 8:00am from 05/01/25 to 05/14/25.
-Amlodipine 5mg was documented not administered on 05/15/25 at 8:00am with medication/treatment not available/pharmacy action required documented for reason not administered.

Review of Resident #6's blood pressures (BP) documented on the resident's vital summary sheet revealed on 04/10/25 at 3:14 pm the resident's BP was 133/68, and on 04/24/25 at 5:33pm the resident's BP was 120/65.

Resident #6's blood pressure reading was obtained on 05/16/25 at 11:00am with a value of 152/77.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 05/15/25 at 3:54pm revealed:
-Amlodipine 5mg for Resident #6 was dispensed on 01/22/25 for a quantity of 30 doses, on 02/27/25 for a quantity of 30 dose, and on 03/31/25 for a quantity of 30 doses.
-Amlodipine 5mg for Resident #6 was dispensed on 05/15/25 for a quantity of 30 doses in response to a request made by the facility staff on 05/15/25.

Interview with the MA staffing the AL medication cart on 05/15/25 at 11:50am revealed:
-She administered morning medications in the SCU on 05/14/25.
-She administered the last dose of Resident #6's amlodipine 5mg from a bingo package at 8:00am

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D 358	Continued From page 36 on 05/14/25. -She reordered amlodipine 5mg for the resident using the eMAR computer's pharmacy reorder system. -The facility's contracted pharmacy should have sent the amlodipine with the evening delivery on 05/14/25. -The facility sometimes had trouble with the facility's contracted pharmacy sending medications that were reordered and sometimes had to reorder medications a couple of times before receiving the medications. (The contracted pharmacy staff would say they received the reorder request). -She did know Resident #6's amlodipine 5mg was not sent in the evening order delivered 05/14/25. Interview Resident #6's primary care provider (PCP) on 05/15/25 at 10:45am revealed: -If she wrote medication orders that had refills indicated, the facility should coordinate with the contracted pharmacy to ensure refill requests were not sent to her for medications that had remaining refills. -If medications needed refills for the contracted pharmacy to provide the medications, the facility or the contracted pharmacy faxed the request directly to her office and she responded promptly. -She expected MAs to be reading medication orders and administering medications as ordered. -Residents not receiving medications as ordered interfered with the provider's ability to determine if changes to medication regimens were required to obtain proper management of medical conditions. -Resident #6 had refills for amlodipine 5mg and should not be out of amlodipine 5mg. Based on observations, interviews, and record review it was determined that Resident #6 was not interviewable.	D 358		

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D 358	Continued From page 37 Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm. Refer to the interview with the Administrator on 05/16/25 at 4:45pm. b. Review of Resident #7's current FL2 dated 09/22/24 revealed: -Diagnoses included diabetes mellitus type II, major depressive disorder, osteoarthritis, and other arthritis. -The resident was semi-ambulatory. -The FL2 was blank for disoriented with no documentation for intermittently or constantly disoriented. -There was an order for Voltaren Gel 1% (a topical gel used to treat pain in joints and muscles) apply 2 grams topically 4 times a day to both knees, left side of neck and lower back. Review of Resident #7's signed physician's order dated 03/11/25 revealed an order for Voltaren Gel 1% apply 2 grams topically 4 times a day for pain to both knees, left side of neck and lower back. Observation of the morning medication pass on 05/15/25 at 7:45 am revealed: -At 7:55am, the medication aide (MA) staffing the assisted living (AL) medication cart prepared 12 oral medications from Resident #7's medications packaged in bubble packages as she compared the medications displayed on the electronic medication administration record (eMAR). -The MA administered 12 tablets with water to Resident #7 who was sitting in a wheel chair at the front entrance lobby of the AL.	D 358		

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D 358	Continued From page 38 -The MA administered an eye drop and an inhaler displayed on the eMAR and scheduled for administration at 8:00am. -The MA returned to the medication cart and documented administration of Resident #7's medications on the eMAR. -There was no Voltaren 1% Gel administered (applied) to Resident #7 with the medications. Review of Resident #7's May 2025 eMAR from 01/01/25 to 05/15/25 on 05/15/25 at 11:00am revealed: -There was an entry for Voltaren Gel 1% apply 2 grams topically 4 times a day to both knees, left side of neck and lower back. -Voltaren Gel 1% was documented as applied on 05/15/25 at 7:55am with location of administration omitted. Observation of Resident #7's medications on hand for administration on 05/15/25 at 10:15am revealed: -There was a partial tube of diclofenac (generic for Voltaren) 3% gel loose in the bottom right-hand drawer of the medication cart that was not in a container or box with no instructions for administration and Resident #7's name written in marker on the outside of the tube. -There was no Voltaren 1% gel labeled apply 2 grams topically 4 times a day for pain to both knees, left side of neck and lower back for Resident #7 on the medication cart. Interview with MA on 05/15/25 at 11:30am revealed: -She had not administered medications from the AL cart for several weeks. -She routinely administered medications in the Special Care Unit (SCU) but was requested to staff the AL medication cart today (05/15/25).	D 358		

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-Resident #7 had multiple morning medications she administered this morning.
-She thought she applied the generic Voltaren gel (3%) that was on the medication cart to Resident #7 prior to the medication pass.
-She would check overstock topical medications stored in the medication room for Voltaren 1% gel for Resident#7.

Observation on 05/15/25 at 11:40am revealed the MA working on the AL medication cart presented 2 tubes of 100 grams each of generic Voltaren 1% in plastic zip closure bags labeled for Resident #7 with a dispensing date of 12/26/24 and instructions to apply topically 4 times a day to both knees, left side of neck and lower back.

Interview with Resident #7 on 05/15/25 at 11:30am revealed:
-She did not have Voltaren 1% gel applied this morning.
-Sometimes the MAs applied the Voltaren 1% gel, depending on the MA working, but not yet today (05/15/25).
-Her knees had some pain most of the time and today the pain was no worse.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 05/15/25 at 3:54pm for revealed:
-Resident #7 was dispensed 2 tubes of generic Voltaren 1% gel on 08/29/24, 10/30/24, and 12/26/24.
-Voltaren gel 1% was a medication the facility would have to request to be refilled.
-Resident #7 had no additional dispensing dates for generic Voltaren 1% gel.

Interview Resident #7's primary care provider (PCP) on 05/15/25 at 10:45am revealed:

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-She expected MAs to be reading medication orders and administering medications as ordered.
-Residents not receiving medications as ordered interfered with the provider's ability to determine if changes to medication regimens were required to obtain proper management of medical conditions.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm.

Refer to the interview with the Administrator on 05/16/25 at 4:45pm.

c. Review of Resident #8's current FL2 dated 03/21/25 revealed diagnoses included cognitive communication deficit, osteoarthritis of left shoulder, chronic obstructive pulmonary disease (COPD) and muscle weakness.

1. Review of Resident #8's signed order summary report dated 04/02/25 revealed:
-There was an additional diagnosis of anxiety disorder.
-There was an order for hydroxyzine 10mg (used to treat anxiety) twice a day for anxiety.

Observation of the morning medication pass on 05/15/25 at 8:15 am revealed:
-The medication aide (MA) staffing the assisted living (AL) medication cart prepared an oral inhaler, and 4 oral medications, from Resident #8 medications packaged in bubble packages, as she compared the medications displayed on the electronic medication administration record (eMAR).
-The MA identified hydroxyzine 10mg as not available for administration after checking the

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medication cart and overstock for the medication.
-At 8:22am, the MA administered the oral inhaler, and 4 tablets with water to Resident #8 who was sitting in a chair at the front entrance lobby of the AL.
-The MA returned to the medication cart and documented administration of Resident #8's medication on the eMAR except hydroxyzine 10mg which she left blank.
-There was no hydroxyzine 10mg administered to Resident #8 with the medications.

Interview with the MA on 05/15/25 at 8:15am revealed:
-She routinely administered medications in the Special Care Unit (SCU) but had been assigned to the medication cart in the AL due to staffing shortages.
-She would call the facility's contracted pharmacy to arrange for the medication to be delivered within the grace period of 1 hour after the scheduled time of administration.

Observation of Resident #8's mediation on hand for administration at 9:50am revealed there was no hydroxyzine 10mg available for administration for Resident #8.

Review of Resident #8's May 2025 eMAR from 05/01/25 to 05/15/25 revealed:
-There was an entry for hydroxyzine 10mg twice a day scheduled for administration at 8:00am and 9:00pm.
-On 05/15/25 at 8:00am, hydroxyzine 10mg was blank for documentation.

On 05/15/25 at 11:45am, the morning MA in the AL notified the surveyor she had received Resident #8's hydroxyzine 10mg for administration at 11:30am.

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D 358	Continued From page 42 Second interview with the morning MA in the AL on 05/15/25 at 11:45am revealed that Resident #8's primary care provider (PCP) was in the facility. -She would notify the PCP for hydroxyzine 10mg administration being late and request guidance related to administering the medication late. Third interview with the morning MA in the AL on 05/15/25 at 11:50am revealed: -The facility sometimes had trouble with the facility's contracted pharmacy sending medications that were reordered. -Sometimes MAs had to reorder medications a couple of times before receiving the medications. -The contracted pharmacy staff said they had not received the reorder request for hydroxyzine 10mg before 05/15/25. Telephone interview with the pharmacist at the facility's contracted pharmacy on 05/15/25 at 3:54pm revealed: -The pharmacy dispensed two bingo packages for a total 60 dose labeled hydroxyzine 10mg labeled take twice a day on 03/26/25, and on 04/19/2. -Resident #8 should have hydroxyzine 10 mg available for administration. Interview with Resident #8's primary care provider (PCP) on 05/15/25 at 10:45am revealed: -The facility should be auditing the quantity of medication on hand for administration and not running out of medications on the medication carts. -If she wrote medication orders that had refills indicated, the facility should be coordinating with the contracted pharmacy to ensure refill requests are not sent to her for medications that have	D 358		

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remaining refills.
-She expected MAs administering medications as ordered.
-Residents not receiving medications as ordered interfered with the provider's ability to determine if changes to medication regimens were required to obtain proper management of medical conditions.

Interview with Resident #8 on 05/15/25 at 1:30pm revealed she did not know the medications she received if she always received all her medications.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm.

Refer to the interview with the Administrator on 05/16/25 at 4:45pm.

2. Review of Resident #8's signed order summary report dated 04/02/25 revealed there was an order for vitamin D3 (used to treat vitamin D deficiency) 5000 international units (IU) one time daily for supplement.

Observation of the morning medication pass on 05/15/25 at 8:15 am revealed:
-The MA staffing the AL medication cart prepared an oral inhaler, and 4 oral medications, from Resident #8's medications packaged in bubble packages, as she compared the medications displayed on the eMAR.
-The MA identified vitamin D3 5000iu as not available for administration after checking the medication cart and overstock for the medication.
-At 8:22am, the MA administered the oral inhaler, and 4 tablets with water to Resident #8 who was

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sitting in a chair at the front entrance lobby of the AL.
-The MA returned to the medication cart and documented administration of Resident #8's medication on the eMAR except vitamin D3 5000iu which she left blank.

Interview with the MA on 05/15/25 at 8:15am revealed she would call the facility's contracted pharmacy to arrange for the vitamin D3 5000iu to be delivered within the grace period of 1 hour after the scheduled time of administration.

Observation of Resident #8's mediation on hand for administration at 9:50am revealed there was no vitamin D3 5000iu available for administration for Resident #8.

Review of Resident #8's May 2025 eMAR from 05/01/25 to 05/15/25 revealed:
-There was an entry for vitamin D3 5000iu one daily for supplement scheduled for administration at 8:00am daily.
-On 05/15/25 at 8:00am, vitamin D3 5000iu was blank for documentation.

On 05/15/25 at 11:45am, the morning MA in the AL notified the surveyor she had received Resident #8's vitamin D3 5000iu for administration at 11:30am.

Second interview with the morning MA in the AL on 05/15/25 at 11:45am revealed that Resident #8's primary care provider (PCP) was in the facility, and she would notify the PCP of the late vitamin d# 5000iu request guidance related to administering the medication late.

Third interview with the morning MA in the AL on 05/15/25 at 11:50am revealed:

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-The facility sometimes had trouble with the facility's contracted pharmacy sending medications that were reordered.
-The MAs sometimes had to reorder medications a couple of times before receiving the medications.
-The contracted pharmacy staff said they received the reorder request.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 05/15/25 at 3:54pm revealed:
-The pharmacy dispensed vitamin D3 5000iu labeled one capsule daily for a quantity of 30 capsules on 04/11/25 and again on 05/15/25.
-The facility had to request refills for Resident #8's vitamin D3 5000iu to be refilled each time.

Interview with Resident #8's primary care provider (PCP) on 05/15/25 at 10:45am revealed:
-The facility should be auditing the quantity of medication on hand for administration and not running out of medications on the medication carts.
-If she wrote medication orders that had refills indicated, the facility should be coordinating with the contracted pharmacy to ensure refill requests are not sent to her for medications that have remaining refills.
-She expected MAs administering medications as ordered.
-Residents not receiving medications as ordered interfered with the provider's ability to determine if changes to medication regimens were required to obtain proper management of medical conditions.

Interview with Resident #8 on 05/15/25 at 1:30pm revealed she did not know the medications she received or if she always received all her medications.

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D 358	Continued From page 46 Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm. Refer to the interview with the Administrator on 05/16/25 at 4:45pm. 2. Review of Resident #2's current FL2 dated 11/21/24 revealed: -Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychiatric disturbance, mood disturbance and anxiety; generalized muscle weakness and unspecified fall (subsequent encounter). -The resident's level of care was documented as Special Care Unit (SCU). Review of Resident #2 medication order from the local hospital emergency department dated 05/14/25 revealed: -There was an order for cephalexin 500mg (used to treat infections) 4 times a day for 7 days. -Start on 05/14/25 was documented on the order. Review of Resident #2's May 2025 electronic medication record (eMAR) from 05/01/25 to 05/16/6/25 revealed: -There was entry for cephalexin 500mg 4 times a day until 05/22/25. Start dose 05/15/25 at 8:00am was documented on the order. -Cephalexin 500mg was scheduled for administration at 8:00am, 12:00pm, 4:00pm and 8:00pm daily. -On 05/14/25, cephalexin 500mg was blocked out for administration at 8:00am, 12:00pm, 4:00pm and 8:00pm to indicate administration was not	D 358		

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started.
-On 05/15/25 at 8:00am, cephalexin 500mg was not administered with medication not available documented.

Interview with the primary care provider (PCP) on 05/15/25 at 10:45am revealed:
-She expected MAs to be reading medication orders and administering medications as ordered.
-If an antibiotic was ordered, she expected the antibiotic to be started as soon as possible but no more than 24 hours after being ordered.
-Infections, including UTI infections, can alter a resident's physical and mental status and residents with dementia can exhibit signs of increased cognitive impairment and inappropriate behaviors like wandering.

Interview with the Resident Care Coordinator (RCC) on 05/15/25 at 11:30am revealed:
-Orders for antibiotics should be considered as stat (meaning the medication should begin as soon as possible) and should begin the day the order was received.
-The facility should receive the medication from the facility's contracted pharmacy with a same-day noon delivery if the order was faxed between 12:00am and 6:00am.
-If an antibiotic could not be supplied by the facility's contracted pharmacy, the facility's contracted pharmacy could contact a local pharmacy designated as a backup pharmacy for medications ordered stat.
-Routine medications ordered before 5:00pm were usually delivered with the nighttime facility's contracted pharmacy delivery and placed on the night shift MA.
-Resident #2's order for cephalexin (generic Keflex) 500mg was faxed to the facility's contracted pharmacy at 1:13am on 05/14/25 and

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D 358	Continued From page 48 should have been delivered at 12:00pm (noon) on 05/14/25. -The MA on duty when medication orders were received was responsible for adding the medication the eMAR, fax the order to the pharmacy, enter the order in the medication tracking log, document a new order was awaiting shipment in the 24 hour shift communication log, and tell the oncoming shift a stat order was supposed to be delivered. -There was no cephalexin 500mg in the facility for administration to Resident #2 as of 05/15/25 at 11:30am. -The MA that received and entered Resident #2's order for cephalexin 500mg on 05/14/25 at 1:13am should not have blocked administration for the day on 05/14/25. -The RCC called the facility's contract pharmacy for information regarding why Resident #2's cephalexin 500mg was not provided on the 05/14/25 since the fax was sent before 6:00am. -The RCC was informed Resident #2's insurance denied the processing of the cephalexin 500mg because the medication was previously filled at another pharmacy. -The RCC reviewed Resident #2's after visit summary from the local emergency department dated 05/13/25 and saw the summary stated the cephalexin 500mg was available to be picked up at a local outside retail pharmacy. -The MAs or the RCC had not contacted the local outside retail pharmacy regarding cephalexin 500mg. -The RCC was going to arrange for pick-up of Resident #2's cephalexin 500mg for administration. Interview with MA on 06/16/25 at 2:00pm revealed: -Orders for antibiotics are considered stat orders	D 358		

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and should begin the day the order is received.
-The 24-hour shift logs are reviewed at the beginning of each shift by the oncoming MA.
-If the facility's contracted pharmacy could not process a medication order because the order was filled at another pharmacy, the contracted pharmacy was supposed to send information notifying the facility in the next medication delivery.
-If the after the visit summary or the facility's contracted pharmacy indicated a medication was to be picked up at an outside pharmacy, the MA, RCC or Health and Wellness Director (HWD) was responsible to contact the family or resident's responsible person to bring the medication to the facility for administration.
-The facility would be responsible for ensuring medications were available for administration.

Interview with the facility's Corporate Nurse Supervisor on 05/16/25 at 2:30pm revealed:
-She was a Corporate Nurse responsible for overseeing several facilities, including this facility, for health care and medication compliance.
-Antibiotics should be started no later than one day after a hospital visit if ordered on the after visit summary.
-Resident #2's after a hospital visit summary dated 05/13/25 would mean the antibiotic should be started on 05/14/25 or no later than 8:00am on 05/15/25.
-The MA were responsible to call the facility's contract pharmacy to find out the status of the order and ensure that Resident #2 received her medication.
-If the MA could not resolve a medication issue, the HWD and/or the RCC should be informed by the MA.

Interview with the HWD on 05/16/25 revealed she

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D 358	Continued From page 50 was not informed Resident #2's cephalexin 500mg was unavailable for administration until today (05/16/25). Observation of medication on hand for administration for Resident #2 on 05/16/25 at 3:10pm revealed there was a bottle of cephalexin 500mg from a local retail pharmacy labeled as dispensed on 05/13/25 for 28 capsules with instructions one capsule 4 times a day with 27 capsules remaining. Interview with the another MA on 05/16/25 at 3:10pm revealed: -The MAs administered medications according to the scheduled times the medications appeared on the eMAR. -She did not work the second shift on 05/15/25. -Resident #2's cephalexin 500mg was documented as administered by the morning shift MA at 12:00pm on 05/16/25 by the morning shift MA.. -The MAs would not have administered Resident #2's cephalexin 500mg on 05/14/25 because the order said to start 05/15/25. -She would administer Resident #2's cephalexin 500mg at 4:00pm as scheduled. Based on observations, interviews, and record review it was determined that Resident #2 was not interviewable. Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm. Refer to the interview with the Administrator on 05/16/25 at 4:45pm.	D 358		

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D 358	Continued From page 51 3. Review of Resident #1's current FL2 dated 04/30/25 revealed diagnoses included dementia, anxiety, depression, insomnia, and cholesterol. a. Review of Resident #1's current FL2 dated 04/30/25 revealed there was an order for memantine (a medication used to treat dementia) 10mg take 1 tablet twice daily. Review of Resident #1's May 2025 electronic medication administration record (eMAR) from 05/07/25 to 05/14/25 revealed: -There was an entry for memantine 10mg take 1 tablet daily scheduled for administration at 9:00am. -There was documentation memantine 10mg was administered from 05/07/25 to 05/14/25 once daily. Observation of Resident #1's medications on hand on 05/15/25 at 10:18am revealed: -There was a bubble pack for 24 tablets of memantine available for administration and was last dispensed on 05/07/25. -The order on the label was for memantine 10mg take 1 tablet twice daily. Interview with Resident #1's primary care provider (PCP) on 05/15/25 at 2:15pm revealed: -Resident #1 was admitted to the facility on 05/07/25. -Resident #1 was ordered memantine 10mg from 1 tablet twice daily. -He had not changed Resident #1's orders for memantine from 1 tablet twice daily since her admission on 05/07/25. -He expected the facility to administer Resident #1's memantine as he ordered unless Resident #1's neurologist changed her orders.	D 358		

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D 358	Continued From page 52 -He expected a possible outcome of cognitive decline and behavioral disturbances if Resident #1 did not receive her memantine as ordered. Interview with Resident #1's neurologist on 05/16/25 at 11:00am revealed: -Resident #1 was ordered memantine 10mg from 1 tablet twice daily the he had not changed Resident #1's orders for memantine. -He expected the facility to administer Resident #1's memantine as what was initially ordered. -He expected a possible outcome of cognitive decline if Resident #1 did not receive her memantine as ordered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/16/25 at 9:03am revealed: -There was a current order on file for memantine 10mg twice daily for Resident #1. -Memantine was dispensed on 05/08/25 for a quantity of 60 tablets. -There was no order on file for memantine 10mg once daily for Resident #1. -The pharmacy was not responsible for updating the eMAR for the facility and the facility staff was responsible for updating residents eMARs. -The pharmacy expected the facility to provide new orders for the pharmacy to have current orders on file. Interview with a medication aide (MA) on 05/15/25 at 10:38am revealed: -She administered Resident #1's medications according to the eMAR entries. -She had administered Resident #1's memantine at 9:00am when she worked as an MA on first shift. -She was not aware the bubble pack medication label has instructions to administer Resident #1's	D 358		

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memantine 2 times a day.
-The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for verifying physician orders and updating the eMAR.

Interview with a second MA on 05/15/25 at 2:55pm revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She had not administered Resident #1's memantine because she usually worked as an MA on second shift.
-She was not aware the bubble pack medication label had instructions to administer Resident #1's memantine 2 times a day.
-The RCC and the Health and Wellness Director HWD were responsible for verifying physician orders and updating the eMAR.

Interview with the RCC on 05/16/25 at 11:55am revealed:
-She administered Resident #1's medications according to the eMAR entries when she worked as an MA on first and second shift.
-She had administered Resident #1's memantine at 9:00am when she worked as an MA on first shift.
-She was not aware the bubble pack medication label had instructions to administer Resident #1's memantine 2 times a day.
-She was not aware the eMAR did not reflect the current physicians' orders.

Interview with the HWD on 05/16/25 at 3:55pm revealed:
-She was not aware Resident #1's memantine was not being administered 2 times a day.
-She was not aware the eMAR did not reflect the current physicians' orders.

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Interview with the Administrator on 05/16/25 at 4:30pm revealed:
-The RCC and HWD were responsible for ensuring orders were entered into the eMAR correctly.
-She was not aware the eMAR did not reflect the current physicians' orders for Resident #1's memantine.
-She expected the MAs, the RCC, and the HWD to update eMAR correctly and for medications to be administered according to physcians' orders.

Refer to interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am.

Refer to interview with the Health and Wellness Director (HWD) on 05/16/25 at 3:55pm.

Refer to interview with the Administrator on 05/16/25 at 4:30pm.

b. Review of Resident #1's current FL2 dated 04/30/25 revealed there was an order for donepezil (a medication used to treat dementia) 10mg take 1 tablet twice daily.

Review of Resident #1's May 2025 electronic medication administration record (eMAR) from 05/07/25 to 05/14/25 revealed:
-There was an entry for donepezil 10mg take one tablet daily at bedtime scheduled for administration at 8:00pm.
-There was documentation donepezil 10mg was administered from 05/07/25 to 05/13/25 once daily at bedtime.

Observation of Resident #1's medications on hand on 05/15/25 at 10:18am revealed:
-There was a bubble pack for 29 tablets of

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donepezil available for administration and was last dispensed on 05/08/25.
-The order on the bubble pack medication label was donepezil 10mg take 1 tablet twice daily.

Interview with Resident #1's PCP on 05/15/25 at 2:15pm revealed:
-Resident #1 had an order for donepezil 10mg 1 tablet 2 times a day.
-He had not changed Resident #1's orders for donepezil from 1 tablet twice daily since her admission on 05/07/25.
-He expected the facility to administer Resident #1's donepezil as he ordered unless Resident #1's neurologist changed her orders.
-He expected a possible outcome of cognitive decline if Resident #1 did not receive her donepezil as ordered.

Interview with Resident #1's neurologist on 05/16/25 at 11:00am revealed:
-Resident #1 had an order for donepezil 10mg 1 tablet twice daily and he had not changed Resident #1's orders for donepezil.
-He expected the facility to administer Resident #1's donepezil as was initially ordered.
-He expected a possible outcome of cognitive decline and hallucinations if Resident #1 did not receive her donepezil as ordered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/16/25 at 9:03am revealed:
-There was a current order on file for donepezil 10mg twice daily for Resident #1.
-Donepezil was dispensed on 05/07/25 for a quantity of 30 tablets.
-There was no order on file for donepezil 10mg once daily for Resident #1.
-The pharmacy was not responsible for updating

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the eMAR for the facility and the facility staff was responsible for updating residents eMARs.
-The pharmacy expects the facility to provide new orders for the pharmacy to have current orders on file.

Interview with a MA on 05/15/25 at 10:38am revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She had not administered Resident #1's donepezil because she usually worked as an MA on first shift.
-She was not aware the bubble pack medication label had instructions to administer Resident #1's donepezil 2 times a day.
-The RCC and the HWD were responsible for verifying physician orders and updating the eMAR.

Interview with a second MA on 05/15/25 at 2:55pm revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She had administered Resident #1's donepezil at 8:00pm because she usually worked as an MA on second shift.
-She was not aware the bubble pack medication label had instructions to administer Resident #1's donepezil 2 times a day.
-The RCC and HWD were responsible for verifying physician orders and updating the eMAR.

Interview with the RCC on 05/16/25 at 11:55am revealed:
-She administered Resident #1's medications according to the eMAR entries when she worked as an MA on first and second shift.
-She had administered Resident #1's donepezil at

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D 358	Continued From page 57 8:00pm when she worked as an MA on second shift. -She was not aware the bubble pack medication label had instructions to administer Resident #1's donepezil 2 times a day. -She was not aware the eMAR did not reflect the current physicians' orders. Interview with the HWD on 05/16/25 at 3:55pm revealed: -She was not aware Resident #1's donepezil was not being administered 2 times a day. -She was not aware the eMAR did not reflect the current physicians' orders. Interview with the Administrator on 05/16/25 at 4:30pm revealed: -The RCC and HWD were responsible for ensuring orders were entered into the eMAR correctly. -She was not aware the eMAR did not reflect the current physicians' orders for Resident #1's donepezil. -She expected the MAs, the RCC, and the HWD to update eMAR correctly and for medications to be administered according to physcians' orders. Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am. Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm. Refer to the interview with the Administrator on 05/16/25 at 4:45pm. 4. Review of Resident #4's current FL2 dated 04/10/25 revealed: -Diagnoses included blindness of both eyes, hypertension, and heart disease.	D 358		

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D 358	Continued From page 58 -There was an order for amlodipine besylate (a medication used to treat hypertension) 5mg take 1 tablet daily. Review of Resident #4's previous FL2 dated 02/13/25 revealed there was an order for amlodipine besylate 5mg take 1 tablet daily. Review of Resident #4's signed physician's order dated 04/10/25 revealed there was an order to check manual blood pressure (BP) twice daily. Review of Resident #4's signed physician's order dated 04/15/25 revealed there was an order to hold all blood pressure medications if systolic BP was 100 or below. Review of Resident #4's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine besylate 5mg take one tablet daily scheduled for administration at 8:00am. -There was documentation amlodipine besylate was administered from 04/01/25 to 04/30/25. -There was an entry for check manual BP twice daily scheduled for once a shift during day shift and once a shift during evening shift at no specified time. -There was documentation Resident #4's BP was checked twice daily from 04/17/25 to 04/30/25. -There was no documentation of specific BP values obtained, only that the BP was checked from 04/17/25 to 04/30/25. -There was an entry to hold BP medications if systolic BP was 100 or less once daily scheduled at 8:00am. -There was documentation the BP values were outside of parameters (no BP value documented) and amlodipine 5mg was held on 04/19/25,	D 358		

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04/20/25, 04/21/25, 04/25/25 and 04/28/25.
-It was not able to be determined if amlodipine besylate 5mg should have been administered or held from 04/17/25 to 04/30/25 because there were no BP values documented or available for review.

Review of Resident #4's May 2025 eMAR from 05/01/25 to 05/14/25 revealed:
-There was an entry for amlodipine besylate 5mg take one tablet daily scheduled for administration at 8:00am.
-There was documentation amlodipine besylate was administered from 05/01/25 to 05/14/25.
-There was an entry for check manual BP twice daily scheduled for once a shift during day shift and once a shift during evening shift at no specified time from 05/01/25 to 05/04/25.
-There was documentation Resident #4's BP was checked twice daily but no BP value was documented from 05/01/25 to 05/04/25.
-There was an entry with a start date of 05/04/25 at 8:00pm for check manual BP twice daily scheduled at 8:00am and 8:00pm.
-There was documentation at 8:00pm to check BP values from 05/04/25 to 05/14/25 with a range of 102/82 to 152/70.
-There was an entry to hold BP medications if systolic BP was 100 or less once daily scheduled at 8:00am.
-There was documentation the BP value was outside of parameters and amlodipine 5mg was held on 05/04/25, 05/09/25, 05/12/25 and 05/14/25.
-It was unable to be determined if amlodipine besylate 5mg should have been administered or held from 05/01/25 to 05/04/25 because there were no BP values documented or available for review.

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D 358	Continued From page 60 Observation of the medications on hand for Resident #4 on 05/15/25 at 4:00pm revealed there was a mail order prescription bottle labeled 02/03/25 with 59 of 90 amlodipine besylate 5mg tablets available for administration on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/16/25 at 9:23am revealed: -There was a current order on file for amlodipine besylate 5mg daily for Resident #4. -Amlodipine besylate was dispensed on 02/13/25 for a quantity of 30 tablets. -There were no other dispense dates after 02/13/25 for amlodipine besylate and he thought Resident #4's medication may be dispensed from a different pharmacy. Attempted telephone interview with a representative from Resident #4's mail order pharmacy on 05/16/25 at 10:19am was unsuccessful. Interview with Resident #4 on 05/16/25 at 2:03pm revealed: -He was unable to tell which medications were administered to him by staff because he was visually impaired. -Staff administered his medications in a medication cup and he never refused his medications. -As far as he could tell, staff always administered his medications over the last few months. -Staff checked his BP twice daily. Interview with Resident #4's primary care provider (PCP) on 05/15/25 at 9:50am revealed: -She did not know if staff recorded Resident #4's BP values from 04/17/25 to 05/04/25.	D 358		

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-There was an order to hold Resident #4's BP medications if his systolic BP was below 100.
-She did not know if staff held any of Resident #4's BP medications from 04/17/25 to 05/04/25 because she had not yet seen any documentation.

Interview with a medication aide (MA) on 05/16/25 at 2:46pm revealed:
-There was an order to check Resident #4's BP twice daily.
-She checked Resident #4's BP in April and May 2025 but there was nowhere to document the BP values on the eMAR from 04/17/25 until 05/04/25.
-Whoever put the order entry to check Resident #4's BP did not click a checkbox to add a space to document BP values.
-The Health and Wellness Director (HWD) added a space for MAs to document Resident #4's BP on 05/04/25.
-She knew Resident #4 had orders to hold BP medications if systolic BP was below 100.
-Resident #4 never refused his amlodipine besylate.
-She and the other MAs administered Resident #4's medications and Resident #4 had never run out of amlodipine.
-She had never held Resident #4's amlodipine because his systolic BP was always above 100 when she checked Resident #4's BP.

Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 12:15pm revealed:
-She knew there was an order to check Resident #4's manual BP twice daily.
-She was unable to find any documented BP values for Resident #4 from 04/17/25 to 05/04/25.
-The MAs were responsible to document Resident #4's BP values.
-She knew there was an order to hold Resident

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D 358	Continued From page 62 #4's BP medications if his systolic BP was 100 or below. -The MAs would have been responsible to hold Resident #4's amlodipine besylate if indicated. -She thought the initial order entry to check Resident #4's BP twice daily was entered incorrectly on the eMAR which resulted in there being nowhere to document BP values on the eMAR. Interview with the HWD on 05/16/25 at 4:20pm revealed: -She did not know there was an order to check Resident #4's manual BP twice daily. -She did not know there was no documentation of Resident #4's BP values from 04/17/25 to 05/04/25. -The MAs were responsible to document Resident #4's BP values. -She did not know there was an order to hold Resident #4's BP medications if his systolic BP was 100 or below. -The MAs would have been responsible to hold Resident #4's amlodipine besylate if indicated. -She would have expected the MAs to fix the order entry on the eMAR so there was a place to document Resident #4's BP values or to let her know so it could have been fixed. Interview with the Administrator on 05/16/25 at 4:43pm revealed: -She did not know there was an order to check Resident #4's manual BP twice daily prior to 05/15/25. -She did not know there was no documentation of Resident #4's BP values from 04/17/25 to 05/04/25. -She did not know there was an order to hold Resident #4's BP medications if his systolic BP was 100 or below prior to 05/15/25.	D 358		

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-The MAs were responsible to check Resident #4's BP twice daily, hold amlodipine besylate if needed and document Resident #4's BP values.
-She would have expected the MAs to fix the order entry on the eMAR so there was a place to document Resident #4's BP values or let the HWD know so it could have been fixed.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm.

Refer to the interview with the Administrator on 05/16/25 at 4:45pm.

5. Review of Resident #3's current FL2 dated 04/30/25 revealed:
-Diagnoses included hypertension, hyperlipidemia, mitral valve insufficiency with murmur, gastroesophageal reflux, allergic rhinitis, cardiomyopathy, atrial fibrillation and mood disorder.
-There was an order for quetiapine (an antipsychotic used to treat various mental health conditions) 25mg one tablet at bedtime.

Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 25mg one tablet two times a day scheduled for administration at 8:00am and 8:00pm.
-There was documentation quetiapine 25mg one tablet two times a day was administered from 04/29/25 to 04/30/25 on the eMAR.

Review of Resident #3's May 2025 eMAR revealed:

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D 358	Continued From page 64 -There was an entry for quetiapine 25mg one tablet two times a day scheduled for administration at 8:00am and 8:00pm. -There was documentation quetiapine 25mg one tablet two times a day was administered from 05/01/25 to 05/14/25 on the eMAR. Telephone interview with Resident #3's primary care provider (PCP) from the Veteran's Administration (VA) hospital on 05/15/25 at 10:45am revealed: -She confirmed an order for 60 tablets of quetiapine 25mg one tablet at bedtime was last dispensed from the VA pharmacy on 04/28/25. -She was not the attending provider that wrote the order and was unsure of who the attending provider was for Resident #3. -She expected the facility to administer Resident #3's quetiapine 25mg one tablet at bedtime as ordered. -She would have expected to be notified to clarify any medication orders. -An expected possible negative outcome from taking quetiapine 25mg tablet twice daily could cause headaches, dizziness and less control of body movements. Observation of medications on hand for Resident #3 on 05/15/25 at 11:40am revealed: -Quetiapine 25mg with a dispensed date of 04/28/25 was on the cart with 38 of 60 doses remaining. -There was a sticker covering the dosage instructions that read one tablet of quetiapine 25mg at bedtime. Interview with a medication aide (MA) on 05/15/25 at 11:45am revealed: -She administered Resident #3's medication according to what was on the eMAR.	D 358		

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D 358	Continued From page 65 -She was not aware the correct order was quetiapine 25mg one tablet at bedtime. -She did not know why the sticker was placed over the dosage on the medication bottle. -The MAs were responsible for entering new medication orders on the eMAR. -Resident #3 had not complained of headaches or dizziness. Interview with the Resident Care Coordinator (RCC) on 05/15/25 at 2:45pm revealed: -She was not aware Resident #3's order for quetiapine was incorrect. -The MA was responsible for entering new orders on the eMAR. -The MA should have contacted the VA pharmacy to clarify the order before it was entered on the eMAR. -She was responsible for cart audits to ensure the medication on the eMAR matched the medications on hand. -There was no way to know the order was wrong if it was not entered correctly. -She expected MAs to enter medications as ordered on the eMAR. Interview with the Health and Wellness Director (HWD) on 05/16/25 at 9:30am revealed: -She was made aware of Resident #3's order for quetiapine was not correct on yesterday 05/15/25. -The MA should have entered the medication order from the current FL2 dated 04/28/25. -The MA should have called the pharmacy to clarify the order. -Her expectation was for the MAs to enter all medications as ordered on the eMAR and to call the pharmacy if they needed to clarify an order. Interview with Resident #3 on 05/16/25 at 9:45am revealed:	D 358		

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	HAL029006	A. BUILDING: _____ B. WING _____	05/16/2025

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-He received all his medications from the VA.
-He was aware he was taking quetiapine but not sure of the dosage.
-He had not had any headaches, dizziness or falls.

Interview with the Administrator on 05/16/25 revealed:
-She was made aware of Resident #3's order for quetiapine was not correct on today 05/16/25.
-The protocol was for the MAs to enter new orders on the eMAR and to call the pharmacy of they need to clarify an order.
-The HWD is responsible for cart audits to clarify new orders to ensure that they match the eMAR and medications on hand.
-She expected the MAs to use the current FL2 or current signed physician order and enter medications as ordered on the eMAR.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/16/25 at 11:55am.

Refer to the interview with the Health and Wellness Director (HWD) on 05/16/25 at 4:15pm.

Refer to the interview with the Administrator on 05/16/25 at 4:45pm.

_____
Interview with the RCC on 05/16/25 at 11:55am revealed:
-The HWD was responsible for updating the eMAR with residents' orders from the FL2 upon admission to the facility.
-The MAs, the RCC, and the Health and Wellness Director (HWD) were responsible for verifying physician orders and updating the eMAR.
-The RCC and the HWD were responsible for auditing eMARs and performing card audits

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D 358	Continued From page 67 weekly but she had been unavailable due to working as an MA and a PCA. Interview with the HWD on 05/16/25 at 4:15pm revealed: -She had worked for the corporation for more than 2 years. -She had been in her current role as the HWD for 4 days (as of 05/16/25) and was still completing orientation via computer and telephone calls with staff from sister facilities. -She was responsible for auditing medication administration but had not performed any audits at the present time. -Going forward she would be reviewing medication orders entered on the eMAR compared to medication orders, omitted documentation on the eMAR, and medications available for administration. -She was not aware residents were not receiving medications as ordered. Interview with the Administrator on 05/16/25 at 4:45pm revealed: -She was filling in for the Administrator who was unavailable during the survey. -Residents should be receiving medications as ordered by the providers. -The MAs should be auditing the medication carts for medication on hand for administration daily when administering medications and ordering medications as needed. -The MA should contact the contracted pharmacy for medications with short supply on hand to ensure medications are available for administration. _____ The facility failed to ensure medications were administered as ordered by the licensed prescribing provider for a resident, who had a	D 358		

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D 358	Continued From page 68 history of dementia, was ordered two medications to aid in memory loss, and eloped from the Special Car Unit (#1); and another resident, who had a history dementia and eloped from the Special Care Unit where she fell and was transported to a local emergency department (#2). The resident was diagnosed with a urinary tract infection and ordered an antibiotic, which was not administered timely within 24 hours per facility protocol. This failure placed the residents at substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 16, 2025 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 16, 2025.	D 358		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and	D 454		

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D 454	Continued From page 69 (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews the facility failed to ensure the notification of the responsible party of 1 of 2 sampled residents (#2) within 24 hours of an elopement resulting in an injury. The findings are: Review of the facility's Missing Resident Policy dated 04/1997 and last revised 03/2025 revealed: -A missing person required immediate associate attention. A visual (face to face) observation of th missing person was considered confirmation the resident had been found. -Elopement from the Alzheimer's and dementia care was defined as any incident where a resident left the secured memory care unit or the secured courtyard, unescorted, with or without injury. -Until the resident was found, the staff (associates) should conduct a search inside the facility, conduct a head count for all residents to confirm and validate the presence of every resident, and conduct thorough search of the	D 454		

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immediate grounds.
-If found, complete an Incident Report according to procedure.

Review of Resident #2's current FL2 dated 11/21/24 revealed:
-Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychiatric disturbance, mood disturbance and anxiety.
-The resident was intermittently disoriented.
-He was non-ambulatory.
-There was no documentation for wandering behaviors.
-The resident's level of care was documented as SCU.

Review of Resident #2's assessments on 10/25/24 and 04/29/25 and care plans reviewed by provider on 10/23/24 and 05/06/25 respectively revealed:
-She was ambulatory and used a manual wheelchair as a mobility aid.
-She wandered and received medication for mental illness/behaviors.

Review of Resident #2's facility's first Accident/Incident (A/I) report dated 05/13/25 revealed:
-The type of incident was documented as elopement.
-On 05/13/25 at 5:45pm (time documented on A/I), Resident #2 was observed in the courtyard (assisted living courtyard).
-The resident had bruising and redness on both knees.
-Emergency Management Services (EMS) was called and the resident was transported to the local hospital emergency department (ED).
-The report documented 05/13/24 at 6:15pm, a

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Medication Aide (MA) notified the facility nurse by telephone, emailed Resident #2's primary care provider (PCP), and called Resident #2's Power of Attorney (POA) but got no answer.

Review of Resident #2's facility's second Accident/Incident (A/I) report dated 05/13/25 revealed:
-The type of incident was documented fall, unwitnessed.
-On 05/13/25 at 5:45pm (time documented on A/I), Resident #2 was observed in the courtyard (assisted living courtyard) by a personal care aide (PCA).
-The resident had bruising and redness on both knees.
-Emergency Management Services (EMS) was called and the resident was transported to the local hospital emergency department (ED).

Interview with the Resident Care Coordinator (RCC) on 05/14/25 at 9:50am revealed:
-She had worked in the AL dining room for the dinner meal service of 05/13/25 during the elopement incident.
-She and a PCA observed two SCU residents outside of the AL dining room window at the edge of the AL patio courtyard.
-She went outside the AL to assist with returning the two residents to the SCU.

Telephone interview with Resident #2's POA/responsible person on 05/16/25 at 9:45am revealed:
-The POA was contacted on 05/13/25 around dinner time (6:30pm to 7:00pm) but she was not certain of the exact time by a staff member (maybe a nurse) from the facility.
-The staff member told her Resident #2 had an altercation with another resident, was pushed

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down to the ground, and was sent to the local emergency department for evaluation.
-The POA was led to believe or thought Resident #2's altercation occurred out the facility in the secured courtyard of the SCU but she did ask the location of the altercation.
-She was not told Resident #2 eloped and was found outside the SCU, at edge of the patio for unsecured AL community.
-Resident #2 was in the SCU and eloping was a problem she would discuss with the facility when she arrived at the facility on her already planned visit to the facility today (05/16/25).

Interview with a second SCU medication aide (MA) on 05/16/25 at 3:25 revealed:
-She was working in the SCU on 05/13/25 at 5:45 when Resident #2 eloped and was found by AL staff close to the AL patio on the ground on her knees.
-She called Resident #2's POA to let her know Resident #2 was sent to a local emergency department for evaluation because her knees were red and dirty from being found on her knees, on the ground.
-She was focused on informing the POA Resident #2 was found outside on her knees and was being sent out for evaluation.
-She did not tell the POA Resident #2 had eloped from the SCU.

Interview with the Administrator on 05/16/25 at 4:30pm revealed:
-She left the facility for the day on 05/13/25 around 5:30pm.
-She received a call while on her way home to return to the facility related to 2 residents found outside the SCU without SCU staff knowledge and Resident #2 was found on her knees and the knees were dirty and red.

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D 454	Continued From page 73 -The Administrator returned to the facility at 6:20pm to assist with caring for the 2 residents and completing requirements for an elopement. -Resident #2 had injuries to her knees and was transported by EMS to a local hospital for evaluation for possible injury from the fall. -The second shift medication aide (MA) in the SCU was assigned to contact the Resident #2's POA, notify the Resident #2's PCP, and ensure the facility's accident/incident forms were completed. -She was unaware Resident #2's POA had not been informed of Resident #2's elopement, only the fall with a hospital visit by EMS for evaluation.	D 454		