Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/21/26 through 04/23/26.	D 000	1. Upon identification of the concern, the facility immediately conducted a 100% audit of all exit doors in both the Assisted Living (AL) and Memory Care (MC) units to ensure all exit door alarms were activated and functioning properly in accordance with North Carolina ALF regulations, including 10A NCAC 13F .0305(h)(4). Any deficiencies identified during the audit were corrected immediately. All exit doors are now secured and equipped with properly functioning audible alarms to ensure resident safety. 2.A facility-wide audit was conducted to ensure no additional areas of risk existed related to resident elopement prevention, supervision, or exit door security.	
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 7 exterior exit doors was equipped with a continuous sounding device that was audible throughout the facility when the door was opened and accessible to one resident (#1) residing in the facility who had diagnoses of Alzheimer's disease and dementia, was intermittently disoriented, and was	D 067		

Reviewed and Acknowledged 06/12/26 BB

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D 067	Continued From page 1 known to wander. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed for 66 beds. Review of the facility's census on 04/21/26 revealed there were 52 residents residing in the facility. Observations of the facility on 04/21/26 between 9:36am-9:59am revealed: -There were three exit doors on the 200 Hall of the facility, two exit doors on the 300 Hall, and one exit door near the resident dining room that were all equipped with alarms that sounded when the door was opened but stopped sounding when the door closed on its own; All of these 6 exit doors led to enclosed courtyards. -Each door had an interior push bar to exit and a switch beside the door to disarm the alarm. -No facility staff responded to the alarms when they were activated between 9:36am-9:59am. -There was a main entrance located in the middle of the front of the facility with two sets of double glass doors. -At 8:45am, the main entrance door was unlocked, and an alarm did not sound when the survey team entered the facility. -There was one resident sitting in the lobby. Observations of the facility on 04/21/26 at 4:45pm revealed when the survey team exited the facility through the front entrance, the door alarm did not sound. Observation of the main entrance door on 04/22/26 at 7:15am revealed:	D 067	3. The facility utilizes a Roam Alert wander management system at the main entrance door and designated exit doors. Any resident identified through the assessment process by the Resident Care Director (RCD) as being at risk for wandering or elopement will have a Roam Alert device placed on their person in accordance with the resident's assessment and care plan. The Roam Alert system immediately alerts staff when a resident approaches the main entrance or other secured exit doors, allowing staff to intervene promptly and maintain resident safety. Resident #1 identified in the Statement of Deficiencies currently has a Roam Alert device in place. The facility provided education to 100% of staff regarding exit door alarm policies and procedures, including requirements that alarms remain activated at all times, monitoring of residents identified as wander/elopement risks, proper response to alarm activation, and immediate reporting of any malfunction or safety concern. 4. The Director of Facility Services or designee will conduct a 100% audit of all exit doors in the AL and MC units daily for twelve (12) weeks to verify that door alarms remain activated, audible, and fully functional. Any identified malfunction will be addressed immediately, including repair and/or implementation of temporary safety measures until the issue is resolved. 5. Date of compliance 6/2/26	

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D 067	Continued From page 2 -No alarm sounded when the survey team entered the facility. -No staff members were sitting at the receptionist's desk in the lobby. Observation of the main entrance door on 04/23/26 at 8:30am revealed: -No alarm sounded when the survey team entered the facility. -There were 3 residents sitting in the lobby. Review of Resident #1's current FL2 dated 02/12/26 revealed: -Diagnoses included Alzheimer's disease, unspecified dementia, hypertension, cardiomyopathy, cardiac pacemaker, type 2 diabetes, muscle weakness, herpes viral infection, cardiomyopathy, cardiac pacemaker, and atrial fibrillation. -He was intermittently disoriented. -He was a wanderer. Review of Resident #1's Resident Register revealed: -He was admitted to the facility on 02/13/23. -His memory was documented as forgetful, needs reminders. Review of Resident #1's electronic chart notes dated 02/01/26-04/21/26 revealed: -On 02/01/26 at 1:07pm, the facility Activity Director (AD) noted Resident #1 was "a danger on wheels". -He navigated his wheelchair by driving backwards and would run over anyone in his way. -He would run people over to get out of entertainment-type activities. -He was not able to participate in group discussions and could only have limited interactions during reminiscence.	D 067		

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D 067	Continued From page 3 -He was rude and disruptive during educational and entertainment events on campus and could not follow intellectual games like Spintopia. -He would make loud noises and disruptive comments when he was bored. -He wandered the building looking for better options. -On 03/05/26 at 6:29pm and on 04/07/26 at 2:21pm, the Resident Care Coordinator (RCC) noted in Resident #1's monthly summaries that his cognition was forgetful. -On 04/13/26 at 2:18pm, Resident #1's Primary Care Provider (PCP) noted that he was alert and oriented x1 (self only) and "memory loss noted". She ordered the continuation of donepezil hydrochloride and memantine for treatment of his dementia. -On 04/14/26 at 3:12pm, a medication aide (MA) noted, "Resident was found wandering in parking lot, resident stated he was looking for gold. Resident was able to be redirected back to front porch of facility." Interview with Resident #1 on 04/22/26 at 3:23pm revealed: -He sat outside every day if he could. -He had "walked all over this place" and even made it to the highway at the top of the property on at least one occasion. -Facility staff did not sit outside with him, but other residents did. -He did not inform anyone when he would go outside. -He did not recall the incident on 04/14/26. Telephone interview with Resident #1's responsible party (RP) on 04/22/26 at 6:12 pm revealed: -He was aware that Resident #1 went outside unsupervised.	D 067		

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D 067	Continued From page 4 -He was not notified of the incident that occurred on 04/14/26. -Resident #1 had "gotten into trouble" a few times before because he went too far on the property and made it to the independent living apartments on at least one occasion. -Resident #1 would "sneak out" of the Skilled Nursing Facility (SNF) section of the property and be found in his previous room in the Assisted Living (AL) section when he required a short-term rehab stay in 2025. -He believed Resident #1's cognitive function was about 30% and stated Resident #1 now believed untrue stories that he had told for years. -Resident #1 had been a wanderer for many years and was unable to stay focused on one destination. Interview with the receptionist on 04/22/26 at 11:46am revealed: -There were three receptionists who worked from 7:00am-7:00pm seven days a week and security guards who worked nights. -Resident #1 sat outside often because he enjoyed sitting in the sun. -When any residents were outside, she physically checked on them every 10-15 minutes. -She would only leave her desk when no vehicles were attempting to enter the locked gate onto the property and no residents were outside. -She would occasionally ask another staff member to cover her desk so she could go to the bathroom. -She was working on 04/14/26 at 3:21pm. -She observed Resident #1 sitting on the left side of the front porch in front of the windows at the receptionist's desk and saw him propel himself with his feet in his wheelchair towards the right side of the porch. -She got up from her desk a short while later and	D 067		

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D 067	Continued From page 5 saw him sitting in his wheelchair in the traffic circle in front of the building. -She assisted him back onto the porch and went to her desk and called the 200 Hall nursing station to report the incident. -She remained outside with Resident #1 until another staff member responded and then she returned to her desk. -She did not inform anyone else of the incident. Interview with a personal care aide (PCA) on 04/22/26 at 9:34am revealed: -Her normal shift at the facility was 3:00pm-11:00pm. -She entered the facility through the front door, and it was never locked upon arriving or leaving. -She never heard an alarm at the front door. -A receptionist was usually sitting at the front desk when she arrived for work and a security guard was sometimes at the desk when she left the facility at night. -Resident #1 sat outside unsupervised almost daily. -She was not aware of the incident on 04/14/26. Interview with a (MA) on 04/22/26 at 9:20am revealed: -Her normal shift at the facility was 7:00am-3:00pm. -She entered the facility through the front door, and it was never locked and had no alarm. -A receptionist was sometimes sitting at the front desk when she arrived for work. -There was a security guard who sat at the front door beginning at 5:00 pm daily and the front desk was never unoccupied. Interview with a second MA on 04/23/26 at 11:02am revealed: -She worked as an MA on 200 Hall five days	D 067		

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D 067	Continued From page 6 weekly and was on duty on 04/14/26 at 3:21pm. -Resident #1 was outside when the receptionist called her to report he was in the parking lot. -She found Resident #1 sitting in his wheelchair in the traffic circle in front of the building and he told her, "I'm just out here looking for gold". -She explained the dangers of leaving the porch to Resident #1 and he was easily redirected back into the facility. -She notified the RCC of the incident immediately after Resident #1 was back inside and requested instructions on how to document the incident. -Resident #1 opened the front door by himself and did not notify staff when he would go outside. -She described Resident #1 as alert and oriented to self, time, place and familiar people; He was not alert and oriented to events and could not recall his medications. -She had never observed Resident #1 experiencing hallucinations and had never known him to leave the front porch since she began her employment in January 2026. Interview with a maintenance staff on 04/22/26 at 11:13am revealed; -The main entrance to the facility was not equipped with an alarm. -All other exit doors in the AL were equipped with alarms and wander guard alarms that could be disabled at the main panel at the nursing station. -All wander guard alarms within the AL were disabled because there were currently no residents who required the wander guard anklets. Interview with the RCC on 04/23/26 at 2:38pm revealed: -The 200 Hall and 300 Hall exit doors and the exit door in the main hallway were all equipped with alarms that sounded when opened. -The front door to the facility had no alarm.	D 067		

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D 067	Continued From page 7 -A wander guard anklet was used when a resident wandered, was exit-seeking, or exhibited increased confusion. -Wander guard and elopement assessments were completed by the Resident Care Director (RCD) upon admission and when changes in a resident's condition occurred. -Resident #1 had been assessed for a wander guard upon admission. -Door alarms were never turned off. -She could not recall being informed of the incident on 04/14/26. -PCAs, MAs and the RCC were required to check on residents who sat outside every 15 minutes. Interview with the RCD on 04/22/26 at 9:54am revealed: -She was on vacation on 04/14/26 and was not aware of the incident that occurred with Resident #1. -She was not aware of any instances where Resident #1 wandered. -She had completed an elopement risk screening and wandering risk assessment for Resident #1 on 04/21/26 and his scores were not high enough to warrant a wander guard anklet. -All exit doors besides the main entrance were equipped with alarms and wander guard alarms. -There were currently no residents in the AL that required a wander guard anklet. Interview with the Administrator on 04/23/26 at 4:12pm revealed; -There were alarms on all exit doors besides the main entrance that sounded when the doors opened and until they closed. -There was a button on the main alarm panel that could disable the alarms. -All staff were expected to respond to the alarms. -She was not aware of the incident on 04/14/26	D 067		

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D 067	Continued From page 8 until 04/22/26. -She was not concerned about Resident #1's safety until she found out about the incident that occurred on 04/14/26. -She expected all staff to conduct visual checks of residents based on their wandering and elopement assessments. _____ The facility failed to ensure 1 of 7 exterior exit doors were equipped with a continuous sounding device that alerted staff when activated for residents who were identified by their physician to be intermittently disoriented and/or wanders, resulting in one resident being found outside the facility on at least one occasion (#1). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2026.	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (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	D 125		

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D 125	Continued From page 9 occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled medication aides (MA) (Staff B, Staff C, Staff E) had completed the 5-hour, 10-hour or 15-hour MA training (Staff C) and a Medication Clinical Skills Competency Validation Checklist (Staff B, Staff C and Staff E) prior to administering medications. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired on 08/22/24 and worked as a MA. -Staff C had taken and passed the written MA examination on 01/30/23. -There was no documentation Staff C had completed the 5-hour, 10-hour or 15-hour MA training course. -There was no documentation Staff C had a Medication Clinical Skills Competency Validation Checklist completed. Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation Staff C administered medication 2 days from 02/01/26 to 02/28/26. Review of a resident's March 2026 eMAR revealed there was documentation Staff C administered medication 3 days from 03/01/26 to	D 125	1. The employees identified with missing 5-hour, 10-hour, or 15-hour medication aide training, and/or a Medication Administration Clinical Skills Checklist were removed from the schedule pending competed training. 2. A 100% audit of all Med Tech and CNA employee files will be conducted to identify any additional staff with the potential for the same deficient practice. This audit will include verification of completion of the required 5-hour, 10-hour, or 15-hour medication aide training, and the presence of a completed Medication Administration Clinical Skills Checklist. Any discrepancies identified during this audit will be corrected immediately to ensure compliance. 3. To prevent recurrence, the facility will implement a standardized Staff Qualification Checklist to ensure all required documentation is present and compliant for all floor staff. This checklist will be utilized during the current audit of all staff files, at the time of hire prior to assignment to the floor or medication administration duties, and during ongoing monthly audits. The Human Resources Director and/or designee will be responsible for completing these audits and ensuring that all staff meet qualification requirements prior to working independently.	

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D 125	Continued From page 10 03/31/26. Review of a resident's April 2026 eMAR from 04/01/26 to 04/23/26 revealed there was documentation Staff C administered medication 3 days from 04/01/26 to 04/23/26. Interview with Staff C on 04/23/26 at 11:20am revealed: -She completed the MA training course and the Medication Clinical Skills Competency Validation Checklist with the facility's previous registered nurse (RN) in August 2024. -She was not sure why the facility did not have her MA training course certificate and the Medication Clinical Skills Competency Validation Checklist in her personnel file. -The Resident Care Director (RCD) was in charge of keeping track of MA certifications and checklists. -Another person was the facility's RCD when she was hired. Interview with the RCD on 04/23/26 at 4:26pm revealed she was not aware Staff C 5-hour, 10-hour or 15-hour MA training certificate and checklist was not in her personnel file. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the RCD on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 10/09/24 and worked as a MA.	D 125	4. The facility will implement a 12-week quality monitoring plan. Following completion of the initial 100% audit and correction of all identified deficiencies, the Human Resources Director and/or designee will verify that the standardized Staff Qualification Checklist is consistently utilized for all new hires prior to assignment to the floor. Monthly employee file audits will be conducted during the 12-week period to ensure continued compliance with staff qualification requirements. The Administrator will review audit findings monthly, and any identified discrepancies will be addressed immediately through removal from duty and completion of required documentation and training. If any non-compliance is identified during the monitoring period, the facility will initiate a full audit of affected staff and provide re-education to responsible personnel to ensure compliance is re-established and maintained. 5. Date of compliance 6/2/26	

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D 125	Continued From page 11 -Staff B had taken and passed the written MA examination on 09/26/23. -There was no documentation Staff B had a Medication Clinical Skills Competency Validation Checklist completed. Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation Staff B administered medication 13 days from 02/01/26 to 02/28/26. Review of a resident's March 2026 eMAR revealed there was documentation Staff B administered medication 16 days from 03/01/26 to 03/31/26. Review of a resident's April 2026 eMAR from 04/01/26 to 04/23/26 revealed there was documentation Staff B administered medication 4 days from 04/01/26 to 04/23/26. Attempted telephone interview with Staff B on 04/23/26 at 11:26am was unsuccessful. Interview with the Resident Care Director (RCD) on 04/23/26 at 4:26pm revealed she was not aware that there was no documentation Staff B had a Medication Clinical Skills Competency Validation Checklist completed. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the RCD on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm.	D 125		

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D 125	Continued From page 12 3. Review of Staff E's personnel record revealed: -Staff E was hired on 05/16/24 and worked as a MA. -Staff E had taken and passed the written MA examination on 03/27/24. -There was no documentation Staff E had a Medication Clinical Skills Competency Validation Checklist completed. Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation Staff E administered medication 14 days from 02/01/26 to 02/28/26. Review of a resident's March 2026 eMAR revealed there was documentation Staff E administered medication 19 days from 03/01/26 to 03/31/26. Review of a resident's April 2026 eMAR from 04/01/26 to 04/23/26 revealed there was documentation Staff E administered medication 12 days from 04/01/26 to 04/23/26. Telephone interview with Staff E on 04/23/26 at 11:29am revealed: -She completed a Medication Clinical Skills Competency Validation Checklist when she was hired. -She was unsure why the facility did not have documentation of her Medication Clinical Skills Competency Validation Checklist in her personnel file. Interview with the Resident Care Director (RCD) on 04/23/26 at 4:26pm revealed she was not aware that there was no documentation Staff E had a Medication Clinical Skills Competency Validation Checklist completed.	D 125		

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D 125	Continued From page 13 Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the RCD on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. _____ Interview with the RCC on 04/23/26 at 2:30pm revealed: -She was only in charge of ensuring new MAs had a mentor to work with. -The RCD was in charge of making sure MAs had completed the 5-hour, 10-hour or 15-hour MA training and a Medication Clinical Skills Competency Validation Checklist prior to administering medications. Interview with the RCD on 04/23/26 at 4:26pm revealed: -She was in charge of ensuring all MAs had completed the 5-hour, 10-hour or 15-hour MA training and a Medication Clinical Skills Competency Validation Checklist prior to administering medications. -The missing documents had been misplaced. -She expected all MAs to have documentation of completed 5-hour, 10-hour or 15-hour MA training and a Medication Clinical Skills Competency Validation Checklist. Interview with the Administrator on 04/23/26 at 4:48pm revealed: -She was not aware personnel documents had been misplaced. -She expected all MAs to have documentation of	D 125		

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D 125	Continued From page 14 completed 5-hour, 10-hour or 15-hour MA training and a Medication Clinical Skills Competency Validation Checklist. The facility failed to ensure Staff C had completed the 5-hour, 10-hour or 15-hour MA training, and Staff B, Staff C and Staff E had a completed Medication Clinical Skills Competency Validation Checklist prior to administering medications. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2026.	D 125		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and	D 161	1. For the staff member identified without documented LHPS validation, the employee was immediately removed from performing delegated tasks until a licensed health professional completed competency validation. Documentation was obtained and placed in the personnel file.	

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D 161	Continued From page 15 abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 of 6 sampled staff (Staff B, Staff C, Staff D, Staff E, Staff F) had Licensed Health Professional Support (LHPS) skills competency validation with return demonstration including transferring, ambulation using assistive devices, and applying and removing compression stockings. The findings are: Review of a resident's LHPS review dated 01/30/26 revealed the resident's LHPS tasks included transferring, ambulation using assistive devices, and applying and removing compression stockings. 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 10/09/24. -There was no documentation Staff B completed an LHPS validation competency. Attempted telephone interview with Staff B on 04/23/26 at 11:26am was unsuccessful. Refer to Interview with the Resident Care	D 161	2.A 100% audit of all personnel files was conducted to ensure LHPS validation was completed for all applicable staff. Any missing documentation was corrected immediately, and staff without validation were not permitted to perform delegated tasks until completed. 3. The administrator will re-educate policy to administrative and nursing staff on requirements that staff must be evaluated and validated as competent by a licensed health professional prior to performing delegated tasks, including proper documentation and timing of validation. 4. To prevent recurrence, the facility implemented a tracking system for LHPS validation that includes a centralized log of all staff requiring LHPS, their hire date, and the date competency validation is completed by a licensed health professional. The Administrator or designee will maintain this log and review it prior to scheduling any new hire independently to ensure staff are validated as competent before performing delegated tasks. The log will also be reviewed monthly in conjunction with personnel file audits to ensure ongoing compliance. Any staff identified without current LHPS validation will be removed from delegated tasks immediately until validation is completed, with re-education provided as needed. 5. Date of compliance 6/2/26	

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D 161	Continued From page 16 Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the Resident Care Director (RCD) on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. 2. Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) on 08/22/24. -There was no documentation Staff C completed an LHPS validation competency. Interview with Staff C on 04/23/26 at 11:20am revealed: -She completed the LHPS skills competency validation with the facility's previous registered nurse (RN) in August 2024. -She was not sure why the facility did not have her LHPS skills competency validation in her personnel file. -The Resident Care Director (RCD) was in charge of keeping track of LHPS skills competency validation checklists. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the RCD on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. 3. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA) on 03/21/25. -There was no documentation Staff D completed an LHPS validation competency.	D 161		

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D 161	Continued From page 17 Attempted telephone interview with Staff D on 04/23/26 at 11:28am was unsuccessful. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the Resident Care Director (RCD) on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. 4. Review of Staff E's personnel record revealed: -Staff E was hired as a medication aide (MA) on 05/16/24. -There was no documentation Staff E completed an LHPS validation competency. Telephone interview with Staff E on 04/23/26 at 11:29am revealed: -She completed a LHPS skills competency validation when she was hired. -She was unsure why the facility did not have documentation of her LHPS skills competency validation in her personnel file. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the Resident Care Director (RCD) on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. 5. Review of Staff F's personnel record revealed: -Staff F was hired as a medication aide (MA) on 02/12/26. -There was no documentation Staff F completed	D 161		

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D 161	Continued From page 18 an LHPS validation competency. Telephone interview with Staff F on 04/23/26 at 11:32am revealed: -She completed LHPS skills competency validation when she was hired. -She was unsure why the facility did not have documentation of her LHPS skills competency validation in her personnel file. -The previous Resident Care Director (RCD) was in charge of LHPS skills competency validation checklists when she was hired. Refer to Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 2:30pm. Refer to Interview with the RCD on 04/23/26 at 4:26pm. Refer to Interview with the Administrator on 04/23/26 at 4:48pm. _____ Interview with the RCC on 04/23/26 at 2:30pm revealed: -She was only in charge of ensuring new MAs had a mentor to work with. -The RCD was in charge of making sure MAs had completed the LHPS skills competency validation prior to administering medications. Interview with the RCD on 04/23/26 at 4:26pm revealed: -She was in charge of ensuring all MAs had completed the LHPS skills competency validation prior to administering medications. -The documents had been misplaced. -She expected all MAs to have documentation of completed LHPS skills competency validation.	D 161		

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D 161	Continued From page 19 Interview with the Administrator on 04/23/26 at 4:48pm revealed: -She was not aware personnel documents had been misplaced. -She expected all MAs to have documentation of completed LHPS skills competency validation.	D 161		
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 record reviews and interviews, the facility failed to ensure 1 of 6 sampled residents (#2) had completed the two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: Review of Resident #2's FL2 dated 04/01/26 revealed diagnoses included hypertension, hyperlipidemia, and major depressive disorder. Review of Resident #2's Resident Register	D 234	1. For the resident identified during the survey without documented TB testing, the facility immediately assessed the resident and ensured TB screening was completed per physician order and in accordance with required admission health screening standards for adult care homes, which require documentation of TB testing or appropriate exemption status upon admission. The resident record was updated to reflect completion and physician notification was completed as indicated. 2. In response to the identified concern, physician orders were obtained for Quantiferon TB blood testing for 100% of current residents to ensure appropriate TB screening documentation was available and maintained. Results and supporting documents were added to resident records as completed.	

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D 234	Continued From page 20 revealed the resident was admitted to the facility on 06/20/25. Review of Resident #2's TB skin tests revealed: -A TB skin test was administered on 01/30/25 and read as negative on 02/01/25. -There was no documentation the resident had received another TB skin test since admission to the facility. Interview with Resident #2 on 04/22/26 at 9:30am revealed he could not recall if he had a second TB skin test completed since being at the facility. Interview with the Resident Care Director (RCD) on 04/23/26 at 9:35am revealed: -She was aware residents needed a two-step TB testing. -She was responsible for ensuring resident TB skin tests were completed. -She was not aware Resident #2 did not have a second TB skin test on file. -She was responsible for record audits. -She had no set schedule for auditing resident records. Interview with the Administrator on 04/23/26 at 4:51pm revealed: -She was aware residents needed completed two-step TB testing. -She was not aware Resident #2 did not have a second TB skin test on file. -Her expectation was that all residents had both steps of the TB skin test completed and documented.	D 234	3. The administrator will reeducate on the policy with nursing and administrative staff regarding the requirement that all residents must have documented TB screening at admission in accordance with North Carolina adult care home admission health requirements, and that no resident may be admitted or maintained without appropriate TB documentation or follow-up orders in place. Staff were educated on proper documentation, tracking, and verification at admission. 4. To ensure ongoing compliance and prevent recurrence, the facility had integrated TB compliance into the daily admissions review process. For every new admission, the RCD or clinical designee will verbal report during morningmeeting on 100% of new admissions admitting in the next 24 hours to verify that the TB test, blood test, or appropriate screening has beencompleted and documented prior to admitting.The RCD or designee will cross-referencethe upcoming admission against the facilitysTB tracking log to ensure accurancy. The administrator or designee will report compliance data from the morning meeting review and the TB tracking log during monthly quality assurance performance improvment meetings. 5. Date of compliance 6/2/26	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 21 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#1) who was wandering outside the facility unsupervised into the front parking lot. The findings are: Review of the facility's confused/wandering residents policy revealed: -The admission process would identify residents who walk or wheel around unrestricted and were a threat to leave the facility unattended due to their confusion. -Pre-admissions screenings would include a review of FL2, hospital discharge summary or other written information and obtain and review information from family members and responsible persons, and/or placement agencies; regarding any history or the risk of wandering. -After admissions, safeguards/assessments would be as follows: Implementation of a wandering list that would be made available to staff; inform staff upon admission and as	D 270	1. All residents have been assessed for risk of wandering and elopement. Assessments included review of cognitive status, history of wandering/elopement, behavioral patterns, and required level of supervision. Residents identified as at risk have had their care plans immediately updated to include individualized supervision interventions, including but not limited to increased observation, staff awareness, and environmental safety measures. Residents assessed as safe to sit outside independently have this clearly documented in their care plans, including defined parameters such as time limits, designated safe areas, and required staff check-ins. 2. A comprehensive, facility-wide audit of all residents was completed to identify any additional residents at risk for wandering or elopement. 3. All resident care plans now include individualized supervision levels, identified wandering triggers, and specific staff interventions. Residents will be reassessed for wandering/elopement risk: Upon admission, with any change in condition, Quarterly and as needed. All exit doors in the Assisted Living and Memory Care units have been checked and confirmed to have functioning, continuous audible alarms when doors are opened or ajar (completed 04/22/2026). Staff have been re-educated on supervision requirements,elopement prevention, and response protocols, including proper documentation and monitoring of residents at risk.	

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D 270	Continued From page 22 necessary if the potential exists for a resident to wander; perform a reassessment and change the care plan accordingly when significant change occurs which may indicate the potential to wander; supervise and implement routine checks, monitoring devices and/or techniques according to the need of each resident. Review of Resident #1's current FL2 dated 02/12/26 revealed: -Diagnoses included Alzheimer's disease, unspecified dementia, hypertension, cardiomyopathy, cardiac pacemaker, type 2 diabetes, muscle weakness, herpes viral infection, cardiomyopathy, cardiac pacemaker, and atrial fibrillation. -He was intermittently disoriented. -He was a wanderer. Review of Resident #1's Resident Register revealed: -He was admitted to the facility on 02/13/23. -His memory was documented as forgetful, needs reminders. Review of Resident #1's electronic chart notes dated 02/01/26-04/21/26 revealed: -On 02/01/26 at 1:07pm, the facility Activity Director (AD) noted Resident #1 was "a danger on wheels" and he wandered the building. -On 03/05/26 at 6:29pm and on 04/07/26 at 2:21pm, the facility Resident Care Coordinator (RCC) noted in Resident #1's monthly summaries that his cognition was forgetful. -On 04/13/26 at 2:18pm, Resident #1's Primary Care Provider (PCP) noted that he was alert and oriented x1 (self only) and "memory loss noted". -She ordered the continuation of donepezil hydrochloride and memantine for treatment of his dementia.	D 270	4. The Administrator or designee will conduct weekly audits of 5 residnets assessments for wandering/elopement risk & Care plans for appropriate supervision interventions. A 100% audit of all exit doors in AL and MC will be conducted daily for a period of twelve (12) weeks to verify that door alarms remain activated and fully functional. Results of audits will be reviewed monthly through the facility's Quality Assurance Performance Improvement (QAPI) program. Any identified issues will result in immediate corrective action and staff re-education as needed. 5. Date of compliance 6/2/26	

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D 270	Continued From page 23 -On 04/14/26 at 3:12pm, a medication aide (MA) noted, "Resident was found wandering in parking lot, resident stated he was looking for gold. Resident was able to be redirected back to front porch of facility." Review of Resident #1's incident and accident reports from 02/01/26-04/21/26 revealed there were no reports available for review. Review of Resident #1's elopement risk screening signed by the Resident Care Director (RCD) on 04/21/26 revealed: -He was disoriented but did not wander. -He had no previous attempts of elopement. -No behaviors were noted. -No mood-altering medications were indicated. -He had one dementia diagnosis. Review of Resident #1's wandering risk assessment signed by the RCD on 04/21/26 revealed: -He was forgetful with a short attention span. -He had no issues with behaviors or mood. -He had a diagnosis of Alzheimer's disease. -He had no history of wandering. Observation of Resident #1 at 3:23pm on 04/22/26 revealed he was sitting outside on the right end of the front porch alone and unsupervised, away from the windows at the receptionist's desk. Second observation of Resident #1 at 1:17pm on 04/23/26 revealed he was sitting outside on the front porch with three other residents, in front of the windows at the receptionist's desk. Interview with Resident #1 on 04/22/26 at 3:23pm revealed:	D 270		

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D 270	Continued From page 24 -He sat outside every day if he could. -He had "walked all over this place" and even made it to the highway at the top of the property on at least one occasion. -Facility staff did not sit outside with him, but other residents did. -He did not inform anyone when he would go outside. -He did not recall the incident on 04/14/26. Telephone interview with Resident #1's responsible party (RP) on 04/22/26 at 6:12pm revealed: -He was aware that Resident #1 went outside unsupervised. -He was not notified of the incident that occurred on 04/14/26. -Resident #1 had "gotten into trouble" a few times before because he went too far on the property and made it to the independent living apartments on at least one occasion. -Resident #1 would "sneak out" of the Skilled Nursing Facility (SNF) section of the property and be found in his previous room in the Assisted Living (AL) section when he required a short-term rehab stay in 2025. -He believed Resident #1's cognitive function was about 30% and stated Resident #1 now believed untrue stories that he had told for years. -Resident #1 had been a wanderer for many years and was unable to stay focused on one destination. Interview with Resident #1's PCP on 04/23/26 at 3:46pm revealed; -She was not aware of the incident that occurred on 04/04/26. -She was unaware of any previous incidents of Resident #1 wandering or exhibiting innappropriate behaviors.	D 270		

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	HAL034023	A. BUILDING: _____ B. WING _____	04/23/2026

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D 270	Continued From page 25 -She would expect facility staff to notify her, her nurse practitioner (NP) or triage staff of such occurrences. -She rounded at the facility on Thursdays and her NP rounded on Mondays, Wednesdays and Fridays. -She felt that there had been a change in Resident #1's cognition based on the NP's note dated 04/13/26. -She would expect facility staff to be more aggressive in monitoring Resident #1. Interview with the receptionist on 04/22/26 at 11:46am revealed: -There were three receptionists who worked from 7:00am-7:00pm seven days a week and security guards who worked nights. -Resident #1 sat outside often because he enjoyed sitting in the sun. -When any residents were outside, she physically checked on them every 10-15 minutes. -She would only leave her desk when no vehicles were attempting to enter the locked gate onto the property and no residents were outside. -She would occasionally ask another staff member to cover her desk so she could go to the bathroom. -She was working on 04/14/26 at 3:21pm. -She observed Resident #1 sitting on the left side of the front porch in front of the windows at the receptionist's desk and saw him propel himself with his feet in his wheelchair towards the right side of the porch. -She got up from her desk a short while later and saw him sitting in his wheelchair in the traffic circle in front of the building. -She assisted him back onto the porch and went to her desk and called the 200 Hall nursing station to report the incident. -She remained outside with Resident #1 until	D 270		

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D 270	Continued From page 26 another staff member responded and then she returned to her desk. -She did not inform anyone else of the incident. Interview with a personal care aide (PCA) on 04/22/26 at 9:34am revealed: -Resident #1 sat outside unsupervised almost daily. -She thought MAs and the receptionist were responsible for monitoring residents who sat outside. -She was not aware of the incident on 04/14/26. Interview with an MA on 04/23/26 at 11:02am revealed: -She worked as an MA on 200 Hall five days weekly and was on duty on 04/14/26 at 3:21pm. -Resident #1 was outside when the receptionist called her to report he was in the parking lot. -She found Resident #1 sitting in his wheelchair in the traffic circle in front of the building and he told her, "I'm just out here looking for gold". -She explained the dangers of leaving the porch to Resident #1 and he was easily redirected back into the facility. -She notified the RCC of the incident immediately after Resident #1 was back inside and requested instructions on how to document the incident. -The RCC did not instruct her to notify anyone else. -She was aware of the facility's wandering and elopement assessments but did not complete them. -Resident #1 sat outside every day, usually with other residents. -She would occasionally sit outside with him. -Resident #1 opened the front door by himself and did not notify staff when he would go outside. -She described Resident #1 as alert and oriented to self, time, place and familiar people; he was	D 270		

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D 270	Continued From page 27 not alert and oriented to events and could not recall his medications. -She had never observed Resident #1 experiencing hallucinations and had never known him to leave the front porch since she began her employment in January 2026. Interview with the RCC on 04/23/26 at 2:38pm revealed: -Wander guard and elopement assessments were completed by the RCD upon admission and when changes in a resident's condition occurred. -She could not recall being informed of the incident on 04/14/26. -All residents were required to sign out when leaving the campus but not when leaving the AL building. -Residents were not required to inform staff when they left the building, but most did. -The PCAs, MAs and the RCC were required to check on residents who sit outside every 15 minutes. -Resident #1 sat outside daily when the weather permitted and she was not aware of any instances of Resident #1 leaving the porch. Interview with the RCD on 04/22/26 at 9:54am revealed: -She was on vacation on 04/14/26 and was not aware of the incident that occurred with Resident #1. -The MA who documented on the incident was not the staff member who responded on 04/14/26 and she documented incorrect information. -Resident #1 went outside unsupervised daily but had never been in the parking lot. -Resident #1 was not confused but was a "jokester" who tried to make people laugh. -She was not aware of any previous instances where Resident #1 wandered.	D 270		

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D 270	Continued From page 28 -There were currently no residents in the AL that required a wander guard anklet. Interview with the Administrator on 04/23/26 at 4:12pm revealed; -She was not aware of the incident on 04/14/26 until 04/22/26. -Residents were only required to sign out when they left the property and not when they sat on the front porch. -Residents were expected to inform staff when they went outside. -She was not concerned about Resident #1's safety until she found out about the incident that occurred on 04/14/26. -She expected all staff to conduct visual checks of residents based on their wandering and elopement assessments. -It was her expectation for all residents to be assessed for wandering and elopement upon admission, following changes in condition and as needed. The facility failed to provide supervision for a resident (#1) who was documented as disoriented and had a history of wandering, and who went outside the facility unsupervised to the front parking lot. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2026.	D 270		

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D 273	Continued From page 29 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 follow-up to meet the routine and acute health care needs of 1 of 6 sampled residents (#5). The findings are: Review of Resident #5's current FL2 dated 11/2/25 revealed diagnoses of polyneuropathy, chronic pulmonary edema, Alzheimer's disease, cardiomegaly, chronic kidney disease, atrial fibrillation, malignant neoplasm of breast and hypertension. Review of Resident #5's signed physician orders dated 04/14/26 revealed an order for thrombo-embolic deterrent (TED) hose daily, apply every morning and remove at bedtime. Review of Resident #5's Licensed Health Professional Support (LHPS) assessments dated 12/09/25 and 03/24/26 revealed the task of applying and removing TED hose. Observation of Resident #5 on 04/22/26 at 2:16pm revealed no TED hose were on her lower extremities. Second observation of Resident #5 at 04/23/26 at 10:24am revealed no TED hose were on her	D 273 D 273	1. For the resident affected, TED hose were immediately applied per physician order, and the physician (MD) and responsible party (RP) were notified of the missed application and any refusals. A second pair of TED hose was ordered to ensure availability. 2. A 100% audit was completed for all residents with TED hose to identify any others at risk. Any identified issues were corrected immediately, including application, documentation, and MD/RP notification as indicated. 3. The administrator or designee will educate on the policy requiring staff to notify the MD and RP of all treatment refusals and to document these notifications in the medical record. Staff education was completed on proper documentation, timely notification, and required follow-up. 4. To prevent recurrence, the facility implemented a process to ensure residents with TED hose orders maintain at least two pairs to prevent missed applications due to laundering, and the RCD or designee will review TARs 5X weekly for compliance and follow-up needs. Ongoing audits will be conducted three times weekly for four weeks, then weekly for four additional weeks, with results reviewed by the Administrator through the Quality Assurance process. 5. Date of compliance 6/2/26	

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D 273	Continued From page 30 lower extremities. Observation of Resident #5's room 04/23/26 at 10:31 am revealed one pair of TED hose hanging in the bathroom. Attempted interview with Resident #5 on 04/23/26 at 10:33 am was unsuccessful. Attempted telephone interview with Resident #5's Responsible Party (RP) on 04/23/26 at 1:39pm was unsuccessful. Interview with Resident #5's Primary Care Provider (PCP) on 04/23/26 at 3:25pm revealed: -She was not the original prescriber of Resident #5's TED hose order. -She received no reports from facility staff that Resident #5 had ever refused the TED hose. -She did not expect any negative outcomes from Resident #5 not wearing the TED hose daily because caffeine, heat and sodium could also cause swelling in her lower extremities. -She expected facility staff to apply the TED hose daily as ordered, if Resident #5 did not refuse. Interview with a Personal Care Assistant (PCA) on 04/23/26 at 10:46am revealed: -She worked mainly on first and second shifts. -She was aware of the order for Resident #5 to wear TED hose daily. -She was not aware that Resident #5 was not wearing TED hose on 04/22/26 and 04/23/26. -PCAs were not allowed to apply TED hose, only Medication Aides (MA). -Resident #5 was usually wearing TED hose when she provided care. -She would notify the MA if Resident #5 was not wearing TED hose. -Resident #5 never refused care when she was	D 273		

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D 273	Continued From page 31 working. Interview with an MA at on 04/23/26 at 10:35am revealed: -She was aware of the order for Resident #5 to wear TED hose daily. -She was not aware that Resident #5 was not wearing TED hose on 04/22/26 or 04/23/26. -Resident #5 was unable to apply or remove the TED hose herself. -The task to apply the TED hose popped up at 6:00am on Resident #5's electronic treatment administration record (eTAR), so it was third shift's responsibility to apply them. -If the task was not clicked off at 6:00am, the task would roll over to first shift. -Resident #5 occasionally refused to allow third shift staff to apply the TED hose, but first shift staff would try again. Interview with the Memory Care Coordinator (MCC) on 04/23/26 at 10:29am revealed: -She was aware of the order for Resident #5 to wear TED hose daily. -She was not aware that Resident #5 was not wearing TED hose on 04/22/26 or 04/23/26. -Third shift staff are responsible for applying Resident #5's TED hose and the staff member who put her to bed nightly was responsible for removing them. -The staff that removed Resident #5's TED hose was responsible for hand washing them afterwards. -Resident #5 initially had two pairs of TED hose but now she only had one. -Resident #5 was unable to put on or take off the TED hose without staff assistance. -Resident #5 may have occasionally refused care but was easily redirected.	D 273		

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D 273	Continued From page 32 Interview with the Resident Care Director (RCD) on 04/23/26 at 2:27pm revealed: -She was aware of the order for Resident #5 to wear TED hose daily. -She was not aware that Resident #5 was not wearing TED hose on 04/22/26 or 04/23/26. -MAs were responsible for applying and removing TED hose. -She was aware of Resident #5 refusing TED hose at least twice but could not recall if the refusals were reported to the PCP. -It was her expectation for staff to apply Resident #5's TED hose daily as ordered, attempt three times if she refused, document refusals on the eTAR, and notify the RP. Interview with the Administrator 04/23/26 at 4:21pm revealed: -She was not aware of Resident #5's order for TED hose. -She had not been informed of Resident #5's TED hose not being applied. -MAs should notify Resident #5's PCP and RP when she refused care. -She expected staff to reattempt care at least three times before documenting refusals. -She expected all orders on the eTARs to be followed, and any refusals be reported to the MCC and/or the RCD.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals,	D 283		

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D 283	Continued From page 33 Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the ice supply for the residents on the Memory Care Unit (MCU) was protected from contamination, as evidenced by the scoop for the ice machine in the kitchenette lying uncovered inside the machine. The findings are: Initial tour of the kitchenette on the MCU on 04/21/26 at 10:30am revealed: -The kitchenette contained one ice machine that supplied the memory care unit of the facility. -The scoop for the ice machine was lying uncovered inside the machine. Second observation of the kitchenette on the MCU on 04/22/26 at 11:18am revealed the ice scoop was lying uncovered inside the ice machine.	D 283	1. The improperly stored ice scoop was immediately cleaned and placed in an approved sanitary storage location to prevent contamination. 2. All staff were re-educated on proper ice utensil storage and sanitation practices. 3. The Dietary Manager or designee will conduct random 3x weekly ice scoop storage audits for 12 weeks, then monthly thereafter. Any issues will be corrected immediately with re-education as needed. 4. Date of compliance 6/2/26	

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D 283	Continued From page 34 Interview with a Personal Care Assistant (PCA) on 04/23/26 at 10:33am revealed: -She was aware that the ice scoop was supposed to remain covered when not in use. -All MCU staff used the ice scoop. -The ice machine on the MCU supplied 15 residents. -She was not aware of the reason the ice scoop needed to remain covered. Interview with a Medication Aide (MA) on 04/23/26 at 10:50am revealed: -She was not aware that the ice scoop in the kitchenette was uncovered inside the ice machine on 04/22/26 and 04/23/26. -The ice scoop was usually kept in a cover on the outside of the ice machine. -All MCU staff and occasionally staff from the skilled nursing unit utilized the ice machine. -Maintenance staff were responsible for cleaning the ice machine and dietary staff were responsible for cleaning the ice scoop, but she did not know how often. Interview with the Memory Care Coordinator (MCC) on 04/23/26 at 10:42am revealed: - She was not aware that the ice scoop in the kitchenette was uncovered inside the ice machine on 04/22/26 and 04/23/26. -All members of the clinical staff on the MCU used the ice scoop daily. -The ice scoop serviced all MCU residents. -She was aware that the ice scoop was to remain covered when not in use in order to prevent infection. -Dietary staff and maintenance staff were responsible for cleaning the ice machine and the ice scoop. Interview with the Dietary Manager on 04/23/26 at	D 283		

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D 283	Continued From page 35 11:24am revealed: -He was not aware that the ice scoop on the MCU was uncovered in the ice machine on 04/22/26 and 04/23/26. -He was aware that the ice scoop should be in a holder when not in use. -Activities staff, clinical staff and kitchen staff were all responsible for ensuring the ice scoop remained covered when not in use. -Kitchen staff were responsible for cleaning the ice scoop daily by running it through the dishwashing machine and cleaning the ice machine quarterly and as needed. -He expected the ice scoop to be in a holder when not in use and for all staff to wash their hands before using the ice scoop. Interview with the Administrator on 04/23/26 at 11:30am revealed: -She was not aware that the ice scoop on the MCU was uncovered in the ice machine on 04/22/26 and 04/23/26. -She was aware that the ice scoop must be stored in a cover when not in use. -She was aware of the potential for cross contamination if the ice scoop was left uncovered. -All PCAs, MAs, activity staff and kitchen staff were responsible for ensuring the ice scoop remained covered when not in use. -Kitchen staff were responsible for cleaning the ice scoop daily. -An outside contractor was responsible for cleaning the ice machine but she didn't know how often. -She expected the ice scoop to be stored in a covered container and not in the ice machine.	D 283		
D 358	10A NCAC 13F .1004 (a) Medication Administration	D 358		

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D 358	Continued From page 36 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 residents (#2) sampled for record review related to a medication for thinning the blood and a medication to treat hypertension or fluid build-up. The findings are: Review of Resident #2's current FL2 dated 04/24/25 revealed diagnoses included hypertension, atrial fibrillation, and congestive/diastolic heart failure. a. Review of Resident #2's signed physician's orders dated 12/21/25 revealed: -There was an order for warfarin (used to thin the blood) 2mg daily on Tuesday, Thursday, and Saturday. -There was an order for warfarin 4mg on Monday, Wednesday, Friday, and Sunday. Review of Resident #2's warfarin monitoring results anticoagulation summary dated 01/27/26 revealed:	D 358	1. A comprehensive audit was conducted of all residents currently prescribed Coumadin. Each physician's order was compared directly to the MAR to verify accurate transcription and implementation. Any discrepancies identified were corrected immediately and clarified with the prescribing physician. Residents affected by any discrepancies were assessed for adverse effects, and appropriate follow-up actions were taken as indicated. 2. The facility will implement and maintain a 2x monthly tracking log for all residents receiving Coumadin therapy. This log will include current physician orders, prescribed dosage, frequency, and any changes to therapy to ensure ongoing accuracy and consistency with the MAR. INR levels for all residents receiving Coumadin will be monitored and documented bimonthly, or more frequently as ordered by the physician. Results will be reviewed and compared against physician orders to ensure therapeutic ranges are maintained. To improve communication and reduce the risk of transcription or treatment errors, education will be provided to residents and/or their RPs regarding the importance of reporting any medication changes or new instructions received from outside providers to facility staff immediately.	

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HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

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D 358	Continued From page 37 -On 01/27/26 the International Normalized Ratio (INR) test results were 1.8 (INR goal was identified as 2.0-2.5). -The American Heart Association (AHA) and similar guidelines recommend a target INR range of 2.0 to 3.0 for most patients with nonvalvular atrial fibrillation (AF) taking warfarin. The goal is to keep the INR at a therapeutic level of 2.5, which minimizes stroke risk while preventing major bleeding. -There was an order dated 01/27/26 for 2.0mg of warfarin every Tuesday, Thursday, and Saturday; 4mg all other days (Monday, Wednesday, Friday and Sunday). -The next INR appointment was scheduled for 02/24/26. Review of Resident #2's February 2026 electronic medication administration record (eMAR) from 02/01/26 to 02/23/26 revealed: -There was an entry for warfarin 2mg one tablet daily on Tuesday, Thursday and Saturday scheduled for 4:00pm. -There was an entry for warfarin 4mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled for 4:00pm -Warfarin was documented administered as ordered from 02/01/26 to 02/23/26. Review of Resident #2's warfarin monitoring results anticoagulation summary dated 02/23/26 revealed: -On 02/23/26 the INR test result was 1.7 (INR goal was identified as 2.0 -2.5). -There was an order dated 02/23/26 for 2.0mg of warfarin every Wednesday and Saturday; 4mg all other days. -The next INR appointment was scheduled for 03/10/26.	D 358	3. The facility will complete twice-monthly MAR-to-cart audits to verify medication availability, accurate transcription, and consistency between physician orders, medications on hand, and the MAR. Any discrepancies identified during these audits will be addressed immediately, with clarification obtained from the prescribing physician as needed. Education will be provided to licensed staff on the Six Rights of Medication Administration, including the right resident, right medication, right dose, right route, right time, and right documentation. 4. The Resident Care Director and/or designee will audit 100% of Coumadin physician orders and corresponding MAR entries two times monthly to ensure ongoing compliance and accurate transcription of orders. MAR-to-cart audits will also be completed two times monthly to verify consistency between physician orders, medications on hand, and MAR documentation. Audit findings will be monitored through the facility QAPI process and reviewed during clinical management meetings. 5. Date of compliance 6/2/26	

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D 358	Continued From page 38 Review of Resident #2's February 2026 eMAR from 02/24/26 to 02/28/26 revealed: -There was an entry for warfarin 2mg one tablet daily on Tuesday, Thursday and Saturday scheduled for 4:00pm. -There was an entry for warfarin 4mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled for 4:00pm -There was no entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days (Monday, Tuesday, Thursday, Friday, and Sunday as ordered 02/23/26. -On 02/24/26 (Tuesday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -On 02/25/26 (Wednesday), Resident #2 had documented administration for warfarin 4mg and should have received 2mg. -On 02/26/26 (Thursday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -There were 3 doses of warfarin administered incorrectly for February 2026. Review of Resident #2's March 2026 eMAR from 03/01/26 to 03/09/26 revealed: -There was an entry for warfarin 2mg one tablet daily on Tuesday, Thursday and Saturday scheduled for 4:00pm. -There was an entry for warfarin 4mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled for 4:00pm -There was no entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Sunday) as ordered on 02/23/26. -On 03/03/26 (Tuesday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg.	D 358		

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D 358	Continued From page 39 -On 03/04/26 (Wednesday), Resident #2 had documented administration for warfarin 4mg and should have received 2mg. -On 03/05/26 (Thursday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -There were 3 doses of warfarin administered incorrectly from 03/01/26 to 03/09/26. Review of Resident #2's warfarin monitoring results anticoagulation summary dated 03/10/26 revealed: -On 03/10/26 the INR test results were 1.9 (INR goal was identified as 2.0-2.5). -There was an order dated 03/10/26 to continue 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Sunday). -The next INR appointment was scheduled for 03/24/26. Review of Resident #2's March 2026 eMAR from 03/10/26 to 03/24/26 revealed: -There was an entry for warfarin 2mg one tablet daily on Tuesday, Thursday and Saturday scheduled for 4:00pm discontinued on 03/12/26. -There was an entry for warfarin 4mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled for 4:00pm discontinued on 03/12/26. -There was no entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Sunday) scheduled for administration at 4:00pm beginning on 03/10/26. -On 03/10/26 (Tuesday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -On 03/11/26 (Wednesday), Resident #2 had documented administration for warfarin 2mg and	D 358		

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D 358	Continued From page 40 should have received 4mg. -On 03/12/26 (Thursday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -On 03/12/26, there was an entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Sunday) scheduled for administration at 4:00pm daily. -There were 3 doses of warfarin administered incorrectly from 03/10/26 to 03/24/26. Review of Resident #2's warfarin monitoring results anticoagulation summary dated 03/24/26 revealed: -On 03/24/26 the INR test results were 1.9 (INR goal was identified as 2.00-2.5). -There was an order dated 03/24/26 to increase warfarin to 2mg every Saturday and 4mg all other days of the week (Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday). -The next INR appointment was scheduled for 04/07/26. Review of Resident #2's March 2026 eMAR from 03/24/26 to 03/31/26 revealed: -There was an entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Sunday) scheduled for administration at 4:00pm daily beginning 03/13/26 thru 03/31/26. -There was no entry for warfarin 2mg every Saturday and 4mg all other days of the week (Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday) as ordered on 03/24/26. -On 03/25/26 (Wednesday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -There was 1 dose of warfarin administered incorrectly from 03/25/26 to 03/31/26.	D 358		

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D 358	Continued From page 41 Review of Resident #2's April 2026 eMAR from 04/01/26 to 04/10/26 revealed: -There was an entry for 2mg of warfarin every Wednesday and Saturday; 4mg all other days of the week (Monday, Tuesday, Thursday, Friday, and Saturday) scheduled for administration at 4:00pm daily discontinued on 04/01/26. -There was no entry for warfarin 2mg every Saturday and 4mg all other days of the week (Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday) as ordered beginning 03/24/26. -On 04/01/26 (Wednesday), Resident #2 had documented administration for warfarin 2mg and should have received 4mg. -There was 1 dose of warfarin administered incorrectly on 04/01/26. Review of Resident #2's warfarin monitoring results anticoagulation summary dated 04/07/26 revealed: -On 04/07/26 the INR test results were 1.9 (INR goal was identified as 2.00-2.5). -There was an order dated 04/07/26 to increase warfarin to 4mg daily -The next INR appointment was scheduled for 04/21/26 Review of Resident #2's warfarin monitoring results anticoagulation summary dated 04/10/26 and the April 2026 eMAR from 04/10/26 to 04/21/26 revealed Resident #2 received 4mg of warfarin daily at 4:00pm as ordered. Review of Resident #2's eMARs from 02/24/26 to 04/01/26 compared to the orders for warfarin revealed there were a total of 11 doses of warfarin incorrectly administered from 02/24/26 to 04/01/26.	D 358		

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D 358	Continued From page 42 Observation of Resident #2's medication on hand for administration on 04/22/26 at 4:00pm revealed: -There was a bingo card of warfarin 2mg dispensed on 03/25/26 for 20 tablets with 8 tablets remaining. -There was a bingo card of warfarin 4mg labeled one tablet daily dispensed for 17 tablets on 4/17/26 with 17 tablets remaining. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/22/26 at 3:00pm revealed: -Resident #2's was cycle filled for 28 days supply. -There was a current order dated 04/10/26 for warfarin 4mg one tablet daily. -The facility entered medication orders into the facility's eMAR system. -The pharmacy dispensed Resident #2's warfarin 4mg labeled one tablet daily on 04/17/26 for 17 tablets. -The pharmacy dispensed Resident #2's warfarin 2mg on 03/26/26 for 8 tablets. Interview with the morning medication aide (MA) on 04/23/26 at 9:50am revealed: -She had been working at the facility for more than 6 months. -The Resident Care Director (RCD) was responsible for ensuring medication orders were correct in the eMAR system. -She did not routinely administer Resident #2's warfarin because it was scheduled in the afternoon after she finished her shift. Interview with the RCD on 04/23/26 at 2:35pm revealed: -She routinely entered the residents' medication orders into the facility's eMAR system, including	D 358		

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D 358	Continued From page 43 Resident #2's warfarin orders. -Resident #2's family member took the resident to her scheduled appointments with the warfarin clinic for scheduled INR draws. -The RCD, the Memory Care Director, or a designated MA entered prescriber's orders into the facility's eMAR system. -The contracted pharmacy could view the residents' orders for dispensing medications. -Orders for warfarin were supposed to be entered and administered the same day received by the facility. -She was out off the facility on a personal leave during the time frame in March 2026 when Resident #2's warfarin dose was not entered into the facility's eMAR system. -She did not currently have a system in place to routinely audit medication orders compared to the eMAR systems orders. -She did not know Resident #2 had incorrect warfarin administration in February 2026, March 2026, and April 2026. Interview with Resident #2's primary care provider (PCP) on 04/23/26 at 2:45pm revealed: - Resident #2 was seen at an outside warfarin clinic for adjusting her warfarin dose. -Incorrect dosing of warfarin to reach a goal level of 2.5 for atrial fibrillation could cause signs of bruising, bleeding gums, or an increased risk for stroke. -Resident #2 was supposed to be on the warfarin dose ordered by the warfarin clinic. -Resident #2 had no apparent signs of negative side effects from the few incorrect doses of warfarin. -She expected the facility to ensure medications were administered as ordered. Interview with the Administrator on 04/23/26 at	D 358		

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D 358	Continued From page 44 4:45pm revealed: -The RCD was responsible to ensure residents received medications as ordered. -She did not know Resident #2 received the incorrect doses of warfarin during February 2026, March 2026, and on 04/01/26. -The RCD should be reviewing medication orders compared to the eMAR system but she did not know how often the audits should occur. Attempted interview with Resident #2 on 04/22/26 at 3:00pm and 04/23/26 at 2:00pm were unsuccessful. Resident #2 was out of the facility. 2. Review of Resident #2's signed physician's orders dated 12/21/25 revealed an order for spironolactone (used to treat hypertension and/or excess fluid) 25mg every morning. Review Resident #2's after visit summary dated 02/10/26 from the cardiologist revealed documentation to continue Resident #2 on spironolactone 25mg "from now on". Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for spironolactone 25mg one tablet in the morning for essential hypertension scheduled for administration at 8:00am daily. -Spironolactone 25mg was documented as administered daily at 8:00am from 02/01/26 to 02/28/26. -Daily weights ranged from 110 to 112 pounds. -Daily blood pressures ranged from 102/71 to 145/88. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for spironolactone 25mg one	D 358		

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D 358	Continued From page 45 tablet in the morning for essential hypertension scheduled for administration at 8:00am daily. -Spironolactone 25mg was documented as administered daily at 8:00am from 03/01/26 to 03/31/26. -Daily weights ranged from 109 to 111.4 pounds. -Daily blood pressures ranged from 105/63 to 158/76. Review of Resident #2's April 2026 eMAR from 04/01/26 to 04/21/26 revealed: -There was an entry for spironolactone 25mg one tablet in the morning for essential hypertension scheduled for administration at 8:00am daily. -Spironolactone 25mg was documented as administered daily at 8:00am from 04/01/26 to 04/21/26. -Daily weights ranged from 109 to 112.3 pounds. -Daily blood pressures ranged from 119/61 to 145/86. Observation of Resident #2's medication on hand on 04/22/26 at 4:00pm revealed: -There was a bingo card of spironolactone 25mg labeled for one-half tablet (12.5mg) every morning dispensed on 04/07/26 for quantity of 2 of one-half tablets, with one-half tablet in each slot and 2 of the one-half tablets remaining. -There was a bingo card of spironolactone 25mg labeled for one-half tablet (12.5mg) every morning dispensed on 04/17/26 for 28 one-half tablets, with 28 of the one-half tablets remaining. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/22/26 at 3:00pm revealed: -Resident #2's spironolactone 25mg was cycle filled monthly for a 28-day supply. -The cycle-filled medications were prepared by the pharmacy early to ensure the medications	D 358		

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D 358	Continued From page 46 were at the facility on the day the cycle-fill was to begin. -Resident #2's original spironolactone 25mg order at the pharmacy was dated April 2025. -There was a current telephone refill order dated 02/06/26 for spironolactone 25mg one-half tablet daily. -The contracted pharmacy had no documentation for receipt of signed physician's order dated 12/21/25 increasing spironolactone to 25mg daily from 12.5mg daily. -The facility entered medication orders into the facility's eMAR system. -The facility was responsible to ensure the medications sent by the pharmacy matched the facility's current orders and notify the pharmacy of any discrepancies. -The pharmacy dispensed Resident #2's spironolactone 25mg labeled one-half tablet (12.5mg) every morning as follows: -On 02/06/26, thirty one-half tablets were cycle dispensed. -On 02/27/26, 03/25/26, and 04/22/26, twenty-eight one-half were cycle dispensed. Interview with a medication aide (MA) on 04/23/26 at 9:50am revealed: -She had been working at the facility for more than 6 months. -She routinely worked the morning shift and administered Resident #2's morning medications, including spironolactone. -She had administered spironolactone 25mg as packaged from the contracted pharmacy for at least 4 months. -The Resident Care Director (RCD) was responsible for ensuring medication orders were correct in the eMAR system. -She administered the contents of one bubble on the bingo card of spironolactone labeled 25mg	D 358		

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D 358	Continued From page 47 but had overlooked the dose of one-half (12.5mg) packaged in the bingo card. Interview with the RCD on 04/23/26 at 10:00am revealed: -She entered the residents' medication orders into the facility's eMAR system. -The contracted pharmacy could view the residents' orders for dispensing medications. -She knew Resident #2's spironolactone order was 25mg every morning. -She conducted monthly medication cart to medication orders in the eMAR system. -She overlooked Resident #2's spironolactone coming from the facility's contracted pharmacy for 12.5mg dose instead of 25mg dose as ordered. Telephone interview with a nurse at Resident #2's cardiology clinic on 04/23/26 at 12:00pm revealed: -Resident #2 should be on spironolactone 25mg daily. -The cardiology office routinely sends a copy of the results from Resident #2's visit with the resident at end of the visit and faxes a copy of the information to the facility. -If there was no significant weight gain or increased blood pressure, there would be no negative side effects from the 12mg dose that should have been administered as 25mg of spironolactone. -The cardiology clinic would fax a new order for spironolactone 25mg daily to the facility's contracted pharmacy to be effective immediately. Interview with Resident #2's primary care provider (PCP) on 04/23/26 at 2:45pm revealed: -She was relatively new as the PCP for Resident #2. -She had seen Resident #2 on a visit to the	D 358		

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D 358	Continued From page 48 facility in early April 2026. -Elevated blood pressures or increases in weight could cause additional load on the heart. -Resident #2's blood pressure was not at dangerous levels when she reviewed the blood pressures on the eMARs. -Resident #2 had no significant weight changes from fluid buildup. -Resident #2 was supposed to be on spironolactone 25mg if ordered by the cardiology. -She expected the facility to ensure medications were administered as ordered. Interview with the Administrator on 04/23/26 at 4:45pm revealed: -The RCD was responsible to ensure residents received medications as ordered. -She did not know Resident #2 received the incorrect dose of spironolactone for February 2026, March 2026, and from April 1-21, 2026. -The MAs should be administering medications according to the eMAR and closely reading the medication packaging from the contracted pharmacy's supplied medications. Attempted interview with Resident #2 on 04/22/26 at 3:00pm and 04/23/26 at 2:00pm was unsuccessful. Resident #2 was out of the facility with family members for appointments. _____ The facility failed to ensure medications were administered as ordered to Resident #2 who had diagnoses of atrial fibrillation and hypertension related incorrectly administering a medication for thinning the blood (warfarin) for a total of 11 doses of from 02/24/26 to 04/01/26, placing the resident at risk for not maintaining a target International Normalized Ratio (INR) range of 2.0 to 2.5)recommended for most patients atrial	D 358		

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D 358	Continued From page 49 fibrillation which minimizes stroke risk while preventing major bleeding. Resident #2 was administered the incorrect dose of a medication to treat hypertension for fluid build-up placing the resident at risk for stroke from elevated blood pressures, or increased heart load from weight gain due to excess fluid buildup. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2026.	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.	D 375	1. Upon identification, medications found in the resident's room were immediately removed and secured per facility policy. The resident was assessed to determine appropriateness for self-administration per physician order and facility policy.	

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D 375	Continued From page 50 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled residents (#2 and #6) had a physician's order to self-administer medications observed in the residents' rooms. The findings are: Review of the facility's undated medication services policy revealed that the resident could safely self-administer medications after the community deemed the resident competent and physically able and a physician order that was kept in the residents record. 1. Review of Resident #2's FL2 dated 04/01/26 revealed diagnoses included hypertension, hyperlipidemia, and major depressive disorder. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/20/25. Observation of the room Resident #2 resided in on 04/21/26 at 9:39am revealed in his bathroom cabinet, there was one bottle of over-the-counter (OTC) cough medication and one bottle of OTC upset stomach relief medication. Review of Resident #2's record revealed there were no orders for self-administration of medications or an assessment completed to self-administer any medications. Review of Resident #2's signed physician orders dated 04/01/26 revealed: -There was no order for OTC cough medication. -There was no order for OTC upset stomach	D 375	2. A 100% audit of all residents' rooms was conducted to ensure no other residents had medications stored in their rooms without proper authorization. Any unauthorized medications identified were removed immediately. A mass communication was sent out to all assisted living and memory care families for educational purposes about not bring medications in without consulting the RCD. 3. The Administrator and/or Resident Care Director have re-educated all medication techs and direct care staff (CNAs) on ensuring that medications are not stored in resident rooms unless formally approved for self-administration. All medications must remain secured and administered by trained staff. Any medications found in resident rooms will be immediately removed, secured, and reviewed for proper storage and compliance. 4. The Administrator or designee will conduct weekly audits of 10 random resident rooms and medication storage practices for 12 weeks. Any issues will be corrected immediately with staff re-education as needed. 5. Date of compliance 6/2/26	

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D 375	Continued From page 51 relief medication. Review of Resident #2's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/21/26 revealed: -There was no entry or documentation OTC cough medication. -There was no entry or documentation OTC upset stomach relief medication. Interview with Resident #2 on 04/22/26 at 9:25am revealed: -He was aware of the OTC medications in his bathroom cabinet. -He brought the medications from home when he was admitted to the facility. -He took the OTC cough medication when he had a cold; he had not taken any in a couple of weeks. -He took the OTC upset stomach relief medication occasionally. -No one had informed him that he could not keep medications in his room without self-administration orders and an assessment. -Staff had never assisted him with taking the OTC medications. Interview with a patient care aide (PCA) on 04/22/26 at 9:35am revealed: -She was not aware Resident #2 had OTC medications in his bathroom cabinet. -If she saw medications in Resident #2's room, she would inform the medication aide (MA). Interview with a MA on 04/22/26 at 9:37am revealed: -She was not aware Resident #2 had OTC medications in his bathroom cabinet. -She was aware Resident #2 did not have an order to self-administer his medications.	D 375		

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D 375	Continued From page 52 -She was aware residents could not have medications in their room without self-administration orders and an assessment. -It was a safety concern for Resident #2 to have OTC medications in his room because they could interact with his prescribed medications. -If she had seen any medication in Resident #2's room she would have informed the Resident Care Coordinator (RCC) or the Resident Care Director (RCD). Interview with Resident #2's primary care physician (PCP) on 04/23/26 at 4:14pm revealed: -She was not sure if the facility had notified her of OTC medications in Resident #2's room. -She would need to have seen Resident #2's cognitive status to determine if she felt comfortable with him self-administering his medications. -She had not conducted an assessment or signed self-administer order for any of his meds Interview with the RCC on 04/23/26 at 2:27pm revealed: -She was not aware Resident #2 had OTC medications in his bathroom cabinet. -She was aware residents could not have medications in their room without self-administration orders and an assessment. -No staff had reported OTC medications in Resident #2's room. -There was no staff designated to check residents rooms for medications. Interview with the RCD on 04/23/26 at 9:30am revealed: -She was not aware Resident #2 had OTC medications in his bathroom cabinet. -She was aware residents could not have medications in their room without	D 375		

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D 375	Continued From page 53 self-administration orders and an assessment. Interview with the Administrator on 04/23/26 at 9:30am revealed: -She was not aware Resident #2 had OTC medications in his bathroom cabinet. -She was aware residents could not have medications in their room without self-administration orders and an assessment. -Daily room rounds were completed by staff, but if medications were not in sight view staff would not confiscate. -She expected all staff to report any medications in resident's rooms to their direct supervisor. 2. Observations of the room where Resident #6 resided on 04/21/26 at approximately 9:45am revealed: -There was one bottle of fluticasone propionate, one box of guaifenesin with dextromethorphan hydrobromide, one bottle of acetaminophen, one container of psyllium husk and one bottle of olopatadine hydrochloride ophthalmic solution inside the cabinet in the bathroom. -The containers had no pharmacy label for instructions for use or self-administration. Review of Resident #6's FL2 and signed physician orders dated 04/22/26 revealed: -Diagnoses included malignant neoplasm of prostate, mild cognitive impairment, repeated falls, osteoarthritis of left knee, hemiplegia and hemiparesis following cerebral infarction. -There was no order for fluticasone propionate, guaifenesin with dextromethorphan hydrobromide or olopatadine hydrochloride ophthalmic solution. -There was an order for psyllium husk 0.4-gram 1 capsule daily as needed. -There was an order for acetaminophen extra strength 500 mg 1 tablet twice daily as needed. -There was no order for self-administration of any	D 375		

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D 375	Continued From page 54 medication. Review of Resident #6's record revealed there was no assessment for self-administration of medications. Review of Resident #6's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/22/26 revealed: -There was no entry for fluticasone propionate, guaifenesin with dextromethorphan hydrobromide or olopatadine hydrochloride ophthalmic solution. - There was an entry for psyllium husk powder; give 0.4 gram by mouth as needed for constipation; 1 capsule one time daily. -There was an entry for acetaminophen 500 mg; give 1 tablet orally every 12 hours as needed. Interview with Resident #6 on 04/23/26 at 8:51am revealed: -Facility staff removed all the medications from his bathroom cabinet on 04/22/26 but had never told him he could not have them in his room. -He purchased most of the medications himself, but his daughter would also shop for him. -He was not aware of the facility's policy for self-administration of medications. -He used the acetaminophen most often for treatment of headaches at night and used the psyllium husk daily. -He used the nasal spray and mucus relief tablets in March 2026 when he had a cold. -He was unaware of the eye drops being in the cabinet. Telephone interview with Resident #6's Primary Care Provider's (PCP) on 04/23/26 at 12:23pm revealed: -Resident #6 had been his patient since 2008. -He had not ordered the acetaminophen or the	D 375		

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D 375	Continued From page 55 psyllium husk but added them to Resident #6's medication list based on him reporting he was purchasing them over the counter and using them at home prior to his admission at the facility. -He was unaware of the facility's policy for self-administration of medications but felt that Resident #6 was capable of self-administering the medications found in his cabinet. -The facility should remove the medications from Resident #6's cabinet until the PCP could have a discussion with him regarding self-administration. -He had not completed an assessment for self-administration of medications for Resident #6. Interview with a housekeeper on 04/21/26 at 1:49pm revealed she cleaned Resident #6's room 5 days per week but never looked in his drawers or cabinets. Interview with a personal care aide (PCA) on 04/23/26 at 8:57am revealed: -She was in Resident #6's room daily when she worked. -She was not aware of the medications in the cabinet of his bathroom because she never looked in the cabinet. -If she were to see medications in Resident #6's room, she would notify the RCC (Resident Care Coordinator). Interview with an MA on 08/14/25 at 11:56am revealed: -She was in Resident #6's room daily when she worked. -She was not aware of the medications in the cabinet of his bathroom because she never looked in the cabinet. -There were no residents on her assignment that were allowed to self-administer medications, and	D 375		

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D 375	Continued From page 56 she was not aware of the facility's policy for self-administration of medications. -The RCC had instructed her to check rooms for medications approximately 2-3 times in the last 4 months but only on the Memory Care Unit (MCU). Interview with the RCC on 04/23/26 at 8:57am revealed: -She was not aware that Resident #6 had medications in his room until 04/21/26. -PCAs and MAs were responsible for monitoring resident rooms. -PCAs should notify MAs or RCC when medications were found. -She was in Resident #6's room 1-2 times per week. -She looked in residents' cabinets when they returned from outside appointments. -The Resident Care Director (RCD) completed self-administration assessments. Interview with the RCD on 04/23/26 at 9:22am revealed: -She was not aware that Resident #6 had medications in his room until 04/21/26. -The RCC was expected to visually check all resident rooms weekly and she would only visit Resident #6's room in an acute situation. -Anyone providing care should report medication in resident rooms to the RCD and administrator and remove the medications immediately. -She completed assessments for self-administration of medications upon admission, but there was none to review for Resident #6. -She expected all staff to communicate with residents and families about storage of medications in resident rooms. Interview with the Administrator on 04/23/26 at	D 375		

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D 375	Continued From page 57 9:38am revealed: -She was not aware that Resident #6 had medications in his room until 04/21/26. -She had never been in Resident #6's room. -The activity director was responsible for daily room rounds on the 300 Hall where resident #6's room was located. -The RCD was responsible for completing self-administration assessments and the resident's PCP must agree if the resident was determined to be capable of self-administering. -She expected any staff member who entered resident rooms to remove all medications found. If anyone was uncomfortable doing so, they were to inform the RCC, RCD or the administrator. -She expected the staff member who found the medications in a resident's room who did not have a self-administration order to inform management so conversations could be had with the resident and their Responsible Party (RP).	D 375		