STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001024	A. BUILDING: _____ B. WING _____	R 06/25/2026

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BROOKDALE BURLINGTON AL (NC)	3615 SOUTH MEBANE STREET BURLINGTON, NC 27215

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/24/26 to 06/25/26.	D 000		
D 056	10A NCAC 13F .0305 (f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (5) the requirements for housekeeping storage are: (A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and (B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a locked storage area for storing cleaning agents and other substances which may be hazardous if ingested, inhaled or handled. The findings are: Observation of a room labeled mechanical room and storage room on 06/24/26 various times from 10:57am to 4:00pm revealed: -The mechanical room was located adjacent to residents' rooms and next to the electrical room. -The door opened easily with each observation at	D 056		

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D 056	Continued From page 1 10:57am, 11:59am, 2:07pm and 3:57pm. -There was a 25-pound bag of quick set joint compound opened and half full of powder. -The warning labeling on the joint compound included hazardous inhalation of dust. -The dust could cause severe respiratory irritation and long-term lung damage. -The dust could cause severe eye irritation. -There were five 5-gallon primer sealer paint containers. -There were five 1-gallon latex paint containers. -The warning label on the paint included moderate eye or skin irritation, and respiratory irritation. -There was a box of urethane elastomeric sealants. -The warning labeling on the urethane elastomeric sealants included allergy or asthma symptoms, breathing difficulties, serious eye irritation, skin reaction and damage to the nervous system and sensory organs. -There was one gallon container of acetic acid (white distilled vinegar), ¼ filled. -The warning label included severe skin burns and eye damage. -The split heating and air conditioning system (HVAC) was in the room. -The warning for a HVAC in a room included, storage of inflammable items (paints, or household clutter) should not be in the HVAC room. Telephone interview with a representative from Poison Control on 06/25/26 at 2:34pm revealed: -Risk for inhaled joint compound dust poses significant risk for short term respiratory irritation and long-term lung disease. -Exposure without proper protection could lead to permanent life threatening conditions. -Seniors, and especially medically compromised	D 056		

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D 056	Continued From page 2 individuals, would need to be monitored for choking, respiratory symptoms, bowel obstruction and treated based on symptoms. -Risk for ingested latex paint included mild upset stomach or minor mouth irritation. -The individual would need to wash hands and face, drink water and eat a small snack. -Risk for ingesting acetic acid included burning the lining of the mouth, throat and esophagus. -The individual would require immediate mouth rinsing, drink water and seek emergency medical care if it was difficult to breathe, trouble swallowing or severe abdominal pain or vomiting. Interview with a medication aide (MA) on 06/25/26 at 4:00pm revealed: -She did not know the door was not locked to the mechanical room or that it should be locked. -She did not know what items were in the room. Interview with the Maintenance Director on 06/25/26 at 4:30pm revealed: -He was aware that the mechanical room door was not locked. -The door had not been locked for over 1 week. -He was not aware that the storage of hazardous agents must be in a locked storage area. -He was not aware of a facility policy for storing hazardous agents. -He was not concerned that the door was not locked. -It was dangerous to have hazardous agents accessible. -He would have to put a lock on the door. Interview with the Health and Wellness Coordinator (HWC) on 06/25/26 at 4:45pm revealed she was not aware that the mechanical room door was not locked.	D 056		

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D 056	Continued From page 3 Interview with the Administrator on 06/25/26 at 5:30pm revealed: -She was not aware that the door to the mechanical room was not locked and there were hazardous agents in the room. -The room should only be used when maintenance needed to wash something during indoor repairs. -She was not aware of a facility policy for storing hazardous agents. -The Maintenance Director had a key to the mechanical room. -Having hazardous agents accessible to the residents was dangerous.	D 056		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a clean and orderly environment free from obstructions and hazards related to an unsecured oxygen cylinder in a residents room. The findings are: According to guidance from the National Fire Protection Association (NFPA) compressed	D 079		

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D 079	Continued From page 4 oxygen (O2) cylinders must be secured in a rack or stand to prevent tipping over. Review of the facilities oxygen cylinder safe handling policy dated March 2001 revealed: -Oxygen cylinders were to be provided with chains, sturdy portable carts, or approved stands to prevent tipping exposure. -Oxygen cylinders were to be stored in secured areas where they could not be knocked over or damaged by passing associates, residents or visitors. Observation of residents room 10 on 06/24/26 at 12:51pm revealed: -There was one oxygen cylinder standing on the floor that was not secured in a rack/stand. -There was no gauge on the tank to indicate the amount of oxygen in the tank. Telephone interview with a representative for the oxygen supply company on 06/25/26 at 11:39am revealed: -The oxygen supply company had delivered one large oxygen cylinder to the resident who resided in room 10 on 06/17/26. -When delivering oxygen cylinders, racks or stands were typically included but there was nothing documented that showed one was delivered to resident room 10. -The facility should not have oxygen cylinders unsecured. -If an oxygen cylinder were to tip over, it could cause compressed gas to "shoot out". Telephone interview with a family member of the resident who resided in room 10 on 06/25/26 at 10:56am revealed: -She did not do anything with the resident's oxygen cylinders.	D 079		

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D 079	Continued From page 5 -She visited the resident who resided in resident room 10 several times a week. -The resident had one oxygen cylinder in his room last time she visited. -She thought the oxygen cylinder was in a rolling stand. Interview with the Director of Maintenance on 06/25/26 at 4:27pm revealed: -The medication aides (MA) were responsible for the oxygen tanks. -He did a weekly check to assure oxygen cylinders were stored correctly. -He had not noticed, nor had anyone reported to him, oxygen tanks not being stored in a rack/stand. -Oxygen tanks should be stored in a rack/stand and not sit directly on the floor. Interview with a MA on 06/25/26 at 4:13pm revealed: -She was not aware resident room 10 had an unsecured oxygen cylinder. -She was not working the day the oxygen cylinder was delivered to resident room 10. -She was aware oxygen cylinders needed to be stored in a rack/stand. Interview with the facility nurse on 06/25/26 at 5:25pm revealed: -She did not recall seeing the oxygen cylinder on the floor in resident room 10. -If a MA saw an oxygen cylinder sitting on the floor, they should notify her or the Health and Wellness Coordinator (HWC). -The oxygen cylinder should have been stored in a stand or a rack. -If an oxygen cylinder was not secured in a stand, it could be knocked over or fall over.	D 079		

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D 079	Continued From page 6 Interview with the HWC on 06/25/26 at 4:24pm revealed: -All oxygen tanks were required to be stored in a rack/stand. -She did not notice there was an oxygen tank not stored in a rack/stand in resident room 10. -She expected oxygen tanks to be stored in a rack/stand so they would not get knocked over because they could bust. Interview with the Health and Wellness Director (HWD) on 06/25/26 at 4:54pm revealed: -She was not aware there was an oxygen tank not stored in a rack/stand in resident room 10. -She expected oxygen tanks to be stored in a rack/stand. Interview with the Administrator on 06/25/26 at 5:36pm revealed: -All staff were responsible for assuring oxygen cylinders were stored in a rack/stand. -She expected all oxygen cylinders to be stored in a rack/stand to keep the tanks from falling. Based on observations, interviews and record reviews, it was determined that the resident who resided in room 10 was not interviewable.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health	D 273		

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D 273	Continued From page 7 care needs of 1 of 5 sampled residents (#2) who had an order for a laboratory test. The findings are: Review of Resident #2's FL2 dated 11/12/25 revealed diagnoses included hypertension, chronic kidney disease stage 3, and type 2 diabetes. Interview with Resident #2 on 06/25/26 at 9:08am revealed: -She had frequent UTIs and had not been able to get rid of them. -When she had UTIs, she had symptoms of urgency, frequency and discomfort. -She had been seen at her primary care provider's (PCP) office on 6/19/26 for UTI symptoms. Interview with Resident #2's PCP's nurse on 06/24/26 at 1:54pm revealed: -The PCP ordered a stat UA and urine culture telephone verbal order on 06/16/26 at 2:00pm during a call with the Assistant Health Care Coordinator (AHCC) regarding the resident having UTI symptoms. -The facility was to bring the urine sample to the PCP's office laboratory. -The urine sample was not dropped off at the PCP's office, and the encounter was entered as a no-show by midnight on 06/16/26. -The facility did not respond as to why the urine sample was not dropped off at the PCP's office. -The resident presented to the PCP's office for a urine sample on 06/19/26. Interview with the medication aide (MA) on 06/25/26 at 4:00 pm revealed: -Any MA could collect a urine sample, label it and	D 273		

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D 273	Continued From page 8	D 273		

place it in the refrigerator for urine samples.
-She was not aware of a urine sample needed for Resident #2 on 06/16/26.
-She was aware that Resident #2 had been complaining of UTI symptoms.
-She did not know why the urine sample was not collected.

Interview with the Health Care Coordinator (HCC) on 06/25/26 at 4:15pm revealed:
-She was not aware of a stat urine sample order for Resident #2.
-The AHCC usually took care of follow-up with labs.
-The order may have been missed because of change in provider.

Interview with the AHCC on 06/25/26 at 5:10 pm revealed:
-She was not sure when she talked with the PCP's office about collecting a UA and urine culture.
-The stat urine sample order may have been missed because she would have checked with the previous provider to prevent double billing before obtaining a urine sample.
-A family member took the resident to the PCP's office on 06/19/26.

Interview with the Administrator 06/25/26 at 5:30pm revealed:
-The urine sample collection may have been missed because of the change in physician.
-She understood the delayed collection of the urine sample delayed the care for ordering the antibiotic.
-The resident now had the PCP's information in her chart.

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D 280	Continued From page 9	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed at least quarterly for 3 of 5 sampled residents (#1, #4 and #5) with LHPS tasks of thrombo-embolic deterrent (TED) hose (#1), eating, toileting, ambulation, bathing, transfers and insulin administration (#5) and collecting and testing of finger stick blood	D 280		

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D 280	Continued From page 10 samples (FSBS) [#4]. The findings are: 1. Review of Resident #1's current FL2 dated 04/01/26 revealed diagnoses included atrial fibrillation, hypertension, and chronic kidney disease. Review of Resident #1's record revealed: -There was one LHPS evaluation available for review dated 08/04/25 with LHPS tasks of TED hose . -There was not a more recent LHPS evaluation available for review after 08/04/25. Review of Resident #1's April 2026, May 2026, and June 2026 (06/01/26-06/25/26) electronic medication administration records (eMARs) revealed: -There was an order entry to apply TED hose every morning at 6:00am, and remove TED hose every evening at 7:00pm. -There was documentation staff applied and removed Resident #1's TED hose daily at 6:00am and 7:00pm. Interview with Resident #1 on 06/25/26 at 11:17am revealed staff assisted her with applying and removing her TED hose daily. Interview with a medication aide (MA) on 06/25/26 at 2:24pm revealed staff assisted Resident #1 with applying and removing her TED hose daily. Interview with the Health and Wellness Director (HWD) on 06/25/26 at 5:00pm revealed she was not aware Resident #1 did not have a completed LHPS evaluation since August 2025.	D 280		

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D 280	Continued From page 11 Interview with the Administrator on 06/25/26 at 5:30pm revealed she was not aware Resident #1 did not have a completed LHPS evaluation since August 2025. Refer to the interview with the HWC on 06/25/26 at 4:31pm. Refer to the interview with the HWD on 06/25/26 at 5:01pm. Refer to the interview with a registered nurse (RN) on 06/25/26 at 5:20pm. Refer to the interview with the Administrator on 06/25/26 at 5:31pm. 2. Review of Resident #5's current FL2 dated 09/12/25 revealed: -Diagnoses included cerebral infarction, hypertension, diabetes, and ulcerative colitis. Review of Resident 5's care plan dated 02/06/26 revealed she required assistance with transfers. Review of Resident #5's LHPS evaluations revealed: -The most recent LHPS evaluation was completed 10/06/25 and Resident #5 had LHPS tasks of eating, toileting, ambulation, bathing, transfers and insulin administration. -There was no LHPS evaluation for first or second quarter. Review of Resident 5's electronic medication administration record (eMAR) for April, May, and June 2026 revealed: -There were entries for daily insulin and as needed insulin. -There was an entry for FSBS checks three times	D 280		

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D 280	Continued From page 12	D 280		

daily, and documentation staff checked Resident #5's FSBS three times daily.

Interview with a registered nurse (RN) on 06/25/26 at 5:17pm revealed:
-The point and click computer system automatically notified her when an LHPS evaluation was due.
-The missed LHPS evaluations for Resident #5 must be due to a computer glitch.
-Currently there was no audit system in place to check the computer system schedule.
-She would complete a manual audit of all of the charts for LHPS dates.

Interview with the Administrator on 06/25/26 at 5:30 pm revealed:
-She was not aware that an LHPS evaluation for Resident #5 had not been completed for the quarter.
-The business office sent a tracker to the assistant Health Care Coordinator that included the due date for the LHPS, and she notified the contracted nurse.

Refer to the interview with the HWC on 06/25/26 at 4:31pm.

Refer to the interview with the HWD on 06/25/26 at 5:01pm.

Refer to the interview with a registered nurse (RN) on 06/25/26 at 5:20pm.

Refer to the interview with the Administrator on 06/25/26 at 5:31pm.

3. Review of Resident #4's current FL2 dated 05/14/26 revealed diagnoses included type 2 diabetes and atrial fibrillation.

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D 280	Continued From page 13 Review of Resident #4's record revealed: -There was one LHPS evaluation available for review dated 12/30/24. -There was not a more recent LHPS evaluation available for review after 12/30/24. -There was documentation Resident #4 was seen by a physical therapist (PT) and occupational therapist (OT) in March and April 2026. Review of Resident #4's April 2026, May 2026, and June 2026 electronic medication administration records (eMARs) revealed: -There was an order entry to check fasting blood sugar in the morning every Monday, Wednesday and Friday. -There was documentation staff checked Resident #4's blood sugar three times weekly. Interview with Resident #4 on 06/24/26 at 9:17am revealed she was diabetic and staff checked her blood sugar three times weekly. Interview with a medication aide (MA) on 06/24/26 at 10:06am revealed staff checked Resident #4's FSBS. Interview with the Health and Wellness Director (HWD) on 06/25/26 at 5:00pm revealed she did not know Resident #4 did not have a completed LHPS evaluation since December 2024. Interview with the Administrator on 06/25/26 at 5:30pm revealed she did not know that Resident #4 did not have a completed LHPS evaluation since December 2024. Refer to the interview with the HWC on 06/25/26 at 4:31pm.	D 280		

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D 280	Continued From page 14 Refer to the interview with the HWD on 06/25/26 at 5:01pm. Refer to the interview with a registered nurse (RN) on 06/25/26 at 5:20pm. Refer to the interview with the Administrator on 06/25/26 at 5:31pm. _____ Interview with the HWC on 06/25/26 at 4:31pm revealed the facility's registered nurse (RN) normally completed the residents' LHPS evaluations. Interview with the HWD on 06/25/26 at 5:01pm revealed: -She knew LHPS evaluations were required to be completed quarterly for residents with LHPS tasks. -The facility's electronic system normally generated an alert when a resident's LHPS evaluation was due. -She let the RN know when residents' LHPS evaluations were due and the RN completed the residents' LHPS evaluations. -She and the RN were responsible to complete the residents' LHPS evaluations. Interview with a registered nurse (RN) on 06/25/26 at 5:20pm revealed: -She normally completed LHPS evaluations for the residents. -The facility's electronic task system normally prompted staff to complete new LHPS evaluations for residents when the LHPS evaluations were due. -She did not know why the system did not prompt staff to complete the LHPS evaluations. -She expected all residents with LHPS tasks to have an LHPS evaluation completed quarterly.	D 280		

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D 280	Continued From page 15 Interview with the Administrator on 06/25/26 at 5:31pm revealed: -She knew LHPS evaluations must be completed quarterly for residents with LHPS tasks. -She did not know why LHPS evaluations were not completed quarterly. -The HWD normally ensured that the RN completed LHPS evaluations.	D 280		
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, 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, interviews, and record	D 283		

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D 283	Continued From page 16 reviews, the facility failed to ensure foods stored in the kitchen were free from contamination related to food that was not labeled or dated. The findings are: Review of the Environmental Health Services (EHS) inspection report dated 05/21/26 revealed: -The kitchen sanitation score was 97.5. -The kitchen received a 1-point deduction for apples not being stored and wrapped correctly. Observation of the refrigerator on 06/24/26 at 11:26am revealed: -There was a pitcher of liquid that was covered but not labeled or dated. -There was a second pitcher of liquid that was covered but not labeled or dated. -There was a third pitcher of liquid that was covered but not labeled or dated. -There was a container of shredded cheese that was covered but not labeled or dated. -There was a container of mixed fruit in a liquid that was covered but not labeled or dated. Interview with the Dietary Manager on 06/25/26 at 3:30pm revealed: -All foods should be labeled and dated. -Whichever staff opened a food item and put it away was responsible for ensuring it was labeled and dated. -She was not sure without looking at the menu when shredded cheese was last use in a meal. -She was not sure without looking at the menu when the mixed fruit in a liquid was last use in a meal. -She was not sure when the three pitchers of liquid were originally poured. -She was aware all food should be labeled and dated.	D 283		

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D 283	Continued From page 17 Interview with a cook on 06/25/26 at 3:56pm revealed: -Whoever cooked was responsible for covering, labeling, and dating leftover foods and opened containers. -She was not aware of the unlabeled foods in the refrigerator. -There was a new cook who may have forgotten to label and date the leftover food. -On Thursdays, kitchen staff inspected the refrigerator for unlabeled and undated foods. -Pitchers of beverages should be covered, labeled, and dated. -Leftover foods should be covered, labeled, and dated. Interview with the Administrator on 06/25/26 at 5:32pm revealed: -She was not aware of the unlabeled foods in the refrigerator. -She was aware all pitchers of beverages and leftover foods should be labeled and dated. -Foodborne illnesses or allergic reactions could occur if food and beverages are not labeled and dated. -She expected all leftover food and pitchers of liqued to be labled and dated.	D 283		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	D 358		

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D 358	Continued From page 18 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2 and #4), including a resident who had orders for an antibiotic (#2) and a resident who had orders for an alpha-andrenergic agonist and a topical cream (#4). The findings are: Review of the facility's Medication Administration policy dated July 2024 revealed: -Medication Administration shall be provided in a safe and timely manner and as prescribed by the resident's physician/healthcare provider. -Medication assistance and administration should be in accordance with the prescriber's orders. 1. Review of Resident #2's FL2 dated 11/12/25 revealed diagnoses included hypertension, chronic kidney disease stage 3, and type 2 diabetes. Review of Resident #2's physician's order dated 06/22/26 revealed there was an order for clindamycin 300mg, (an antibiotic used to treat infections) 1 capsule by mouth three times daily for 3 days. Review of Resident #2's June 2026 electronic medication administration record (eMAR) from 06/01/26 through 06/24/26 revealed: -There was an entry for clindamycin 300mg 1 capsule three times a day for 3 days scheduled to start on 06/24/26 at 9:00am. -There was documentation clindamycin had been	D 358		

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administered at 9:00am on 06/24/26.
-There was no other documenation that clindamycin was administered.

Interview with Resident #2 on 06/24/26 at 9:08am revealed:
-She had frequent urinary tract infections (UTI) and had not been able to get rid of them.
-When she had UTIs, she had symptoms of urgency, frequency and discomfort.
-She was seen at her primary care provider's (PCP) office on 6/19/26 for UTI symptoms.
-Her PCP ordered an antibiotic for her UTI.
-She was very concerned and had been asking the medication aide (MA) for several days when she would start her antibiotic.
-It did not usually take that long to start antibiotics.
-The pain caused by the UTI had increased.
-She had obtained cranberry juice and aloe to see if that would help with her pain.

Telephone interview with a representative from the facility's contracted pharmacy on 06/25/26 at 3:23pm revealed:
-An electronic prescription for clindamycin three times daily for Resident #2 was received on 06/22/26 at 4:53pm.
-The pharmacy received a confirmation signature from the facility accepting the antibiotic on 06/23/26 at 2:49am.
-The expectation was the medication would start 06/23/26 and Resident #2 should have received three doses on that date.
-Adverse effects for not receiving the antibiotic timely included worsening and progression of the infection affecting the kidneys and or sepsis.
Telephone interview with Resident #2's PCP's nurse on 06/25/26 at 12:20pm revealed:
-The electronic prescription was sent to the

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pharmacy once the urine cultures returned on 06/22/26 at 12:15pm.
-The expectation was the medication to start 06/22/26.
-The danger of not receiving the medication timely could result is progression or the infection and sepsis.

Interview with the MA on 06/25/26 at 3:50pm.
-The entry for Resident #2's antibiotic was entered on the eMAR on the evening shift 06/24/26.
-The process for entering new orders on the eMAR was normally completed by the night shift MA and checked in the morning by the Health and Wellness Coordinator (HWC).
-The HWC would then check the order on the eMAR for accuracy.

Interview with the HWC on 06/25/26 at 4:30pm revealed:
-She was not aware of an order for Resident #2's clindamycin.
-She was not aware that the clindamycin for Resident #2 was on the medication cart on 06/23/26.
-The process when a medication would come during the night was the MA would enter the medication on the eMAR and then the she would check and verify the medication order.

Interview with the Administrator on 06/25/26 at 5:30pm revealed:
-She was not aware of the delay in starting Resident #2's clindamycin.
-She was concerned about the delay starting her clindamycin and that it could cause Resident #2 to have worsening symptoms.

2. Review of Resident #4's current FL2 dated

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D 358	Continued From page 21 05/14/26 revealed diagnoses included type 2 diabetes, atrial fibrillation, and chronic kidney disease. a. Review of Resident #4's current FL2 dated 05/14/26 revealed there was an order for midodrine HCl (a medication used to treat low blood pressure) 5 mg take 1 tablet every 12 hours PRN for low blood pressure (BP) if systolic BP (SBP) was less than 100. Review of Resident #4's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for midodrine HCl 5mg tablet take 1 tablet every 12 hours PRN for low blood pressure if SBP less than 100. -There was no documentation midodrine HCL was administered. -There was documentation Resident #4's BP was checked twice daily. -There was documentation Resident #4's BP was 96/63 on 05/22/26 at 9:00am. -Midodrine HCL should have been administered one time in May 2026. Review of Resident #4's June 2026 eMAR from 06/01/26 to 06/23/26 revealed: -There was an entry for midodrine HCl 5mg tablet take 1 tablet every 12 hours PRN for low blood pressure if SBP less than 100. -There was no documentation midodrine HCL was administered. -There was documentation Resident #4's BP was checked twice daily. -There was documentation Resident #4's BP was 99/65 on 06/12/26 at 9:00pm. -Midodrine HCL should have been administered one time in May 2026.	D 358		

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Observation of the medications on hand for Resident #4 on 06/25/26 at 2:12pm revealed:
-There was a midodrine HCl 5mg medication card with a dispensed date of 05/15/26 with 18 of 30 tablets remaining on the medication cart.
-There should have been 28 of 30 tablets remaining based on Resident #4's documented BP values if midodrine HCl was administered according to the order parameters.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/25/26 at 3:25pm revealed:
-Resident #4 had a current order for midodrine HCl 5mg every 12 hours PRN for SBP less than 100.
-Midodrine HCl was dispensed on 05/15/26 for a quantity of 30 tablets.
-Midodrine HCl could raise blood pressure if it was administered outside of order parameters.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/25/26 at 5:11pm was unsuccessful.

Interview with Resident #4 on 06/25/26 at 1:53pm revealed:
-She did not know which medications she was taking.
-Staff checked her BP twice daily.

Interview with a medication aide (MA) on 06/25/26 at 3:53pm revealed:
-She knew Resident #4 had an order for PRN midodrine.
-She did not think she had administered PRN midodrine to Resident #4 when it should not have been administered.
-If PRN midodrine was administered to Resident #4, staff would have had to document Resident

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D 358	Continued From page 23 #4's BP in the progress notes and document the administration. Interview with the Health and Wellness Coordinator (HWC) on 06/25/26 at 4:30pm revealed staff completed medication cart audits weekly to ensure medications being administered to residents were up-to-date. Interview with the Health and Wellness Director (HWD) on 06/25/26 at 5:00pm revealed: -She did not know PRN midodrine was administered to Resident #4 ten times when it should not have been administered. -She or the HWC completed weekly audits where they checked for expired medications on the medication cart and checked to ensure the eMARs matched the medications on the cart. -Staff administering medications was responsible to administer medications as ordered. Interview with the Administrator on 05/16/25 at 4:43pm revealed: -She did not know PRN midodrine was administered to Resident #4 ten times when it should not have been administered. -The HWC and HWD completed weekly audits where they checked for expired medications on the medication carts and that medications were being administered correctly. -Anyone administering medications was responsible to administer medications as ordered, including MAs and nurses. b. Review of Resident #4's signed physician order dated 06/01/26 revealed there was an order for a topical cream 453 grams, apply liberally to upper extremities at least twice a day, patient can self-administer.	D 358		

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D 358	Continued From page 24 Observation of the medications on hand for Resident #4 on 06/25/26 at 2:12pm revealed there was a full jar of topical cream 453 grams dispensed on 06/02/26 on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/25/26 at 3:25pm revealed: -Resident #4 had a current order for topical cream 453 grams, apply at least twice daily. -There was a one-pound jar of topical cream 453 grams dispensed on 06/02/26 for Resident #4. Attempted telephone interview with Resident #4's PCP on 06/25/26 at 5:11pm was unsuccessful. Interview with Resident #4 on 06/25/26 at 1:53pm revealed she did not have any topical cream in her room. Interview with a MA on 06/25/26 at 3:53pm revealed: -She did not know Resident #4's jar of topical cream 453 grams was full on the medication cart. -She thought Resident #4's topical cream was started but she was thinking of a different medication. Interview with the HWC on 06/25/26 at 4:30pm revealed she did not know Resident #4's jar of topical cream was full on the medication cart or that the medication was not started. Interview with the HWD on 06/25/26 at 5:00pm revealed she did not know Resident #4's jar of topical cream had not been used and the medication was not started. Interview with the Administrator on 05/16/25 at 4:43pm revealed:	D 358		

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D 358	Continued From page 25 -She did not know Resident #4's jar of topical cream was full on the medication cart and not administered. -Anyone administering medications was responsible to administer medications as ordered, including MAs and nurses.	D 358		