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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey from 04/14/26 to 04/15/26. | D 000 | | |
| D 125 | 10A NCAC 13F .0403(a) Qualifications Of Medication Staff<br><br>10A NCAC 13F .0403 Qualifications Of Medication Staff<br>(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (MAs) (Staff A) had completed a Medication Clinical Skills Competency Validation Checklist and passed the written examination prior to administering medications.<br><br>The findings are:<br><br>Review of Staff A's personnel record revealed:<br>-Staff A was hired on 01/20/26 and worked as a MA.<br>-There was no documentation Staff A had taken and passed the written MA examination.<br>-There was no documentation Staff A had a Medication Clinical Skills Competency Validation Checklist completed. | D 125 | | |

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| D 125 | Continued From page 1<br><br>Review of April 2026 electronic medication administration records (eMAR) revealed there was documentation Staff A administered medication 1 day from 04/01/26 to 04/15/26.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 2:38pm revealed:<br>-Staff A was hired as a patient care aide (PCA) on 01/20/26 and began orientation to become a MA on 01/29/26.<br>-New MAs worked alongside seasoned MAs during the orientation period.<br>-During MA orientation, Staff A signed into the eMAR to sign off on medications she administered.<br>-When scheduled to complete her Medication Clinical Skills Competency Validation Checklist, Staff A always had a reason as to why she needed to reschedule.<br>-Staff A had not taken and/or passed the written MA examination.<br>-She was aware of the timeframe required for MAs to pass the written MA examination.<br>-The Health and Wellness Director (HWD) was responsible for auditing the personnel records.<br>-Staff A no longer worked at the facility.<br><br>Interview with the HWD on 04/15/26 at 2:51pm revealed:<br>-She was responsible for auditing the personnel records.<br>-She knew to look for the Medication Clinical Skills Competency Validation Checklist and the written MA examination when she audited.<br>-She was aware Staff A had not completed a Medication Clinical Skills Competency Validation Checklist or the written MA examination.<br>-Because Staff A was still in orientation, she | D 125 | | |

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| D 125 | Continued From page 2<br>thought Staff A still had time to complete the Medication Clinical Skills Competency Validation Checklist and written MA examination.<br>-She was aware MAs had 60 days from the date of hire to complete the Medication Clinical Skills Competency Validation Checklist and written MA examination.<br><br>Interview with the Administrator on 04/15/26 at 2:58pm revealed:<br>-She was aware Staff A did not complete the Medication Clinical Skills Competency Validation Checklist and written MA examination.<br>-She was unaware Staff A had administered medications.<br>-She expected MAs to complete the Medication Clinical Skills Competency Validation Checklist and MA examination before administering medications. | D 125 | | |
| D 259 | 10A NCAC 13F .0802 (a) (c) Resident Care Plan<br><br>10A NCAC 13F .0802 Resident Care Plan<br><br>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.<br>(c) The care plan shall include the following:<br>(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's | D 259 | | |

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| D 259 | Continued From page 3<br>assessment in Rule .0801 of this Section;<br>(2) frequency of the services or tasks to be performed;<br>(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;<br>(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;<br>(5) a dated signature of the assessor upon completion; and<br>(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure that 1 of 6 sampled residents (#4) had a care plan completed within 30 days of admission and at least annually thereafter, including ensuring the Primary Care Provider (PCP) approved and signed care plan. | D 259 | | |

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| D 259 | Continued From page 4<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 11/07/25 revealed diagnoses included cognitive communication deficit, lack of coordination, and muscle weakness.<br><br>Review of Resident #4's facility assessment and care plan dated 11/11/25 revealed:<br>-The resident was assessed for assistance in ADLs of bathing, grooming, dressing, toileting, eating (nutrition), ambulation, and mobility and transfers.<br>-The assessment and care plan was not signed by Resident #4's PCP.<br>-There was no subsequent care plan available for review.<br><br>Interview with the Health and Wellness Director (HWD) on 04/15/26 at 3:43pm revealed:<br>-She was not aware Resident #4's assessment and care plan was not signed.<br>-She was in charge of assuring PCPs signed assessments and care plans.<br>-She was not sure why Resident #4's PCP did not sign the assessment and care plan.<br>-She faxed Resident #4's care plan and assessment to her PCP but the PCP returned it with no signature.<br><br>Interview with the Administrator on 04/15/26 at 3:50pm revealed:<br>-She was aware assessments and care plans required a signature from a PCP within 15 days of the assessment.<br>-She was not aware Resident #4's assessment and care plan was not signed by her PCP.<br>-Resident #4 saw an outside PCP which made it more difficult to get documents signed. | D 259 | | |

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| D 259 | Continued From page 5<br>-She expected all residents to have PCP signed assessments and care plans. | D 259 | | |
| D 278 | 10A NCAC 13F .0903(a) Licensed Health Professional Support<br><br>10A NCAC 13F .0903 Licensed Health Professional Support<br>(a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks:<br>(1) applying and removing ace bandages, ted hose, binders, and braces and splints;<br>(2) feeding techniques for residents with swallowing problems;<br>(3) bowel or bladder training programs to regain continence;<br>(4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;<br>(5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;<br>(6) chest physiotherapy or postural drainage;<br>(7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;<br>(8) collecting and testing of fingerstick blood samples;<br>(9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);<br>(10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; | D 278 | | |

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| D 278 | Continued From page 6<br>(11) inhalation medication by machine;<br>(12) forcing and restricting fluids;<br>(13) maintaining accurate intake and output data;<br>(14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);<br>(15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin.<br>(16) oxygen administration and monitoring;<br>(17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints;<br>(18) oral suctioning;<br>(19) care of well-established tracheostomy, not to include indo-tracheal suctioning;<br>(20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule);<br>(21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP);<br>(22) application of prescribed heat therapy;<br>(23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;<br>(24) ambulation using assistive devices that requires physical assistance;<br>(25) range of motion exercises;<br>(26) any other prescribed physical or occupational therapy;<br>(27) transferring semi-ambulatory or non-ambulatory residents; or<br>(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 | D 278 | | |

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| D 278 | Continued From page 7<br>NCAC 36. | D 278 | | |

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure licensed health professional support (LHPS) evaluations were completed quarterly for 1 of 6 sampled residents (#4) who required assistance with tasks including applying and removing thromboembolic deterrent (TED) hose.

The findings are:

Review of Resident #4's current FL2 dated 11/07/25 revealed diagnoses included cognitive communication deficit, lack of coordination, and muscle weakness.

Review of Resident #4's physician orders dated 11/11/25 revealed there was an order to apply TED hose every morning.

Review of Resident #4's Resident Register revealed an admission date of 09/11/23.

Review of Resident #4's LHPS evaluation dated 08/15/25 revealed there was documentation for an LHPS evaluation review for assistance with applying and removing TED hose.

Review of Resident #4's record revealed there were no subsequent or quarterly LHPS evaluation reviews completed for Resident #4.

Interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:38pm revealed:

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| D 278 | Continued From page 8<br><br>-She was not aware Resident #4 did not have a completed quarterly LHPS on file.<br>-She was aware resident with tasks needed completed quarterly LHPS evaluations.<br>-The facilities registered nurse (RN) was in charge of completing and keeping track of residents quarterly LHPS evaluations.<br>-She was not sure why the facilities RN had not completed a quarterly LHPS evaluation for Resident #4.<br><br>Interview with the Administrator on 04/15/26 at 1:43pm revealed:<br>-She was aware LHPS evaluations needed to be complete quarterly.<br>-She was not aware Resident #4 did not have an updated LHPS evaluation.<br>-She expected all resident's with tasks to have quarterly LHPS evaluations completed.<br><br>Attempted telephone interview with the facilities RN on 04/15/26 at 1:49 was unsuccessful. | D 278 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION | D 358 | | |

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| D 358 | Continued From page 9<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with policies and procedures for 2 of 5 residents (#5, and #6) observed during the medication pass including errors with an anti-anxiety medication (#5) and an inhaler (#6); and for 1 of 5 residents sampled for record review related to errors with an anti-anxiety medication and including errors with insulin (#5).<br><br>The findings are:<br><br>1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am medication pass on 04/15/26.<br><br>a. Review of Resident #6's current FL2 dated 02/25/25 revealed diagnosis included hypertension, chronic obstructive pulmonary disease, and depression.<br><br>Review of Resident #6's physician orders dated 03/03/26 revealed there was an order for trelegy ellipta 100-62.5-25 mcg/act (a medication used to treat chronic obstructive pulmonary disease) inhale 1 puff one time a day, rinse mouth after use.<br><br>Observation of the morning medication pass on 04/15/26 at 7:58am revealed:<br>-The medication aide (MA) removed Resident #6's medication bubble packs, and a box that contained trelegy ellipta 100-62.5-25 mcg/act, from the medication cart.<br>-The MA prepared 9 and a half pills from the medication bubble packs.<br>-The MA removed trelegy ellipta 100-62.5-25 mcg/act from the packaging. | D 358 | | |

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| D 358 | Continued From page 10 | D 358 | | |

-The MA entered the main living room where Resident #6 was located and administered 9 and a half pills and the inhaler.
-The MA did not instruct Resident #6 to rinse his mouth after administration of his inhaler.
-The MA returned to the medication cart, returned the inhaler to the medication cart, and signed off on the electronic medication administration record (eMAR).

Review of Resident #6's April 2026 eMAR for 04/15/26 revealed:
-There was an entry for trelegy ellipta 100-62.5-25 mcg/act inhale one puff one time a day for shortness of breath related to chronic obstructive pulmonary disease with a scheduled administration time of 8:00am.
-There was documentation that trelegy ellipta 100-62.5-25 mcg/act was administered on 04/15/26 at 8:00am.

Observation of Resident #6's medication on hand on 04/15/26 at 7:58am revealed there was a box with a trelegy ellipta inhaler for Resident #6 with instructions to rinse mouth after use.

Interview with Resident #6 on 04/15/26 at 1:34pm revealed:
-He was not aware he was supposed to rinse his mouth after using his trelegy ellipta inhaler.
-No one had ever instructed him to rinse his mouth after using his trelegy ellipta inhaler.

Interview with the MA on 04/15/26 at 12:30pm revealed:
-She was aware of the rinse orders for Resident #6's trelegy ellipta inhaler.
-She did not instruct Resident #6 to rinse his mouth after using the trelegy ellipta inhaler because Resident #6 did not like to rinse his

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| D 358 | Continued From page 11 | D 358 | | |

mouth.
-She had not contacted Resident #6's primary care provider (PCP) about Resident #6 not rinsing his mouth because she did not know she needed to.

Interview with Resident #6's PCP on 04/15/26 at 12:36pm revealed:
-She was not aware Resident #6 was not rinsing his mouth after using his trelegy ellipta inhaler.
-It was important for Resident #6 to rinse his mouth after using his trelegy ellipta inhaler because the inhaler could cause yeast and thrush formation inside of his mouth.

Interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:34pm revealed:
-She was aware of the rinse orders for Resident #6's trelegy ellipta inhaler.
-MAs were trained to read medication administration instructions on packaging before administering medications.
-She expected MAs to administer medications as ordered.

Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 1:47pm revealed:
-She was aware of Resident #6's rinse orders for his trelegy ellipta inhaler.
-She expected MAs to administer medications as ordered.

Interview with the Administrator on 04/15/26 at 1:45pm revealed:
-She was aware that some inhaler medications had instructions to rinse after use.
-She expected MAs to read medication instructions before administering to ensure they were administered correctly.

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| D 358 | Continued From page 12<br>Refer to the interview with a MA on 04/15/26 at 1:05pm.<br><br>Refer to the interview with another MA on 04/15/26 at 3:15pm.<br><br>Refer to the interview with the Resident Care Coordinator (RCC) on 04/15/26 at 12:40pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:45pm.<br><br>Refer to the interview with the Administrator on 04/15/26 at 2:00pm.<br><br>b. Review of Resident #5's current FL2 dated 11/06/25 revealed diagnoses included rhabdomyolysis, hypertensive chronic kidney disease, Type 2 diabetes mellitus, spinal stenosis, and osteoarthritis of the left knee.<br><br>Review of Resident #5's physician orders dated 03/03/26 revealed there was an order for sertraline (a medication used to treat depression and anxiety) 25mg take 1 tablet daily.<br><br>Review of Resident #5's physician orders dated 03/12/26 revealed there was an order to discontinue sertraline 25mg take 1 tablet daily and start sertraline 50mg take 1 tablet daily.<br><br>Observation of the morning medication pass on 04/15/26 at 7:54am revealed:<br>-The medication aide (MA) removed Resident #5's medication bubble packs from the medication cart.<br>-The MA prepared 7 pills from the medication bubble packs.<br>-The MA entered Resident #5's bedroom and administered 7 pills. | D 358 | | |

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| D 358 | Continued From page 13<br>-The MA returned to the medication cart and signed off on the electronic medication administration record (eMAR).<br><br>Observation of Resident #5's medication on hand on 04/15/26 at 7:54am revealed there was a medication bubble pack for sertraline 25mg take 1 tablet daily.<br><br>Review of Resident #5's April 2026 eMAR for 04/15/26 revealed:<br>-There was an entry for sertraline 25mg take 1 tablet daily.<br>-There was documentation sertraline 25mg was administered on 04/15/26.<br>-There was no entry for sertraline 50mg take 1 tablet daily.<br>-There was no documentation sertraline 50mg was administered on 04/15/26.<br><br>Interview with a MA on 04/15/26 at 1:05pm revealed:<br>-She administered Resident #5's sertraline every morning.<br>-She did not know Resident #5 had an order for sertraline 50mg take 1 tablet daily.<br>-Sertraline 50mg was not on Resident #5's eMAR and she administered medications according to the eMAR.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the medication change to Resident #5's sertraline.<br><br>Interview with another MA on 04/15/26 at 3:15pm revealed:<br>-She was not aware Resident #5 had an order for sertraline 50mg take 1 tablet daily.<br>-The facility had an order tracking system for medication orders but she had not seen any form | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 14<br>for the dosage change to Resident #5's sertraline.<br><br>Interview with the RCC on 04/15/26 at 12:40pm revealed:<br>-She was not aware Resident #5 had an order change for sertraline 50mg take 1 tablet daily from 03/12/26.<br>-The HWD and the Administrator were responsible for reviewing the MHPs orders but she had not been informed of any medication changes for Resident #5.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the dosage change to Resident #5's sertraline.<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg on 04/15/26.<br><br>Interview with the HWD on 04/15/26 at 1:45pm revealed:<br>-She was not aware Resident #5 had an order change for sertraline 50mg take 1 tablet daily from 03/12/26.<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg on 04/15/26.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the dosage change to Resident #5's sertraline.<br>-She was responsible for reviewing the MHPs orders but she could not recall if she reviewed Resident #5's sertraline order change.<br><br>Interview with the Administrator on 04/15/26 at 2:00pm revealed:<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg on 04/15/26.<br>-She was not aware an order tracking form was not started for the Resident #5's order change | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 15<br>from sertraline 25mg to 50mg from 03/12/26.<br><br>Refer to the interview with a MA on 04/15/26 at 1:05pm.<br><br>Refer to the interview with another MA on 04/15/26 at 3:15pm.<br><br>Refer to the interview with the Resident Care Coordinator (RCC) on 04/15/26 at 12:40pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:45pm.<br><br>Refer to the interview with the Administrator on 04/15/26 at 2:00pm.<br>2. Review of Resident #5's current FL2 dated 11/06/25 revealed diagnoses included rhabdomyolysis, hypertensive chronic kidney disease, Type 2 diabetes mellitus, spinal stenosis, and osteoarthritis of the left knee.<br><br>a. Review of Resident #5's physician orders dated 01/15/26 revealed there was an order for sertraline (a medication used to treat depression and anxiety) 25mg take 1 tablet daily.<br><br>Review of Resident #5's physician orders dated 03/12/26 revealed there was an order to discontinue sertraline 25mg take 1 tablet daily and start sertraline 50mg take 1 tablet daily.<br><br>Review of Resident #5's March 2026 electronic medication administration record (eMAR) revealed:<br>-There was an entry for sertraline 25mg take 1 tablet daily.<br>-There was documentation sertraline 25mg was administered on 03/01/26 to 03/31/26.<br>-There was no entry for sertraline 50mg take 1 | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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tablet daily from 03/12/26 to 03/31/26.
-There was no documentation sertraline 50mg was administered from 03/12/26 to 03/31/26.

Review of Resident #5's April 2026 eMAR from 04/01/26 to 04/13/26 revealed:
-There was an entry for sertraline 25mg take 1 tablet daily.
-There was documentation sertraline 25mg was administered on 04/01/26 to 04/13/26.
-There was no entry for sertraline 50mg take 1 tablet daily from 04/01/26 to 04/13/26.
-There was no documentation sertraline 50mg was administered from 04/01/26 to 04/13/26.

Observation of Resident #5 on 04/15/26 at 9:39am revealed:
-He was seated in his wheelchair in his room and was agitated with staff.
-He yelled he "did not want to talk with anyone right now."

Observation of the medications on hand for Resident #5 on 04/15/26 at 1:00pm revealed:
-There were 6 tablets remaining of 28 tablets dispensed on 02/19/26 in a bubble pack labeled as sertraline 25mg take 1 tablet daily.
-There was no sertraline 50mg available for administration on the medication cart.
-When asked for any other additional medications the MA could produce the sertraline 50mg.

Telephone interview with a representative from the facility's contracted pharmacy on 04/15/26 at 11:45am revealed:
-There was a previous order for Resident #5 for sertraline 25mg take 1 tablet daily that was discontinued by Resident #5's physician on 03/12/26.
-Sertraline 25mg was last dispensed for Resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 17<br>#5 on 02/19/26 for 28 tablets.<br>-There was an active order on file for Resident #5 for sertraline 50mg take 1 tablet daily from 03/12/26.<br>-Sertraline 50mg was last dispensed for Resident #5 on 03/17/26 for 28 tablets and on 04/09/26 for 28 tablets.<br>-The facility staff was responsible for updating the residents' eMARs as the pharmacy's system did not interface with the facility's eMAR system.<br><br>Telephone interview with Resident #5's responsible party on 04/15/26 at 9:42am revealed Resident #5's anxiety and agitation had increased since he was admitted to the facility in November 2025.<br><br>Telephone interview with Resident #5's mental health provider (MHP) on 04/15/26 at 12:48pm revealed:<br>-He had changed Resident #5's sertraline 25mg to 50mg on 03/12/26 due to his increased agitation and anxiety with the facility staff.<br>-He was not aware the medication aides (MA) had administered sertraline 25mg to Resident #5 instead of 50mg.<br>-He expected the MAs to administer Resident #5's sertraline as he had ordered.<br>-If the facility staff continued not to administer Resident #5's sertraline as ordered, Resident #5 could experience increased agitation which could be detrimental with complications of hostility.<br><br>Interview with a personal care aide (PCA) on 04/15/26 at 1:30pm revealed:<br>-Resident #5 was "rough around the edges" and was agitated all the time.<br>-Resident #5 yelled at objects in his room and would become aggravated when things went different than his expectations. | D 358 | | |

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| D 358 | Continued From page 18<br>-Resident #5 had become more agitated over the last month and was not satisfied with the staff's care and interaction.<br><br>Interview with a MA on 04/15/26 at 1:05pm revealed:<br>-She administered Resident #5's sertraline every morning.<br>-She did not know Resident #5 had an order for sertraline 50mg take 1 tablet daily.<br>-Sertraline 50mg was not on Resident #5's eMAR and she administered medications according to the eMAR.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the medication change to Resident #5's sertraline.<br>-Resident #5 was agitated with staff most of the time but had not had any issues with him.<br><br>Interview with another MA on 04/15/26 at 3:15pm revealed:<br>-She was not aware Resident #5 had an order for sertraline 50mg take 1 tablet daily.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the dosage change to Resident #5's sertraline.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/15/26 at 12:40pm revealed:<br>-She was not aware Resident #5 had an order change for sertraline 50mg take 1 tablet daily from 03/12/26.<br>-The HWD and the Administrator were responsible for reviewing the MHPs orders but she had not been informed of any medication changes for Resident #5.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the dosage change to Resident #5's sertraline. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 19<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg from 03/12/26 to 04/13/26.<br>-She was aware Resident #5 would become aggravated with the staff but was never agitated with the residents.<br><br>Interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:45pm revealed:<br>-She was not aware Resident #5 had an order change for sertraline 50mg take 1 tablet daily from 03/12/26.<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg from 03/12/26 to 04/13/26.<br>-The facility had an order tracking system for medication orders but she had not seen any form for the dosage change to Resident #5's sertraline.<br>-She was responsible for reviewing the MHPs orders but she could not recall if she reviewed Resident #5's sertraline order change.<br>-She was aware Resident #5 was aggravated at times but assumed his aggravation was not a constant occurrence.<br><br>Interview with the Administrator on 04/15/26 at 2:00pm revealed:<br>-She was not aware Resident #5 was administered sertraline 25mg instead of 50mg from 03/12/26 to 04/13/26 until today (04/15/26).<br>-She was not aware an order tracking form was not started for the Resident #5's order change from sertraline 25mg to 50mg from 03/12/26.<br><br>Refer to interview with a MA on 04/15/26 at 1:05pm.<br><br>Refer to interview with another MA on 04/15/26 at 3:15pm. | D 358 | | |

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Refer to interview with the Resident Care Coordinator (RCC) on 04/15/26 at 12:40pm.

Refer to interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:45pm.

Refer to interview with the Administrator on 04/15/26 at 2:00pm.

Observations and record reviews determined an interview with Resident #5 on 04/15/26 at 9:39am was not interviewable.

b. Review of Resident #5's current FL2 dated 11/06/25 revealed an order insulin glargine pen (a medication used to treat diabetes mellitus) 100 unit/ml inject 17 units once daily.

Review of Resident #5's physician orders dated 02/25/26 revealed there was an order insulin glargine pen 100 unit/ml inject 17 units once daily, hold for finger stick blood sugar (FSBS) less than 70.

Review of Resident #5's physician orders dated 03/10/26 revealed there was an order insulin glargine pen 100 unit/ml inject 12 units once daily, hold for FSBS less than 110.

Review of Resident #5's physician orders dated 03/21/26 revealed there was an order insulin glargine pen 100 unit/ml inject 8 units once daily, hold for FSBS less than 110.

Review of Resident #5's physician orders dated 04/03/26 revealed there was an order insulin glargine pen 100 unit/ml inject 5 units once daily, hold for FSBS less than 110.

Review of Resident #5's March 2026 electronic

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medication administration record (eMAR) from revealed:
-There was an entry for insulin glargine pen 100 unit/ml inject 17 units once daily to be administered at 7:00am, hold for FSBS less than 70 with a stop date of 03/11/26.
-There was a second entry for insulin glargine pen 100 unit/ml inject 12 units once daily to be administered at 7:00am, hold for FSBS less than 110 with a start date of 03/12/26 and a stop date of 03/25/26.
-There was a third entry for insulin glargine pen 100 unit/ml inject 8 units once daily to be administered at 7:00am, hold for FSBS less than 110 with a start date of 03/26/26.
-There was a space on the eMAR to document Resident #5's FSBS values and Resident #5's FSBS ranged from 69 to 240.
-There was documentation insulin glargine was administered once when it should have been held, with an example as follows:
-On 03/16/26 Resident #5's FSBS value was documented as 86 at 7:00am and insulin glargine was documented as administered.

Review of Resident #5's April 2026 eMAR from 04/01/26 to 04/13/26 revealed:
-There was an entry for insulin glargine pen 100 unit/ml inject 8 units once daily to be administered at 7:00am, hold for FSBS less than 110 with a stop date of 04/06/26.
-There was a second entry for insulin glargine pen 100 unit/ml inject 5 units once daily to be administered at 7:00am, hold for FSBS less than 110 with a start date of 04/07/26.
-There was a space on the eMAR to document Resident #5's FSBS values and Resident #5's ranged from 81 to 187.
-There was documentation insulin glargine was administered four times when it should have been

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held, with an example as follows:
-On 04/02/26 Resident #5's FSBS value was documented as 98 at 7:00am and insulin glargine was documented as administered.
-On 04/08/26 Resident #5's FSBS value was documented as 94 at 7:00am and insulin glargine was documented as administered.
-On 04/09/26 Resident #5's FSBS value was documented as 100 at 7:00am and insulin glargine was documented as administered.
-On 04/11/26 Resident #5's FSBS value was documented as 81 at 7:00am and insulin glargine was documented as administered.

Observation of Resident #5 on 04/15/26 at 9:39am revealed he yelled he "did not want to talk with anyone right now."

Observation of the medications on hand for Resident #5 on 04/15/26 at 1:00pm revealed a pen of insulin glargine was available for administration and was dispensed on 04/06/26.

Telephone interview with a representative from the facility's contracted pharmacy on 04/15/26 at 11:45am revealed:
-Resident #5 had a current order on file for insulin glargine 100 unit/ml inject 5 units once daily to be administered at 7:00am, hold for FSBS less than 110.
-Resident #5's insulin glargine was last dispensed on 04/06/26.

Telephone interview with Resident #5's responsible party on 04/15/26 at 9:42am revealed Resident #5 had not experienced issues of dizziness or fatigue related to FSBS levels.

Telephone interview with Resident #5's primary care physician (PCP) on 04/15/26 at 12:18pm

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revealed:
-She did not know there were errors with Resident #5's insulin glargine administration in March 2026 and April 2026.
-She had no concerns related to low blood sugar levels for Resident #5 but she expected the facility staff to administer Resident #5's insulin glargine as she had ordered according to the FSBS values.
-If the facility staff continued not to administer Resident #5's insulin glargine as ordered, Resident #5 could experience increased hypoglycemia which could be detrimental to him and cause complications of dizziness and confusion.

Interview with a MA on 04/15/26 at 1:05pm revealed:
-She administered medications to Resident #5 and she followed the medication orders in the eMAR system when administering medications to residents.
-She knew there was a parameter to hold Resident #5's insulin if his FSBS was lower than "some" number but she was not sure of the exact parameter number.
-The third shift MAs usually administered Resident #5's insulin due to the early morning administration time in the eMAR.
-She did not know there were errors with Resident #5's insulin glargine administration in March 2026 and April 2026 until the HWD told her that morning (04/15/26).

Interview with another MA on 04/15/26 at 3:15pm revealed:
-She was aware Resident #5 had a parameter to hold insulin if his FSBS was lower than 110 because she had occasionally worked third shift.
-She was not aware there were errors with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL034035 | A. BUILDING: _____ B. WING _____ | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE REYNOLDA ROAD | 2980 REYNOLDA ROAD WINSTON SALEM, NC 27106 |

| (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 358 | Continued From page 24<br>Resident #5's insulin glargine administration in March 2026 and April 2026.<br><br>Interview with the RCC on 04/15/26 at 12:40pm revealed:<br>-She was aware Resident #5 had a parameter to hold insulin if his FSBS was lower than 110.<br>-She was not aware there were errors with Resident #5's insulin glargine administration in March 2026 and April 2026.<br><br>Interview with the HWD on 04/15/26 at 1:45pm revealed:<br>-She was aware Resident #5 had a parameter to hold insulin if his FSBS was lower than 110.<br>-She was not aware there were errors with Resident #5's insulin glargine administration in March 2026 and April 2026 until today (04/15/26).<br>-She and the RCC were responsible for reviewing the eMAR to ensure any medication errors were identified and addressed with the MAs but the insulin errors must have been overlooked.<br><br>Interview with the Administrator on 04/15/26 at 2:00pm revealed:<br>-She was not aware there were errors with Resident #5's insulin glargine administration in March 2026 and April 2026 until today (04/15/26).<br>-She expected the MAs to follow provider orders and MAs were responsible to hold Resident #5's insulin if it should be held.<br><br>Refer to the interview with a MA on 04/15/26 at 1:05pm.<br><br>Refer to the interview with another MA on 04/15/26 at 3:15pm.<br><br>Refer to the interview with the Resident Care Coordinator (RCC) on 04/15/26 at 12:40pm. | D 358 | | |

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|---|---|---|---|---|
| D 358 | Continued From page 25<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 04/15/26 at 1:45pm.<br><br>Refer to the interview with the Administrator on 04/15/26 at 2:00pm.<br><br>Observations and record reviews determined an interview with Resident #5 on 04/15/26 at 9:39am was not interviewable.<br><br>_____<br>Interview with a MA on 04/15/26 at 1:05pm revealed the RCC and HWD were responsible for reviewing the eMAR but she had not been informed of any medication errors.<br><br>Interview with another MA on 04/15/26 at 3:15pm revealed the RCC and the HWD were responsible for reviewing the eMAR but she had not been informed of any medication errors.<br><br>Interview with the RCC on 04/15/26 at 12:40pm revealed the HWD was responsible for reviewing the eMAR and she was responsible for medication cart audits which involved monitoring medication expiration dates and ensuring medications were labeled correctly.<br><br>Interview with the HWD on 04/15/26 at 1:45pm revealed she and the RCC were responsible for reviewing the eMAR to ensure any medications errors were identified and addressed with the MAs.<br><br>Interview with the Administrator on 04/15/26 at 2:00pm revealed:<br>-The RCC and the HWD were responsible for reviewing the eMAR and physician orders monthly to identify any medication errors and educate the MAs. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| D 358 | Continued From page 26<br><br>-The MAs, the RCC, and the HWD were responsible for reviewing any medication orders, starting the order tracking process, entering the order in the eMAR, and sending the orders to the pharmacy.<br>-She expected the MAs, the RCC, and the HWD to review physician orders, start the order tracking process, and enter the orders correctly into the eMAR.<br>-She expected the RCC and HWD to audit eMARs and identify any medication administration errors to ensure medications were administered according to the physician's orders.<br><br>_____<br>The facility failed to ensure medications were administered as ordered for 2 of 5 residents from the medication pass including a resident who did not receive the correct amount of an anti-anxiety medication (#5) which could result in increased agitation and anxiety and a resident who was not instructed to rinse his mouth after administration of his inhaler (#6) which could result in the risk for thrush; also to 1 of 5 sampled residents for record reviews related to errors with an anti-anxiety medication which could result in increased agitation and anxiety: and also who was diabetic and was administered insulin when it should have been held per ordered parameters, placing the resident at risk for low blood sugar levels (#5). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/26 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 30, 2026. | D 358 | | |