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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 07/22/25 and 07/23/25.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the environment was clean and free of hazards related to the cleanliness of a common area bathroom tub that had dead bugs in it, dead bugs on a bathroom window seal, dirty sunroom floor, windows and exhaust fans, a detached exhaust fan in the sunroom, a partly detached fire alarm cover, missing molding throughout the facility and rotting wooden molding in one bathroom. The findings are: Observation of the restroom closest to the resident hall exit door on 07/22/25 at 9:15am	D 079		

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D 079	Continued From page 1 revealed: -There was no trashcan in the restroom. -The restroom smelled strongly of urine. -There was a rusty screw in the one shower and the hot water tap did not work. -There were rotten wooden baseboards in the shower room. -There was dirt and fine debris in the shower and along the baseboards and corners. Observation of the patient hall exit door and surroundings on 07/22/25 at 9:25am revealed the wall fire alarm pull was hanging halfway off the wall. Observation of the second to last resident hall restroom on 07/22/25 at 9:30am revealed the room smelled strongly of urine. Observation of the sunroom on 07/22/25 at 9:34am revealed: -The floor was concrete and dirty. -There were 3 couches with wooden frames and leather type cushions. -Most of the couch cushions were ripped. -There were thick spider webs in the corners of the windows. -There were 2 exhaust fans in the ceiling. -Both exhaust fans were dirty. -One of the exhaust fans was detached from the ceiling on one side. Observation of the common bathroom across the hall from resident rooms 1 and 2 on 07/22/25 at 9:39am revealed: -There were dried, brown stains running down the walls beside the toilet in the first and second toilet stalls. -There were dried brown stains inside the toilet bowl in the second stall.	D 079		

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D 079	Continued From page 2 -The black wooden molding around the walls and baseboards inside the toilet stalls was chipped and had missing paint. -There was dirt and debris scattered on the floor in front of the toilets. -There was chipped and missing paint on the wall between the toilet stalls. -There was a black straight back chair beside the bathtub with a white towel with brown stains lying in the seat. -There was dirt, debris, and multiple dead bugs scattered in the bottom of the bathtub. -There was dirt, debris, and multiple dead bugs scattered in the windowsill near the bathtub. Observation of residents from 9:00am to 5:00pm on 07/22/25 and 07/23/25 revealed: -All residents had to go through the sunroom to get to the outside patio/smoking area. -None of the residents sat in the sunroom. Observation of the men's common bathroom across the hall from resident rooms 2 and 3 on 07/22/25 at 10:01am revealed: -There were dried brown stains inside the toilet bowl and around the seat of the toilet. -The floor around the base of the toilet had dark brown stains. -The floor in the toilet stall was wet and had dirt and debris scattered all over the tile. -There were dark brown and black stains in the grout of the tile flooring. -The black wooden molding and baseboards were missing paint and had multiple areas of rotting wood. -There were multiple areas on the walls beside the toilet with water damage and rotting wood. -There were yellow and brown stains on the walls beside the toilet. -There was an odor of urine in the bathroom.	D 079		

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D 079	Continued From page 3	D 079		

-The white door to the bathroom had missing paint and multiple areas of rust.
-There were yellow stains in the bottom of the bathtub.
-There was dirt, debris, and dead bugs in the bottom of the bathtub.

Second observation of the common bathroom across the hall from resident rooms 1 and 2 on 07/22/25 at 3:38pm revealed the room had not been cleaned and it was in the same condition as noted on 07/22/25 at 9:39am.

Second observation of the men's common bathroom across the hall from resident rooms 2 and 3 on 07/22/25 at 3:37pm revealed the room had not been cleaned and it was in the same condition as noted on 07/22/25 at 10:01am.

Interview with a resident on 07/22/25 at 3:36pm revealed:
-The bathrooms were often dirty with dirt, urine, or feces on the floor or walls.
-The toilets were often clogged with tissue preventing them from flushing and causing water to overflow onto the floor from the toilet.

Interview with a resident on 07/22/25 at 3:45pm revealed:
-The men's common bathroom had not been cleaned today (07/22/25).
-The men's common bathroom sometimes did not get cleaned every day.
-The men's common bathroom sometimes smelled like urine and feces.
-The toilets sometimes had stains on them.
-He did not use the bathtub in the men's common bathroom; he used a shower in a different bathroom down the hall.

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D 079	Continued From page 4 Interview with the Maintenance Director on 07/23/25 at 10:39am revealed: -He handled any issues with the heating, ventilation and air conditioning (HVAC) system, electrical issues and minor plumbing. -When there were major plumbing issues, he contacted another company for assistance because he had a small crew. -He had been working with the facility for a year and a half. -He serviced the HVAC system twice a year. -The facility Operations Manager or a staff member in the main office contacted him when repairs were needed. -When he visited the facility, he walked around and checked things other than what he was called for. -He was in the facility because he was contacted yesterday (07/21/25) about the light in the staff bathroom not working. -He had not been informed about the detached exhaust fan in the sunroom, but he could fix it by putting the screws back in that came loose. -He was contacted about missing molding throughout the building as well as rotting molding around 1 of the bathroom showers 3 to 4 weeks ago; but he got sick and just started working again about 2 weeks ago. -He was shown a picture of rotten baseboards around one of the resident showers and stated he had purchased wood to replace the baseboards and this was the next job that will be completed. Interview with a cook, who also assisted with housekeeping, on 07/23/25 at 1:29pm revealed: -When cleaning, he went through the rooms using his background in janitorial services as opposed to using a list provided by the facility. -He was trained to clean each room every day. -He went to each room and looked around to see	D 079		

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D 079	Continued From page 5	D 079		

what needed to be done.
-He swept, mopped and disinfected each room.
-Common areas to include bathrooms were cleaned daily.
-When cleaning the bathrooms, he cleaned the toilet, sink, shower, swept, mopped, disinfected and changed the garbage.
-The 2 bathtubs were shut down due to a sewer issue with the "back tub" being down for about 2 to 3 weeks.
-He still cleaned the tubs because there was a shower in there.
-He was the housekeeper yesterday (07/22/25) but he did not clean the bathrooms yesterday due to arriving to work late and assisting with moving boxes and furniture.

Interview with a personal care aide (PCA) on 07/23/25 at 1:40pm revealed:
-He used the tub across from rooms 1 and 2 to assist a resident with bathing last night (07/22/25) and there were no bugs in the tub.
-He cleaned the tubs before every use.

Interview with the Director of Operations on 07/23/25 at 12:07pm revealed:
-The person identified as the Maintenance Director was the handy man.
-The handy man handled blown light bulbs, baseboards, HVAC and minor plumbing.
-If the handy man could not come for plumbing issues, they called another company.
-The baseboards/molding were off in lots of areas of the building.
-The handy man was contacted about the molding 01/08/25 and 04/12/25 and had the replacement materials onsite.
-The handy man got sick but brought the supplies to fix the molding in April 2025.
-The facility had a list generated from the

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D 079	Continued From page 6 Environmental Health Services (EHS) visit that the handy man was working on. -The couches in the sunroom were trash and had been pushed to the side but the residents pulled the furniture back out. -The residents were informed that the couches were trash. -There were new benches outside for the residents to use. -All staff were cross trained for housekeeping. -At least 3 facility employees all took turns cleaning resident rooms and common areas such as bathrooms and the living room. -There was a list used for cleaning that showed what room was to be cleaned, what day the room was to be cleaned and what tasks were to be performed in each room. -Common areas were cleaned daily. -When cleaning the bathroom, the toilets and floors were to be cleaned, and the soap dispenser and paper towels were to be refilled. -Bathroom tubs were supposed to be cleaned daily but one tub did not work. -She was not aware that there were dead bugs in one bathroom tub and on a bathroom window seal. -She expected bathroom tubs to be cleaned whether in use or not. -She noticed the bugs in the window seals on 06/22/25 so all window seals were cleaned 06/23/25. -The sunroom was supposed to be pressure washed by a staff member about 3 weeks ago, but she found out today (07/23/25), that was not done. -She did not know that the fire alarm pull was hanging off the wall near the exit door but one resident in the building would often pull anything she could off the wall.	D 079		

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D 079	Continued From page 7 Attempted telephone interview with the Administrator on 07/23/25 at 5:01pm was unsuccessful.	D 079		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of	D 253		

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D 253	Continued From page 8 daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 3	D 253		

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residents (#2) was assessed and had a care plan developed annually.

The findings are:

Review of Resident #2's FL-2 dated 07/07/25 revealed diagnoses included dementia, schizoaffective disorder, anxiety disorder, breast cancer, and vitamin d deficiency.

Review of Resident #2's Resident Register revealed an admission date of 09/22/22.

Review of Resident #2's last completed Personal Care Physician Authorization and Care Plan dated 11/07/23 revealed:
-She had disruptive and socially inappropriate behavior.
-She was receiving mental health services.
-Her respiratory, skin, bowel, and bladder systems were normal.
-She communicated with slurred speech and was forgetful.
-She required supervision for meals, transfers, and limited assistance for ambulation.
-She required extensive assistance with toileting, bathing, dressing, and grooming.
-She could not administer her own medication.

Record review revealed that there was no care plan developed for Resident #2 since 11/07/23.

Interview with a patient care aide (PCA) on 07/23/25 at 1:40pm revealed:
-He assisted Resident #2 with dressing, hair and nail care, and bathing.
-Resident #2 was more independent on some days than others for her personal care needs.
-Resident #2's care needs and ability to participate in personal care had not changed

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D 253	Continued From page 10 recently. Interview with the facility Operations Manager on 07/23/25 at 9:40am revealed: -She or one of the medication aides completed new care plans for residents. -Care plans were completed at admission to the facility and with any significant changes. -She was told by the facility Administrator that admission and changes triggered the need for a new care plan. -She did not know that care plans should be updated annually. -The facility Administrator was responsible for ensuring that care plans are current and updated. Attempted interview with the facility Administrator with voicemail asking for return call on 07/23/25 at 5:01pm was unsuccessful. Based on observations, interviews, and record reviews, Resident #2 was not able to be interviewed.	D 253		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure foods prepared in the kitchen were free from contamination related to employee personal items stored on the shelves with pots and pans.

The findings are:

Observation of the kitchen on 07/22/25 at 9:47am revealed there were multiple personal items to include a backpack, tote bag, lunch bag and bags of chips stored on the shelves, located to the right of the kitchen door entrance, with clean pots and pans.

Review of the Environmental Health Services (EHS) inspection report dated 03/17/25 revealed:
-The kitchen sanitation score was 90.
-A point deduction of 0.5 was received due to an employee's plated food being stored on the clean dish shelf above clean equipment.
-Employee beverages and food should be stored in a manner that did not pose a contamination risk to clean equipment.
-Facility staff found a better location to store the employees' food and drinks.

Interview with the cook on 07/22/25 at 9:47am revealed:
-The personal items stored on the shelf with the

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D 283	Continued From page 12 clean pots and pans belonged to her. -She knew she was not supposed to store her personal belongings on the shelf with the clean pots and pans. -She usually stored her personal belongings in the chair beside the shelf. -She moved her personal belongings from the chair to the shelf when she sat in the chair this morning. -She removed her personal belongings from the shelf. Interview with the Operations Manager on 07/23/25 at 10:03am revealed: -Personal belongings were to be kept in the "locked office" (an office located outside of the dining area that is kept locked). -She was not aware personal items were stored on the shelf with the clean pots and pans. -She did not know why personal items were stored on the shelf with the clean pots and pans. -All staff were aware personal belongings were not to be stored in the kitchen. -Proper storage of personal belongings was discussed during training upon hire for all staff. -Proper storage of personal belongings was discussed with staff on the same day that EHS cited the facility for an employee's lunch being stored in the kitchen refrigerator. Attempted telephone interview with the Administrator on 07/23/25 at 5:01pm was unsuccessful.	D 283		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with policies and procedures for 2 of 3 residents (#7, #8) observed during the medication pass including errors with medications for constipation, diabetes, and an inhaler for chronic obstructive pulmonary disease (#7) and a topical gel for pain relief and a topical antifungal powder (#8); and for 1 of 3 residents (#3) sampled for record review related to administering expired insulin.

The findings are:

1. The medication error rate was 21% as evidenced by 6 errors out of 28 opportunities during the 8:00am medication pass on 07/23/25.

a. Review of Resident #7's current FL-2 dated 05/23/25 revealed:
-Diagnoses included diabetes mellitus, gastroesophageal reflux disease, hyperlipidemia, anxiety disorder, schizophrenia, post-traumatic stress disorder, history of seizures, low Vitamin B12, and low Vitamin D.
-There was an order for Symbicort 160-4.5mcg inhale 2 puffs twice daily. (Symbicort is used to treat chronic obstructive pulmonary disease (COPD). According to the manufacturer, to prime a Symbicort inhaler, 2 test sprays needed to be released into the air before the first use, or if the

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inhaler had not been used in 7 days or had been dropped. This ensures the inhaler delivers the correct dose of medication. Before each priming spray, the inhaler should be shaken vigorously for about 5 seconds. After priming, the inhaler was ready for use.)

Observation of the 8:00am medication pass on 07/23/25 revealed:
-The medication aide (MA) retrieved a Symbicort inhaler from the top drawer of the medication cart for Resident #7.
-The MA noticed the Symbicort dose counter was in the red area indicating the inhaler was empty.
-The MA retrieved an unopened box with a new Symbicort 160-4.5mcg inhaler for Resident #7.
-The MA handed the new inhaler to Resident #7 and told him to "do twice" with no other instructions.
-The MA did not prime or shake the new inhaler prior to handing it to the resident.
-The resident put the inhaler mouthpiece in his mouth and pressed down 2 quick times in a row at 7:45am.
-The resident did not inhale, hold his breath, or wait between the puffs. (Inhaling, holding breath for a few seconds, and waiting at least one minute between puffs ensures the dosage goes into the lungs.)
-The medication vapors came back out of the resident's mouth.
-The new Symbicort inhaler was not primed, and the proper technique was not used to ensure the correct dose was received.

Review of Resident #7's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs twice daily for COPD scheduled at

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8:00am and 8:00pm.
-Symbicort was documented as administered twice daily from 07/01/25 - 07/23/25 (8:00am).

Observation of Resident #7's medications on hand on 07/23/25 at 10:08am revealed:
-There was a new Symbicort 160-4.5mcg inhaler dispensed on 07/08/25 with 120 inhalations.
-The instructions were to inhale 2 puffs twice daily for COPD.
-The dose counter indicated there were 120 of 120 inhalations remaining (due to the inhaler not being primed).

Interview with the MA on 07/23/25 at 10:04am revealed:
-She did not know a new Symbicort inhaler was supposed to be primed prior to first use.
-Resident #7 liked to hold the inhaler himself.
-She did not recall having training on proper use of inhalers and she was not aware she needed to instruct the resident to wait a minute between puffs.
-The resident sometimes had shortness of breath when he walked around.

Interview with Resident #7 on 07/23/25 at 8:07am revealed:
-He usually took 2 puffs of the Symbicort inhaler every day.
-He could not recall if anyone had instructed him on how to properly use the inhaler.
-He thought the inhaler helped with his breathing problems.
-He had shortness of breath every day when he walked around.

Interview with the Operations Manager on 07/23/25 at 10:40am revealed:
-She was responsible for oversight of the MAs on

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a daily basis.
-The MAs had been trained and should know to prime the Symbicort inhaler.
-The facility's nurse had also trained the MAs to wait at least one minute between puffs.
-Resident #7 would need instructions from the MA to know to shake the inhaler, hold his breath, and to wait between puffs.
-She had not noticed the resident being short of breath.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 07/23/25 at 3:52pm was unsuccessful.

b. Review of Resident #7's current FL-2 dated 05/23/25 revealed an order for Metformin ER 500mg 1 tablet every day with breakfast. (Metformin ER is used to treat diabetes by lowering blood sugar. According to the manufacturer, Metformin should be taken with a meal or after a meal to reduce or prevent gastrointestinal side effects such as nausea, upset stomach, diarrhea, and vomiting.)

Observation of the 8:00am medication pass on 07/23/25 revealed:
-The medication aide (MA) prepared and administered Metformin ER 500mg to Resident #7 at 7:43am.
-The resident's breakfast was served at 8:30am.
-Metformin ER was administered 47 minutes prior to breakfast instead of with breakfast as ordered.

Review of Resident #7's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Metformin ER 500mg 1 tablet every day with breakfast scheduled at 8:00am.

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D 358	Continued From page 17 -Metformin ER was documented as administered daily at 8:00am from 07/01/25 - 07/23/25. Observation of Resident #7's medications on hand on 07/23/25 at 10:04am revealed: -There was a supply of Metformin ER 500mg tablets dispensed on 07/06/25. -The instructions were to take 1 tablet every day with breakfast. -There were 13 of 31 tablets remaining. Interview with Resident #7 on 07/23/25 at 9:59am revealed: -He usually received his morning medications about 5 to 10 minutes before breakfast. -Breakfast was served later than normal that morning (07/23/25). -He denied any stomach upset after receiving the medications on an empty stomach. Interview with the MA on 07/23/25 at 10:04am revealed: -She usually administered Resident #7's morning medications, including the Metformin ER while the resident was eating breakfast or a little before breakfast. -Breakfast was usually served at 8:00am. -She did not know why breakfast was served late today (07/23/25). Interview with the Operations Manager on 07/23/25 at 10:40am revealed: -She was responsible for oversight of the MAs on a daily basis. -If a medication was ordered with a meal, the medication should be administered while the resident was eating. -The MA should have administered Resident #7's Metformin ER while the resident was eating breakfast as ordered.	D 358		

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D 358	Continued From page 18 Attempted telephone interview with Resident #7's primary care provider (PCP) on 07/23/25 at 3:52pm was unsuccessful. c. Review of Resident #7's current FL-2 dated 05/23/25 revealed an order for Senna 8.6mg take 2 tablets (17.2mg) every day. (Senna is a laxative used to treat and prevent constipation.) Observation of the 8:00am medication pass on 07/23/25 revealed: -The medication aide (MA) prepared and administered 1 Senna 8.6mg tablet to Resident #7 at 7:43am. -The resident was administered 1 Senna 8.6mg tablet instead of 2 tablets as ordered. Review of Resident #7's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Senna 8.6mg take 2 tablets (17.2mg) every day for constipation scheduled at 8:00am. -Senna 8.6mg 2 tablets daily was documented as administered at 8:00am from 07/01/25 - 07/23/25. Observation of Resident #7's medications on hand on 07/23/25 at 10:07am revealed: -There was a supply of Senna 8.6mg tablets dispensed on 07/06/25. -The instructions were to take 2 tablets (=17.2mg) every day for constipation. -There was 1 Senna 8.6mg tablet packaged per bubble. -There were 44 of 62 tablets remaining. Interview with the MA on 07/23/25 at 10:04am revealed: -She thought Resident #7 was only supposed to	D 358		

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receive 1 Senna 8.6mg tablet.
-The pharmacy usually packaged 2 tablets in each bubble if the resident was supposed to get 2 tablets.
-She had not noticed the instructions on the eMAR and medication label were to administer 2 tablets.
-The resident was not currently having any issues with constipation.

Interview with Resident #7 on 07/23/25 at 9:59am revealed:
-He usually received 1 Senna tablet each morning to help keep his bowels regular.
-He denied any current issues with constipation.

Interview with the Operations Manager on 07/23/25 at 10:40am revealed:
-She was responsible for oversight of the MAs on a daily basis.
-The MAs were expected to read the eMARs and the medication labels prior to administering medications.
-The MAs should administer the medications according to the instructions on the label and eMAR.
-The pharmacy did not always package 2 tablets in one bubble if the order was for 2 tablets at one time.
-The MA should have administered 2 Senna 8.6mg tablets to Resident #7.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 07/23/25 at 3:52pm was unsuccessful.

d. Review of Resident #7's current FL-2 dated 05/23/25 revealed an order for Miralax mix 17 grams in 8 ounces of water and drink daily. (Miralax is a laxative used to treat and prevent

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D 358	Continued From page 20 constipation.) Observation of the 8:00am medication pass on 07/23/25 revealed: -The medication aide (MA) prepared and administered Resident #7's 8:00am medications at 7:43am. -The MA did not prepare of offer Miralax to Resident #7 during the 8:00am medication pass. Review of Resident #7's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax mix 17 grams in 8 ounces of water and drink daily for constipation scheduled at 8:00am. -Miralax was documented as administered daily at 8:00am from 07/01/25 - 07/22/25. -No Miralax was documented as administered on 07/23/25. Review of Resident #7's pharmacy dispensing records dated 01/01/25 - 07/23/25 revealed: -One 510-gram (30 doses) bottle of Miralax was dispensed on 01/07/25. -One 510-gram (30 doses) bottle of Miralax was dispensed on 02/04/25. -No Miralax was dispensed after 02/04/25. Observation of Resident #7's medications on hand on 07/23/25 at 10:04am revealed: -There was one 510-gram bottle of Miralax dispensed on 02/04/25 with instructions to mix 17 grams in 8 ounces of water and drink daily for constipation. -The bottle was approximately half full of Miralax powder. Interview with the MA on 07/23/25 at 10:04am revealed:	D 358		

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D 358	Continued From page 21 -She usually administered Resident #7's Miralax when she administered the resident's other morning medications scheduled at 8:00am. -She forgot to administer the resident's Miralax that morning (07/23/25) when she administered the resident's other morning medications. -Resident #7 did not usually refuse to take the Miralax. -She could not explain why the Miralax bottle dispensed with a 30-day supply on 02/04/25 was still half full on 07/23/25 and had not been used. -There was no other Miralax on hand for Resident #7. Interview with Resident #7 on 07/23/25 at 8:33am revealed: -He did not usually receive Miralax every day and he was not sure why. -He did not receive Miralax that morning on 07/23/25 and none was offered to him. -He denied any current issues with constipation. Interview with the Operations Manager on 07/23/25 at 10:40am revealed: -She was responsible for oversight of the MAs on a daily basis. -The MAs were expected to read the eMARs and administer medications as ordered. -She thought Resident #7 liked the Miralax mixed in his coffee. -The MA should have administered Resident #7's Miralax that morning on 07/23/25. -She was not aware the 30-day supply of Miralax dispensed on 02/04/25 had not been used and none had been dispensed since that time. -The resident should receive Miralax every day as ordered. Attempted telephone interview with Resident #7's primary care provider (PCP) on 07/23/25 at	D 358		

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D 358	Continued From page 22 3:52pm was unsuccessful. e. Review of Resident #8's current FL-2 dated 03/31/25 revealed: -Diagnoses included diabetes mellitus type 2, pruritic rash, hypertension, hyperlipidemia, asthma, gastroesophageal reflux disease, allergic rhinitis, and paranoid schizophrenia. -There was an order for Diclofenac Sodium 1% Gel apply 2 grams to affected area 4 times a day. (Diclofenac Sodium Gel is a topical pain reliever.) Review of Resident #8's physician's orders revealed no order to clarify where the Diclofenac Sodium 1% Gel should be applied. Observation of the 8:00am medication pass on 07/23/25 revealed: -The medication aide (MA) used the plastic calibrated measuring device to measure 2 grams of Diclofenac Sodium 1% Gel. -The MA used her gloved hands to remove the Diclofenac Sodium Gel from the plastic measuring card. -The MA rubbed her gloved hands together spreading an undetermined amount of the measured 2 grams on each of her gloved hands. -The MA put one gloved hand on each knee of the resident and rubbed the Diclofenac Sodium Gel onto each knee at 7:54am. Review of Resident #8's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Diclofenac Sodium 1% Gel apply 2 grams to affected area 4 times per day for pain scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Diclofenac Sodium 1% Gel was documented as administered from 07/01/25 - 07/23/25 (8:00am)	D 358		

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except on 6 occasions when the resident refused it.

Observation of Resident #8's medications on hand on 07/23/25 at 10:27am revealed:
-There were three 100-gram tubes (300 grams total) of Diclofenac Sodium 1% Gel dispensed on 05/17/25.
-The instructions were to apply 2 grams to affected area 4 times per day for pain.
-There was one 100-gram tube remaining that was approximately half full.

Interview with the MA on 07/23/25 at 10:24am revealed:
-She had not noticed Resident #8's order did not specify where the Diclofenac Sodium Gel should be applied.

-She usually applied Diclofenac Sodium Gel to the resident's knees because that was where the resident complained of having pain.
-The resident said it helped with her knee pain.
-Either the MAs or the Operations Manager were responsible for clarifying medication orders.

Interview with Resident #8 on 07/23/25 at 9:56am revealed:
-She had arthritis in both knees.
-The MAs usually put Diclofenac Sodium Gel on both of her knees.
-The Diclofenac Sodium Gel usually helped with the pain in her knees.
-The MAs did not apply the gel anywhere else.

Interview with the Operations Manager on 07/23/25 at 10:40am revealed:
-She was responsible for oversight of the MAs on a daily basis.
-The MAs were responsible for clarifying

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medication orders.
-Resident #8's Diclofenac Sodium Gel had always been applied to the resident's knees to her knowledge.
-She was not aware the order did not specify where the gel should be applied.
-The order needed to be clarified to specify which areas it should be applied and how many grams for each area.

Review of Resident #8's primary care provider (PCP) Triage orders dated 07/23/25 revealed a clarification order for Diclofenac Sodium 1% Gel apply 2 grams to both knees 4 times daily.

Attempted telephone interview with Resident #8's PCP on 07/23/25 at 3:52pm was unsuccessful.

f. Review of Resident #8's physician's order dated 01/27/25 revealed an order for Nystatin 100,000 units/gram Topical Powder, apply a small amount to skin under breasts twice a day until healed. (Nystatin Topical Powder is used treat and prevent fungal rashes and infections.)

Observation of the 8:00am medication pass on 07/23/25 revealed:
-The medication aide (MA) applied Nystatin Powder to the skin between Resident #8's breasts at 7:56am.
-The MA did not apply Nystatin Powder to the skin under the resident's breasts as ordered.
-The MA did not check underneath the resident's breasts during the medication pass.

Review of Resident #8's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Nystatin Powder 100,000 units/gram apply a small amount topically under

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breasts 2 times a day until area healed.
-Nystatin Powder was scheduled for administration at 8:00am and 8:00pm.
-Nystatin Powder was documented as administered twice daily from 07/01/25 - 07/23/25 (8:00am).

Observation of Resident #8's medications on hand on 07/23/25 at 10:23am revealed:
-There was a 30-gram bottle of Nystatin 100,000 units/gram Topical Powder dispensed on 05/14/25.
-The instructions were to apply a small amount topically under breasts 2 times a day until area healed.

Interview with Resident #8 on 07/23/25 at 9:56am revealed:
-The MAs usually applied the Nystatin powder between her breasts.
-She did not think she currently had a rash under her breasts.

Interview with the MA on 07/23/25 at 10:24am revealed:
-She usually applied the Nystatin Topical Powder under Resident #8's breasts because the skin was red and sometimes she put it between the resident's breasts if that area was red.
-She did not put Nystatin Topical Powder under the resident's breasts that morning on 07/23/25 because she helped the resident get dressed that morning and thought it was clear with no redness under her breasts.
-She did not check again during the medication pass.
-She had not thought to notify the resident's primary care provider (PCP) that the resident sometimes had redness between her breasts.

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D 358	Continued From page 26 Observation of Resident #8 on 07/23/25 at 10:32am revealed: -There was a pink rash on the skin under the resident's right breast. -There was no rash or discoloration on the skin under the resident's left breast. -There was a pink rash on the skin between the resident's breasts. Second interview with Resident #8 on 07/23/25 at 10:32am revealed: -She had rashes at times underneath and between her breasts. -The rashes sometimes itched. -She denied any current itching on the skin underneath her breasts or between her breasts. Interview with the Operations Manager on 07/23/25 at 10:40am revealed: -She was responsible for oversight of the MAs on a daily basis. -The MAs should follow the order and apply the Nystatin Powder as instructed in the order, underneath the resident's breasts. -The MA should have used telemed to notify the PCP that the resident had a rash between her breasts so the PCP could give an order to apply the Nystatin Powder to that area as well. Attempted telephone interview with Resident #8's PCP on 07/23/25 at 3:52pm was unsuccessful. 2. Review of the facility's Policy and Procedure for Insulin Administration dated 01/06/25 revealed: -Once opened, insulin vials or pens must be labeled with the date opened and stored at room temperature unless otherwise directed. -Opened insulin is considered expired 28 days after opening unless specified differently by the manufacturer.	D 358		

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D 358	Continued From page 27	D 358		

-Staff must check expiration dates regularly and discard expired insulin immediately following facility policy and biohazard procedures.

Review of Resident #3's current FL-2 dated 07/21/25 revealed:
-Diagnoses included type 2 diabetes, hypothyroidism, schizoaffective disorder, and bipolar disorder.
-There was an order for Humulin R insulin 5 units subcutaneously 3 times a day with meals. (Humulin R is short-acting insulin used to lower blood sugar.)

Review of Resident #5's prescription dated 01/07/25 revealed an order for Humulin R insulin 5 units 3 times a day with meals, hold for blood sugar less than (<) 110.

Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Humulin R insulin 5 units 3 times a day with meals, hold for blood sugar < 110.
-Humulin R insulin was scheduled at 8:00am, 12:00pm, and 6:00pm.
-Humulin R insulin was documented as administered 3 times a day except on 10 occasions when the resident's blood sugar was documented as < 110.
-The resident's blood sugar ranged from 79 - 265 from 06/01/25 - 06/30/25.

Review of Resident #5's July 2025 eMAR revealed:
-There was an entry for Humulin R insulin 5 units 3 times a day with meals, hold for blood sugar < 110.
-Humulin R insulin was scheduled at 8:00am,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL007025	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANTEGO REST HOME	143 SWAMP ROAD PANTEGO, NC 27860

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D 358	Continued From page 28	D 358		

12:00pm, and 6:00pm.
-Humulin R insulin was documented as administered 3 times a day except on 11 occasions when the resident's blood sugar was documented as < 110.
-The resident's blood sugar ranged from 82 - 254 from 0701/25 - 07/22/25.

Observation of Resident #3's medications on hand on 07/22/25 at 4:10pm revealed:
-There was a vial of Humulin R insulin dispensed on 06/06/25.
-There was an auxiliary sticker on the vial with an area to document the date opened.
-The auxiliary sticker indicated to discard the insulin after 28 days.
-There was no open date documented on the auxiliary sticker or on the manufacturer's box.
-The vial had been opened and was approximately half full.
-There was no other Humulin R insulin on hand for the resident.

Interview with a medication aide (MA) on 07/22/25 at 4:17pm revealed:
-The MAs were supposed to document the opened date on all insulins.
-The insulin usually expired after 28 days of opening the vial.
-The MAs were not supposed to administer expired insulin.
-He thought the Humulin R insulin vial may have been opened around the time it was dispensed but he was not sure.
-The Humulin R vial dispensed on 06/06/25 was the one he had been using to administer to the resident, and it was the only one on hand.
-He had not noticed there was no opened date written on the label.
-He would order a new vial of Humulin R insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL007025	A. BUILDING: _____ B. WING _____	07/23/2025

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D 358	Continued From page 29 for the resident today, 07/22/25. Review of Resident #3's pharmacy dispensing records dated 01/01/25 - 07/23/25 revealed: -One vial of Humulin R insulin was dispensed on 01/08/25. -One vial of Humulin R insulin was dispensed on 02/18/25. -One vial of Humulin R insulin was dispensed on 06/06/25. -One vial of Humulin R insulin was dispensed on 07/23/25. Interview with the Operations Manager on 07/23/25 at 5:15pm revealed: -The MAs were supposed to document the opened date on all insulin vials and pens. -The insulin should be discarded 28 days after opening. -The MAs were not supposed to administer expired insulin. -Resident #3's Humulin R insulin should not have been administered if the MAs did not know when it was opened and were not sure when it expired. -Since it was dispensed on 06/06/25, over 28 days ago, the MA should order a new vial. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/23/25 at 3:52pm was unsuccessful.	D 358		