STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on December 17, 2025 through December 19, 2025.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#1, #5) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health. The findings are: Review of the facility's Tuberculosis (TB) Screening/Testing policy for Residents, revised January 2025 revealed: -Residents will be screened or tested for TB per state guidelines. -Testing should be performed on each new resident within three months prior to admission or	D 234		

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D 234	Continued From page 1	D 234		

within one week of admission or per state regulation.
-Testing methods may include Mantoux skin test-using the two-step method, chest x-ray, whole blood assay, or physician/healthcare certification that includes verification of the test results.

1. Review of Resident #5's current FL2 dated 06/23/25 revealed:
-Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.
-She was intermittently disoriented.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 06/20/25.

Review of Resident #5's records revealed:
-She had a TB test given on 06/13/25 and read as negative on 06/16/25.
-She did not have documentation that a second-step TB test was completed.

Attempted telephone interviews with Resident #5's hospice provider on 12/19/25 at 10:07am and 2:17pm were unsuccessful.

Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:54pm.

Refer to interview with the Administrator on 12/19/25 at 4:07pm.

2. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Resident #1 had a diagnosis of unspecified anemia.
-The recommended level of care was domiciliary.

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D 234	Continued From page 2 Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25. Review of Resident #1's records revealed: -Resident #1 had a TB test given on 6/17/25 and read as negative on 06/20/25. -Resident #1 did not have documentation that a second-step TB test was completed. Interview with the Area Nurse Manager on 12/18/25 at 3:48pm revealed there was not a second step TB test for Resident #1. Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:54pm. Refer to interview with the Administrator on 12/19/25 at 4:07pm. _____ Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:54pm revealed: -The Health and Wellness Director (HWD) or the HWC were responsible to make sure each resident had a two-step TB skin test. -The facility no longer had a HWD. -The facility utilized a compliance tracker to keep up with reminders for the residents such as due dates for care plans and TB skin tests. -Information was entered into the compliance tracker and a reminder for TB skin test was placed on the calendar. -She checked the compliance tracker weekly. -It was an oversight that the residents did not have their second TB skin tests. -TB testing was important to make sure the residents were not exposed to TB.	D 234		

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D 234	Continued From page 3 Interview with the Administrator on 12/19/25 at 4:07pm revealed: -It was the responsibility of the HWD or the HWC to make sure each new resident had TB testing completed upon admission to the facility. -For a new resident with no TB test, the primary care provider (PCP) was contacted and encouraged to provide a TB test. -If a resident was admitted, then follow up with the HWD or the HWC, and PCP was required to make sure the two-step TB tests were completed. -It was important for each resident to have TB screening to prevent the introduction of a communicable disease to the community.	D 234		
D 238	10A NCAC 13F .0703 (f) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to clarify an FL-2 for 1 of 5 sampled residents related to an order for a resident with an order for insulin (#1).	D 238		

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D 238	Continued From page 4 The findings are: Review of Resident #1's most recent FL-2 dated 10/30/25 revealed: -Resident #1 had a diagnosis of unspecified anemia. -The recommended level of care was domiciliary. -Resident #1's ambulatory status was documented as both semi-ambulatory and non-ambulatory. -The resident required personal care assistance with bathing and dressing. -Resident #1 was incontinent of bowel and bladder. -Resident #1 was admitted to the facility from a skilled nursing facility. -There was an order for "Humalog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 0-200 = 0 units Notify provi" (Humalog KwikPen is a device used to deliver fast acting insulin to control blood sugar). -There was not an order to check fingerstick blood sugars (FSBS). Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25. Review of a Hospital Discharge Summary dated 11/14/25 revealed: -Resident #1 was sent to the hospital due to hypotension and bradycardia. -She was admitted on 11/11/25 and discharged on 11/14/25. -There was an order for Insulin lispro 100 unit/mL give subcutaneous four times a day before meals and bedtime (Insulin Lispro is a fast-acting insulin given to control blood sugar).	D 238		

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D 238	Continued From page 5 Review of Resident #1's November 2025 electronic medication administration record (eMAR) revealed: -There was not an entry for Humalog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML. -There was an entry for Insulin Lispro Injection Solution, inject as per sliding scale: 181-200 = 1 unit; 201-250 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 5 units and if greater than 400 call the physician, subcutaneously before meals and at bedtime. Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed: -Resident #1's Humalog pens only came from the facility's contracted pharmacy. -Sometimes there was a change in the hospital. -The current Humalog pen was from the facility's contracted pharmacy. -The sliding scale was applied as it was listed on the eMAR entry. -She did not know of any clarifications made for the sliding scale insulin orders on 10/30/25. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed: -MA's and the Health and Wellness Director (HWD) made sure medications were on the cart and performed cart audits every two weeks. -She would compare medications on the cart to the eMAR. -If MA's entered an order then a 2nd MA or HWC should check behind using a medication tracking form. -If an MA entered orders, she would check behind them. -Prior to Resident #1's rehabilitation stay, she was on sliding scale insulin.	D 238		

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-She guessed that staff used the old sliding scale.
-The MA's looked at what was on the eMAR and would not review the FL-2.
-The HWD would review the FL-2 and make the entry to the eMAR.
-In the absence of the HWD, she could make the entry to the eMAR.
-The previous HWD did Resident #1's admission for the 10/30/25 FL-2.

Interview with the Area Nurse Manager on 12/18/25 at 3:00pm revealed:
-MA's, the HWD, or the HWC entered orders into the eMAR.
-If an option called "choose standard MAR" was selected then the order would show on the eMAR.
-When medication arrived then clinical managers verified that the eMAR was completed.
-The facility received copies of orders that were sent directly to the pharmacy.
-She was unable to locate any clarification of the sliding scale insulin on the FL-2

Interview with the Administrator on 12/19/25 at 4:08pm revealed:
-There would need to be an update in the order for sliding scale insulin if there was a change in the sliding scale.
-There needed to be a sliding scale with the order for insulin.
-Anytime there was a question about medication, staff should check with the HWD or primary care provider (PCP).

Telephone interview with the primary care provider for Resident #1 on 12/19/25 at 1:48 pm revealed:
-The eMAR entry for Resident #1's sliding scale insulin was appropriate.
-Clarification was expected if staff could not see

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D 238	Continued From page 7 the sliding scale on the FL-2.	D 238		
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 daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring,	D 253		

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D 253	Continued From page 8 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 interviews, and record review, the facility failed to ensure 3 of 5 sampled residents (#2, #3 and #5) had assessments completed within 30 days of admission and annually.	D 253		

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D 253	Continued From page 9 The findings are: Review of the facility's Evaluation Process Policy revised November 2024 revealed: -Residents should be evaluated to determine the level of care and services needed or requested utilizing various systems and processes (e.g. personal services systems (PSS), software programs, physician/healthcare provider orders). -The evaluations will be used to determine the price for needed care and services or other requests by the resident and family/responsible party. -Once service needs are determined, specifics of the services required and or requested will be documented in the service plan. -A trained facility associate (e.g. Executive Director, Health and Wellness Director (HWD), Assisted Living Director (ALD), Nurse) should complete an evaluation(s) prior to the resident's move into a community. -A sales and marketing representative may gather resident information and should communicate this information to the HWD/Nurse. -The final resident evaluation should be completed by a licensed nurse or registered nurse (RN) if required per state regulations at move-in, within 14-30 days of move-in, every 6 months or as required more frequently by state regulatory requirements, and as soon as possible after a change in condition that results in altered care needs over a period of greater than two weeks. -The evaluation should be completed in the presence of the resident with their requests and/or preferences considered whenever possible. -Additional potential information sources may include the resident's family as requested, legally	D 253		

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responsible party, ombudsman, the physician plan of care, hospital, nursing home, and any other pertinent 3rd party provider of care such as home health, hospice, etc.
-Evaluation results should be entered into the software programs and the original forms signed by a community representative, and resident or responsible party.
-The signed form should be placed in the resident record.
-The original and most recent copies of the evaluation should be kept in the resident record.
-Old copies of resident evaluations should be stored and retained according to the records retention policy.

1. Review of Resident #2's current FL2 dated 05/28/25 revealed:
-Diagnoses included chronic atrial fibrillation, non-rheumatic aortic valve disorder, peripheral vascular disease and hypertension.
-He was constantly disoriented.

Review of Resident #2's Resident Register revealed he was admitted to the facility on 02/21/24.

Review of Resident #2's care plan dated 04/01/24 revealed:
-The resident used a walker as a mobility aid and was independent with ambulation.
-He required staff assistance with medication management; he was able to administer his eye drops independently.
-He had hypertension, hyperlipidemia, chronic atrial fibrillation, peripheral vascular disease, hypothyroidism, rheumatic aortic valve disorder with an artificial valve, and per family history during the assessment, he had a diagnosis of heart failure as well.

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-He was independent with eating.
-He was independent with toileting, bathing, dressing, personal hygiene, grooming and transferring.
-The care plan was signed by the Health and Wellness Director (HWD) on 04/03/24.
-The care plan was signed by a primary care provider (PCP) on 04/05/24.

Review of Resident #2's 10/08/24 care plan revealed:
-He took seven or more medications.
-He required staff assistance with medications; he was able to administer his eye drops independently.
-He had a history of cardiac arrhythmia.
-He had hypertension, hyperlipidemia, chronic atrial fibrillation, peripheral vascular disease, hypothyroidism, rheumatic aortic valve disorder with an artificial valve, and per family history during the assessment, he had a diagnosis of heart failure as well.
-He was independent with eating.
-He diet was no added salt.
-He did not require dressing and grooming assistance.
-He did not require showering and bathing assistance.
-He did not require bathroom assistance.
-He used a walker as a mobility aid.
-He was independent going to and from the dining room or community activities.
-The care plan was signed by the HWD only on 10/08/24.
-The was no PCP signature on the care plan signature page.

Review of Resident #2's 11/07/25 care plan revealed:
-He took seven or more medications.

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D 253	Continued From page 12 -He required staff assistance with medications; he was able to administer his eye drops independently. -He had a history of cardiac arrythmias. -He had hypertension, hyperlipidemia, chronic atrial fibrillation, peripheral vascular disease, hypothyroidism, rheumatic aortic valve disorder with an artificial valve, and per family history during the assessment, he had a diagnosis of heart failure as well. -He was independent with eating. -He diet order was no added salt. -He did not require dressing and grooming assistance. -He did not require showering and bathing assistance. -He did not require bathroom assistance. -He used a walker as a mobility aid. -He was independent going to and from the dining room or community activities. -The care plan was signed by the HWD only on 11/08/25. -The care plan was signed by Resident #2's responsible party (RP) on 12/18/25. -The was no PCP signature on the care plan signature page Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/19/25 at 11:19am was unsuccessful. Refer to interview with the medication aide (MA) on 12/19/25 at 10:28am. Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:44pm. Refer to interview with the Administrator on 12/19/25 at 4:11pm.	D 253		

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D 253	Continued From page 13 2. Review of Resident #5's current FL2 dated 06/23/25 revealed: -Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema. -She was intermittently disoriented. Review of Resident #5's Resident Register revealed she was admitted to the facility on 06/20/25. Review of Resident #5's care plan dated 06/24/25 revealed: -The resident self-administered medications. -The resident took seven or more medications. -The resident took narcotic medications. -The resident took benzodiazepine medications. -The resident had heart failure. -The resident had chronic persistent pain. -The resident had a history of depression. -The resident had a history of cardiac arrythmias. -She did not require dressing and grooming assistance. -She did not require showering or bathing assistance. -She was incontinent of bladder but did not require bathroom assistance. -Hospice assisted with showering. -Provide staff attention and/or verbal prompts to and from the dining room and/or community activities as needed. -Provide physical assistance to and from the dining room and/or community activities as needed. -Be alert to heightened risk for falling. -The resident had fallen in the last 12 months. -The resident had fallen without apparent harm/injury. -The resident used a walker as a mobility aid. -There were no signatures on the 06/24/25 care	D 253		

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D 253	Continued From page 14 plan signature page. Review of Resident #5's care plan dated 08/04/25 revealed: -The resident self-administered medications. -The resident took seven or more medications. -The resident took narcotic medications. -The resident took benzodiazepine medications. -The resident had heart failure. -The resident had chronic persistent pain. -The resident had a history of depression. -The resident had a history of cardiac arrhythmia. -She did not require dressing and grooming assistance. -She did not require showering or bathing assistance. -She was incontinent of bladder but did not require bathroom assistance. -Hospice assisted with showering. -The resident was independent going to and from the dining room or community activities. -Be alert to heightened risk for falling. -The resident had fallen in the last 12 months. -The resident had fallen without apparent harm/injury. -The resident used a walker as a mobility aid. -There were no signatures on the 08/04/25 care plan signature page. Review of Resident #5's care plan dated 08/21/25 revealed: -Order and coordinate medications between family, health care providers and pharmacy. -The resident self-administered medications. -The resident took seven or more medications. -The resident took narcotic medications. -The resident took benzodiazepine medications. -The resident had heart failure. -The resident had chronic persistent pain. -The resident had a history of depression.	D 253		

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-The resident had a history of cardiac arrhythmia.
-She did not require dressing and grooming assistance.
-She did not require showering or bathing assistance.
-She was incontinent of bladder but did not require bathroom assistance.
-The resident had a bedside commode in her room provided by hospice services.
-Hospice assisted with showering.
-The resident was independent going to and from the dining room or community activities.
-Be alert to heightened risk for falling.
-The resident had fallen in the last 12 months.
-The resident had fallen without apparent harm/injury.
-The resident used a walker as a mobility aid.
-There were no signatures on the 08/21/25 care plan signature page.

Attempted telephone interviews with Resident #5's hospice provider on 12/19/25 at 10:07am and 2:17pm were unsuccessful.

Refer to interview with the medication aide (MA) on 12/19/25 at 10:28am.

Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:44pm.

Refer to interview with the Administrator on 12/19/25 at 4:11pm.

3. Review of Resident #3's current FL2 dated 11/21/25 revealed:
-Diagnoses included mild cognitive impairment, anxiety disorder, hypertension, and hyperlipidemia.
-The resident was intermittently disoriented and was ambulatory.

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D 253	Continued From page 16 Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/27/22. Review of Resident #3's care plan dated 09/20/24 revealed: -The resident took benzodiazepine medications. -The resident had mild cognitive impairment, anxiety, hypertension, and hyperlipidemia. -The resident was able to dress and groom herself but required physical assistance as needed. -The resident required physical assistance with toileting. -The resident required staff to pay attention to her and/or provide verbal prompts when the resident ambulated. -The resident had fallen in the last 12 months. -The care plan was signed by facility staff on 09/20/24. -There was a signature on the care plan from the resident's primary care provider (PCP) dated 10/15/24. Attempted telephone interview with Resident #3's PCP on 12/19/25 at 2:30pm was unsuccessful. Refer to interview with the medication aide (MA) on 12/19/25 at 10:28am. Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:44pm. Refer to interview with the Administrator on 12/19/25 at 4:11pm. _____ Interview with the medication aide (MA) on 12/19/25 at 10:28am revealed the Health Wellness Coordinator (HWC) or the Health and	D 253		

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D 253	Continued From page 17 Wellness Director (HWD) did care plan assessments for the residents. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:44pm revealed: -The previous Health and Wellness Director (HWD) was responsible for the residents' care plan. -The HWD left in October 2025, and she was trying to catch up on care plans. -She ran a "due and error report" that included residents that were due for care plans. -She was not sure who entered the resident's data into the "due and error report". -The residents had a care plan upon admission and updated every 6 months or if there was a significant change in condition. -Having updated care plans was important so that staff would know the level of care and tasks needed for each resident. Interview with the Administrator on 12/19/25 at 4:11pm revealed: -The HWD was responsible for completing care plans for the residents. -The facility no longer had a HWD and in the absence of the HWD, the HWC was responsible for completing the care plans for the residents. -The resident care plan was important because it served as the contract between the community and the resident and indicated the care to be provided to the resident.	D 253		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a	D 254		

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resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:
(1) Significant change is one or more of the following:
(A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating;
(B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury;
(C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma;
(D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a

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D 254	Continued From page 19 six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care.	D 254		

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This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to update the care plan in a timely manner for 1 of 1 resident (#1) following significant changes in her functional status for locomotion, dressing, grooming, bathing, and toileting.

The findings are:

Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Resident #1 had a diagnosis of unspecified anemia.
-Resident #1 was admitted from a skilled nursing facility.
-The recommended level of care was domiciliary.
-Resident #1's ambulatory status was documented as both semi-ambulatory and non-ambulatory.
-The resident required personal care assistance with bathing and dressing.
-Resident #1 was incontinent of bowel and bladder.

Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25.

Review of a care plan for Resident #1 dated 06/20/25 revealed:
-Resident #1 required assistance with medications
-Resident #1 required assistance to manage

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D 254	Continued From page 21 chronic conditions including diabetes. -Resident #1 was independent with eating. -Resident #1 did not require assistance with dressing and grooming tasks. -Resident #1 did not require assistance with showering or bathing. -Resident #1 did not require bathroom assistance. -Resident #1 required supervision and verbal assistance with mobility using a walker. -Resident #1 was oriented to person, place and time and did not require communication assistance. -Resident #1 required assistance for service coordination. -The care plan was not signed by a representative of the facility. -The care plan was not signed by the resident or responsible party. -The care plan was not signed by a physician. Review of a care plan for Resident #1 dated 07/21/25 revealed: -Resident #1 required assistance with medications -Resident #1 required assistance to manage chronic conditions including diabetes. -Resident #1 was independent with eating. -Resident #1 did not require assistance with dressing and grooming tasks. -Resident #1 required physical assistance with showering or bathing. -Resident #1 did not require bathroom assistance. -Resident #1 was modified independent with mobility using a walker. -Resident #1 was not always oriented to time. -Resident #1 required assistance for service coordination -The care plan was not signed by a	D 254		

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representative of the facility.
-The care plan was not signed by the resident or responsible party.
-The care plan was not signed by a physician.

Review of a care plan for Resident #1 dated 12/01/25 revealed:
-Resident #1 required assistance with medications
-Resident #1 required assistance to manage chronic conditions including diabetes.
-Resident #1 required as needed (PRN) nebulizer treatments
-Resident #1 was independent with eating.
-Resident #1 required assistance with all dressing and grooming tasks.
-Resident #1 received required assistance with showering or bathing through hospice.
-Resident #1 needed staff attention for toileting and changing briefs when soiled.
-Resident #1 required assistance with mobility.
-Resident #1 required assistance with memory, was sometimes disoriented, and had difficulty with communication.
-Resident #1 required assistance for service coordination.
-The care plan was not signed by a representative of the facility.
-The care plan was not signed by the resident or responsible party.
-The care plan was not signed by a physician.

Observation of Resident #1 on 12/18/25 at 8:40am revealed:
-Resident #1 was brought to the dining hall via transport chair, receiving total assistance for locomotion.
-Resident #1 sat with family, self-feeding with set-up assistance.

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D 254	Continued From page 23 Interview with a personal care aide (PCA) on 12/18/25 at 13:01pm revealed: -Sometimes Resident #1 was not steady, so staff would help her get up. -Sometimes Resident #1 tried to get up without assistance, but staff helped and encouraged her to use the rolling walker. Interview with a second PCA on 12/19/25 at 2:32pm revealed: -Resident #1 required occasional assistance with mobility. -Staff was always there when Resident #1 moved around and Resident #1 used a necklace to call staff's pagers for assistance. -About 1 and a half months ago Resident #1 started requiring more assistance to the bathroom. -Resident #1 could get up by herself occasionally. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed: -Care plans were done by the Health and Wellness Director (HWD). -The HWD left in October. -She did care plans now, and took that over in October. -She ran a report in the computer to see that care plans needed to be signed. -Care plans need to be signed for a change of condition or every six months. -The HWD was responsible to make sure care plans were signed. -A "Due and error report" displayed care plans that needed to be signed. -Care plans were used to let staff know what the resident needed help with. -The importance of a care plan for significant change was to let staff know who needed	D 254		

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D 254	Continued From page 24 assistance. -Assignment sheets were printed once a week and care plan data went to the assignment sheet. -PCA's received the assignment sheets and it let staff know who needed assistance with tasks. -She tried to update care plan information as it happened. Interview with the Area Nurse Manager on 12/19/25 at 3:52pm revealed the HWD was responsible for care plans. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -The HWD was responsible for updated care plans. -In the absence of the HWD, the HWC was responsible to update the care plans. -Care plans were the contract with the facility and the residents as far as the care provided. -Care plans should be changed to reflect the resident's needs.	D 254		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the health care needs for 4 of 5 sampled residents including refusal of medications (#2, #5), delayed report to the physician following a change in a resident's condition (#1), and failure to schedule a follow up	D 273		

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appointment for a resident after she returned to the facility from the hospital from a fall with a laceration to her left eye (#3).

The findings are:

Review of the facility's Medication and Treatment Refusal policy revised August 2022 revealed:
-Residents have the right to refuse medications and treatments provided in the community.
-If a resident refuses a medication and/or treatment, the associate assisting with medications should continue to offer the medication and/or treatment again within the acceptable timeframe.
-Documentation of the refusal should be made in the medication and/or treatment record.
-For electronic medication administration record (eMAR) systems, the associate will document the appropriate chart code in the administration details that reflects the refusal, additional explanation of the refusal may be documented on the progress notes tab.
-The nurse or designee should contact the physician/healthcare provider and legally responsible party to report the refusal, if the refusal could jeopardize the health of the resident, the physician should be contacted immediately.
-The nurse or designee should document that the resident and legally responsible party have been informed of the consequence of the refusal.
-Documentation in the resident record should include physician/healthcare provider notification along with physician/healthcare provider instructions and responsible party notification.

1. Review of Resident #2's current FL2 dated 05/28/25 revealed:
-Diagnoses included chronic atrial fibrillation,

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non-rheumatic aortic valve disorder, peripheral vascular disease and hypertension.
-He was constantly disoriented.

Review of Resident #2's signed physicians order sheet dated 11/10/25 revealed an order polyethylene glycol (a medication used to treat constipation) 3350 17grams/scoop, one scoop one time a day for constipation, mix in 8 ounces of juice or water.

Review of Resident #2's November 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol 3350, give one scoop one time a day, mix with 8 ounces of juice or water scheduled at 9:00am.
-Polyethylene glycol was documented as not administered on 17 occasions between 11/11/25 and 11/30/25 at 9:00am with the exception documented as 02=med refused on each occasion.

Review of Resident #2's December 2025 eMAR revealed:
-There was an entry for polyethylene glycol 3350, give one scoop one time a day, mix with 8 ounces of juice or water scheduled at 9:00am.
-Polyethylene glycol was documented as not administered on 9 occasions between 12/01/25 and 12/11/25 at 9:00am with the exception documented as 02=med refused on each occasion.

Interview with the medication aide (MA) on 12/18/25 at 1:15pm revealed:
-If a resident refused their medications, she tried to encourage them to take it.
-The resident's primary care provider should be contacted after a resident refused their

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medications for 3 days.
-Resident #2 frequently refused his polyethylene glycol.
-She had not thought to notify Resident #2's primary care provider (PCP) of his multiple refusals of polyethylene glycol.

Second interview with the MA on 12/19/25 at 10:25am revealed:
-She had not notified Resident #2's PCP of his refusals of polyethylene glycol because he did not refuse it every day.
-In many cases, when medications were discontinued due to multiple refusals, the resident would decide later they wanted to take the medication, and a new order would be needed.

Interview with the Heath and Wellness Coordinator (HWC) on 12/19/25 at 2:58pm revealed:
-A resident's PCP was to be notified of medication refusals after three refused doses.
-A notification form was completed by the MA and sent to the resident's PCP via fax, notifying of the medication refusal and requesting either a medication change or discontinue order.
-She was not aware of Resident #2's multiple refusals of polyethylene glycol.
-Resident #2's PCP should have been notified of his multiple refusals of polyethylene glycol.

Attempted telephone interview with Resident #2's primary care provider on 12/19/25 at 11:19am was unsuccessful.

Refer to interview with the Administrator on 12/19/25 at 4:15pm.

2. Review of Resident #5's current FL2 dated 06/23/25 revealed:

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D 273	Continued From page 28 -Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema. -She was intermittently disoriented. -There was an order for aspirin (aspirin can be used as a blood thinner) 325mg, take one tablet daily. Review of Resident #5's signed physicians order sheet dated 11/06/25 revealed an order for aspirin 325mg, take one tablet daily related to cerebrovascular disease. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 325mg, one tablet one time a day scheduled at 9:00am. -Aspirin 325mg was documented as administered at 9:00am on 12/01/25 through 12/06/25. -Aspirin 325mg was documented as not administered at 9:00am on 12/07/25 through 12/11/25 with the exception documented as 02=med refused on each occasion. -Aspirin 325mg was documented as administered at 9:00am on 12/12/25. -Aspirin 325mg was documented as not administered at 9:00am on 12/13/25 and 12/14/25 with the exception documented as 02=med refused on both occasions. -Aspirin 325mg was documented as administered at 9:00am on 12/15/25 through 12/18/25. Interview with the medication aide (MA) on 12/18/25 at 1:15pm revealed: -If a resident refused their medications, she tried to encourage them to take it. -The resident's primary care provider (PCP) should be contacted after a resident refused their medications for 3 days.	D 273		

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D 273	Continued From page 29 -Resident #5 had recently had some teeth pulled and refused her aspirin quite a bit since. -She was not sure if she had contacted Resident #5's hospice provider about her refusal of aspirin but she planned to. Interview with the Heath and Wellness Coordinator (HWC) on 12/19/25 at 2:58pm revealed: -A resident's PCP was to be notified of medication refusals after three refused doses. -A notification form was completed by the MA and sent to the resident's PCP via fax, notifying of the medication refusal and requesting either a medication change or discontinue order. -She was not aware that Resident #5 had refused her aspirin 325mg on seven occasions in December 2025. -Resident #5's hospice provider should have been notified of her refusals of aspirin. Attempted telephone interviews with Resident #5's hospice provider at 10:07am and 2:17pm on 12/19/25 were unsuccessful. Refer to interview with the Administrator on 12/19/25 at 4:15pm. _____ Interview with the Administrator on 12/19/25 at 4:15pm revealed: -The MAs should always document medication or treatment refusals on the residents' eMAR. -The MAs were expected to notify the resident's PCP of repeated medication refusals. 3. Review of the facility's falls management policy dated October 2013 revealed: -Residents had the potential to fall and therefore the facility identified universal fall precautions applicable to residents. -A fall risk evaluation was to be completed at the	D 273		

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time of move in/admission or per state regulations. A witnessed or reported unwitnessed fall, with or without injury, was to be reported in the facility's incident reporting system.
-Residents who sustained a fall were to have a post fall evaluation completed to consider-possible interventions to reduce the potential for future falls and injury.
-The Executive Director (ED) was responsible for verifying that associates had completed the facility's falls management training course during orientation and should review annually thereafter.
-A fall risk evaluation was completed at the time of move-in or per state regulation.
-Resident falls were noted in the resident record and entered into the facility's incident reporting system.
-A post fall evaluation was to be completed after a resident fall, individualized interventions were to be considered, and the evaluation was a part of the resident record.
-When a fall occurred, staff was to assist the resident and provide first aid or call 911 as indicated and follow the directions of the 911 operator.
-When a fall occurred, staff was to notify the Health and Wellness Director (HWD)/nurse/designee and ED.
-When a fall occurred, staff was to notify the resident's physician/healthcare provider (HCP) for evaluation, care, and treatment if indicated and document in the resident record.

Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Resident #1 had a diagnosis of unspecified anemia.
-The recommended level of care was domiciliary.
-Resident #1's ambulatory status was documented as both semi-ambulatory and

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non-ambulatory.
-The resident required personal care assistance with bathing and dressing.
-Resident #1 was incontinent of bowel and bladder.
-Resident #1 was admitted to the facility from a skilled nursing facility.

Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25.

Review of a care plan for Resident #1 dated 06/20/25 revealed:
-Resident #1 did not require assistance with dressing and grooming tasks.
-Resident #1 did not require assistance with showering or bathing.
-Resident #1 did not require bathroom assistance.
-Resident #1 required supervision and verbal assistance with mobility using a walker.
-Resident #1 was oriented to person, place and time and did not require communication assistance.
-The care plan was not signed by a representative of the facility.
-The care plan was not signed by the resident or responsible party.
-The care plan was not signed by a physician.

Review of a care plan for Resident #1 dated 07/21/25 revealed:
-Resident #1 did not require assistance with dressing and grooming tasks.
-Resident # required physical assistance with showering or bathing.
-Resident #1 did not require bathroom assistance.
-Resident #1 was modified independent with

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mobility using a walker.
-Resident #1 was not always oriented to time.
-The care plan was not signed by a representative of the facility.
-The care plan was not signed by the resident or responsible party.
-The care plan was not signed by a physician.

Review of Provider Collaboration Notes from Occupational Therapy on 10/07/25 revealed:
-Resident #1 required assistance with transfers.
-Resident #1 required assistance with dressing.
-Resident #1 was using a transport chair.

Review of an incident report for Resident #1 revealed:
-Resident #1 fell at approximately 4:50pm on 10/11/25.
-There was no apparent harm / injury to Resident #1 after the fall on 10/11/25.
-There was no record of Resident #1's vital signs on the report.
-The HWD was notified of the fall on 10/11/25 at 5:10pm.
-Resident #1's family member was notified of the fall on 10/11/25 at 5:10pm.
-The provider was notified of the fall on 10/13/25 at 10:10am via fax.
-The Health and Wellness Coordinator (HWC) approved the report on 10/13/25 at 9:14am.

Review of Progress Notes for Resident #1 revealed:
-A note entered on 10/12/25 at 6:36am revealed the Resident #1 had been up all shift, walking in the hallway and 200 hall parlor, yelling for the nurse, and went to the bathroom on her own.
-A note entered on 10/12/25 at 2:39pm revealed Resident #1 had been yelling constantly all day and requiring staff to help her to the bathroom

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every 15 or 20 minutes.
-A note entered on 10/12/25 at 10:42pm reported Resident #1 was transferred to the hospital by emergency medical services (EMS) on 10/12/25 at approximately 8:20pm.
-A note entered on 10/12/25 at 10:43pm reported Resident #1 was short of breath due to being changed and transported from chair to bed; Resident #1 could not catch her breath; No as needed (PRN) treatment was available, so Resident #1 was monitored; A sitter noticed Resident #1's pupils were two different sizes; The writer checked and left pupil was "tiny" and the right pupil was "huge"; The writer asked Resident #1 if she was okay and the resident responded "to my knowledge I am."; The writer called the HWD and HWC to inform them.

Review of a Hospital Discharge Summary for Resident #1 dated 10/20/25 revealed:
-Resident #1 was admitted on 10/12/25 and discharged on 10/20/25
-Resident #1 was admitted for acute on chronic anemia.
-Hospital problems included complicated UTI secondary to pyelonephritis, hypertension, acute encephalopathy, acute on chronic anemia, CKD stage IV, permanent atrial fibrillation, and type 2 diabetes.
-A 7-day course of Ceftriaxone was completed for Resident #1's urinary tract infection and pyelonephritis (Ceftriaxone is an antibiotic medication used to treat infections).

Telephone interview with a family member for Resident #1 on 12/18/25 at 3:57pm revealed:
-Care for Resident #1 was difficult and she may have to move to memory care.
-There were conversations with staff about memory care, but they had not made a decision.

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D 273	Continued From page 34 -Resident #1 was under hospice care and they wanted to keep her out of the hospital. -Resident #1 had been hospitalized with body organ systems failures. -Resident #1's medications were in flux with hospice and her dementia issues. -The facility was doing what it could to prevent falls, but Resident #1 did not call for help and tried to get up without using a device. -Since June, Resident #1 had been hospitalized seven or eight times, he could not remember. -Outside help was in the room for Resident #1 at night, hired for supervision between 12:00am and 6:00am Interview with an MA on 12/19/25 at 1:28pm revealed -She wrote the progress note for Resident #1 at 2:39pm on 10/12/25. -Resident #1 was agitated and she put in the progress note. -The HWD and HWC were notified on 10/12/25. -She was not sure what happened next. Interview with Area Nurse Manager on 12/19/25 at 3:52pm revealed staff should notify the HWD about Resident #1 on 10/12/25 to get guidance from the nurse and follow that guidance. Interview with the HWC on 12/19/25 at 2:45pm revealed for incidents, the primary care provider (PCP) was notified so that the PCP would be aware of what was happening with the resident. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -If there was a change in the resident's behavior they would try to notify the HWD. -Going to the bathroom every 15 minutes was not normal and was a change in Resident #1's	D 273		

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baseline.

Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed:
-The facility was doing everything that it could for Resident #1's falls.
-Resident #1 would fall with a sitter in the room, and Resident #1 did physical therapy.
-She would have to review the chart to comment on 10/12/25.
-Resident #1 had a history of different pupil sizes.
-She did not know if she was notified on 10/12/25 and could not say what her expectations were.

4. Review of Resident #3's current FL2 dated 11/21/25 revealed:
-Diagnoses included mild cognitive impairment, anxiety disorder, hypertension, and hyperlipidemia.
-The resident was intermittently disoriented and was ambulatory.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/27/22.

Review of Resident #3's care plan dated 09/20/24 revealed:
-The resident took benzodiazepine medications.
-The resident had mild cognitive impairment, anxiety, hypertension, and hyperlipidemia.
-The resident was able to dress and groom herself but required physical assistance as needed.
-The resident required physical assistance with toileting.
-The resident required staff to pay attention to her and/or provide verbal prompts when the resident ambulated.
-The resident had fallen in the last 12 months.

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D 273	Continued From page 36 Review of an Incident Report for Resident #3 dated 12/11/25 revealed: -The resident had an unwitnessed fall in her bedroom on 12/11/25 at 9:00pm. -The resident had bruising, a cut, and swelling to her left eye. -First aid was applied; the resident's blood pressure was 168/83 with a pulse of 142. -Staff called 911 and the resident was transported to the local emergency department. -There was a narrative that the resident was found sitting on her bottom on the floor beside her bed, the resident had significant bleeding and bruising to her left eye, the resident was sent to the local emergency department for further evaluation. -There was documentation that the Health and Wellness Coordinator (HWC) was notified of the incident on 12/11/25 at 9:05pm. -There was documentation that the resident's family was notified of the incident on 12/11/25 at 9:10pm. -There was documentation that the resident's primary care provider (PCP) was notified of the incident on 12/18/25 at 5:00pm. -There was documentation that the Adult Home Specialist (AHS) with the local Department of Social Services (DSS) was notified of the incident on 12/18/25 at 5:30pm. Review of an After Visit Summary from the local emergency department for Resident #3 dated 12/11/25 revealed: -The resident was diagnosed with an accidental fall with left eye injury with a superficial laceration of the left eye. -There were instructions to schedule an appointment with the resident's PCP "as soon as possible for a visit in 2 days" (around 12/14/25).	D 273		

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D 273	Continued From page 37 Review of an electronic progress note for Resident #3 dated 12/12/25 revealed: -There was an entry at 2:00am that the resident returned to the facility by ambulance. -The resident had a superficial laceration to her left eye; there were no medication changes. -There was documentation "follow up appointment" with the resident's PCP. Review of an electronic progress note for Resident #3 dated 12/12/25 at 2:29pm revealed the resident complained of pain and was administered a prn Tylenol for pain. Interview with a medication aide (MA) on 12/19/25 at 10:13am revealed: -MAs were responsible for notifying the resident's PCP of a return to the facility from the local emergency department. -MAs were responsible for scheduling the resident's follow up appointment with their PCP if it was ordered on the After Visit Summary from the hospital. -If a resident returned to the facility during hours that the PCP office was not open, the MA was expected to report to the next shift MA that an appointment needed to be made for the resident. -MAs had access to the appointment and transportation book and documented when they scheduled a resident's appointment in the book. -She was not working when Resident #3 was sent to the local emergency department, but the MA on duty or the MA that came on first shift should have made the resident's follow up appointment with Resident #3's PCP. -If the MA was too busy to make the appointment, the MA could ask the Health and Wellness Director (HWD) or HWC to schedule the appointment for the resident.	D 273		

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D 273	Continued From page 38 Interview with the HWC on 12/19/25 at 2:58pm revealed: -The MA that was working when Resident #3 returned to the facility from the local emergency department should have scheduled the resident's follow up appointment with her PCP. -The resident needed to be seen by the PCP because there was a discharge order for her to be seen and she had an injury to her left eye from an unwitnessed fall. -If the MA was not able to schedule the resident's appointment, the MA should have reported the need for the referral to the MA that was coming on the next shift. -The MA that came on for the new shift should have scheduled the resident's appointment with her PCP. -When a MA received an After Visit Summary for a resident, they were supposed to place a copy of the report in her box so she could follow up on the what the resident needed. -She had not seen the After Visit Summary for Resident #3 after her fall on 12/11/25. Interview with an Area Nurse Manager on 12/18/25 at 2:07pm revealed: -Resident #3 had not seen her PCP since she fell and went to the local emergency department on 12/11/25. -The HWD, HWC or a MA should have scheduled the resident's follow up appointment with her PCP following her fall. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -The MA on duty when Resident #3 returned to the facility on 12/12/25 should have followed instructions on the After Visit Summary report. -The MAs were able to schedule appointments in	D 273		

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D 273	Continued From page 39 the appointment and transportation book, and if a MA was too busy to make the appointment, they should notify the HWD or the HWC so they could coordinate the appointment for the resident. -Resident #3 should have been seen by her PCP after her fall on 12/11/25 to prevent possible complications from her fall and because it was a physician order that staff should have followed. Attempted telephone interview with Resident #3's PCP on 12/19/25 at 2:30pm was unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents who had an order for compression stockings (#5). The findings are: Review of Resident #5's current FL2 dated 06/23/25 revealed: -Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.	D 276		

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D 276	Continued From page 40 -She was intermittently disoriented. Review of a hospice provider order dated 06/25/25 revealed an order for compression stockings to be applied every morning to bilateral lower extremities and removed at bedtime for edema (swelling). Review of Resident #5's signed physician's order sheet dated 08/14/25 revealed an order for compression stocking, on in the morning and off in the evening for circulation. Review of Resident #5's signed physicians order sheet dated 11/06/25 revealed an order for compression stockings, on in the am and off in the evening for circulation. Telephone interview with a representative from the facility's contracted pharmacy on 12/19/25 at 8:54am revealed: -An order was received from hospice for Resident #5 on 06/25/25 for compression stockings to both lower legs each morning and remove in the evening. -Resident #5's measurements for compression stockings were sent to the pharmacy on 07/11/25 but the pharmacy did not supply compression stockings for Resident #5. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings, on in the am and off in the pm, one time a day for circulation and removed per schedule, scheduled at 6:00am and 6:00pm. -Compression stockings were documented as placed at 6:00am on 12/01/25 through 12/18/25. -Compression stockings were documented as	D 276		

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removed at 6:00pm on 12/01/25 and 12/02/25.
-Compression stockings were documented as not removed at 6:00pm on 12/03/25 with the exception documented as 18= other/see med note.
-Compression stockings were documented as removed at 6:00pm on 12/04/25 and 12/05/25.
-Compression stockings were documented as not removed at 6:00pm on 12/06/25 and 12/07/25 with the exception documented as 18=other/see med note on both days.
-Compression stockings were documented as removed at 6:00pm on 12/08/25 through 12/17/25.

Observation of Resident #5 on 12/18/25 at 12:11pm revealed:
-Resident #5 was sitting in her room on her bed.
-Resident #5 was not wearing her compression stockings.

Interview with Resident #5 on 12/18/25 at 12:11pm revealed:
-Staff offered to put her compression stockings on but she always told them she would do it herself.
-She kept her compression stockings in her top drawer.
-She did not wear her compression stockings every day.
-She only used the compression stocking on her right leg and only if it was swollen.
-She did not put her compression stockings on today because she did not have any swelling in her right leg.

Interview with Resident #5's responsible party (RP) on 12/19/25 at 9:48am revealed:
-She supplied Resident #5's compression stockings.

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D 276	Continued From page 42 -She knew Resident #5 was not always complaint with use of her compression stockings and would not wear them every day as she should. Interview with a personal care aide (PCA) on 12/19/25 at 2:36pm revealed the medication aides (MAs) were responsible for applying Resident #5's compression stockings. Interview with the MA on 12/18/25 at 1:01pm revealed: -Resident #5's compression stockings were scheduled to be placed at 6:00am so the night shift MA was responsible for putting Resident #5's compression stockings on. -Resident #5 was independent and would put her compression stockings on herself. -She had not noticed that Resident #5 was not wearing her compression stockings today. -She did not check to make sure Resident #5 wore her compression stockings. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:14pm revealed: -The night shift MA was responsible to apply Resident #5's compression stockings. -She expected the MAs to apply Resident #5's compression stockings as ordered. -She was not aware that staff were not putting Resident #5's compression stockings on. Interview with the Administrator on 12/19/25 at 4:15pm revealed: -It was the responsibility of the MAs to make sure all treatments and orders were carried out. -Staff should not document a treatment was provided if it was not. -If a treatment or medication was not provided, then an exception should always be documented	D 276		

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D 276	Continued From page 43 on the resident's eMAR. Attempted telephone interview with Resident #5's hospice provider on 12/19/25 at 10:07am and 2:17pm were unsuccessful.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS)	D 280		

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D 280	Continued From page 44 reviews and evaluations identified all tasks for 2 of 5 sampled residents (#1 and #5) pertaining to applying compression stockings, and oxygen administration and monitoring (#5), collecting and testing of fingerstick blood samples, medication administration through injection, inhalation medication by machine, and assistance with ambulation (#1). The findings are: Review of the facility's Evaluation Process Policy for Licensed Health professional Support (LHPS) dated May 2024 revealed: -Residents should be evaluated to determine the level of care and services needed or requested utilizing various systems and processes (e.g. personal services systems (PSS), software programs, physician/healthcare provider orders). -The evaluations will be used to determine the price for needed care and services or other requests by the resident and family/responsible party. -Once service needs are determined, specifics of the services required and or requested will be documented in the service plan. -A Registered Nurse (RN) should complete an evaluation prior to the resident's move into a community. -A sales and marketing representative may gather resident information and should communicate this information to the Health and Wellness Director (HWD)/Nurse. -The final resident evaluation should be completed by an RN at move-in, within 14-30 days of move-in, quarterly, and as soon as possible after a change in condition that results in altered care needs over a period of greater than two weeks. -The evaluation should be completed in the	D 280		

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presence of the resident with their requests and/or preferences considered whenever possible.
-Additional potential information sources may include the resident's family as requested, legally responsible party, ombudsman, the physician plan of care, hospital, nursing home, and any other pertinent 3rd party provider of care such as home health, hospice, etc.
-Evaluation results should be entered into the software programs and the original forms signed by a community representative, and resident or responsible party.
-The signed form should be placed in the resident record.
-Based on evaluation, triggers may prompt further review by a nurse and/or District leadership of the resident's care and service needs.
-The original and most recent copies of the evaluation should be kept in the resident record.
-Old copies of resident evaluations should be stored and retained according to the records retention policy.

1. Review of Resident #5's current FL2 dated 06/23/25 revealed:
-Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.
-She was intermittently disoriented.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 06/20/25.

Observations of Resident #5's room on 12/17/25 at 9:56am revealed:
-Resident #5 was sitting on the side of her bed visiting with company.
-There was an oxygen concentrator sitting on the

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floor.
-Resident #5 was not wearing oxygen.

Review of a hospice provider order sheet dated 06/24/25 revealed:
-There was an order to start oxygen gas inhalation, administer 2L/minute via nasal cannula for respiratory distress or shortness of breath.
-May titrate up by 1 liter if current liter not effective with a maximum of 5 liters.

Interview with Resident #5 on 12/19/25 at 8:25am revealed:
-She used oxygen as needed and did not need it often.
-She had not used her oxygen for about 3-4 days.
-She mainly used oxygen at night if she used it all.

Interview with the medication aide (MA) on 12/19/25 at 10:25am revealed:
-Resident #5 had an oxygen concentrator to use as needed.
-Resident #5 rarely used her oxygen.
-She thought Resident #5's oxygen was ordered at 2 liters per minute.
-She was not sure why Resident #5's as needed oxygen order was not listed on her eMAR.
-She thought hospice set Resident #5's oxygen concentrator to deliver 2 liters per minute when in use.

Review of a hospice provider order dated 06/25/25 revealed an order for compression stockings to be applied every morning to bilateral lower extremities and removed at bedtime for edema (swelling).

Review of Resident #5's signed physician's order

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D 280	Continued From page 47 sheet dated 08/14/25 revealed an order for compression stocking, on in the morning and off in the evening for circulation. Review of Resident #5's signed physicians order sheet dated 11/06/25 revealed an order for compression stockings, on in the am and off in the evening for circulation. Review of Resident #5's LHPS evaluation dated 07/25/25 revealed: -The resident was alert and oriented and was independent with most activities of daily living (ADL's). -Staff assisted her with ambulation by pushing her in a wheelchair or on her rollator walker. -The resident self-administered medications. -Changes and follow-up recommended to meet the residents' needs were documented as will continue to monitor for any changes. -There was a LHPS personal care task provided for physical assistance with ambulation and staff competency was documented as validated. -There was no LHPS task documented for applying and removing ace bandages, ted hose (compression stockings), binders and braces and splints. -There was no LHPS task documented for oxygen administration and monitoring. Review of Resident #5's LHPS evaluation dated 11/24/25 revealed: -The resident was alert and oriented. -She only required staff assistance with medication management and remained independent with dressing, grooming, bathing and bathroom tasks. -The resident ambulated through the community using her walker or self-propelled in her wheelchair.	D 280		

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D 280	Continued From page 48 -She continued to be followed by hospice. -There were no LHPS tasks identified at this time. -Changes and follow-up recommended to meet the residents' need were documented as monitor for any changes in behavior that do not follow the resident's baseline, monitor for skin changes or areas of concern, notify hospice and provider of any changes. -LHPS personal care task provided was documented as no tasks. -There was no LHPS task documented for applying and removing ace bandages, ted hose (compression stockings), binders and braces and splints. -There was no LHPS task documented for oxygen administration and monitoring. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:57pm revealed: -The Health and Wellness Director (HWD) was responsible for the LHPS evaluations for the residents. -The facility no longer had a HWD so the regional RN currently performed the LHPS evaluations for the residents. Interview with the Area Nurse Manager on 12/19/25 at 3:52pm revealed: -She trained the HWD to review the residents' medication list and orders when performing a resident's LHPS evaluations. -The resident's care plan and progress notes were reviewed as well as interviewing the resident during an LHPS evaluation. -She was not sure why there were no LHPS tasks identified for Resident #5 for her oxygen and compression stockings. Attempted telephone interviews with Resident	D 280		

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#5's hospice provider on 12/19/25 at 10:07am and 2:17pm were unsuccessful.

Refer to interview with the Administrator on 12/19/25 at 4:39pm.

2. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Diagnosis included unspecified anemia.
-The recommended level of care was domiciliary.
-Resident #1's ambulatory status was documented as both semi-ambulatory and non-ambulatory.
-There was an order for "Humalog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 0-200 = 0 units Notify provi"
-There was an order for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally via nebulizer.

Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25.

Review of an unsigned care plan for Resident #1 dated 06/20/25 revealed:
-Resident #1 required assistance to manage chronic conditions including diabetes.
-Resident #1 required supervision and verbal assistance with mobility using a walker.

Review of an unsigned care plan for Resident #1 dated 07/21/25 revealed:
-Resident #1 required assistance to manage chronic conditions including diabetes.
-Resident #1 was modified independent with mobility using a walker.

Review of an unsigned care plan for Resident #1

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D 280	Continued From page 50 dated 12/01/25 revealed: -Resident #1 required assistance to manage chronic conditions including diabetes. -Resident #1 required as needed (PRN) nebulizer treatments. -Resident #1 required physical assistance with mobility. -Resident #1 used a walker as a mobility aid. Observation on 12/18/25 at 1:53pm revealed there was an unopened compressor nebulizer for Resident #1 on the medicine cart. Observation of medications on hand on 12/18/25 at 1:54pm revealed there was an Insulin Lispro Kwikpen labeled with Resident #1's name. Review of LHPS for Resident #1 dated 07/21/25 -Resident #1 had no LHPS tasks. -Resident #1 recently had some increased periods of confusion. -Resident #1 had elevated blood pressure on two recent episodes and was at the hospital due to elevated BP. -Resident #1 was independent with most activities of daily living, receiving shower assist only. -Resident #1 ambulated with a rollator walker. -The assessment was signed by a previous Health and Wellness Director (HWD). Review of LHPS for Resident #1 dated 11/24/25 revealed: -Personal care tasks currently present were medication administration through injection, inhalation of medication by machine, and collecting and testing of fingerstick blood samples. -Resident #1 required staff assistance with bathing and medication management, and	D 280		

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remains independent with dressing, grooming and bathroom tasks.
-Resident #1 has a PRN for nebulizer treatments and scheduled insulin.
-Resident ambulated through the community using her walker.
-Resident #1 was followed by hospice.
-Staff competency was validated for use of the nebulizer.
-There was no task indicated for ambulation with assistive device that required physical assistance.
-The form was completed by the Area Nurse Manager.

Interview with a personal care aide (PCA) on 12/18/25 at 1:01pm revealed:
-Sometimes Resident #1 was not steady, so staff would help her get up.
-Sometimes Resident #1 tried to get up without assistance, but staff helps and encourages her to use the rolling walker.

Interview with a second PCA on 12/19/25 at 2:32pm revealed:
-Resident #1 required occasional assistance with mobility.
-Staff was always there when Resident #1 moved around and Resident #1 used a necklace to call staff's pagers for assistance.
-About 1 and a half months ago Resident #1 started requiring more assistance to the bathroom.
-Resident #1 could get up by herself occasionally.

Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed:
-Resident #1 required assistance with all her activities of daily living.
-Resident #1 walked with a walker 80% of the time and the other 20% of the time she used a

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wheelchair.
-Sometimes Resident #1 would get up independently, but staff needed to assist Resident #1.
-When Resident #1 was confused she would stand up by herself and ask for help.

Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed:
-The HWD left in October.
-The HWD usually updated the LHPS.
-The Area Nurse Manager had been doing the LHPS.

Interview with Area Nurse Manager on 12/19/25 at 3:52pm revealed:
-The HWD was responsible to fill out the LHPS.
-She trained nurses to review orders, medication lists, and progress notes to identify LHPS tasks.
-Her interpretation was that residents who ambulated with an assistive device were still ambulating independently if staff did not help them.
-Resident #1's care plan in the system showed that she was independent with mobility, so the LHPS form was filled out accordingly.
-She must have overlooked the fingerstick blood sugars and injections staff competency.
-Staff was trained to perform fingerstick blood sugars and injections.

Refer to interview with the Administrator on 12/19/25 at 4:39pm.

_____

Interview with the Administrator on 12/19/25 at 4:39pm revealed:
-LHPS evaluations must be completed by a Registered Nurse (RN).
-LHPS evaluations were performed by the Health

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D 280	Continued From page 53 and Wellness Director (HWD) or the Regional RN in the absence of the HWD. -He expected the LHPS evaluations to reflect the needs of the residents.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 6 sampled residents (#4) who had a physician's order for a texture modified diet (#4). The findings are: Review of the facilities diet orders policy dated January 2025 revealed: -Each resident must have a diet order prescribed by a physician/healthcare provider. -The diet order should match the diet terminology approved by Brookdale per the Brookdale Approved Diets Policy. -If the diet order does not match the diet terminology approved by Brookdale, a nurse/designee, Executive Director (ED) or Health and Wellness Director (HWD) or Health and Wellness Coordinator (HWC) should work with the physician to get the diet order changed to match the diet terminology approved by	D 310		

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Brookdale.
-The diet order communication process required the HWD to communicate all diet orders to the dining services using the dining services communication form.
-The diet order communication process also required the HWD to communicate all diet orders to dining services using various tools which included a Nutrition Tracker Report and a physician diet order form.

Review of Resident #4's current FL-2 dated 08/04/25 revealed:
-Diagnosis included unspecified dementia.
-There was no diet order listed on the FL-2.

Review of Resident #4's signed physician order dated 07/24/25 revealed a diet order for a texture modified diet.

Observation of a list of residents on special diets posted in the kitchen dated 12/10/25 revealed Resident #4 was on a pureed diet.

Observation of a posted Nutrition Tracker Report dated 10/27/25 revealed:
-The Nutrition Tracker Report was posted in the kitchen.
-Resident #4 had a texture modified diet order listed on the Nutrition Tracker Report.

Observation of the breakfast meal service on 12/18/25 from 7:55am to 8:55am revealed:
-Resident #4 was served a pureed meal that consisted of scrambled eggs, sausage, waffle, and fruit at bedside by a personal care aide (PCA).
-The consistency of the pureed meal was smooth with no lumps and had the texture of pudding.
-The resident was also served orange juice,

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water, milk and coffee.
-The PCA provided feeding assistance to Resident #4.
-According to the American Dietetic Association a texture modified diet should be moist, semi solid foods, minced or ground meats, and a food consistency that is easy to chew.

Observation of the lunch meal service on 12/18/25 from 12:07pm to 12:38pm revealed:
-Resident #4 was served a pureed meal that consisted of chicken nuggets, mashed potatoes with gravy, string beans, and ice cream.
-The consistency of the pureed meal was smooth with no lumps and had the texture of pudding.
-The resident was also served water, milk, and tea.
-The resident was served in the dining room and a PCA provided feeding assistance.

Interview with a PCA on 12/18/25 at 8:00am revealed:
-The dietary staff called out to staff in the Special Care Unit (SCU) dining area when a residents' meal plate was ready to be served to each resident.
-She was provided with a pureed meal from dietary staff for Resident #4.

Interview with a medication aide (MA) on 12/18/25 at 8:58am revealed:
-Dietary staff directed MAs and PCAs to serve residents each plate of food by calling out the name of any special diets.
-She followed the directions from the dietary staff when she was handed a plate of food for a resident with a special diet.

Interview with the Dietary Manager on 12/19/25 at 2:40pm revealed:

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D 310	Continued From page 56 -He received a Nutrition Tracker Report when there was a change in any resident's diet order, or when they had a new admission. -The Nutrition Tracker Report contained all residents residing in the facility. -The HWD or HWC provided him with an updated Nutrition Tracker Report, he updated his printed list in the kitchen for any residents that were on a therapeutic diet. -He served Resident #4 a pureed diet because he had her listed as receiving a pureed diet on his diet order sheet in the kitchen. -He did not realize that the Nutrition Tracker Report from October 2025 that was posted in the kitchen had the resident listed with an order for a texture modified diet. -He was no sure how he made the mistake of serving the resident the incorrect diet order. Interview with the HWC on 12/19/25 at 2:58pm revealed: -The Nutrition Tracker Report was run every Monday morning by the Administrator. -She provided a copy of the report to the Dietary Manager every Monday. -The Administrator printed an updated Nutrition Tracker Report if a resident had a change in their diet order or if the facility had a new admission. -She or the HWD were able to enter any diet order changes in the Nutrition Tracker Report when a resident had a new diet order. -The Dietary Manager kept updated Nutrition Tracker Reports posted in the kitchen. -The Dietary Manager was supposed to follow orders on the Nutrition Tracker Report to prevent choking hazards for residents. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -When a resident had a change in their diet order	D 310		

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D 310	Continued From page 57 or there was a new admission, he printed an updated Nutrition Tracker Report that had been updated by the HWD or the HWC. -A copy of the Nutrition Tracker Report was provided to the Dietary Manager to be maintained in the kitchen so staff could ensure they served each resident the correct type of diet that their PCP ordered. -The HWD or HWC updated the resident's medical record by updating their care plan and at times they also completed an electronic progress note about the change in a resident's diet order. -The Dietary Manager should not have served Resident #4 a pureed diet, the resident should have received a texture modified diet as ordered by her PCP. Attempted telephone interview with Resident #4's primary care provider (PCP) on 12/19/25 at 2:38pm was unsuccessful.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication and treatment orders were clarified for 2 of 5 sampled residents (#1, #5) including an order for oxygen (#5) and orders for a medication used to treat pain (#1).

The findings are:

1. Review of Resident #5's current FL2 dated 06/23/25 revealed:
-Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.
-She was intermittently disoriented.

Observations of Resident #5's room on 12/17/25 at 9:56am revealed:
-Resident #5 was sitting on the side of her bed visiting with company.
-There was an oxygen concentrator sitting on the floor.
-Resident #5 was not wearing oxygen.

Review of a hospice provider order sheet dated 06/24/25 revealed:
-There was an order to start oxygen gas inhalation, administer 2L/minute via nasal cannula for respiratory distress or shortness of breath.
-May titrate up by 1 liter if current liter not effective with a maximum of 5 liters.

Review of Resident #5's signed physicians order sheet dated 08/14/25 revealed there was no order for oxygen.

Review of Resident #5's signed physicians order sheet date 11/06/25 revealed there was no order

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D 344	Continued From page 59 for oxygen. Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen for Resident #5. Review of Resident #5's November 2025 eMAR revealed there was no entry for oxygen for Resident #5. Review of Resident #5's December 2025 eMAR revealed there was no entry for oxygen for Resident #5. Telephone interview with Resident #5's responsible party (RP) on 12/19/25 at 9:48am revealed: -Resident #5 had an oxygen concentrator to use as needed. -Resident #5 was to use her oxygen as needed, especially at night. Interview with Resident #5 on 12/19/25 at 8:25am revealed: -She used oxygen as needed and did not need it often. -She had not used her oxygen for about 3-4 days. -She mainly used oxygen at night if she used it all. Interview with the medication aide (MA) on 12/19/25 at 10:25am revealed: -Resident #5 had an oxygen concentrator to use as needed. -Resident #5 rarely used her oxygen. -She thought Resident #5's oxygen was ordered at 2 liters per minute. -She was not sure why Resident #5's as needed oxygen order was not listed on her eMAR.	D 344		

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D 344	Continued From page 60 -She thought hospice set Resident #5's oxygen concentrator to deliver 2 liters per minute when in use. -There was nowhere to document when Resident #5 used her oxygen. Interview with the Area Nurse Manager on 12/18/25 at 2:05pm revealed: -She thought Resident #5 had the oxygen concentrator when she was admitted to the facility. -She was not sure why oxygen was not listed on Resident #5's admitting FL2. -She was not sure why oxygen was not listed on Resident #5's physicians orders or on her eMAR. -She had to look for the order for Resident #5's as needed oxygen. Second interview with the Area Nurse Manager on 12/19/25 at 10:54am revealed: -She located the 06/24/25 hospice order for Resident #5's oxygen. -The hospice provider would have to be contacted about Resident #5's oxygen order because the facility did not titrate oxygen. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:04pm revealed: -Staff would not know what to set Resident #5's oxygen at without an order. -Resident #5's hospice provider should have been contacted for clarification of her oxygen order. -Resident #5's oxygen order should have been added to her eMAR. Interview with the Administrator on 12/19/25 at 4:15pm revealed: -Resident #5's oxygen concentrator was provided	D 344		

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by hospice.
-The oxygen order for Resident #5 should have been clarified with the hospice provider and entered into the eMAR system.

Attempted telephone interview with Resident #5's hospice provider on 12/19/25 at 10:07am and 2:17pm were unsuccessful.

2. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Resident #1 had a diagnosis of unspecified anemia.
-The recommended level of care was domiciliary.
-There was an order for Tramadol HCl Tablet 50 MG Give 0.5 tablets every 8 hours as needed (PRN) for pain.

Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25.

Review of a Hospital Discharge Summary dated 11/14/25 revealed:
-Resident #1 was sent to the hospital due to hypotension and bradycardia.
-She was admitted on 11/11/25 and discharged on 11/14/25.
-There was an order for Tramadol 50mg tablet take 0.5 tablets (25mg total) at bedtime (Tramadol is medication used to treat pain).

Review of Resident #1's November 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol HCL Tablet 25mg give one tablet every 8 hours PRN for pain.
-Tramadol HCL Tablet 25mg PRN was documented as administered once on 11/23/25

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and 11/27/25.
-There was an entry for Tramadol 25mg give one tablet at bedtime for pain
-Scheduled Tramadol was documented as not administered due to leave of absence 11/01/25-11/02/25.
-Scheduled Tramadol was documented as administered on 11/03/25 and 11/04/25.
-Scheduled Tramadol was documented as discontinued on 11/05/25 at 3:46pm.

Review of a Controlled Substance Log for Resident #1 revealed:
-There was an entry for a quantity of 30 Tramadol, received 09/19/25, with directions to take ½ tab (25mg) by mouth every 8 hours PRN for pain.
-The PRN Tramadol 50mg ½ tablet was documented as administered once on 11/04/25, 11/23/25, and 11/27/25 for a total of 3 doses.

Review of a Controlled Substance Log for Resident #1 revealed:
-There was an entry for a quantity of 30 Tramadol, received 09/25/25, with directions to take ½ tab (25mg) every night at bedtime.
-There was no documentation that the nightly Tramadol was ever administered.

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol HCL Tablet 25mg give one tablet every 8 hours PRN for pain.
-There was no documentation that Tramadol had been administered in December.
-There was not an entry for scheduled Tramadol

Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on

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D 344	Continued From page 63 12/19/25 at 9:10am revealed: -The first and only Tramadol PRN was dispensed on 09/19/25 in a quantity of 30 half-tablets, 25 mg doses. -Scheduled Tramadol 50mg tablets were dispensed on 09/25/25 in a quantity of 15, doses were 25mg. Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed: -It was confusing when Resident #1 came back from the hospital. -She followed what the eMAR entry showed. -Tramadol was previously ordered as scheduled for Resident #1 but was not showing as scheduled now. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed: -The Health and Wellness Director (HWD) left in October. -MA's and the HWD made sure medications were on the cart and performed cart audits every two weeks. -She would compare medications on the cart to the eMAR. -If MA's entered an order then a 2nd MA or HWC should check behind using a medication tracking form. -If an MA entered orders, she would check behind them. -Tramadol should be given based on the last order. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -If staff received a change from what was in the eMAR for Tramadol, they should have that changed to the most current order.	D 344		

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D 344	Continued From page 64 -Anytime there was a question about medication, staff should check with the HWD or primary care provider (PCP). Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed: -She would only want Resident #1 on PRN Tramadol because of Resident #1's falls. -Resident #1's medication administration record (MAR) was sent to the hospital. -The last order she gave for Tramadol was PRN.	D 344		
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policy and procedure for medication administration for 3 of 5 residents (#1, #2, and #5) sampled for record review including errors with a medication used to prevent blood clots, (#2) and a medication used to treat moderate to severe pain (#5), a vitamin supplement, a medication to treat constipation, a sodium supplement, and a blood pressure medication (#1).	D 358		

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D 358	Continued From page 65 The findings are: Review of the facility's Medication and Treatment General Guidelines revised September 2025 revealed: -Trained and/or licensed associates may administer or assist the resident with medication and management or medication administration and treatments per physician/healthcare provider order and per state regulation. -Trained or licensed associates administering or assisting with medications should follow the "7 Rights of Medication Administration, right medication, right dose, right time, right route, right resident, right documentation, and the right to refuse. -Follow the medication label, pharmacy, and manufacturer directions for each individual medication prescribed, expiration dates should be checked on medications or treatments before administration. -Document medications administered/assisted with on the medication administration record (MAR). -Documentation of medications administered/assisted, or treatments administered/assisted, should occur promptly after the resident has taken the medication or treatment performed. -Medication or treatment directions on the physician order and pharmacy label should correlate with the medication and directions on the MAR or treatment administration record (TAR). -Medications and treatments should be administered within the parameters of the physician orders. -Each resident who has a blood glucose check ordered should have a defined parameter for physician notification (e.g. notify physician if blood	D 358		

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glucose is less than 70 or greater than 400).
-Medication and/or treatment errors should be reported promptly and according to the facility's reportable event policy and grid.
-A resident change in condition or other concerns should be communicated to the nurse/designee/Executive Director as soon as possible for follow-up action and or notification to the physician.

1. Review of Resident #2's current FL2 dated 05/28/25 revealed:
-Diagnoses included chronic atrial fibrillation, non-rheumatic aortic valve disorder, peripheral vascular disease and hypertension.
-He was constantly disoriented.
-There was an order for Eliquis (Eliquis is a blood thinner used to prevent serious blood clots, reducing stroke risk in atrial fibrillation) 5mg, take one tablet two times a day,

Review of Resident #2's emergency department (ED) provider note dated 10/08/25 revealed:
-Resident #2 had a history of atrial fibrillation and was on Eliquis.
-He presented at the ED after a mechanical fall landing on his right hip.
-He had swelling and ecchymosis (bruising) over the right hip concerning for a large hematoma.
-The hematoma has not extended past borders of mark in the last several hours.
-He was not tender and had full range of motion.
-He was able to ambulate with his walker.
-X-ray of the pelvis were done to rule out fracture or dislocation and was negative.
-Advised him and his responsible party (RP) to keep an eye on the hematoma and to come back if it started extending past the borders of marking.

Review of a handwritten physician/healthcare

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provider visit form for Resident #2 dated 10/14/25 revealed:
-Status post fall with hematoma extending posteriorly to popliteal fossa.
-Right hip, cleanse with soap and water, cover with dry gauze, secure with tape and change daily.
-Hold Eliquis until physician orders to resume.

Review of Resident #2's 10/22/25 cardiology after visit summary revealed:
-There was an order to change Eliquis from 5mg twice a day to 2.5mg twice a day.
-Wait 2 weeks before restarting Eliquis 2.5mg twice a day, if right hip hematoma persists, continue to hold.

Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 5mg, one tablet two times a day scheduled at 8:00am and 8:00pm.
-Eliquis 5mg was documented as administered at 8:00am on 10/01/25 through 10/10/25.
-Eliquis 5mg was documented as administered at 8:00pm on 10/01/25 through 10/09/25.
-Eliquis 5mg was documented as not administered at 8:00am on 10/11/25 through 10/15/25, with the exception documented as H= on hold by physician.
-Eliquis 5mg was documented as not administered at 8:00pm on 10/10/25 through 10/14/25, with the exception documented as H= on hold by physician.
-Eliquis 5mg was documented as administered at 8:00am on 10/16/25 through 10/22/25.
-Eliquis 5mg was documented as administered at 8:00pm on 10/15/25 through 10/21/25.
-Eliquis 5mg was documented as not

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administered at 8:00am on 10/23/25 through 10/31/25 with the exception documented as discontinued.
-Eliquis 5mg was documented as not administered at 8:00pm 10/22/25 though 10/31/25 with the exception documented as discontinued.

Review of Resident #2's November 2025 eMAR revealed:
-There was an entry for Eliquis 2.5mg, one tablet twice a day scheduled at 8:00am and 8:00pm.
-Eliquis 2.5mg was documented as administered at 8:00am and 8:00pm on 11/05/25 through 11/30/25.

An order to hold Eliquis 5mg on 10/10/25 through 10/15/25 was requested on 12/18/25 at 4:14pm and was not provided.

An order to resume Eliquis 5mg on 10/15/25 was requested on 12/18/25 at 4:14pm and was not provided.

Interview with the Administrator on 12/19/25 at 10:52am revealed:
-There was no written order for Resident #2 to hold Eliquis 5mg on 10/10/25 and to resume Eliquis 5mg on 10/15/25.
-The previous Health and Wellness Director (HWD) held Resident #2's Eliquis due to a large hematoma on his hip after a fall.
-The previous HWD had verbal orders to hold Resident #2's Eliquis 5mg but had not received the written order to hold his Eliquis as requested.
-He was not sure why the previous HWD did not document the conversation with Resident #2's PCP about holding his Eliquis in his progress notes.

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D 358	Continued From page 69 Telephone interview with a representative from the facility's contracted pharmacy provider on 12/19/25 at 9:06am revealed: -Eliquis 5mg, was originally ordered for Resident #2 on 12/12/24 to take one twice a day. -Eliquis 5mg was dispensed for Resident #2 on 09/16/25, and on 10/14/25 for 56 tablets for 28 days supply on both occasions to take twice daily. -There was no order to hold Eliquis 5mg starting 10/10/25 on file for Resident #2. -There was no order to hold Eliquis 5mg starting 10/14/25 on file for Resident #2. -A new order was received for Resident #2 for Eliquis 2.5mg, take one twice a day on 10/22/25. Telephone interview with the Registered Nurse (RN) at Resident #2's cardiology office on 12/19/25 at 1:25pm revealed: -Resident #2 had a history of atrial fibrillation and Eliquis was prescribed to help prevent blood clots. -Resident #2 had an emergency department (ED) visit on 10/08/25 for a fall that resulted in a hematoma noted on his hip. -Instructions from the 10/08/25 ED discharge summary were to continue Eliquis 5mg twice a day. -There was documentation that Resident #2's primary care provider (PCP) was contacted on 10/10/25 and Resident #2's hematoma had expanded and his PCP ordered Resident #2's Eliquis to be held until he seen by his PCP on 10/14/25. -There was documentation from the 10/14/25 PCP visit, that Resident #2's PCP recommended Eliquis 5mg be held until his return visit the cardiologist on 10/22/25. -Resident #2 was seen at the cardiologist office on 10/22/25 and his Eliquis was decreased to 2.5mg twice a day to resume in 2 weeks.	D 358		

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D 358	Continued From page 70 -Continuing to take Eliquis when it was supposed to be held could cause Resident #2's hematoma to get larger and not re-absorb. Interview with a medication aide (MA) on 12/19/25 at 10:25am revealed she thought either the previous HWD or the HWC entered the order to hold and resume Resident #2's Eliquis 5mg. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:14pm revealed: -If a resident had a provider visit, the after-visit summary and any written orders were reviewed by either the MA, the HWC, or the HWD and were faxed to the pharmacy. -The MAs, the HWD, or the HWC could enter orders into the eMAR system for the residents. -The previous HWD had been in touch with Resident #2's PCP about his Eliquis 5mg after his October 2025 fall. -She had not seen Resident #2's order from 10/14/25 to hold his Eliquis 5mg. -When she reviewed an order for a resident, she always initialed and dated the order once it was faxed to the pharmacy. -Resident #2's 10/14/25 order sheet, with the order to hold Eliquis was not initialed or signed by facility staff. -She was not sure why Resident #2's 10/14/25 order sheet to hold Eliquis was not reviewed and not initialed or signed. Second interview with the Administrator on 12/19/25 at 4:35pm revealed: -Resident #2's 10/14/25 order to hold Eliquis should have been reviewed by either the HWD or the HWC. -Resident #2's 10/14/25 order to hold Eliquis 5mg should have been entered in the eMAR system	D 358		

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and followed.
-He expected the residents' medications to be administered as ordered.

Attempted telephone interview with Resident #2's RP on 12/19/25 at 10:03am was unsuccessful.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/19/25 at 11:24am was unsuccessful.

Attempted telephone interview with Resident #2's cardiologist on 12/19/25 at 1:25pm was unsuccessful.

2. Review of Resident #5's current FL2 dated 06/23/25 revealed:
-Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.
-She was intermittently disoriented.
-There was an order for oxycodone-acetaminophen (an opioid medication used to treat moderate to severe pain) 10/325mg, one tablet every eight hours as needed (PRN) for moderate to severe pain.

Review of a hospice order for Resident #5 dated 08/22/25 revealed an order to discontinue the current PRN order for oxycodone and start oxycodone 10-325mg, three times daily for pain.

Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone-acetaminophen 10-325mg, one tablet three times per day, scheduled at 8:00am, 2:00pm and 8:00pm.
-Oxycodone-acetaminophen 10-325mg was

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documented as administered at 8:00am, 2:00pm and 8:00pm on 10/01/25 through 10/06/25.
-Oxycodone-acetaminophen 10-325mg was documented as not administered at 8:00am, 2:00pm and 8:00pm on 10/07/25 with the exception documented as 20= medication/treatment not available/pharmacy action.
-Oxycodone-acetaminophen 10-325mg was documented as administered at 8:00am, 2:00pm and 8:00pm on 10/08/25 through 10/31/25.

Telephone interview with a representative from the facility's contracted pharmacy on 12/19/25 at 8:54am revealed:
-There was an order for oxycodone-acetaminophen 10-325mg, take one three times per day.
-Oxycodone-acetaminophen 10-325mg was dispensed for Resident #5 on 09/16/25 for 45 tablets for a 15-day supply.
-Oxycodone-acetaminophen 10-325mg was dispensed for Resident #5 on 10/07/25 for 45 tablets for a 15-day supply with packing slip delivery date of 10/08/25 at 1:22am.

Interview with Resident #5 on 12/19/25 at 1:45pm revealed:
-She took oxycodone for back pain.
-She thought the facility ran out of her oxycodone a couple months ago, but they got her refill in pretty quickly.

Interview with a medication aide (MA) on 12/18/25 at 1:15pm revealed:
-The MAs were responsible to make sure medications were on the medication cart and available for the residents.
-She always requested narcotic medication refills when there were 5 to 7 doses remaining in case a

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new prescription was needed.
-Some MAs did not request medication refills until the resident was out.

Second interview with the MA on 12/19/25 at 10:25am revealed:
-She contacted hospice for Resident #5's oxycodone refill in October.
-She was not sure why a refill was not requested for Resident #5's oxycodone before her prescription ran out in October.

Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:58pm revealed:
-It was the responsibility of the MAs to make sure medications were on the medication cart for the residents.
-Medication cart audits were performed every two weeks, looking for expired medications and to make sure all medications were available for the residents.
-Narcotic medications should be ordered when there were 7 days of medication remaining to make sure the resident was not without medication.
-There had been instances in the past when the hospice provider indicated an order had been sent but the pharmacy did not receive.
-She expected medications to be available and administered to the residents as ordered.

Interview with the Administrator on 12/19/25 at 4:15pm revealed:
-The MAs were responsible to make sure all medications were available for administration on the medication cart.
-The medication cart audits were performed monthly to ensure medications were available for the residents.

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-Medication refills should be requested when there was seven days of medication remaining to prevent running out a medication.

Attempted telephone interview with Resident #5's hospice provider on 12/19/25 at 8:29am and 2:17pm were unsuccessful.

3. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed:
-Resident #1 had a diagnosis of unspecified anemia.
-The recommended level of care was domiciliary.

Review of the Order Summary Report for Resident #1 revealed she was admitted to the facility on 06/20/25.

a. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed there was an order for Amlodipine Besylate Tablet 10 MG Give 1 tablet one time a day (Amlodipine is medication used to treat high blood pressure).

Review of a Hospital Discharge Summary dated 11/14/25 revealed:
-Resident #1 was sent to the hospital due to hypotension and bradycardia.
-She was admitted on 11/11/25 and discharged on 11/14/25.
-There was an order to change Amlodipine to one 5mg tablet take one in the morning and hold for low blood pressure 100/70 or less.

Review of Resident #1's November 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine besylate tablet 5mg give 1 tablet once a day, hold for low blood pressure 100/70 or less.

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-Amlodipine besylate tablet 5mg was documented as administered 11/19/25 when BP was 132/67, 11/21/25 when BP was 147/65, 11/23/25 when BP was 168/69, 11/25/25 when BP was 180/67, 11/26/25 when BP was 148/61, 11/28/25 when BP was 151/67.

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine besylate tablet 5mg give 1 tablet once a day, hold for low blood pressure 100/70 or less.
-Amlodipine besylate tablet 5mg was documented as administered 12/10/25 when BP was 155/69, 12/11/25 when BP was 136/63, 12/12/25 when BP was 136/63, 12/14/25 when BP was 129/68, and 12/16/25 when BP was 138/55

Observation of medications on hand on 12/18/25 at 1:37pm revealed:
-There was a package containing 26 remaining Amlodipine 5mg tablets and two pills had been removed.
-The label for the Amlodipine 5mg tablets had a printed start date of 12/16/25 and a quantity of 28.
-The instructions on the label for Amlodipine 5mg were "TAKE ONE TABLET BY MOUTH EVERY MORNING *HOLD FOR LOW BPS 100/70 OR LESS*".

Interview with a medication aide (MA) on 12/19/25 at 1:28pm revealed
-If the bottom blood pressure number was too low, but the top number was above 100 she would still give Amlodipine.
-She was not sure if she brought that up with her supervisor before.
-The order for Amlodipine was confusing.
-Usually they did not have orders to hold

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medication at 70, usually 60 on the lower number.
-70 was okay to her, but below 60 was low.
-The medication was given if the bottom number was too low because the top number was above 100.

Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed:
-The Health and Wellness Director (HWD) left in October.
-If staff had questions about the amlodipine or if something needed to be clarified she could contact the doctor.
-There was one time where Resident #1 was sent to the hospital prior to the new Amlodipine order, but no problems were observed since the new Amlodipine order.

Interview with the Administrator on 12/19/25 at 4:08pm revealed:
-Staff should be giving Resident #1's Amlodipine per the order.
-If the Amlodipine order was tricky then it needed to be clarified.
-Anytime there was a question about medication, staff should check with the HWD or primary care provider (PCP).

Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed:
-The way that the hospital wrote the order for Amlodipine was tricky.
-She would clarify the Amlodipine order for the facility.

b. Review of a Hospital Discharge Summary dated 11/14/25 revealed:
-Resident #1 was sent to the hospital due to hypotension and bradycardia.

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-She was admitted on 11/11/25 and discharged on 11/14/25.
-There was an order for Glycolax 17 gram/dose powder, take 17g in the morning, mix in eight ounces of juice or water (Glycolax is medication used to treat constipation).

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed there was not an entry for Glycolax powder.

Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 12/19/25 at 9:10am revealed 30-day supplies of Glycolax were dispensed 09/12/25 and 10/08/25.

Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed:
-It was confusing when Resident #1 came back from the hospital.
-She followed what the eMAR entry was showing.
-Resident #1's Glycolax was not given since 11/05/25 and was not on the December eMAR.

Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed:
-The Health and Wellness Director (HWD) left in October.
-MA's and the HWD made sure medications were on the cart and performed cart audits every two weeks.
-She would compare medications on the cart to the eMAR.
-If MA's entered an order then a 2nd MA or HWC should check behind using a medication tracking form.
-If an MA entered orders, she would check behind them.

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-Glycolax should be given based on the last order.

Interview with the Administrator on 12/19/25 at 4:08pm revealed:
-Anytime there was a question about medication, staff should check with the nurse or primary care provider (PCP).
-If Glycolax was discontinued, they should remove it from the cart.
-He did not know if Glycolax was discontinued because the nurses provided oversight.
-He would have to ask the nurse about Glycolax.

Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed:
-Resident #1's medication administration record (MAR) was sent to the hospital.
-The hospital did not reconcile Resident #1's Glycolax.
-There was no harm in Resident #1 not receiving Glycolax.

c. Review of Resident #1's most recent FL-2 dated 10/30/25 revealed there was an order for Cholecalciferol Tablet 1000 UNIT Give 1 tablet one time a day (Cholecalciferol is a vitamin D3 supplement used to treat or prevent vitamin deficiency).

Review of a Hospital Discharge Summary dated 11/14/25 revealed:
-Resident #1 was sent to the hospital due to hypotension and bradycardia.
-She was admitted on 11/11/25 and discharged on 11/14/25.
-There was an order to continue cholecalciferol 25mcg (1000 unit) tablet every morning.

Review of Resident #1's November 2025

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electronic medication administration record (eMAR) revealed:
-There was an entry for cholecalciferol tablet 1000 unit give one tablet once a day with a discontinued date of 11/14/25.
-There was a second entry for cholecalciferol 1000 unit give one capsule in the morning with a discontinued date of 11/03/25.
-There was no documentation of administration or exceptions from 11/15/25-11/30/25 for Resident #1's cholecalciferol.

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed there was not an entry for Cholecalciferol on the December 2025 eMAR.

Observation of medications on hand on 12/18/25 at 1:37pm revealed here was no Cholecalciferol on the cart for Resident #1.

Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 12/19/25 at 9:10am revealed Cholecalciferol was dispensed in a quantity of 28 tablets on 10/14/25, 11/11/25, and 12/09/25.

Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed:
-Cholecalciferol was not being given to Resident #1.
-It was confusing when Resident #1 came back from the hospital.
-She followed what the eMAR entry was showing.

Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed:
-The Health and Wellness Director (HWD) left in October.

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-MA's and the HWD made sure medications were on the cart and performed cart audits every two weeks.
-She would compare medications on the cart to the eMAR.
-Refills could be ordered by the MA's or by her.
-If MA's entered an order then a 2nd MA or HWC should check behind using a medication tracking form.
-If an MA entered orders, she would check behind them.
-Without an order to discontinue cholecalciferol, staff was required to give the medication.

Interview with the Administrator on 12/19/25 at 4:08pm revealed anytime there was a question about medication, staff should check with the Nurse (RN) or primary care provider (PCP).

Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed Resident #1 not taking cholecalciferol would not have caused her any harm.

d. Review of a Hospital Discharge Summary dated 11/14/25 revealed:
-Resident #1 was sent to the hospital due to hypotension and bradycardia.
-She was admitted on 11/11/25 and discharged on 11/14/25.
-There was an order for sodium chloride 1000mg take one tablet three times a day with meals (sodium chloride is a medication used to treat sodium deficiency).

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed there was not an entry for sodium chloride.

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D 358	Continued From page 81 Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 12/19/25 at 9:10am revealed: -Sodium chloride 1000mg was dispensed in a quantity of 84 on 10/14/25, quantity of 12 on 11/14/25, quantity of 84 on 11/17/25, and quantity of 84 on 12/09/25. -The 84 tablets sent to the facility on 11/17/25 were sent back to the pharmacy. Interview with a medication aide (MA) on 12/19/25 at 10:08am revealed: -It was confusing when Resident #1 came back from the hospital. -She followed what the eMAR entry was showing. -She pulled sodium chloride from the cart on Tuesday (12/17/25), and it was not on hand. -Sodium chloride was discontinued and was not on the eMAR so she pulled it from the cart. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 2:45pm revealed: -The Health and Wellness Director (HWD) left in October. -MA's and the HWD made sure medications were on the cart and performed cart audits every two weeks. -She would compare medications on the cart to the eMAR. -If MA's entered an order then a 2nd MA or HWC should check behind using a medication tracking form. -If an MA entered orders, she would check behind them. -Sodium chloride should be given based on the last order. Interview with the Administrator on 12/19/25 at 4:08pm revealed:	D 358		

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D 358	Continued From page 82 -If sodium chloride was not on the eMAR, the MA was correct in pulling it from the cart. -If sodium chloride was listed on the orders, staff should verify the order. Telephone interview with the PCP for Resident #1 on 12/19/25 at 1:48 pm revealed: -Resident #1's medication administration record (MAR) was sent to the hospital. -Resident #1's last sodium level was normal on 11/13/25 so the medication was no longer needed and it was fine that the sodium chloride was discontinued.	D 358		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled residents (#2, #5) had physicians' orders	D 375		

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D 375	Continued From page 83 to self-administer medications used to treat bacterial infections, constipation (#5), an over-the-counter joint supplement and a nasal saline spray (#2). The findings are: Review of the facility's Self Administration of Medication policy revised on August 2023 revealed: -Resident who desire to self-administer medication shall be permitted to do so if the admitting physician verifies it is appropriate, the nurse confirmed the resident's abilities in this regard and applicable state requirements are met. -This includes over the counter medications as well as prescription drugs. -The healthcare provider will be notified if the resident cannot successfully pass the self-administration review criteria. -If a resident desires to self-administer medications, an evaluation should be conducted by the Nurse, of the resident's cognitive, physical, and visual ability to carry this out. -The evaluation will be completed using the self-administration of medications review form initially, quarterly, or per state regulation and with change in resident's condition. -The nurse should print a list of current medications, including over the counter medications to use when evaluating the resident's ability to self-administer medications. -The resident's ability to self-administer medications, including over the counter medications, should be determined by means of a skills evaluation as follows, the resident should be able to identify the medication either by reading the label on the medication bottle or identifying the pill in a pill organizer, state what	D 375		

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D 375	Continued From page 84 each medication is for (purpose), state what time medications are to be taken, state the proper dosage and route of each medication, identify the expiration date of the medication, verbalize the steps involved in medication administration for non-solid forms, properly store medications and locking apartment door upon departure from the apartment, self-administer oxygen including proper storage, changing of tubing and regulating meter flow per physician order. -If a resident successfully passes the self-medication evaluation, an order should be obtained from the physician and should be reflected on the physician care plan. -Locking the resident's apartment door is considered the first level for securing medications in their apartment. -Residents who self-administer their on medications may store and secure their non-controlled medications in their apartment by locking their apartment door each time upon departure., should store their controlled medications in a locked drawer or cabinet so they are not accessible to others, controlled medications are considered double locked when locked in a drawer/cabinet and when the apartment door is locked. -If a resident is unable to successfully pass the self-medication evaluation, the resident should no longer be allowed to self-administer medications, and an alternative plan should be devised, the resident, the resident's physician, and their responsible party should be made aware that the resident is no longer able to self-administer medications and the medications should be secured for staff assistance with medication administration, if the resident refuses, the Executive Director should be made aware and follow-up per state regulation. -Unless specifically allowed per state regulation,	D 375		

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the community will assume full responsibility for medication administration if the resident is unable to successfully pass the self-administration of medication review evaluation.

1. Review of Resident #5's current FL2 dated 06/23/25 revealed:
-Diagnoses included heart failure, atrial fibrillation, peripheral vascular disease, polyneuropathy, and emphysema.
-She was intermittently disoriented.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 06/20/25.

a. Observations of Resident #5's room on 12/18/25 at 8:49am revealed:
-Resident #5 was sitting on the side of her bed eating breakfast.
-There was brown pharmacy labeled prescription bottle with Resident #5's name of amoxicillin (amoxicillin is an antibiotic used to treat bacterial infections) 500mg capsules, take one capsule every 8 hours until gone, dated 12/12/25 for a quantity of 21 capsules.
-There were 6 capsules remaining in the prescription bottle labeled amoxicillin 500mg for Resident #5.

Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed there was no entry for amoxicillin 500mg capsules, take one capsule every 8 hours.

Telephone interview with a representative from the facility's contracted pharmacy on 12/19/25 at 8:46am revealed there was no order on file for amoxicillin 500mg capsules for Resident #5.

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D 375	Continued From page 86 Telephone interview with a pharmacist with a local retail pharmacy on 12/18/25 at 12:24pm revealed: -An order was received for Resident #5 on 12/12/25 for 21 capsules of amoxicillin 500mg to take one every eight hours until gone from a local dentist. -The amoxicillin 500mg prescription was picked up for Resident #5 on 12/12/25. Interview with Resident #5 on 12/18/25 at 8:48am revealed: -She recently had 20 teeth pulled and was given the prescription for amoxicillin by her dentist. -Her family member took her to her dental appointment and picked up the amoxicillin prescription for her. -She took the amoxicillin three times a day with her meals and had another day or two remaining. -She did not give the amoxicillin bottle to the facility staff because she knew how to take her medications. -She used to administer all her own medications. -She kept the amoxicillin bottle on her bedside table. Interview with a personal care aide (PCA) on 12/18/25 at 11:02am revealed: -Resident #5 did not have a self-administer order. -If she found medications in a resident's room, she notified the medication aide (MA) or the nurse. -She had never noticed medications in Resident #5's room. Interview with a medication aide (MA) on 12/18/25 at 1:01pm revealed: -Resident #5 used to self-administer her medications but not in the last 3 to 4 months. -She found loose pills in Resident #5's room	D 375		

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D 375	Continued From page 87 under her pillow and it was then determined that Resident #5 could no longer self-administer her medications. -She had not noticed a prescription medication bottle in Resident #5's room for amoxicillin 500mg. -Resident #5 should not have any prescription or over-the-counter medications in her room. Interview with Resident #5's responsible party (RP) on 12/19/25 at 9:40am revealed: -Another family member took Resident #5 to the dentist on 12/12/25. -She knew Resident #5 was prescribed an antibiotic after the 12/12/25 dental visit and she told Resident #5 to be sure to give the antibiotic prescription to the facility staff. -Resident #5 self-administered her medications when she first came to the facility, but it was determined that she was not taking all of her medications correctly and was unable to fill her pill organizer and staff took over administration of Resident #5's medications several months ago. Second interview with the MA on 12/19/25 at 10:25am revealed: -Resident #5 did not currently have a self-administration order for medications. -She was not working when Resident #5 returned from her dental visit on 12/12/25 and she never saw any paperwork related to the 12/12/25 dental visit. Attempted telephone interview with Resident #5's dentist on 12/19/25 at 8:15am was unsuccessful. Attempted telephone interview with Resident #5's hospice provider on 12/19/25 at 8:29am and 2:17pm were unsuccessful.	D 375		

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D 375	Continued From page 88 Refer to interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:04pm. Refer to interview with the Area Nurse Manager on 12/18/25 at 2:16pm. Refer to interview with the Administrator on 12/19/25 at 4:15pm. b. Interview with Resident #5 on 12/18/25 at 9:23am revealed: -She moved to the facility several months ago. -She used to manage her own medications but now staff administered most of her medications. -She had a bottle of docusate (a medication used to treat constipation) in her purse that she used as needed. Observation of Resident #5's room on 12/18/25 at 9:23am revealed: -Resident #5 produced a pharmacy labeled prescription bottle of docusate sodium 100mg capsules, take one capsule two times a week as needed for constipation, may take one daily as needed, for a quantity of 15 capsules, dispensed on 06/22/25 from her purse. -There were several capsules remaining in the labeled docusate prescription bottle. Review of Resident #5's signed physicians order sheet dated 11/06/25 revealed there was an order for docusate sodium 100mg, take one capsule every 24 hours as needed or constipation. Review of Resident #5's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium 100mg, give one capsule every 24 hours as needed for constipation.	D 375		

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D 375	Continued From page 89 -Docusate sodium 100mg capsules were not documented as administered at any time on the November 2025 eMAR. Review of Resident #5's December 2025 eMAR revealed: -There was an entry for docusate sodium 100mg, give one capsule every 24 hours as needed for constipation. -Docusate sodium 100mg capsules were not documented as administered at any time on the December 2025 eMAR. Observation of Resident #5's medications on hand on 12/18/25 at 1:10pm revealed there was no docusate sodium 100mg capsules on the medication cart for Resident #5. Telephone interview with a pharmacist with a local retail pharmacy on 12/18/25 at 12:24pm revealed: -An order was received for Resident #5 for docusate sodium 100mg on 06/22/25, take one capsule two times per week as needed for constipation, may take daily as needed. -Docusate sodium 100mg was filled for 15 capsules on 06/22/25 and was purchased on 07/03/25. Telephone interview with a representative from the facility's contracted pharmacy on 12/19/25 at 8:46am revealed: -An order for docusate sodium 100mg, take one capsule daily as needed was received on 06/23/25 for Resident #5. -Docusate sodium 100mg was dispensed for the first time today 12/19/25 for Resident #5 for 30 capsules to take one daily as needed for constipation. -There were no dispense dates prior to 12/19/25 for Resident #5's docusate sodium.	D 375		

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D 375	Continued From page 90 -There was no current self-administration that she could see on file for Resident #5's docusate sodium. Interview with a medication aide (MA) on 12/18/25 at 1:01pm revealed: -Resident #5 used to self-administer her medications but not in the last 3 to 4 months. -She found loose pills in Resident #5's room under her pillow and it was then determined that Resident #5 could no longer self-administer her medications. -She had not noticed a prescription medication bottle in Resident #5's room for docusate sodium 100mg capsules. -Resident #5 should not have any prescription or over-the-counter medications in her room. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:04pm revealed: -A resident must have a self-administration assessment and order from their primary care provider to self-administer medications. -Resident #5 no longer had a self-administration order. -Resident #5 should not have any medications in her room. -Family members were always instructed to give all medications for the residents to staff. -Staff had not reported to her that Resident #5 had medications in the room. Attempted telephone interview with Resident #5's hospice provider on 12/19/25 at 8:29am and 2:17pm were unsuccessful. Refer to interview with the Area Nurse Manager on 12/18/25 at 2:16pm.	D 375		

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D 375	Continued From page 91 Refer to interview with the Administrator on 12/19/25 at 4:15pm. 2. Review of Resident #2's current FL2 dated 05/28/25 revealed: -Diagnoses included chronic atrial fibrillation, non-rheumatic aortic valve disorder, peripheral vascular disease and hypertension. -He was constantly disoriented. Observation of Resident #2's room on 12/17/25 at 9:45am revealed: -There was a box containing a 50ml bottle of saline nasal mist (saline nasal mist is used to moisten dry passages) on a tray table in Resident #2's room. -There was a bottle of saline nasal mist in Resident #2's shirt pocket. -There was a bottle of Osteo Bi-Flex (a supplement used for joint health) with 2 tablets remaining in the bottle, on a tray table in Resident #2's room. Interview with Resident #2 on 12/18/25 at 10:42am revealed: -He used the saline nasal mist spray daily after being told by a previous provider to do so. -He took the Osteo-Bi-Flex occasionally but was not sure why. -He could not remember how he obtained the nasal saline spray and the Osteo Bi-Flex. Review of Resident #2's signed physicians order sheet dated 11/10/25 revealed: -There was no order for saline nasal mist spray. -There was no order for Osteo-Bi-Flex. Review of Resident #2's November 2025 electronic medication administration record (eMAR) revealed:	D 375		

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D 375	Continued From page 92 -There was no entry for saline nasal mist spray. -There was no entry for Osteo Bi-Flex. Review of Resident #2's December 2025 eMAR revealed: -There was no entry for saline nasal mist spray. -There was no entry for Osteo Bi-Flex. Telephone interview with a representative with the facility's contracted pharmacy on 12/19/25 at 9:02am revealed: -There was no order on file for Resident #2 for saline nasal mist. -There was no order on file for Resident #2 for Osteo Bi-Flex. -There was no self-administer order on file for Resident #2. Interview with a personal care aide (PCA) on 12/18/25 at 11:02am revealed: -Resident #2 did not have a self-administer order. -If she found medications in a resident's room, she notified the medication aide (MA) or the nurse. -She had never noticed medications in Resident #2's room. Interview with the medication aide (MA) on 12/18/25 at 1:42pm revealed: -Resident #2 used to have an order to self-administer his eye drops but that order had been discontinued. -Resident #2 was constantly disoriented and no longer had a self-administer order. -All medications including over the counter medications required an order from the resident's primary care provider (PCP). -She had not noticed that Resident #2 had nasal saline mist and Osteo Bi-Flex in his room. -Had she noticed medications in Resident #2's	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	12/19/2025

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D 375	Continued From page 93 room, she would have notified management. Interview with the Health and Wellness Coordinator (HWC) on 12/19/25 at 3:04pm revealed: -A resident must have a self-administration assessment and order from their primary care provider to self-administer medications. -Resident #2 previously had an order to self-administer eyedrops only. -Resident #2 should not have any medications in his room. -Family members were always instructed to give all medications for the residents to staff. -Staff had not reported to her that Resident #2 had medications in his room. Attempted telephone interview with Resident #2's Responsible Party (RP) on 12/19/25 at 10:03am was unsuccessful. Attempted interview with Resident #2's primary care provider (PCP) on 12/19/25 at 11:19am was unsuccessful. Refer to interview with the Area Nurse Manager on 12/18/25 at 2:16pm. Refer to interview with the Administrator on 12/19/25 at 4:15pm. _____ Interview with the Area Nurse Manager on 12/18/25 at 2:16pm revealed: -Resident #2 and Resident #5 did not have orders or an assessment for self-administration of medications. -The PCAs and MAs were expected to report any medications or over-the medications found in a resident's room to the clinical managers.	D 375		

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D 375	Continued From page 94 -Staff were instructed to be on the lookout for medications in the residents' rooms. Interview with the Administrator on 12/19/25 at 4:15pm revealed: -The residents were not allowed to self-administer medications without a self-administer assessment. -If the resident passed the self-administer assessment, then a self-administer order was required from the resident's primary care provider (PCP). -He expected staff to be on the lookout for medications and over the counter medications in the residents' rooms when they were providing care.	D 375		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete incident/accident reports and notify the county Department of Social Services (DSS) and the resident's primary care provider (PCP) for 1 of 5 sampled residents	D 451		

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D 451	Continued From page 95	D 451		

sampled (#3) who required medical intervention greater than first aid at a local emergency department.

The findings are:

Review of Resident #3's current FL2 dated 11/21/25 revealed:
-Diagnoses included mild cognitive impairment, anxiety disorder, hypertension, and hyperlipidemia.
-The resident was intermittently disoriented and was ambulatory.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/27/22.

Review of an Incident Report for Resident #3 dated 12/11/25 revealed:
-The resident had an unwitnessed fall in her bedroom on 12/11/25 at 9:00pm.
-The resident had bruising, a cut, and swelling to her left eye.
-First aid was applied; the resident's blood pressure was 168/83 with a pulse of 142.
-Staff called 911 and the resident was transported to the local emergency department.
-There was a narrative that the resident was found sitting on her bottom on the floor beside her bed, the resident had significant bleeding and bruising to her left eye, the resident was sent to the local emergency department for further evaluation.
-There was documentation that the Health and Wellness Coordinator (HWC) was notified of the incident on 12/11/25 at 9:05pm.
-There was documentation that the resident's family was notified of the incident on 12/11/25 at 9:10pm.

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D 451	Continued From page 96	D 451		

-There was documentation that the Adult Home Specialist (AHS) with the local Department of Social Services (DSS) was notified of the incident on 12/18/25 at 5:30pm.

A written request was made by a state surveyor on 12/19/25 at 2:43pm for documentation that Resident #3's primary care provider (PCP) was notified of the resident's fall and local emergency department visit on 12/11/25.

Review of a facsimile transmission report provided to the state surveyor on 12/19/25 at 3:00pm revealed:
-There was a facsimile transmission report that Resident #3's PCP was notified of her fall that occurred on 12/11/25.
-Resident #3's PCP was notified of her fall and visit to the local emergency department on 12/18/25 at 5:02pm.

Review of an After Visit Summary from the local emergency department for Resident #3 dated 12/11/25 revealed:
-The resident was diagnosed with an accidental fall with left eye injury with a superficial laceration of the left eye.
-There were instructions to schedule an appointment with the resident's PCP "as soon as possible for a visit in 2 days" (around 12/14/25).

Review of an electronic progress note for Resident #3 dated 12/12/25 revealed:
-There was an entry at 2:00am that the resident returned to the facility by ambulance.
-The resident had a superficial laceration to her left eye; there were no medication changes.
-There was documentation "follow up appointment" with the resident's PCP.

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D 451	Continued From page 97 Interview with a medication aide (MA) on 12/19/25 at 10:13am revealed MAs were responsible for notifying the resident's PCP when they had a fall that required evaluation or treatment at the local emergency department. Interview with the HWC on 12/19/25 at 2:58pm revealed: -The MA that was working when Resident #3 fell and injured her eye should have sent an Incident and Accident Report to DSS and the resident's PCP. -If a MA was busy, they could ask her to notify DSS or a resident's PCP. Interview with the Administrator on 12/19/25 at 4:08pm revealed: -MAs usually completed Incident and Accident Reports and sent the report to the resident's PCP and DSS. -He was not sure why the MA on duty did not send the report from 12/11/25 to the resident's PCP or DSS. -The report should have been faxed to the residents' PCP and DSS. Attempted telephone interview with Resident #3's PCP on 12/19/25 at 2:30pm was unsuccessful.	D 451		