STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036012	A. BUILDING: _____ B. WING _____	R 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Gaston County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation from June 16, 2026 to June 18, 2026. The complaint was initiated by the Gaston County Department of Social Services on April 28, 2026.	D 000		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review and interviews the facility failed to ensure plumbing equipment was maintained in a safe and operating condition related to an unrepaired leaking shower head in a resident's bathroom that resulted in a resident being injured (#3). The findings are: Review of Resident #3's current FL2 dated 12/03/25 revealed: -Diagnoses included hypertension, type 2	D 105		

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D 105	Continued From page 1	D 105		

diabetes, dementia without behaviors, hyperlipidemia, and benign prostatic hyperplasia and diverticulitis.
-Resident #3's level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 12/02/25.

Review of Resident #3's care plan dated 12/23/25 revealed:
-Resident #3 was independent with activities of daily living (ADLs) such as use of his hearing devices and did not require assistance with dressing, grooming, bathing, showering, and bathroom assistance.
-Resident #3 was ambulatory and used a walker.
-Floors should be clean, dry and spills promptly cleaned.
-Housekeeping provided service on Mondays.
-Resident #3 was on the fall intervention/ management program.
-Resident #3 was not always oriented to time.
-Resident #3 communicated his needs and preferences verbally.

Review of the facility's daily stand-up meeting notes for 04/14/26 to 04/15/26 revealed:
-The Administrator led and took notes during the daily stand-up meeting on 04/14/26 and 04/15/26.
-The maintenance section of the daily stand-up meeting notes dated 04/14/26 revealed the bathroom shower between Resident #3's room and another resident's room was leaking.
-The maintenance section of the daily stand-up notes dated 04/15/26 revealed the leaking shower head located in the bathroom between Resident #3's room and another resident's room was "broken."

Review of the work proposal from a local

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D 105	Continued From page 2	D 105		

plumbing and heating company dated 03/06/26 for the leaking shower head in the bathroom between Resident #3's room and another resident's room revealed the need for a shower cartridge (the internal valve that controls water flow and temperature) replacement.

Review of the facility's service order from a local plumbing and heating company dated 04/30/26 for the leaking shower head in the bathroom between rooms 26 and 27 revealed:
-The work order was not repaired on the leaking shower head until 04/29/26.
-The completed repair was tested for proper operation and there were no further leaks or dripping.

Review of an incident report dated 04/26/26 revealed:
-At 4:05am on 04/26/26, Resident #3 had an unwitnessed fall in his bathroom and sustained a head/ scalp injury with laceration.
-Vitals were obtained (blood pressure 168/78, pulse 82, respirations 18, temperature 97.4 degrees), a medication aide (MA) contacted 911, Resident #3 was checked for injury, and a MA called emergency contact and the nurse and/or Administrator.
-Emergency Medical Response (EMS) responded and transported Resident #3 to the emergency department (ED) and Resident #3 was admitted to the hospital.

Review of hospital records dated 04/26/26 revealed:
-Resident #3 presented to the emergency department (ED) on 04/26/26 due to a fall in the bathroom, hit the back of his head, resulted in a 3cm laceration and complained of neck and back pain.

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-Resident #3 was taking 81mg of aspirin daily.
-Resident #3's medical history included heart attack, neuropathy, and osteoarthrosis.
-Resident #3 received a head scan (CT) that showed evidence of subdural hemorrhage (life-threatening medical emergency where blood collects between the brain and its tough outer lining).
-Resident #3 was transferred to the intensive care unit.
-After Resident #3 was transferred out of the intensive care unit, physical therapy evaluated him and identified decreased level of functioning, poor posture control and required moderate assistance with Activities of Daily Living (ADLs) such as feeding, transfers and walking.

Interview with a resident on 06/17/26 at 2:35pm revealed:
-He shared the bathroom with Resident #3 who occupied the room on the other side of the bathroom.
-He tried to help Resident #3 off the bathroom floor after Resident #3 fell early in the morning at the end of April 2026, but could not, due to water leaking from the bathroom shower head onto the floor, causing the floor to be slippery.
-He went to find staff and told them Resident #3 needed help in the bathroom.
-The shower head had been leaking for an unknown number of months.
-Someone tried to fix the leaking shower head before, but it was not fixed until after Resident #3 fell.

Interview with the substitute Maintenance Director on 06/17/26 at 11:31am revealed:
-He worked at another facility and went to fill in at a sister-facility to provide monthly checks of facility doors.

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-While at the sister-facility the Administrator asked him to take a look at the leaking shower head in Resident #3's bathroom.
-He attempted to repair the leaking shower head by tightening the shower head then positioning it downward on the shower deck.
-He was able to reduce the leak to a drip and informed the Administrator that a plumber was needed to repair the leaking valve.
-He did not know how long the shower head been leaking and did not return to the sister-facility because the facility's Maintenance Director returned to work.
-He did not know what happened with the shower head after he attempted to repair it in April 2026.

Interview with a MA on 05/06/26 at 9:40am revealed:
-The shower head in Resident #3's bathroom used to leak and she thought it was fixed.
-In the middle of April 2026, it was mentioned in the daily staff stand-up meeting, that the shower head in Resident #3's bathroom started leaking again.
-The shower head was leaking around the time Resident #3 had a fall in the bathroom on 04/26/26.

Interview with a personal care aide (PCA) on 05/06/26 at 9:50am revealed she knew there was a water leak in Resident #3's shower head.

Interview with another PCA on 05/20/26 at 3:35pm revealed:
-She often observed water on Resident #3's bathroom floor.
-In April 2026, the shower head in Resident #3 had a leak and she observed a white blanket on the bathroom floor at times to soak up the water on the floor.

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D 105	Continued From page 5 Interview with a housekeeping technician on 05/12/26 at 11:40am revealed: -She observed the shower head leaking in Resident #3's bathroom for a month prior to Resident #3's fall on 04/26/26. -She did not report it to anyone because she thought someone else reported it since it had been leaking for a month. -She observed a blanket on the bathroom floor to soak up the water from the leaking shower head. -The leaking shower head was eventually fixed (unknown date) but started leaking again. Interview with the Resident Care Coordinator (RCC) on 05/06/26 at 9:25am and 06/08/26 at 12:45pm revealed: -She found out about Resident #3's leaking shower head during a stand-up meeting on 04/23/26. -The Administrator was to contact someone to have the leak repaired. -The leaking shower head was repaired on 04/29/26, after Resident #3 fell in the bathroom. -She thought the leak was fixed when she saw service men in the building before Resident #3 fell in the bathroom on 04/26/26, but she could not recall the date the service men were in the building. -In the past, she used a maintenance logbook to submit maintenance requests, or she reported the maintenance issue directly to the Maintenance Director or the Administrator. -She did not know how long the facility was without a regular Maintenance Director. -The current Maintenance Director started at the beginning of May 2026. Interview with Resident #3's family member on 06/10/26 at 2:45pm revealed:	D 105		

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-Resident #3 was transferred from the hospital to a skilled nursing facility for rehabilitation where his health further declined.
-Resident #3's health rapidly declined as evidenced by his inability to function as he did prior to his fall and head injury on 04/26/26.
-Resident #3 passed away on 05/29/26.

Interview with the Administrator on 05/19/26 at 12:00pm revealed:
-On 04/26/26 a MA informed her that Resident #3 fell in his bathroom and sustained a head injury with bleeding.
-She was also informed there was water leaking from the shower head onto the floor and there were blue incontinence pads on the floor at that time.
-Resident #3 was transported to a local hospital.
-She knew there was a leak in the shower head in Resident #3's bathroom prior to 04/26/26.
-She observed the shower head was still leaking, the day after Resident #3 fell, on 04/27/26.
-She contacted the Regional Maintenance Director and arranged for an outside plumber to repair the shower head.
-The shower head was repaired on 04/29/26.

Interview with the Administrator on 06/18/26 at 3:00pm revealed:
-On 03/06/26, she arranged for a service call from a local plumbing and heating company who provided an estimate of repair costs.
-On 03/11/26, she contacted the Regional Maintenance Director, who attempted to repair the shower head with a newly hired Maintenance Director and determined certain parts were needed.
-It was determined that a plumber was needed to replace the shower valve.
-The leaking shower head in Resident #3's room

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D 105	Continued From page 7 was reported during the daily stand-up meetings, and she was responsible for taking notes. -She was ultimately responsible for ensuring the leaking shower head in Resident #3's room was repaired and follow-up was made. _____ The facility failed to ensure plumbing equipment was maintained in a safe and operating condition related to a leaking shower head that was not repaired when it was first reported in March 2026. Due to the leak, water collected in the shower and bathroom floor. While attempting to use the bathroom, Resident #3 slipped and fell, hitting his head. Resident #3 was sent to the hospital then moved to a skilled nursing facility, where he died on 05/29/26. The resident sustained a head laceration, subdural hematoma and brain bleed. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/17/26 for this violation. THE CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED JULY 18, 2026.	D 105		
D 183	10A NCAC 13F .0604 Management of Facilities With A Census of 10A NCAC 13F .0604 Management of Facilities with A Census of 81 or More Residents (a) For an adult care home with a census of 81 or more residents, there shall be an administrator on-duty at the facility at least eight hours per day,	D 183		

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D 183	Continued From page 8 five days per week, and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home. If there is more than one facility under the same ownership on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor or other staff in this campus setting. (b) When the administrator is not on-duty, there shall be a manager on-duty. The supervisor may serve simultaneously as the manager if the individual meets the qualifications required in Rule .0402 of this Subchapter. Each facility on a contiguous parcel of land or campus setting, as described in Paragraph (a) of this Rule, shall have a person designated as the manager in the facility when the administrator is not on-duty. (c) The administrator shall be on-call, at all times when not on-duty. This Rule is not met as evidenced by: Based on interviews, obervations and record reviews, the facility failed to ensure aide hours met the minimum requirements for the Assisted Living (AL) facility for 4 of 12 sampled weekend shifts from 04/25/26 to 04/26/26 and 05/23/26 to	D 183		

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05/24/26.

The findings are:

Review of the facility's current license effective 01/01/26 revealed the assisted living facility was licensed for a capacity of 78 beds.

Review of the Daily Census Report dated 04/25/26 to 04/26/26 revealed the AL had a census of 52 residents which required 16 aide hours on third shift.

Review of staff timecards dated 04/25/26 revealed there were a total of 15.5 aide hours provided on second shift leaving a shortage of .30 hours.

Review of staff timecards dated 04/26/26 revealed there were a total of 15.5 aide hours provided on second shift leaving a shortage of .5 hours.

Review of the Daily Census Report dated 05/23/26 to 05/24/26 revealed the AL had a census of 52, which required 16 aide hours on third shift.

Review of staff timecards dated 05/23/26 revealed there were a total of 15.0 aide hours provided on second shift leaving a shortage of 1 hour.

Review of staff timecards dated 05/24/26 revealed there were a total of 14.5 aide hours provided on second shift leaving a shortage of 1.5 hours.

Interview with the Business Office Manager (BOM) on 06/18/26 at 10:00am revealed:

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-Prior to Monday (06/14/26) she was the Resident Care Coordinator (RCC).
-She was responsible for completing the staff schedules.
-The cooperate office mandated she scheduled 32 staff hours for first and second shift and 16 staff hours for third shift.
-She was not allowed to exceed the benchmark of 16 hours for third shift.
-She had not considered the two staff 30-minute lunch break would cause a shortage in required hours.
-She would have to get permission from the cooperate office to overlap staff hours to accommodate the third shift lunch breaks.

Interview with the Administrator on 06/18/26 at 11:00am revealed:
-She was not aware of the hour shortage on third shift prior to the BOM notifying her today (06/18/26).
-The cooperate office set the benchmark hours to meet the state requirements for each shift.
-She was not aware there needed to be coverage for lunch breaks on third shift.
-Her expectation was to meet or exceed the state required hours based on interviews and record reviews, the facility failed to ensure aide hours met the minimum requirements for the Assisted Living (AL) facility for 4 of 12 sampled weekend shifts from 04/25/26 to 04/26/26 and 05/23/26 to 05/24/26.

The findings are:

Review of the facility's current license effective 01/01/26 revealed the assisted living facility was licensed for a capacity of 78 beds.

Review of the Daily Census Report dated

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D 183	Continued From page 11 04/25/26 to 04/26/26 revealed the AL had a census of 52 residents which required 16 aide hours on third shift. Review of staff timecards dated 04/25/26 revealed there were a total of 15.5 aide hours provided on second shift leaving a shortage of .30 hours. Review of staff timecards dated 04/26/26 revealed there were a total of 15.5 aide hours provided on second shift leaving a shortage of .5 hours. Review of the Daily Census Report dated 05/23/26 to 05/24/26 revealed the AL had a census of 52, which required 16 aide hours on third shift. Review of staff timecards dated 05/23/26 revealed there were a total of 15.0 aide hours provided on second shift leaving a shortage of 1 hour. Review of staff timecards dated 05/24/26 revealed there were a total of 14.5 aide hours provided on second shift leaving a shortage of 1.5 hours. Interview with the Business Office Manager (BOM) on 06/18/26 at 10:00am revealed: -Prior to Monday (06/14/26) she was the Resident Care Coordinator (RCC). -She was responsible for completing the staff schedules. -The cooperate office mandated she scheduled 32 staff hours for first and second shift and 16 staff hours for third. -She was not allowed to exceed the benchmark of 16 hours for third shift.	D 183		

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D 183	Continued From page 12 -She had not considered staff's 30-minute lunch break would cause a shortage in required hours. -She would have to get permission from the cooperate office to overlap staff hours to accommodate the third shift lunch breaks. Interview with the Administrator on 08/01/24 at 1:50pm revealed: -She was not aware of the hour shortage on third shift prior to the BOM notifying her today (06/18/26). -The cooperate office sent the benchmark to meet the state requirements for each shift. -She was not aware there needed to be coverage for lunch breaks on third shift. -Her expectation was to meet or exceed the required hours set by the state for all three shifts.	D 183		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.	D 235		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had a current FL2 completed annually.

The findings are:

Review of Resident #4's current FL2 dated 04/16/25 revealed:
-Diagnoses included hypertension, chronic kidney disease stage 3 and hyperlipidemia.
-She was ambulatory and intermittently disoriented.
-She was continent of bladder and bowel.
-Resident #4's level of care was domiciliary (rest home).

Review or Resident #4's Resident Register revealed an admission date of 03/24/22.

Review of Resident #4's record revealed there was no updated FL2 provided by survey exit on 06/18/26.

Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 1:50pm revealed:
-The Health and Wellness Director (HWD) was responsible for ensuring resident FL2s were updated annually and as needed.
-She moved into the role of RCC on Monday 06/14/26, when the previous RCC became the Business Office Manager (BOM).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 235	Continued From page 14 Interview with the BOM on 06/18/26 at 2:24pm revealed: -Prior to Monday (06/14/26) she was the RCC. -The HWD was responsible for ensuring FL2s were completed annually. -She did not know the date, but when the HWD left she found the quarterly pharmacy review saying Resident #4's FL2 was out of date. -She completed a new FL2 for Resident #4, but it had not yet been signed by the Primary Care Provider (PCP). Interview with the Administrator on 06/18/26 at 1:50pm revealed: -The HWD was responsible for ensuring FL2s were updated annually. -The HWD had a tracking tool in the computer system that alerted her when a resident's FL2 needed updated. -She did not know why the HWD did not update Resident #4's FL2 timely.	D 235		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 15 Based on observations, record reviews and interviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents related to starting medications to treat inflammation, redness and itching (#2) and a nasal spray to treat allergy symptoms (#5). . The findings are: 1. Review of Resident #2's current FL2 dated 04/06/26 revealed: -Diagnoses included pneumonia. -There was an order for triamcinolone 1% cream, apply to lower back twice daily. Review of Resident #2's Nurse Practitioner's (NP) note dated 04/09/26 revealed: -Resident #2 returned to the facility after being hospitalized for pneumonia. -She returned to the facility with a skin rash to her back and was on triamcinolone cream twice daily which was to continue. -The NP ordered clotrimazole cream (a medication to treat fungal infections) twice daily for 30 days in addition to the triamcinolone cream for Resident #2. Review of Resident #2's April 2026, May 2026 and June 2026 electronic medication administration records (eMAR) revealed there was no documentation triamcinolone 1% cream was administered twice daily to Resident #2. Observations of medications on hand for Resident #2 on 06/17/26 at 1:10pm revealed there was no triamcinolone 1% cream available for administration Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at	D 276		

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D 276	Continued From page 16 8:32am revealed: -The pharmacy did not have an order for Resident #2 for triamcinolone 1% cream. -The facility entered medication orders on the resident's eMARs. -The facility was responsible to fax all orders to the pharmacy so the medication could be dispensed. Interview with Resident #2 on 06/18/26 at 10:18am revealed: -She had a rash when she returned to the facility at her waist area. -She did not know for sure but thought staff stopped putting cream on it about one to two weeks ago. Interview with a medication aide (MA) on 06/18/26 at 10:27am revealed: -She did not know triamcinolone 1% cream was not available for administration for Resident #2. -The Health and Wellness Director (HWD) was responsible for entering medication orders into the eMAR system and faxing the order to pharmacy. -The MAs were administering clotrimazole cream to Resident #2's rash for 30 days. -She thought Resident #2's rash had been cleared. Interview with Resident #2's NP on 06/18/26 at 11:58am revealed: -She was not aware Resident #2 did not receive triamcinolone 1% cream for her rash. -She expected facility staff to get all ordered medications into the facility for administration and to notify her if there were any concerns or problems. Refer to the interview with the Resident Care	D 276		

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D 276	Continued From page 17 Coordinator (RCC) on 06/18/26 at 12:44pm. Refer to the interview with the Administrator on 06/18/26 at 1:50pm. 2. Review of Resident #5's current FL2 dated 05/06/26 revealed: - Diagnoses included fracture of left femur (hip), chronic lymphocytic leukemia and type 2 diabetes mellitus. - There was an order for fluticasone (a medication to treat allergy symptoms) nasal spray 50mcg/actuation (act), one spray in each nostril daily in the morning. Review of Resident #5's staff progress note dated 05/11/26 at 2:00pm revealed Resident #5 returned to the facility after a stay at a skilled nursing facility for rehabilitation following a hip fracture. Review of Resident #5's Nurse Practitioner's (NP) order dated 05/13/26 revealed there was an order for fluticasone nasal spray 50mcg/act, one spray in each nostril in the morning. Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry with a start date of 05/23/26 for fluticasone nasal spray 50mcg/act, one spray in each nostril daily scheduled at 8:00am. -Fluticasone 50mcg/act, one spray in each nostril was documented administered to Resident #5 from 05/23/26 through 05/31/26. Observations of medications on hand for Resident #5 on 06/17/26 at 1:06pm revealed there was a bottle of fluticasone 50mcg/act available for administration.	D 276		

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D 276	Continued From page 18 Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed: - Resident #5 had an order dated 05/11/26 for fluticasone 50mcg/act, one spray in each nostril daily in the morning. - Fluticasone 50mcg/act, 15ml bottle was dispensed on 05/11/26. -The facility was responsible for entering resident medication orders in the eMAR system. -There was no delay in dispensing fluticasone 50mcg/act for Resident #5. - Resident #5 could experience runny nose and allergy symptoms if he was not administered fluticasone 50mcg/act, one spray daily in the morning as ordered. Interview with Resident #5 on 06/18/26 at 1:00pm revealed: -He did not know the names of his medications. -The medication aides (MA) brought his medications to him. Interview with a medication aide (MA) on 06/18/26 at 10:27am revealed the Health and Wellness Director (HWD) was responsible for entering medication orders into the eMAR system and faxing the order to pharmacy. Interview with Resident #'5's NP on 06/18/26 at 11:58am revealed: -She was not aware Resident #5's fluticasone nasal spray was not implemented until 05/23/26. -She expected facility staff to get all ordered medications into the facility for administration and to notify her if there were any concerns or problems. Refer to the interview with the Resident Care	D 276		

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D 276	Continued From page 19 Coordinator (RCC) on 06/18/26 at 12:44pm. Refer to the interview with the Administrator on 06/18/26 at 1:50pm. _____ Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm revealed: -Resident medication and treatment orders should be entered into the resident's eMAR immediately when they return to the facility with new orders. -The Health and Wellness Director (HWD) was responsible for updating resident eMARs when a resident returned from the hospital or a skilled nursing facility (SNF). -The RCC or the MA could enter orders if the HWD was not in the facility. Interview with the Administrator on 06/18/26 at 1:50pm revealed: -The HWD was responsible for entering resident orders into the eMAR system when a resident returned to the facility from a hospital or SNF stay. -The HWD was responsible for ensuring any new medications were dispensed from the pharmacy and available for administration. - If the HWD was not available to enter orders when a resident returned to the facility, any new orders were to be faxed to the area and regional nurses.	D 276		
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	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (#4) observed during the morning medication pass with errors of three medications to lower blood pressure and 1 of 5 sampled residents (#5) for errors with medications to lower blood pressure and lower blood sugar levels.

The findings are:

The medication error rate was 11.5% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00am medication pass on 06/17/26.

1. Review of Resident #4's most recent FL2 dated 04/16/25 revealed diagnoses included hypertension.

a. Review of Resident #4's current FL2 dated 04/16/25 revealed an order for carvedilol (a medication to lower blood pressure) 12.5mg, one tablet twice daily.

Review of Resident #4's signed Nurse Practitioner's (NP) orders dated 03/20/26 revealed:
-There was an order for carvedilol 12.5mg, one tablet twice daily.
-Carvedilol 12.5mg, one tablet twice daily was to be held for blood pressure less than 110/60.

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Observation of the morning medication pass on 06/17/26 at 8:46am revealed:
-The medication aide (MA) checked Resident #4's blood pressure and it was 109/66.
-The MA placed Resident #4's multi-dose pack medications containing carvedilol 12.5mg one tablet into a medication cup
-The MA administered carvedilol 12.5mg one tablet to Resident #4.

Interview with the MA on 06/17/26 at 9:04am revealed:
-She placed Resident #4's multi-dose pack medications containing carvedilol 12.5mg, one tablet into Resident #4's medication cup.
-She administered the medications containing carvedilol 12.5mg one tablet to Resident #4.
-She should not have administered carvedilol 12.5mg to Resident #4 because her systolic blood pressure was 109.
-She was nervous and did not pay attention to the carvedilol 12.5mg parameters like she should have.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed:
-Resident #4 had a current order dated 01/09/26 for carvedilol 12.5mg, one tablet twice daily, hold for systolic blood pressure less than 110.
-Carvedilol 12.5mg one tablet twice daily 14 tablets were last dispensed for Resident #4 in her weekly multi-dose packs on 06/17/26.
-Resident #4 could experience light-headedness and dizziness if she received carvedilol 12.5mg one tablet when her systolic blood pressure was less than 110.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm.

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D 358	Continued From page 22 Refer to the interview with the Administrator on 06/18/26 at 1:50pm. b. Review of Resident #4's most recent FL2 dated 04/16/25 revealed an order for amlodipine (a medication to lower blood pressure) 10mg, one tablet daily. Review of Resident #4's signed NP's orders dated 03/20/26 revealed: -There was an order for amlodipine 10mg, one tablet daily. -Amlodipine 10mg, one tablet daily was to be held for blood pressure less than 110/60. Observation of the morning medication pass on 06/17/26 at 8:46am revealed: -The medication aide (MA) checked Resident #4's blood pressure and it was 109/66. -The MA placed Resident #4's multi-dose pack medications containing amlodipine 10mg, one tablet into a medication cup -The MA administered amlodipine 10mg, one tablet to Resident #4. Interview with the MA on 06/17/26 at 9:04am revealed: -She placed Resident #4's multi-dose pack medications containing amlodipine 10mg, one tablet into Resident #4's medication cup. -She administered the medications containing amlodipine 10mg one tablet to Resident #4. -She should not have administered amlodipine 10mg to Resident #4 because her systolic blood pressure was 109. -She was nervous and did not pay attention to the amlodipine 10mg parameters like she should have.	D 358		

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Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed:
-Resident #4 had a current order dated 01/09/26 for amlodipine 10mg, one tablet daily, hold for systolic blood pressure less than 110.
-Amlodipine 10mg one tablet daily 7 tablets were last dispensed for Resident #4 in her weekly multi-dose packs on 06/17/26.
-Resident #4 could experience light-headedness and dizziness if she received amlodipine 10mg one tablet when her systolic blood pressure was less than 110.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm.

Refer to the interview with the Administrator on 06/18/26 at 1:50pm.

c. Review of Resident #4's most recent FL2 dated 04/16/25 revealed an order for losartan (a medication to lower blood pressure) 100mg, one tablet daily.

Review of Resident #4's signed NP's orders dated 03/20/26 revealed:
-There was an order for losartan 100mg, one tablet daily.
-Losartan 100mg, one tablet daily was to be held for blood pressure less than 110/60.

Observation of the morning medication pass on 06/17/26 at 8:46am revealed:
-The medication aide (MA) checked Resident #4's blood pressure and it was 109/66.
-The MA placed Resident #4's multi-dose pack medications containing losartan 100mg, one tablet into a medication cup
-The MA administered losartan 100mg, one tablet

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to Resident #4.

Interview with the MA on 06/17/26 at 9:04am revealed:
-She placed Resident #4's multi-dose pack medications containing losartan 100mg, one tablet into Resident #4's medication cup.
-She administered the medications containing losartan 100mg one tablet to Resident #4.
-She should not have administered losartan 100mg to Resident #4 because her systolic blood pressure was 109.
-She was nervous and did not pay attention to the losartan 100mg parameters like she should have.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed:
-Resident #4 had a current order dated 01/09/26 for losartan 100mg, one tablet daily, hold for systolic blood pressure less than 110.
-Losartan 100mg, one tablet daily 7 tablets were last dispensed for Resident #4 in her weekly multi-dose packs on 06/17/26.
-Resident #4 could experience light-headedness and dizziness if she received losartan 100mg, one tablet when her systolic blood pressure was less than 110.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm.

Refer to the interview with the Administrator on 06/18/26 at 1:50pm.

2. Review of Resident #5's current FL2 dated 05/06/26 revealed diagnoses included fracture of left femur (hip) and type 2 diabetes mellitus.

a. Review of Resident #5's Nurse Practitioner's

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D 358	Continued From page 25 (NP) order dated 05/13/26 revealed there was an order for insulin lispro (a medication to lower blood sugar levels) 100 unit/ml, inject 2 units with meals. Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry with a start date of 05/22/26 for insulin lispro, inject 2 units with meals scheduled at 8:00am, 12:00pm and 5:00pm. -The were 11 of 28 opportunities insulin lispro, 2 units was documented not administered due to finger stick blood sugar (FSBS) being "outside of parameter". -For example, on 05/29/26 at 8:00am Resident #5's FSBS was 105 and insulin lispro 2 units was not documented as administered. Review of Resident #5's June 2026 eMAR revealed: -There was an entry with a start date of 05/22/26 and a D/C date of 06/12/26 for insulin lispro, inject 2 units with meals scheduled at 8:00am, 12:00pm and 5:00pm. -The were 15 of 35 opportunities insulin lispro, 2 units was documented not administered due to finger stick blood sugar (FSBS) being "outside of parameter" on the entry with a start date of 05/22/26. -For example, on 06/02/26 at 12:00pm Resident #5's FSBS was 102 and insulin lispro 2 units was not documented as administered. -There was a second entry for insulin lispro, inject 2 units with meals scheduled at 8:00am, 12:00pm and 5:00pm with a start date of 06/12/26. -The were 4 of 12 opportunities on the second entry insulin lispro, 2 units was documented not administered due to finger stick blood sugar (FSBS) being "outside of parameter".	D 358		

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D 358	Continued From page 26 -For example, on 06/14/26 at 12:00pm Resident #5's FSBS was 119 and insulin lispro 2 units was not documented as administered. Observation of medication on hand for Resident #5 on 06/17/26 at 1:06pm revealed there was a insulin lispro flexpen available for administration. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed: -Resident #5 had a current order dated 05/11/26 for insulin lispro, 2 units with meals. -Insulin lispro 100units/ml, 2 pens containing 3ml each were dispensed for Resident #5 on 05/20/26. -Resident #5's order for insulin lispro, 2 units with meals did not have any parameters of when not to administer. -If Resident #5 did not receive insulin lispro, 2 units with meals his blood sugar levels could increase, and he could experience increased thirst, frequent urination, headaches and fatigue. Interview with a medication aide (MA) on 06/18/26 at 10:27am revealed: -The MAs were responsible for reading each order on the residents' eMARs and administering medications according to the order and all parameters. -Resident #5 did not have any parameters for his insulin lispro, 2 units with meals. -She did not know why she did not administer insulin lispro, 2 units to Resident #5 on 05/29/26 at 8:00am and 12:00pm. -She did not know why she documented insulin lispro 2 units was "outside of parameter" on 05/29/26 at 8:00am and 12:00pm because Resident #5's insulin lispro 2 units with meals order did not have any parameters.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 Interview with Resident #5 on 06/18/26 at 1:00pm revealed: -The MAs brought him his medications. -He did not know if he had diabetes or if he was administered insulin injections. Refer to the interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm. Refer to the interview with the Administrator on 06/18/26 at 1:50pm. b. Review of Resident #5's Nurse Practitioner's (NP) order dated 05/13/26 revealed there was an order for metoprolol (a medication to lower blood pressure and heart rate) 25mg, one tablet each morning and hold for systolic blood pressure (SBP) less than 110 or heart rate less than 60. Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 15mg, one tablet daily scheduled at 7:00am. -The were 2 of 16 opportunities metoprolol 25mg, one tablet was documented administered to Resident #5 when his SBP was less than 110. -On 06/06/26 at 7:00am Resident #5's blood pressure was 103/39 and metoprolol 25mg, one tablet was documented as administered. -On 06/16/26 at 7:00am Resident #5's blood pressure was 108/57 and metoprolol 25mg, one tablet was documented as administered. Observation of medication on hand for Resident #5 on 06/17/26 at 1:06pm revealed metoprolol 25mg, one tablet was included in Resident #5's daily morning medication multi-dose packs.	D 358		

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Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed:
-Resident #5 had a current order dated 06/03/26 for metoprolol 25mg, one tablet every morning and hold for SBP less than 110.
-Metoprolol 25mg, one tablet daily, a seven-day supply was dispensed weekly in Resident #5's multi-dose medication packs.
-If Resident #5 received metoprolol 25mg, one tablet when his SBP was less than 110 he could experience light-headedness or dizziness.

Interview with a medication aide (MA) on 06/18/26 at 10:27am revealed:
-The MAs were responsible for reading each order on the residents' eMARs and administering medications according to the order and all parameters.
-Resident #5's metoprolol 25mg, one tablet should not have been administered on 06/06/26 and 06/16/26 because his SBP was less than 110.
-She did not know if there were any audits of resident eMARs completed for medications administered outside of parameters.

Interview with Resident #5 on 06/18/26 at 1:00pm revealed:
-The MAs brought him his medications.
-He did not know if he took medication for high blood pressure.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm.

Refer to the interview with the Administrator on 06/18/26 at 1:50pm.

_____
Interview with the Resident Care Coordinator

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D 358	Continued From page 29 (RCC) on 06/18/26 at 12:44pm revealed: -The MAs were responsible for administering resident medications as ordered. -The MAs were responsible to review any parameters on medication orders and to hold the medication if ordered. Interview with the Administrator on 06/18/26 at 1:50pm revealed: -The MAs were responsible for administering resident medications as ordered and following any ordered parameters. -She did not know if there were audits of resident eMARs for medications administered according to parameters.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 5 sampled resident (#1) take her medications that were left on the resident's nightstand.	D 366		

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D 366	Continued From page 30 The findings are: Review of the facility's policy for oral medication administration by MA's revealed: -The MA should punch or remove the medication from the bubble pack or container into a cup or the resident's hand. -The MA should observe the resident take the medication and initial the electronic medication administration record (eMAR) once the medications are administered. Review of Resident #1's current FL2 dated 11/26/25 revealed diagnoses included hypoosmolality, dysuria, unspecified pain, thrombophilia, hypertension, irritable bowel syndrome, impaired fasting glucose and paroxysmal atrial fibrillation. Observation during the initial facility tour on 06/16/26 at 9:25am revealed there was a small white paper cup with 5 pills inside sitting on the nightstand beside Resident's #1 bed. Interview with a Resident # 1 on 06/16/26 at 9:30am revealed -The MA left her medications on the nightstand table that morning because she was asleep. -Most of the MA's watched her take her medication and some leave them in the room. Review of Resident #1's primary care physician (PCP) orders dated revealed: -There was an order for amlodipine (used to treat hypertension) 10 mg one tablet daily. -There was an order for Culturelle (used to treat irritable bowel syndrome) one capsule daily. -There was an order for loratadine (used to treat allergies) 10mg at bedtime. -There was an order for losartan potassium (used	D 366		

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to treat hypertension) 100 mg one tablet daily.
-There was an order for omeprazole (used to treat acid reflux) 20mg one capsule daily.
-There was an order for Xarelto (used to treat atrial fibrillation) 15 mg one capsule two times daily.
-There was an order for metoprolol tartrate (used to treat hypertension) 25mg two tablets two times daily.

Review of Resident #1's June 2026 eMAR from 06/01/26 to 0 06/16/26 revealed:
-There was an entry for amlodipine 10mg take 1 tablet daily, scheduled for administration at 9:00am and documented as administered at 9:00am on 06/16/26.
-There was an entry for Culturelle 1 capsule daily, scheduled for administration at 8:00am and documented as administered at 9:00am on 06/16/26.
-There was an entry for losartan potassium 100mg 1 tablet daily, scheduled for administration at 8:00am and documented as administered at 9:00am on 06/16/26.
-There was an entry for omeprazole 20mg 1 capsule daily, scheduled for administration at 8:00am and documented as administered at 8:00am on 06/16/26.
-There was an entry for metoprolol tartrate 25mg 1 capsule twice daily, scheduled for administration at 8:00am and 8:00pm documented as administered at 8:00am on 06/16/26.

Interview with the MA on 06/17/26 at 9:00am revealed:
-She had administered 8:00am medications to Resident #1 on Tuesday 06/16/26.
-She was training a new MA who helped her

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administer medications on 06/16/26.
-They entered Residents #1's room together to administer the medication.
-She did not stay in the room with the MA in training and assumed she watched the resident take the medication.
-It was her responsibility to confirm the resident had taken the medication.
-She was aware of the medication administration policy and knew you should watch all residents take their medication before documenting it as administered on the eMAR.

Interview a second MA on 06/17/26 at 10:00am revealed:
-She was training on the medication cart the morning on 06/16/26.
-She went into Resident #1's room to administer the medications.
-The resident took one pill and said she would take the other pills later.
-She did not see the resident swallow the one pill.
-She left the medication in a cup on the nightstand.
-She knew she should have watched the resident take the remaining pills.
-She made a mistake.

Interview with the Resident Care Coordinator on 06/17/26 at 10:25am revealed:
-She was aware of the oral medication administration policy.
-The MAs had been trained and knew they should observe residents swallowing their medications prior to documenting they have been administered on the eMAR.
-The MA training another staff was still responsible for ensuring the residents took their medication and should have checked behind the trainee.

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D 366	Continued From page 33 Interview with the Administrator on 06/17/26 at 11:00am revealed: -She was not aware medications were left in a resident's room. -MAs should know the correct protocol for administering medications. -They should not document anything on the eMAR until they have identified the correct medication, prepared and administered the medication to the resident. -If a resident refused a medication, the MA should dispose of the medication and document the refusal. -She expected all MAs and MAs in training to always follow the medication administration policy.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering	D 367		

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the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 1 of 5 residents (#5) related to documentation of a medicated patch to treat pain (#5).

The findings are:

Review of Resident #5's current FL2 dated 05/06/26 revealed:
-Diagnoses included fracture of left femur (hip).
-There was an order for lidocaine (a medication to treat pain) patch 5%, apply to right and left knee daily.

Review of Resident #5's Nurse Practitioner's (NP) order dated 05/13/26 revealed there was an order for lidocaine patch 4% apply to bilateral knees daily in the morning and remove in the evening.

Review of Resident #5's orders dated 05/15/26 revealed Resident #5's lidocaine patch dosage was to be changed to 4%.

Review of Resident #5's record revealed he was hospitalized on 03/15/26, went to a skilled nursing facility for rehabilitation and returned to the facility on 05/11/26.

Review of Resident #5's May 2026 electronic

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medication administration record (eMAR) revealed:
-There was an entry for lidocaine patch 5%, apply to right knee topically in the morning.
-The lidocaine patch 5% had a start date of 05/12/26 and a discontinue date of 05/13/26.
-Lidocaine patch 5% was documented applied to Resident #5's right knee on 05/12/26.
-Lidocaine patch 5% was documented not administered on 05/13/26 because the medication was not available.
-There was an entry for lidocaine patch 4%, apply to right knee daily in the morning scheduled at 8:00am and remove as scheduled at 8:00pm.
-The lidocaine patch 4% had a start date of 05/17/26.
-Lidocaine patch 4% was documented applied to Resident #5's right knee from 05/17/26 to 05/31/26 except on 05/24/26 because the resident refused the medication.

Review of Resident #5's June 2026 eMAR revealed:
-There was an entry for lidocaine patch 4%, apply to right knee daily in the morning scheduled at 8:00am and remove as scheduled at 8:00pm.
-Lidocaine patch 4% was documented applied to Resident #5's right knee from 06/02/26 to 06/03/26, on 06/05/26, from 06/08/26 to 06/09/26 and from 06/14/26 to 06/16/26.
-Lidocaine patch 4% was documented not applied to Resident #5's right knee on 06/01/26, 06/04/26, from 06/06/26 to 06/07/26 and from 06/10/26 to 06/13/26 because the resident refused the medication.

Observation of medication on hand for Resident #5 on 06/17/26 at 1:06pm revealed:
-There was plastic bag containing lidocaine 4% patches for Resident #5.

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-The lidocaine patches 4% label indicated one patch was to be applied in the morning and removed at bedtime to both knees.

Interview with Resident #5 on 06/18/26 at 1:00pm revealed:
-The medication aides (MA) usually applied the lidocaine patches 4% to both of his knees.
-He only had one patch on his left knee that day (06/18/26) because he refused it on the right knee.

Interview with a MA on 06/17/26 at 1:05pm revealed:
-She applied lidocaine patch 4% to both of Resident #5's knees unless he refused.
-Resident #5's order for lidocaine patches in the eMAR system said apply to right knee but there was a note in parentheses that stated to apply to both knees.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/18/26 at 8:32am revealed:
-Resident #5 had an active order dated 05/16/26 for lidocaine patch 4%, apply to both knees in the morning, leaving the patch on for 12 hours and removing the patch for 12 hours.
-Lidocaine patch 4%, 30 patches were dispensed for Resident #5 on 05/16/26.
-If Resident #5 did not receive his lidocaine patch 4% to both knees as ordered he could experience knee pain.

Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 12:44pm revealed:
-The Health and Wellness Director (HWD) was responsible for entering resident orders in the eMAR system.
-Resident #5's lidocaine patches 4% were to be

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D 367	Continued From page 37 applied to both knees unless he refused. -She did not know the printed eMAR indicated Resident #5's lidocaine patch 4% was applied to his right knee only. -She did not know if there were any audits of resident eMARs. Interview with the Administrator on 06/18/26 at 1:50pm revealed: -The HWD was responsible for entering orders into the eMAR system. -The HWD was responsible to audit resident medication orders monthly. -She did not know if the HWD reviewed the eMARs for accuracy.	D 367		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled residents (#4 and #5). The findings are: 1. Review of Resident #5's current FL2 dated 05/06/26 revealed diagnoses included fracture of left femur (hip) and hyperlipidemia.	D 406		

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D 406	Continued From page 38 Review of a quarterly pharmacy drug review for Resident #5 dated 05/31/26 revealed: -Resident #5 metoprolol 25mg, one tablet daily order stated to hold for systolic blood pressure (SBP) less than 110. -Ensure Resident #5's metoprolol 25mg, one tablet daily was held when indicated. Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg, one tablet daily scheduled at 7:00am. -The were 2 of 16 opportunities metoprolol 25mg, one tablet was documented administered to Resident #5 when his SBP was less than 110. -On 06/06/26 at 7:00am Resident #5's blood pressure was 103/39 and metoprolol 25mg, one tablet was documented as administered. -On 06/16/26 at 7:00am Resident #5's blood pressure was 108/57 and metoprolol 25mg, one tablet was documented as administered. Telephone interview with the facility's contracted Pharmacist on 06/18/26 at 9:19am revealed: -When she completed the quarterly medication review on 05/31/25 for Resident #5, she recommended the facility ensure his metoprolol 25mg, one tablet daily was held as ordered. -She did not know if she noticed times Resident #5 was administered metoprolol 25mg, one tablet daily when his SBP was less than 110 or if she put it in her recommendations just as a reminder. -She emailed her recommendations to the Health and Wellness Director (HWD) and the Administrator. -It was the facility's responsibility to follow up on her recommendations.	D 406		

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Interview with the Business Office Manager (BOM) on 06/18/26 at 2:24pm revealed:
-She was the Resident Care Coordinator (RCC) until this past Monday (06/15/26) when she started her duties as the BOM.
-The HWD was responsible to follow up on the recommendations in the quarterly pharmacy reviews.

Refer to interview with the Administrator on 06/18/26 at 1:50pm.

2. Review of Resident #4's current FL2 dated 04/16/25 revealed diagnoses included hypertension, chronic kidney disease stage 3 and hyperlipidemia.

Review of Resident #4's record revealed there was no FL2 dated after 04/16/25.

Review of a quarterly pharmacy drug review for Resident #4 dated 05/31/26 revealed:
-Resident #4's FL2 in her record was out of date.
-The facility should obtain a new FL2 for Resident #4.

Telephone interview with the facility's contracted Pharmacist on 06/18/26 at 9:19am revealed:
-When she completed the quarterly medication review on 05/31/25, she saw the FL2 for Resident #4 was out of date and recommended the facility obtain an updated copy.
-She emailed her recommendations to the Health and Wellness Director (HWD) and the Administrator.
-It was the facility's responsibility to follow up on her recommendations.

Interview with the Business Office Manager (BOM) on 06/18/26 at 2:24pm revealed:

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BROOKDALE UNION	1717 UNION ROAD GASTONIA, NC 28054

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D 406	Continued From page 40 -She was the Resident Care Coordinator (RCC) until this past Monday (06/15/26) when she started her duties as the BOM. -The HWD was responsible to follow up on the recommendations in the quarterly pharmacy reviews. -After the previous HWD left in May 2026, she saw the quarterly pharmacy review dated 05/31/26 in her office. -She completed a new FL2 for Resident #4 but it had not yet been signed by her Primary Care Provider (PCP). Refer to interview with the Administrator on 06/18/26 at 1:50pm. _____ Interview with the Administrator on 06/18/26 at 1:50pm. -The HWD was responsible for ensuring the consultant pharmacist's recommendations were followed up on. -She did not know if the HWD received the quarterly pharmacy review dated 05/31/26 before she left her position. -The RCC, the Area Registered Nurse or the Regional Registered Nurse were to follow up on the quarterly pharmacy reviews if a HWD was not available.	D 406		