STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on June 4, 2026.	C 000		
C 034	10A NCAC 13G .0302 (n) Design and Construction 10A NCAC 13G .0302 Design and Construction (n) The facility shall maintain and have available for review current sanitation and fire safety inspection reports. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure sanitation inspection reports were current, maintained in the facility and were available for review. The findings are: Review of the facility's current license effective 01/01/26 revealed: -The facility was licensed for 6 beds. -The facility's occupancy was 4. -The license would expire on 12/31/26. Observation of the facility on 06/04/26 at 8:45am and 1:30pm revealed there were two staff and four residents present. Review of the facility's sanitation inspections revealed: -There was a report on file in the facility dated 11/02/23. -The facility's last sanitation inspection was completed on 10/28/24.	C 034		

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C 034	Continued From page 1 -There was not a copy of the 10/28/24 inspection available for review in the facility. Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was aware that she was to contact the Health and Inspection Department to set up an appointment for her annual sanitation inspection. -She had emailed the department in 2024 and did not hear back from anyone. -She had not followed up with the department about the sanitation inspection in 2025 and 2026. -She was responsible to ensure the sanitation inspection was done annually.	C 034		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.	C 069		

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C 069	Continued From page 2 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had an audible sounding device when the doors were opened and accessible to 2 of 3 sampled residents (#1, #3) who were documented to be constantly disoriented (#1), and had a diagnosis of vascular dementia (#3). The findings are: Review of the facility's current license effective 01/01/26 revealed: -The facility was licensed for 6 beds. -The license would expire on 12/31/26. Observation of the front exit door on 06/04/26 at 8:45am revealed there was not an audible alarm activated at the door when it opened. Observation of the back exit door on 06/04/26 at 8:48am revealed there was not an audible alarm activated at the door when it opened. Observation of a side exit door on 06/04/26 at 8:52am revealed there was not an audible alarm activated at the door when it opened. 1. Review of Resident #1's current FL-2 dated 07/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. -The resident was constantly disoriented and ambulatory. Interview with a medication aide (MA) on 06/04/26 at 11:30am revealed Resident #1 had memory issues, but he did not exhibit wandering	C 069		

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C 069	Continued From page 3	C 069		

behaviors.

Telephone interview with Resident #1's primary care provider (PCP) on 06/04/26 at 4:23pm revealed:
-She was not aware the exit doors to the facility did not alarm when the doors opened.
-Her last primary care visit with Resident #1 was on 10/22/25.
-Resident #1 diagnosis was dementia and he had baseline confusion and dysphasia.
-If Resident #1 wandered outside of the facility her concern was for his safety and harm if he was not monitored.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

Refer to the interview with the medication aide (MA) on 06/04/26 at 11:30am

Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 2:30pm.

Refer to interview with the Administrator on 06/04/26 at 7:45pm.

2. Review of Resident #3's current FL-2 dated 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria.

Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24.

Interview with a medication aide (MA) on

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C 069	Continued From page 4 06/04/26 at 11:30am revealed Resident #3 had memory issues and had to be redirected throughout the day, but he did not exhibit wandering behaviors. Attempted telephone interview with Resident #3's primary care provider (PCP) on 06/04/26 at 4:58pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Refer to the interview with the medication aide (MA) on 06/04/26 at 11:30am Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 2:30pm. Refer to interview with the Administrator on 06/04/26 at 7:45pm. _____ Interview with a medication aide (MA) on 06/04/26 at 11:30am revealed: -She did not know why the exit doors did not alarm. -The doors had not alarmed since she began working at the facility three months ago. -The keypad would sound with quick beeps about every day at random times. -She did not notice if the sound came from a particular door. -She would put the code in the keypad to stop the sound. -She had not contacted her supervisor regarding the doors not alarming and the keypad alarming at random times. Interview with the Supervisor-in-Charge (SIC) on	C 069		

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C 069	Continued From page 5 06/04/26 at 2:30pm revealed: -She did not know why the exit doors did not alarm. -The keypad would sound without a door being open. -Several people from different companies came out to fix the problem with the keypad. -February 2026 was the last time someone had come out to look at the system. -She did contact the Administrator to inform her that the alarm was not fixed after someone looked at the system. -She had not received any reports of residents walking out of the door or away from the facility. Interview with the Administrator on 06/04/26 at 7:45pm revealed: -She was not aware the exit doors did not alarm, and no one had notified her about the issue. -She was aware the keypad alarmed at random times during the day. -An alarm company came out in April 2026 to fix the keypad, and she believe the alarm activation was turned off accidentally. -She was aware that the exit door alarm should be operable when the doors were opened to ensure the safety of all residents.	C 069		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family 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.	C 202		

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C 202	Continued From page 6	C 202		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health.

The findings are:

1. Review of Resident #2's current FL-2 dated 05/21/26 revealed
diagnoses included acute respiratory distress, acute pulmonary edema, and end stage renal disease.

Review of Resident #2's Resident Register revealed the resident's admission date was 11/27/23.

Review of Resident #2's record revealed there was no documentation of a first or second tuberculosis (TB) skin test for Resident #2.

Interview with the Administrator on 06/04/26 at 7:05pm revealed:
-She was not aware that Resident #2's TB skin tests were not in his record.
-Resident #2 received his two step TB skin tests, but she did not know why the test results were not in the record.

Refer to the interview with the Administrator on

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C 202	Continued From page 7 06/04/26 at 7:05pm. 2. Review of Resident #3's current FL-2 dated 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria. Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24. Review of Resident #3's record revealed there was no documentation of a first or second TB skin test for Resident #3. Interview with the Administrator on 06/04/26 at 7:05pm revealed: -She was not aware that Resident #3's first and second TB skin tests were not in his record. -Resident #3 received his two step TB skin tests, but she did not know why the test results were not in the record. Refer to the interview with the Administrator on 06/04/26 at 7:05pm. 3. Review of Resident #1's current FL-2 dated 07/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. Review of Resident #1's record revealed: -There was documentation of a TB skin test administered on 08/15/25 and read as negative on 08/17/25. -There was no documentation of a second TB skin test for Resident #1.	C 202		

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C 202	Continued From page 8 Interview with the Administrator on 06/04/26 at 7:05pm revealed: -She was not aware that Resident #1's second TB skin test was not in his record. -Resident #1 received his second TB skin test, but she did not know why the test results were not in the record. Refer to the interview with the Administrator on 06/04/26 at 7:05pm. _____ Interview with the Administrator on 06/04/26 at 7:05pm revealed: -Prior to resident admission to the facility, she would ask for the most recent TB skin test results. -She was responsible for ensuring the TB skin test was administered and the two-step completed for all residents. -She was responsible for filing the paperwork and for following up if the paperwork was not in the record.	C 202		
C 207	10A NCAC 13G .0702 (f) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination and Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.	C 207		

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C 207	Continued From page 9	C 207		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to contact the residents' primary care provider (PCP) for clarification of medication orders on the FL2 for 1 of 3 sampled residents related to orders for a medication used to treat high blood pressure and to control seizures (#2).

The findings are:

Review of Resident #2's current FL-2 dated 05/21/26 revealed diagnoses included acute respiratory distress, acute pulmonary edema, and end stage renal disease.

Review of Resident #2's Resident Register revealed the resident's admission date was 11/27/23.

a. Review of Resident #2's current FL-2 dated 05/21/26 revealed there was an order for Levetiracetam to be administered once daily, with no dosage indicated on the order (used to prevent and control seizures).

Review of Resident #2's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Levetiracetam 500mg,1 tablet to be administered twice daily scheduled at 8:00am and 8:00pm.
-There was documentation Levetiracetam 500mg was administered at 8:00am from 05/22/26 to 05/31/26.

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C 207	Continued From page 10 -There was documentation Levetiracetam 500mg was not administered at 8:00am on 05/21/26 due to the resident was out of the facility. -There was documentation Levetiracetam 500mg was administered at 8:00pm from 05/22/26 to 05/27/26 and from 05/29/26 to 05/31/26 . -There was documentation Levetiracetam 500mg was not administered at 8:00pm on 05/21/26 and 05/28/26 due to the resident was out of the facility. Review of Resident #2's June 2026 eMAR revealed: -There was documentation for Levetiracetam 500mg,1 tablet to be administered twice daily scheduled at 8:00am and 8:00pm. -There was documentation Levetiracetam 500mg was administered daily at 8:00am from 06/01/26 to 06/04/26. -There was documentation Levetiracetam 500mg was administered daily at 8:00pm from 06/01/26 to 06/03/26. Telephone interview with a pharmacist the facility's contracted pharmacy on 06/04/26 at 5:40pm revealed the pharmacy had an order for Levetiracetam 500mg,1 tablet to be administered twice daily, and the original order was dated on 03/06/26. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 207		

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C 207	Continued From page 11 b. Review of Resident #2's current FL-2 dated 05/21/26 revealed there was an order for Losartan with no directions of dosage or how often to be administered (used to treat high blood pressure). Review of Resident #2's May 2026 eMAR revealed: -There was documentation for Losartan 25mg, 1 tablet to be administered once daily scheduled at 8:00am. -There was no documentation Losartan 25mg was administered once daily at 8:00am from 05/21/26 to 05/27/26. -The exception for those dates did not provide a reason Resident #2 was not administered Losartan at 8:00am. -There was documentation for Losartan 25mg was administered once daily at 8:00am from 05/28/26 to 05/31/26. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for Losartan 25mg,1 tablet to be administered once daily scheduled at 8:00am. -There was documentation Losartan 25mg was administered once daily at 8:00am from 06/01/26 to 06/04/26. Telephone interview with a pharmacist the facility's contracted pharmacy on 06/04/26 at 5:40pm revealed the pharmacy had an order for Losartan 25mg, 1 tablet to be administered once daily, and the original order was dated 05/28/26. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on	C 207		

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C 207	Continued From page 12 06/04/26 at 6:45pm. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. _____ Interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm revealed: -She had been in the role as the SIC for three weeks. -She was in the process of training for her new position. -During primary care provider (PCP) visits at the facility, the PCP would verbally change a medication, but she never saw a written order that the medication had changed. -She would then see the new order on the medication administration record (MAR) from the pharmacy and thought the PCP sent the order to the pharmacist. -She had not learned how to compare the FL2 or physician orders with the MAR to ensure the medications were correct. Interview with the Administrator on 06/04/26 at 6:45pm revealed: -She was aware of the PCP giving verbal medication orders. -It had been a challenge getting the medications to match the FL2 or the physician orders with the MAR. -She had not asked for physician orders sheets to be signed by the PCP. -The PCP recently changed and the facility would work with them to get written orders for the residents' records. -She was in the process of training the SIC how match the FL2 with the MAR. -She was responsible for clarifying medications on the resident's FL2s.	C 207		

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C 218	10A NCAC 13G .0704 (b) Resident Contract, Information on Facility 10A NCAC 13G .0704 Resident Contract, Information On Facility, and Resident Register (b) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D- 4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website,	C 218		

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AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 218	Continued From page 14 https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf, at no charge. The facility may use a resident information form other than the Resident Register as long as it contains same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed, signed, and dated within 72 hours of admission for 2 of 3 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/25 revealed diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. Review of Resident #1's record revealed there was no Resident Register available for review for Resident #1. Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was not aware that Resident #1's Resident Register was not in his record. -She was not sure why his Resident Register was not in his record. Refer to the interview with the Administrator on 06/04/26 at 7:18pm.	C 218		

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C 218	Continued From page 15 2. Review of Resident #2's current FL-2 dated 05/21/26 revealed diagnoses included acute respiratory distress, acute pulmonary edema, and end stage renal disease. Review of Resident #2's Resident Register revealed: -Resident #2's admission date was 11/27/23. -The Resident Register was not signed or dated by Resident #2's representative. -The Resident Register was signed but not dated by the Administrator or Supervisor-in-Charge (SIC). Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was not aware that Resident #2's Resident Register was not signed or dated by the representative. -She was not aware that Resident #2's Resident Register was not dated by the Administrator. Refer to the interview with the Administrator on 06/04/26 at 7:18pm. _____ Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was aware the Resident Register should be completed within 72 hours of admission. -She was responsible for ensuring the Resident Register was completed for each resident. -Her last audit for reviewing residents' records was in July or August 2025 and she had not noticed any documentation missing in the residents' records.	C 218		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan	C 236		

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C 236	Continued From page 16 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed	C 236		

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C 236	Continued From page 17 for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 2 of 3 sampled residents (#1, #3) had a completed care plan that was signed by a physician. The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. -The resident was constantly disoriented and ambulatory. Review of Resident #1's record revealed there was no care plan available for review for Resident #1. Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was not aware Resident #1's care plan was not in his record. -She was not sure why his care plan was not in his record. -She was responsible for ensuring resident care plans were completed, signed, and placed in the resident's record. 2. Review of Resident #3's current FL-2 dated	C 236		

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C 236	Continued From page 18 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria. Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24. Review of Resident #3's current care plan dated 05/07/26 revealed: -The care plan was signed and dated by the staff who completed the care plan. -The primary care provider (PCP) had not signed the care plan. -Resident #3 was ambulatory with aide or device and needed extensive assistance. -Resident #3 was incontinent and needed extensive assistance with toileting. -Resident #3 was totally dependent with bathing, dressing, and transferring. Interview with the Administrator on 06/04/26 at 7:18pm revealed: -She was aware that the primary care provider (PCP) did not review or sign Resident #3's care plan. -The PCP was coming for a routine visit on 06/16/26 and she had planned to get the PCP to sign then. -She was aware that the care plan should be reviewed and signed by the PCP within a few weeks of completion. -She was responsible for ensuring resident care plans were completed and signed annually. -She had not sent the care plan assessment to the primary care provider (PCP) for signature. Based on observations, interviews and record	C 236		

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C 236	Continued From page 19 reviews, it was determined Resident #3 was not interviewable.	C 236		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, TED hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage; (10) care for pressure ulcers, up to and including a Stage II pressure ulcer, which is a superficial	C 252		

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C 252	Continued From page 20 ulcer presenting as an abrasion, blister, or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube. For the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established; (15) medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent; (20) administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule; (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational	C 252		

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C 252	Continued From page 21 therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure licensed health professional support (LHPS) evaluations were completed quarterly for 2 of 3 sampled residents who required assistance with tasks including ambulation with assistive device and transferring (#2, #3). The findings are: 1. Review of Resident #2's current FL-2 dated 05/21/26 revealed: -Diagnoses included acute respiratory distress, acute pulmonary edema, and end stage renal disease. -Resident #2 was non-ambulatory. Review of Resident #2's Resident Register revealed the resident's admission date was 11/27/23. Observation of Resident #2 on 06/04/26 at 10:00am revealed resident propelling himself in his wheelchair in the hallway. Review of Resident #2's current care plan dated	C 252		

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C 252	Continued From page 22 05/07/26 revealed: -Resident #2 was ambulatory with aide or device and needed extensive assistance. -Resident #2 was totally dependent extensive assistance with transferring. -Resident #2 needed limited assistance with toileting, bathing, dressing, and grooming. Review of Resident #2's record revealed there was no Licensed Health Professional Support (LHPS) evaluation for Resident #2. Refer to the interview with the Administrator on 06/04/26 at 7:15pm. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria. Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24. Observation of Resident #3 on 06/04/26 at 8:30am revealed Resident #3 had a bilateral above-knee amputation propelling himself in his wheelchair to the breakfast table for breakfast. Review of Resident #3's current care plan dated 05/07/26 revealed: -Resident #3 was ambulatory with aide or device and needed extensive assistance. -Resident #3 was incontinent and needed extensive assistance with toileting.	C 252		

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C 252	Continued From page 23 -Resident #3 was totally dependent with bathing, dressing, and transferring. Review of Resident #3's record revealed there was no Licensed Health Professional Support (LHPS) evaluation for Resident #3. Refer to the interview with the Administrator on 06/04/26 at 7:15pm. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. _____ Interview with the Administrator on 06/04/26 at 7:15pm revealed: -She was not aware that the residents' LHPS assessments were not completed quarterly. -Residents' LHPS were completed and signed by the Registered Nurse (RN) quarterly. -She was not sure why the LHPS were not in the residents' record and could not say where they would be located. -She was responsible for ensuring the LHPS were completed and placed in the residents' record.	C 252		
C 269	10A NCAC 13G .0904 (c)(6) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets.	C 269		

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C 269	Continued From page 24 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a licensed dietitian/nutritionist approved therapeutic diets for 1 of 3 sampled residents (#1) who had an order for a pureed diet. The findings are: Review of Resident #1's current FL-2 dated 07/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. -There was a diet order for a low concentrated sweets and pureed diet. Review of Resident #1's diet order dated 10/29/25 revealed there was an order for regular, low concentrated sweets, and pureed diet. Review of the facility's diet list on 06/04/26 at 11:55am revealed Resident #1's diet was listed as a pureed diet. Observation of the facility's therapeutic diet menu on 06/04/26 at 11:55am revealed: -There was no therapeutic diet menu in the facility. -A pureed diet menu was not available for staff guidance. Observation of the breakfast meal on 06/04/26 from 9:00am to 9:30am revealed: -The meal consisted of sausage patty, eggs, toast, yogurt and tea.	C 269		

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C 269	Continued From page 25 -Resident #1 was served sausage patty, eggs, toast that all had a pureed consistency, and yogurt with tea. -He ate 100% of the sausage patty, eggs, toast, and drank 100% of the tea. Interview with the Administrator on 06/04/26 at 6:50pm revealed: -A dietitian visited, did not remember the date, and reviewed the menus and gave her instructions on how to prepare special diets. -The dietitian did not provide a therapeutic menu for guidance. -The dietitian showed the facility staff how to prepare pureed foods for Resident #1. -She did not realize that she needed a therapeutic menu for guidance.	C 269		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 1 of 3 sampled residents with a physician order for a low concentrated sweets and pureed diet (#1).	C 270		

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C 270	Continued From page 26 The findings are: Review of Resident #1's current FL-2 dated 07/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. -The resident was constantly disoriented and ambulatory. -There was a diet order for a low concentrated sweets and pureed diet. Review of Resident #1's diet order dated 10/29/25 revealed there was an order for regular, low concentrated sweets, and pureed diet. Review of the facility's diet list on 06/04/26 at 11:55am revealed Resident #1's diet was listed as a pureed diet. Observation of the facility's kitchen on 06/04/26 at 11:55am revealed: -There was no current therapeutic diet menu posted for Resident #1 with a low concentrated sweets and pureed diet. -A pureed diet menu was not available for staff guidance. Observation of the breakfast meal on 06/04/26 from 9:00am to 9:30am revealed: -The meal consisted of sausage patty, eggs, toast, yogurt and tea. -Resident #1 was served sausage patty, eggs, toast that had a pureed consistency, and yogurt with tea. -He ate 100% of the sausage patty, eggs, toast, and drank 100% of the tea. Interview with a medication aide (MA) on	C 270		

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C 270	Continued From page 27 06/04/26 at 12:13pm revealed: -She was aware that Resident #1 was on a low concentrated sweets and pureed diet. -She knew how to prepare a pureed diet from previous experience at another facility. -She was told by the Supervisor-in-Charge (SIC) to puree Resident #1's food. -She did not remember anyone showing her how to puree the food, but she was shown how to use the puree grinder for pureeing foods. Interview with the SIC on 06/04/26 at 2:55pm revealed: -She was aware that Resident #1 was on a low concentrated sweets and pureed diet. -She knew how to prepare a pureed diet from previous experience at another facility. -She used the grinder machine to puree Resident #1's food and added gravy when needed to ensure a pureed consistency and the food was not dry. -She had not seen a therapeutic menu to show her how to puree Resident #1's food. -She taught the new staff how to prepare pureed foods for Resident #1. Interview with the Administrator on 06/04/26 at 6:50pm revealed: -She was aware that Resident #1 was on a low concentrated sweets and pureed diet. -She learned how to prepare a pureed diet from a dietician. -The dietitian showed the facility staff how to prepare pureed foods for Resident #1, but she did not remember the date. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	C 270		

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C 280	Continued From page 28	C 280		
C 280	10A NCAC 13G .0904(d)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water during the breakfast and lunch meal. The findings are: Observation of the breakfast meal on 06/04/26 at 9:00am revealed: -At 9:20am, one resident started coughing during the meal and asked for water and was served a glass of water. -Three residents were not served water during the breakfast meal. -The residents were served tea. Observation of the lunch meal on 06/04/26 at 12:10pm revealed: -Four residents were not served water during the lunch meal. -The residents were served tea. Interview with a medication aide (MA) on 06/04/26 at 12:13pm revealed: -She was aware that water should be provided at each meal.	C 280		

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C 280	Continued From page 29 -She did not see water being provided at each meal, so she did not provide water at each meal. -She alternated beverage, if she provided tea for breakfast, she would give water during lunch but could not say why she did not serve water at lunch. Interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 3:00pm revealed: -She was aware that water should be provided at each meal. -She was not aware that water was not provided during breakfast and lunch on 06/04/26. -During orientation, she explained water was to be provided at each meal. -She had not followed-up to see if water was being served at each meal. Interview with the Administrator on 06/04/26 at 7:45pm revealed: -She was aware that water should be provided at each meal. -She was not aware that water was not provided during breakfast and lunch on 06/04/26. -She expected staff to serve water at each meal.	C 280		
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be	C 291		

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C 291	Continued From page 30 posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop and implement an activity program to engage residents with each other and the community. The findings are: Observation of the facility's activity calendar on 06/04/26 from 9:00am to 4:00pm revealed: -An activity calendar was posted on the wall in the hall area near the kitchen. -The calendar was handwritten and the month shown was the month of "November" faintly written.	C 291		

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C 291	Continued From page 31 -The day Thursday, 06/04/26 was written as Tuesday on the activity calendar. -The activity for that day was "Uno" with no beginning time or ending time. Observation of the facility on 06/04/26 at 10:30am and at 2:30pm revealed: -One of the four residents sat in the living room in front of the television. -Three of the four residents were in their bedrooms watching television. -There were no activities offered on 06/04/26. Interview with a resident on 06/04/26 at 2:45pm revealed: -He liked to play card games and board games. -The facility provided activities sometimes. -He could not remember the last time there was an activity. Interview with a resident on 06/04/26 at 2:50pm revealed: -He liked to play bingo and card games. -The facility provided activities a couple of times a week; however, it had been awhile since the last activity. -He could not remember the date of the last activity. Interview with a medication aide (MA) on 06/04/26 at 12:13pm revealed: -The Supervisor in Charge (SIC) wrote the activities on the activity calendar. -She did not notice the month, and the dates were incorrect for the month of June 2026 on the calendar board. -She went by the activity calendar but if there was not an activity scheduled she would come up with an activity to do. -She played cards, checkers, and assisted with	C 291		

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gardening outside with the residents.
-There were no certain times during the day to do activities.
-Activities lasted about 30 minutes once a day.
-Activities depended on the resident and what was going on that day.
-She did not do activities on 06/04/26 because she got behind with her tasks.

Interview with the SIC on 06/04/26 at 2:25pm revealed:
-She was aware the month, and the dates were incorrect for the month of June 2026 on the calendar board.
-She could not erase the word "November" from the calendar.
-April 2026 was the last time she did activities with the residents.
-She did not use the calendar and decided on an activity based on how the residents were feeling that day.
-She did not know what activities the staff did when she was not there.
-She was responsible for the facility activity program.

Interview with the Administrator on 06/04/26 at 6:45pm revealed:
-She was not aware there were no activities provided on 06/04/26.
-Staff provided activities per the activity calendar.
-She was not aware the month, and the dates were incorrect for the month of June 2026 on the calendar board.
-An activity coordinator came on Monday, Wednesday, and Friday around 2:00pm weekly to implement activities with the residents.
-A volunteer came from 1:00pm to 6:00pm three days a week to help with activities.
-No one came to do activities on Tuesday and

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C 291	Continued From page 33 Thursday. -The SIC was responsible for the facility activity program.	C 291		
C 292	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide at least 14 hours of activities per week. The findings are: Observation of the facility's activity calendar on 06/04/26 from 9:00am to 4:00pm revealed: -An activity calendar was posted on the wall in the hall area near the kitchen. -The calendar was handwritten and the month shown was the month of "November" faintly written. -The day Thursday, 06/04/26 was written as Tuesday on the activity calendar. -The activity for that day was "Uno" with no beginning time or ending time. -There were 28 days written on the calendar. -There were five days showing a blank space inside the box. -The other twenty-three days showed one activity	C 292		

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C 292	Continued From page 34 inside the box. -There were no activities offered on 06/04/26. Interview with a resident on 06/04/26 at 2:45pm revealed: -He liked to play card games and board games. -The facility provided activities sometimes. -He could not remember the last time there was an activity. Interview with a resident on 06/04/26 at 2:50pm revealed: -He liked to play bingo and card games. -The facility provided activities a couple of times a week; however, it had been awhile since the last activity. -He could not remember the date of the last activity. Interview with a medication aide (MA) on 06/04/26 at 12:13pm revealed: -The Supervisor-in-Charge (SIC) wrote the activities on the activity calendar. -She went by the activity calendar but if there was not an activity scheduled she would come up with an activity to do. -There were no certain times during the day to do activities. -Activities lasted about 30 minutes once a day. -Activities depended on the resident and what was going on that day. -She did not know there should be 14 hours of activities a week. Interview with the SIC on 06/04/26 at 2:25pm revealed: -April 2026 was the last time she did activities with the residents. -She did not use the calendar and decided on an activity based on how the residents were feeling	C 292		

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C 292	Continued From page 35 that day. -She did not know there should be 14 hours of activities a week. -She was responsible for the facility's activity program. Interview with the Administrator on 06/04/26 at 6:45pm revealed: -Staff provided activities per the activity calendar. -She was not aware the activity calendar should specify the times the activity began and ended. -She did know there should be 14 hours of activities a week. -The SIC was responsible for the facility activity program.	C 292		
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were maintained in the residents' records for 2 of 3 sampled residents (#1, #3) who had an order for medication used to treat anxiety and blood sugar (#1) and who had an order for medication used to treat constipation, anxiety, enlarged prostate, and insomnia (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/25 revealed diagnoses included Alzheimer's disease, type 2 diabetes mellitus with	C 316		

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C 316	Continued From page 36 diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. a. Review of Resident #1's current FL-2 dated 07/09/25 revealed there was an order for Risperidone 0.25mg, 1 tablet to be administered once daily at bedtime (used to treat anxiety). Review of Resident #1's record revealed there were no additional orders for Risperidone 0.25mg. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Risperidone 0.25mg, 1 tablet to be administered three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Risperidone 0.25mg was administered at 8:00am from 04/01/26 to 04/30/26. -There was documentation Risperidone 0.25mg was administered at 2:00pm from 04/01/26 to 04/30/26. -There was documentation Risperidone 0.25mg was administered at 8:00pm on 04/01/26, 04/07/26, 04/09/26, from 04/11/26 to 04/16/26, 04/21/26, and from 04/24/26 to 04/30/26. -There was no documentation Risperidone 0.25mg was administered at 8:00pm from 04/02/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, and from 04/22/26 to 04/23/26. -The exception at 8:00pm for Resident #2 was the medication was withheld per the primary care provider (PCP) orders from 04/02/26 to 04/03/26 on . -The exception at 8:00pm for Resident #2 was	C 316		

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out of the facility on 04/17/26 and 04/22/26.
-There was no exception recorded at 8:00pm for Resident #2 from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, and from 04/18/26 to 04/20/26.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Risperidone 0.25mg, 1 tablet to be administered three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Risperidone 0.25mg was administered at 8:00am from 05/01/26 to 05/31/26.
-There was documentation Risperidone 0.25mg was administered at 2:00pm from 05/01/26 to 05/31/26.
-There was documentation Risperidone 0.25mg was administered at 8:00pm from 05/01/26 to 05/05/26, from 05/08/26 to 05/17/26, from 05/19/26 to 05/20/26, from 05/22/26 to 05/27/26, from 05/29/26 to 05/31/26.
-There was no documentation Risperidone 0.25mg was administered at 8:00pm from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26.
-There was no exception recorded for Resident #2 at 8:00pm from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26.

Review of Resident #1's June 2026 eMAR revealed:
-There was an entry for Risperidone 0.25mg, 1 tablet to be administered three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Risperidone 0.25mg was administered at 8:00am from 06/01/26 to 06/04/26.
-There was documentation for Risperidone 0.25mg was administered at 2:00pm from 06/01/26 to 06/03/26.

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C 316	Continued From page 38 -There was documentation for Risperidone 0.25mg was administered at 8:00pm from 06/01/26 to 06/03/26. Observation of Resident #1's medications on hands on 06/04/26 at 5:30pm revealed: -There was a supply of Risperidone 0.25mg, 90 tablets dispensed on 05/25/26 with instructions to take 1 tablet three times a day. -There were 77 of 90 tablets remaining. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's current FL-2 dated 07/09/25 revealed there was an order for Metformin 1,000mg, 1 tablet to be administered with a meal once daily (used to control blood sugar levels). Review of Resident #1's record revealed there were no additional orders for Metformin 850mg. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 850mg, 1 tablet to be administered once daily scheduled at 8:00am. -There was documentation for Metformin 850mg was administered at 8:00am from 04/01/26 to 04/30/26.	C 316		

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C 316	Continued From page 39 Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Metformin 850mg, 1 tablet to be administered once daily scheduled at 8:00am. -There was documentation for Metformin 850mg was administered at 8:00am from 05/01/26 to 05/31/26. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Metformin 850mg, 1 tablet to be administered once daily scheduled at 8:00am. -There was documentation Metformin 850mg was administered at 8:00am from 06/01/26 to 06/04/26. Observation of Resident #1's medications on hands on 06/04/26 at 5:30pm revealed: -There was a supply of Metformin 850mg, 60 tablets dispensed on 05/05/26with instructions to take 1 tablet with meal daily. -There were 27 of 60 tablets remaining. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #3's current FL-2 dated 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral	C 316		

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C 316	Continued From page 40 above-knee amputation, chronic heart failure, and acute cystitis with hematuria. Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24. a. Review of Resident #3's current FL-2 dated 08/22/25 revealed there was no order for Melatonin 3mg, 2 tablets to be administered once daily at bedtime (used to treat insomnia). Review of Resident #3's record revealed there were no orders for Melatonin 3mg. Observation of Resident #3's medications on hands on 06/04/26 at 5:30pm revealed: -There was a supply of Melatonin 3mg, 2 tablets 90 tablets dispensed on 05/01/26 with instructions to take 2 tablets at bedtime. -There were 22 of 90 tablets remaining. Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed: -There was documentation for Melatonin 3mg, 2 tablets to be administered once daily at bedtime scheduled at 8:00pm. -There was documentation Melatonin 3mg was administered daily at bedtime at 8:00pm on 04/01/26, 04/03/26, 04/07/26, 04/09/26, from 04/11/26 to 04/16/26, 04/21/26, from 04/24/26, 04/26/26 and 04/27/26, and from 04/29/26 to 04/30/26. -There was no documentation Melatonin 3mg was administered at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26 and 04/28/26. -Melatonin 3mg at 8:00pm was initialed with a	C 316		

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C 316	Continued From page 41	C 316		

circled on 04/25/26.
-The exception showed Resident #3 was out of the facility on 04/25/26.
-There was no exception recorded for Resident #3 at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26 and 04/28/26.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Melatonin 3mg , 2 tablets to be administered once daily at bedtime scheduled at 8:00pm.
-There was documentation Melatonin 3mg , 2 tablets was administered at bedtime at 8:00pm from 05/01/26 to 05/05/26, from 05/08/26 to 05/17/26, from 05/19/26 to 05/20/26, from 05/22/26 to 05/27/26, 05/29/26, and 05/31/26.
-There was no documentation for Melatonin 3mg, 2 tablets were administered at 8:00pm from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, 05/28/26, and 05/30/26.
-The exception showed Resident #3 was out of the facility on 05/24/26 and no information was recorded on 05/23/26.
-There was no exception recorded for Resident #3 at 8:00pm on from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, 05/28/26, and 05/30/26.

Review of Resident #1's June 2026 eMAR revealed:
-There was an entry for Melatonin 3mg, 2 tablets to be administered daily at bedtime scheduled at 8:00pm.
-There was documentation Melatonin 3mg was administered at bedtime at 8:00pm from 06/01/26 to 06/03/26.

Telephone interview with a pharmacist at the

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C 316	Continued From page 42 facility's contracted pharmacy on 06/04/26 at 5:40pm revealed: -There was a current order for Melatonin 3mg, 2 tablets to be administered once daily at bedtime. -Melatonin 3mg was dispensed for Resident #3 on 05/01/26 for a quantity of 60 tablets. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. b. Review of Resident #3's current FL-2 dated 08/22/25 revealed there was no order for Senna Plus 8.6-50mg, 1 tablet to be administered once daily at bedtime (used to treat constipation). Review of Resident #3's record revealed there were no orders for Senna Plus 8.6-50mg. Observation of Resident #3's medications on hands on 06/04/26 at 5:30pm revealed: -There was a supply of Senna Plus 8.6-50mg, 1 tablet 120 tablets dispensed on 02/02/26 with instructions to take 1 tablet at bedtime. -There were 15 of 120 tablets remaining. Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Senna Plus 8.6-50mg, 1 tablet to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Senna Plus 8.6-50mg was administered at bedtime at 8:00pm on 04/01/26, 04/03/26, 04/07/26, 04/09/26, from 04/11/26 to 04/16/26, 04/21/26, from 04/24/26 to 04/27/26, and from 04/29/26 and 04/30/26.	C 316		

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C 316	Continued From page 43 -There was documentation Senna Plus 8.6-50mg was not administered at 8:00pm and due to the resident being out of the facility on 04/25/26. -There was no documentation Senna Plus 8.6-50mg was administered at bedtime at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26 and 04/28/26 and there were no exceptions recorded for these dates. Review of Resident #1's May 2026 eMAR revealed: -There was documentation for Senna Plus 8.6-50mg, 1 tablet to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Senna Plus 8.6-50mg was administered at bedtime at 8:00pm from 05/01/26 to 05/05/26, from 05/08/26 to 05/17/26, from 05/19/26 to 05/20/26, from 05/22/26 to 05/27/26, 05/29/26, and 05/31/26. -There was no documentation Senna Plus 8.6-50mg was administered at 8:00pm on 05/22/26 and 05/24/26 due to the resident being out of the facility . -There was no documentation Senna Plus 8.6-50mg was administered at bedtime at 8:00pm from 05/06/26 to 05/07/26, 05/18/26, 05/21/26 and 05/28/26. -There was no exception recorded for Resident #3 at 8:00pm on from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Senna Plus 8.6-50mg, 1 tablet to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Senna Plus 8.6-50mg was administered at bedtime at 8:00pm from 06/01/26 to 06/03/26.	C 316		

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C 316	Continued From page 44 Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 5:40pm revealed: -There was a current order on 05/12/26 for Senna Plus 8.6-50mg, 1 tablet to be administered daily at bedtime. -Senna Plus 8.6-50mg was dispensed for Resident #3 on 05/12/26 for a quantity of 30 tablets. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. c. Review of Resident #3's current FL-2 dated 08/22/25 revealed there was no order for Trazodone 50mg, ½ tablet to be administered once daily at bedtime (used to treat insomnia). Review of Resident #3's record revealed there were no orders for Trazadone 50mg ½ tablet. Observation of Resident #3's medications on hands on 06/04/26 at 5:30pm revealed: -There was a supply of Trazadone 50mg, ½ tablet 90 tablets dispensed on 03/04/26 with instructions to take ½ tablet at bedtime. -There was 1/2 tablet remaining. Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone 50mg, ½ tablet to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Trazodone 50mg was	C 316		

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C 316	Continued From page 45 administered at bedtime at 8:00pm on 04/01/26, 04/03/26, 04/07/26, 04/09/26, from 04/11/26 to 04/16/26, 04/21/26, from 04/24/26 to 04/27/26, and from 04/29/26 to 04/30/26. -There was no documentation Trazodone 50mg was administered at bedtime at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26, 04/23/26, and 04/28/26. -The exception showed Resident #3 was out of the facility on 04/24/26. -There was no exception recorded for Resident #3 at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26, 04/25/26, and 04/28/26. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Trazodone 50mg, ½ tablet to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Trazodone 50mg was administered at bedtime at 8:00pm from 05/01/26 to 05/05/26, from 05/08/26 to 05/17/26, from 05/19/26 to 05/20/26, from 05/22/26 to 05/27/26, 05/29/26 to 05/31/26. -There was no documentation Trazodone 50mg was administered at 8:00pm on 05/22/26 and 05/24/26 due to the resident being out of the facility. -There was no documentation Trazodone 50mg was administered daily at bedtime at 8:00pm from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26. -There was no exception recorded for Resident #3 at 8:00pm on from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26. Review of Resident #1's June 2026 eMAR	C 316		

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C 316	Continued From page 46	C 316		

revealed:
-There was an entry for Trazodone 50mg, ½ tablet to be administered daily at bedtime scheduled at 8:00pm.
-There was documentation Trazodone 50mg, was administered at bedtime at 8:00pm from 06/01/26 to 06/03/26.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 5:40pm revealed:
-There was a current order on 09/12/25 for Trazodone 50mg, ½ tablet to be administered daily at bedtime.
-Trazadone 50mg was dispensed for Resident #3 on 03/02/26 for a quantity of 30 tablets.

Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm.

Refer to the interview with the Administrator on 06/04/26 at 6:45pm.

d. Review of Resident #3's current FL-2 dated 08/22/25 revealed there was no order for Tamsulosin 0.4mg. 2 capsules to be administered once daily at bedtime (used to treat enlarged prostate) for Resident #3.

Review of Resident #3's record revealed there were no orders for Tamsulosin 0.4mg.

Observation of Resident #3's medications on hands on 06/04/26 at 5:30pm revealed there was a supply of Tamsulosin 0.4mg, 2 capsules dispensed on 04/12/26 with instructions to take 2 capsules at bedtime.

Review of Resident #3's April 2026 electronic

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C 316	Continued From page 47	C 316		

medication administration record (eMAR) revealed:
-There was an entry for Tamsulosin 0.4mg, 2 capsules to be administered once daily at bedtime scheduled at 8:00pm.
-There was documentation Tamsulosin 0.4mg was administered at bedtime at 8:00pm on 04/01/26, 04/03/26, 04/07/26, 04/09/26, from 04/11/26 to 04/16/26, 04/21/26, from 04/24/26 to 04/27/26, and from 04/29/26 to 04/30/26.
-There was no documentation Tamsulosin 0.4mg was administered at bedtime at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26 and 04/28/26.
-The exception showed Resident #3 was out of the facility on 04/24/26 and 04/25/26.
-There was no exception recorded for Resident #3 at 8:00pm on 04/02/26, from 04/04/26 to 04/06/26, 04/08/26, 04/10/26, from 04/17/26 to 04/20/26, from 04/22/26 to 04/23/26, and 04/28/26.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Tamsulosin 0.4mg, 2 capsules to be administered daily at bedtime scheduled at 8:00pm.
-There was documentation Tamsulosin 0.4mg was administered at bedtime at 8:00pm from 05/01/26 to 05/05/26, from 05/08/26 to 05/17/26, from 05/19/26 to 05/20/26, from 05/22/26 to 05/27/26, 05/29/26, and 05/31/26.
-There was no documentation Tamsulosin 0.4mg was administered at 8:00pm on 05/22/26 and 05/24/26 due to the resident being out of the facility.
-There was no documentation for Tamsulosin 0.4mg was administered daily at bedtime at 8:00pm from 05/06/26 to 05/07/26, 05/18/26,

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C 316	Continued From page 48 05/21/26, 05/28/26, and 05/30/26. -There was no exception recorded for Resident #3 at 8:00pm on from 05/06/26 to 05/07/26, 05/18/26, 05/21/26, and 05/28/26. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Tamsulosin 0.4mg, 2 capsules to be administered daily at bedtime scheduled at 8:00pm. -There was documentation Tamsulosin 0.4mg was administered at bedtime at 8:00pm from 06/01/26 to 06/03/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/26 at 5:40pm revealed there was a current order on 04/12/26 for Tamsulosin 0.4mg, 2 capsules to be administered daily at bedtime. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/04/26 at 6:30pm. Refer to the interview with the Administrator on 06/04/26 at 6:45pm. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. _____ Interview with the Supervisor in Charge (SIC) on 06/04/26 at 6:30pm revealed: -She had been in the role as the SIC for three weeks. -She was in the process of training for her new position. -During primary care provider (PCP) visits at the facility, the PCP would verbally change a medication, but she never saw a written order	C 316		

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C 316	Continued From page 49 that the medication had changed. -She had not learned how to compare the FL2 or physician orders with the medication administration record (MAR) to ensure the medications were correct. -She would then see the new order on the MAR from the pharmacy and thought the PCP sent the order to the pharmacist. Interview with the Administrator on 06/04/26 at 6:45pm revealed: -She was aware of the PCP giving verbal medication orders. -It had been a challenge getting the medications to match the FL2 or the physician orders with the MAR. -She had not asked for physician orders sheets to be signed by the PCP. -The PCP recently changed and the facility would work with them to get written orders. -She was in the process of training the SIC how to do this task of matching the FL2 with the MAR.	C 316		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident	C 375		

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C 375	Continued From page 50 which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the quarterly pharmaceutical reviews were completed for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/25 revealed diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, mood affective disorder, hyperlipidemia, benign prostatic hyperplasia, and dysphagia. Review of Resident #1's record revealed: -There was a quarterly pharmaceutical review dated 12/26/25.	C 375		

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C 375	Continued From page 51 -There was no subsequent quarterly pharmaceutical review. Refer to interview with the Administrator on 06/04/26 at 7:15pm revealed: Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #2's current FL-2 dated 05/21/26 revealed diagnoses included acute respiratory distress, acute pulmonary edema, and end stage renal disease. Review of Resident #2's Resident Register revealed the resident's admission date was 11/27/23. Review of Resident #2's record revealed: -There was a quarterly pharmaceutical review dated 12/26/25. -There was no subsequent quarterly pharmaceutical review. Refer to interview with the Administrator on 06/04/26 at 7:15pm revealed: Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 3. Review of Resident #3's current FL-2 dated 08/22/25 revealed diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria. Review of Resident #3's Resident Register revealed the resident's admission date was	C 375		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 52 06/03/24. Review of Resident #3's record revealed: -There was a quarterly pharmaceutical review dated 12/26/25. -There was no subsequent quarterly pharmaceutical review. Refer to interview with the Administrator on 06/04/26 at 7:15pm revealed: Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. _____ Interview with the Administrator on 06/04/26 at 7:15pm revealed: -Residents' quarterly pharmaceutical reviews were completed and signed by the pharmacy quarterly. -The consultant pharmacist sent the pharmaceutical review report by electronic mail (email), and she printed and placed it in each residents' record. -She was not sure why the quarterly pharmaceutical reviews were not in the residents' record and could not say where they would be located. -She was responsible for following up on the residents' quarterly pharmaceutical review.	C 375		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R 06/04/2026

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C 444	Continued From page 53 incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of accidents or incidents (A/I) for 1 of 3 sampled residents requiring emergency evaluation (#3). The findings are: Review of the facility's Accident and Incident Policy (policy undated) revealed: -The facility will notify the county Department of Social Services (DSS) and the resident's responsible person of any accident or incident resulting in resident's death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. -The appropriate county's report must be completed and electronically mailed (emailed) or faxed to the county monitor within twenty-four (24) hours of the incident. Review of Resident #3's current FL-2 dated 08/22/25 revealed: -Diagnoses included falls, moderate vascular dementia, status post bilateral above-knee amputation, chronic heart failure, and acute cystitis with hematuria. -There was no information of Resident #3's orientation.	C 444		

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C 444	Continued From page 54 Review of Resident #3's Resident Register revealed the resident's admission date was 06/03/24. Review of Resident #3's current care plan dated 05/07/26 revealed: -Resident #3 was ambulatory with aide or device and needed extensive assistance. -Resident #3 was incontinent and needed extensive assistance with toileting. -Resident #3 was totally dependent with bathing, dressing, and transferring. a. Review of Resident #3's accident or incident (A/I) report dated 06/11/25 revealed: -Resident #3 attempted to move forward in his wheelchair but fell backwards outside on the facility's grounds. -He sustained a bump on the back of the head, bruises on his left elbow, and a laceration on his upper right back. -The resident was sent to the emergency department (ED) for further evaluation on 06/11/25. -Resident #3's responsible party was notified. -There was no documentation of an A/I report sent to the county DSS. Review of Resident #3's ED record dated 06/11/25 revealed: -The reason for the visit was for a fall. -Resident #3's testing consisted of a computed axial tomography (CAT) scan of the head and spine without intravenous (IV) contrast. -He was discharged back to the facility on 06/11/25. Refer to interview with Administrator on 06/04/26 at 7:00pm.	C 444		

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C 444	Continued From page 55 b. Review of Resident #3's A/I report dated 08/20/25 revealed: -Resident #3 fell in the shower unwitnessed and bruises and abrasions were visible. -The resident was sent to the emergency department (ED) for further evaluation on 08/20/25. -Resident #3's responsible party was notified. -There was no documentation of an A/I report sent to the county Department of Social Services (DSS). Review of Resident #3's hospital after visit summary (AVS) dated 08/20/25 revealed: -The reason for the visit was for a fall in the shower when his shower chair collapsed and hitting his right side of his chest and head. -Resident #3 chief complaint was of right sided rib pain. -Resident #3 testing consisted of a complete laboratory work up, a computed axial tomography (CAT) scan of the head and spine, and CAT scan of the chest without rib fractures. -He was discharged back to the facility on 08/22/25. Refer to interview with Administrator on 06/04/26 at 7:00pm. _____ Interview with the Administrator on 06/04/26 at 7:00pm revealed: -She was aware to notify the county DSS regarding any resident who needed medical attention other than first aid. -She sent A/I reports to the county DSS after she received the paperwork from the ED or hospital because DSS would ask for the discharge summary.	C 444		

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C 444	Continued From page 56 -She faxed the A/I incident reports dated 06/11/25 and 08/20/25 to the county DSS but could not recall the exact date. -She did not receive a printout of the confirmation for faxes dated 08/20/25 and 06/11/25. -She was responsible to notify the county DSS of A/I reports.	C 444		