STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Fayetteville	2461 Legion Road Fayetteville, NC 28306

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Consultant Pharmacist, and Physician, the facility failed to ensure documentation of administered doses of Resident # 1's seizure medication could be accurately reconciled with the number of tablets dispensed from the pharmacy and removed from Resident # 1's supply of seizure medication, which could indicate the possibility that the seizure medication may not have been given as ordered or that staff were borrowing the medication from other residents' supplies. This was for 1 of 2 residents whose medications were reviewed (Resident # 1). The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE]. The resident's diagnoses included a history of subarachnoid hemorrhage with shunt placement and epilepsy. Medications listed on the 5/6/26 hospital discharge summary included two medications for Resident # 1's epilepsy. One of these two medications was Levetiracetam 750 mg (milligrams) two tablets two times per day.Review of facility admission orders, dated 5/6/26, revealed Resident # 1 was ordered to receive the Levetiracetam 750 mg (milligrams) two tablets two times per day along with the other ordered seizure medication.Review of Resident # 1's May 2026 MAR revealed the Levetiracetam 750 mg two tablets was scheduled to be given at 9:00 AM and 9:00 PM. Between the dates and times of 5/7/26 at 9:00 AM and 5/24/26 at 9:00 AM, there were 35 times the Levetiracetam was documented as administered. This documentation indicated the Levetiracetam had been administered as ordered. Given that two tablets were ordered to be given with each administration time, this indicated there should have been 70 tablets total administered between these dates and times.A facility pharmacist was interviewed on 6/2/26 at 2:01 PM and reported the following information. The pharmacy's records showed the pharmacy first sent Resident # 1's supply of Levetiracetam 750 mg on the night of 5/7/26. On 5/7/26 the pharmacy dispensed 56 tablets, and this was the only supply dispensed prior to the night of 5/24/26 when the pharmacy dispensed 56 more tablets. According to the pharmacist, if given correctly, Resident # 1 would have run out of medication prior to 5/24/26. The pharmacist did not stipulate when the facility had reordered the medication for it to be sent on the night of 5/24/26. The pharmacy records showed that the facility staff only removed Levetiracetam from the facility's back up supply one time from 5/7/26 to 5/24/26 for Resident # 1. This was on 5/24/26 when they signed out two 500 mg tablets and two 250 mg tablets at 9:45 AM. The pharmacist reported the staff should not be borrowing from other residents' supply of medications. According to the pharmacist, the new supply of 56 tablets of Levetiracetam 750 mg was sent to the facility on the night of 5/24/26.Review of nursing notes revealed an entry on 5/24/26 at 3:32 PM that Resident # 1 was transferred to the hospital when her whole body was observed to be twitching. Review of a hospital Discharge summary, dated [DATE], revealed Resident # 1 was hospitalized from [DATE] through 5/28/26 due to having a seizure. Review of the 5/28/26 discharge summary revealed upon discharge Resident # 1's Levetiracetam dosage was changed. The new Levetiracetam dosage was 500 mg two tablets two times per day.Review of facility admission orders revealed an order on 5/28/26 for Levetiracetam 500 mg two tablets two times per day.Review on 6/2/26 of Resident # 1's May and June 2026 MARs revealed since Resident # 1's readmission date (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 5/28/26, Resident # 1 had been documented to receive the ordered Levetiracetam 500 mg two tablets 10 times. The ten documented times were between the dates and times of 5/28/26 at 9:00 PM and 6/2/26 at 9:00 AM and which indicated the Levetiracetam 500 mg two tablets two times per day had been given correctly. Given that the 500 mg two tablets had been administered 10 times, this indicated that 20 tablets should have been removed from Resident # 1's supply or from the facility's back up supply.On 6/2/26 at 5:25 PM Resident # 1's Levetiracetam supply of 750 mg tablets, which had been filled on 5/24/26 by the pharmacy, was observed with the DON (Director of Nursing.) There were eight tablets punched out of the bubble card from Resident # 1's supply of 750 mg Levetiracetam tablets which had been dispensed after the resident was transferred to the hospital on 5/24/26. The DON was interviewed at this time as to why any doses would have been punched out from this Levetiracetam supply given that this 5/24/26 Levetiracetam supply was dispensed after the resident was discharged and upon readmission her dosage was no longer 750 mg. The DON reported she did not have an answer to that.Resident # 1's new supply of Levetiracetam 500 mg was also observed with the DON on 6/2/26 at 5:25 PM. The card noted the Levetiracetam had been filled on 5/29/26. There were twelve tablets punched out from the Levetiracetam 500 mg card. The DON was interviewed regarding the discrepancy between the MAR reflecting that 20 tablets of Levetiracetam 500 mg had been administered since 5/28/26 while the Levetiracetam supply cards showed that 8 tablets of 750 mg were punched after 5/24/26 and 12 tablets of 500 mg had been punched out from the 500 mg supply. The DON reported she had talked to some of the nurses who had been documenting the administration and they had reported that there was more on the cart from where the nurses could have obtained the correct dosage, but she was not sure at that time where the doses had specifically been taken from. According to the DON, the nurses were not supposed to borrow, and the MAR documentation should be able to be reconciled with the medication that was dispensed for Resident # 1.During an interview with the facility's Consultant Pharmacist on 6/3/26 at 11:42 AM, the Consultant Pharmacist reported that nursing staff should not be borrowing medications. The facility staff should order medications to get them in stock for administration availability. If staff were totally out of a resident's medication before a medication could be dispensed, then they should acquire the medication from the facility's back up medication supply or order it to be delivered from the pharmacy stat (right away).During an interview with Medication Aide (MA) # 1 on 6/3/26 at 11:10 AM (who had been responsible for the first documented dose of Levetiracetam on 5/7/26 at 9:00 AM), MA # 1 reported there were other residents on Levetiracetam, and she had borrowed medication for Resident # 1 from another resident on that specific date.During an interview with the DON on 6/3/26 at 9:05 AM the DON confirmed that other residents in the facility were receiving Levetiracetam which would indicate the possibility that some doses may have been borrowed.Resident # 1's Physician was interviewed on 6/3/26 at 12:45 PM and reported that when Resident # 1 seized on 5/24/26, Resident # 1 was on an antibiotic (Levaquin) which could lower the threshold for seizure activity.