Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032001	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 conducted a follow-up and annual survey from 06/30/26-07/02/26.	D 000		
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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 7 sampled residents (#3) related to a resident who had a fall that resulted in a skin tear that became infected and required hospitalization. The findings are: Review of Resident #3's FL2 dated 02/12/26 revealed: -Diagnoses included lung carcinoma. -He was intermittently disoriented. -The original date the FL2 was signed was 02/12/26 but there was documentation the FL2 was reviewed and signed on 04/01/26 by the physician. Review of Resident #3's Resident Register revealed: -The date of admission was 04/02/26. -Resident #3 was forgetful and needed reminders. Review of Resident #3's care plan dated 04/07/26	D 273	See attached	

The Plan of Correction with addendum on page 43 was reviewed and acknowledged on 08/04/26.

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revealed:
-He required limited assistance from staff with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-He was always disoriented.
-He had significant memory loss and must be directed.

Review of Resident #3's incident and accident report dated 06/22/26 revealed:
-Resident #3 tripped over another resident's walker.
-He reopened a skin tear on his knees and inner calf.

Review of Resident #3's primary care provider's (PCP) after-visit summary dated 06/25/26 revealed:
-Resident #3 was a poor historian due to cognitive/psychiatric impairment.
-Resident #3 had metastatic lung cancer and a history of pulmonary embolism and a recent fall.
-Resident #3 had a fall a couple of days ago and had a skin tear on his left leg that he was covered with a bandage.
-He reported pain in the joint area near the injury; he denied worsening pain.
-Skin assessment showed a large skin tear on the lower left extremity, still leaking.
-Under the Assessment and Plan section, there was documentation to keep the skin tear covered until it healed to prevent infection and further bleeding.
-Monitor for any sign of infection or worsening of the condition.
-Keep the leg wound covered and watch for any signs of infection.

Observation of Resident #3 on 06/30/26 at 9:10am revealed:

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D 273	Continued From page 2 -He was lying on his bed on top of the bedspread. -He was wearing shorts. -His left leg was visibly red and swollen. -He had a large oval-shaped wound on his leg, 1.5 inches in length, that had black tissue around the edges of wound that extended one-half inch from the center of the wound and a small amount of yellow tissue was visible in the wound bed; it was not covered. Interview with Resident #3 on 06/30/26 at 9:10am revealed: -He used Neosporin (a triple-antibiotic ointment used to prevent infection in minor cuts and scrapes) on his leg once a day. -No one told him to use Neosporin on his leg. -He had a fall that caused a sore on his leg and he was applying the Neosporin. -Staff knew he had a sore on his leg; the staff saw it when it happened. -No one had told him what to do about the sore on his leg. -He thought the PCP knew about the sore, but he was not sure. -Staff had not looked at the sore on his leg since he fell. -He had the sore uncovered so it could "air out". Review of Resident #3's incident and accident report dated 07/01/26 at 3:30am revealed: -Resident #3's leg was red and swollen with a small hole in it with a little fluid coming out of it. -Resident #3 was sent out to the hospital. Review of Resident #3's emergency medical services (EMS) report dated 07/01/26 revealed: -Resident #3 reported he noticed swelling in his legs a couple of days ago and it had become progressively worse. -There was obvious swelling noted to the	D 273		

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D 273	Continued From page 3 resident's left lower leg and was hot to touch. Review of Resident #3's hospital records dated 07/01/26 revealed: -Resident #3 was brought into the emergency department (ED) with complaints of swelling and redness to lower left extremity (LLE) that had progressively worsened since a "couple of days ago". -EMS was called due to worsening pain and the skin was hot to the touch. -There was a concern of necrotizing infection. -Resident #3 reported LLE pain began 2-3 days ago, was worse with pressure, especially in the calf. -He first noted the erythema around the wound on his shin on Sunday 06/28/26 or Monday 06/29/26. -He was unable to walk on the leg. -He had extensive erythema (redness) to the LLE. -Resident #3 had an open wound that was draining on admission. -The wound was surrounded by erythema, induration, warmth, and pain. -Diagnosis was necrotizing soft-tissue infection. -He was started on intravenous (IV) antibiotics. -A left leg debridement was performed. Interview with the Resident Care Coordinator (RCC) on 06/30/26 at 12:42pm revealed when she received the after-visit summary she only looked at the orders section on the PCP's after-visit summary to see if there were any orders. Interview with the RCC on 07/01/26 at 11:21am revealed: -Resident #3 was sent to the hospital because he complained his legs were hurting. -She noticed yesterday, 06/30/26, his legs were	D 273		

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red and he appeared to be sleepy.
-Resident #3 told her he thought his melatonin (used to treat insomnia) was causing him to be sleepy.
-She told staff to keep an eye on him.
-She received the call at 3:00am that Resident #3 reported his leg was hurting.

Interview with a medication aide (MA) on 07/01/26 at 3:50pm revealed:
-Resident #3 had a skin tear on his leg as noted in the incident report dated 06/22/26.
-When she saw the skin tear on 06/22/26, it was like a small scratch, so she had not looked at it since then.
-Resident #3 had not said anything to her about the skin tear.
-She saw Resident #3's "whole leg was red" on 07/01/26 and he had a wound about the size of a fifty-cent piece on his leg.
-It looked like the wound had a cream on it.
-She had not put a cream on Resident #3's wound.
-She did not ask Resident #3 if he had put an ointment on the wound or not.
-She saw the wound around 7:00pm and asked him what happened and he did not answer.
-She asked him if he wanted to go to the hospital and he said his family wanted him to go to the hospital.
-Resident #3 said he did not want to go to the hospital.
-She had not been told to look at his leg or to check his leg.
-Around 10:30pm, she asked Resident #3 about going to the hospital and he said his leg was not hurting anymore and did not want to go to the hospital.

Telephone interview with another MA on 07/02/26

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D 273	Continued From page 5 at 7:53am revealed: -She worked third shift last night, 07/01/26. -Normally Resident #3 would go outside 4-5 times per night. -When she saw Resident #3 outside around 3:00am, he could not catch his breath and was complaining his leg was hurting. -She could see that Resident #3's leg was completely swollen. -He told her his legs were giving him trouble. -She told him she was going to let his PCP know about his legs. -She heard Resident #3 tell the EMS first responder that he had bumped his leg on the walker. -She did not know what caused Resident #3's leg to "get like that". -Resident #3 could not even stand up straight to walk. -She did not know Resident #3 had hit his leg on a walker. -No other staff told her Resident #3 had hit his leg and had a skin tear. -Resident #3 told her he hit his leg a while back on a walker. -Resident #3 usually wore shorts when she saw him at night. -Resident #3's leg was not red when she had worked two nights before that. -When she saw Resident #3's leg red at 3:00am on 07/02/26, that was the only time she had seen his leg red. Interview with the Supervisor on 07/02/26 at 8:19am revealed: -The only thing she knew about Resident #3's leg was that the RCC told her to keep an eye on it, on Tuesday morning, 06/30/26. -She saw Resident #3's leg on Tuesday, and it was a "little red" but not enough to be concerned.	D 273		

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D 273	Continued From page 6 -She did not see a scab on Resident #3's leg, she just saw that his leg was red. -She was not aware that Resident #3 had done anything to his leg in the past two weeks. -She had not been told prior to Tuesday, 06/30/26, to keep an eye on any injury or skin tear Resident #3 had. Interview with a personal care aide (PCA) on 07/02/26 at 1:09pm revealed: -Resident #3 was independent with all personal care. -The staff reminded Resident #3 of his shower days, but he did his showers himself. -No one had told her to keep an eye out on anything related to Resident #3's skin. -She was not aware Resident #3 had a skin tear. Interview with the RCC on 07/02/26 at 10:39am revealed: -On Tuesday afternoon, in the courtyard, she noticed Resident #3 was very sleepy. -On 06/22/26, Resident #3 was holding a door for another resident and hit his leg on the other resident's walker and opened a skin tear. -Resident #3's skin tear on 06/22/26 was the size of a dime. -The PCP saw Resident #3 on 06/25/26 and there were no orders to do anything for Resident #3 from the PCP on 06/25/26. -Resident #3 always had edema and redness in his legs. -Resident #3 told her he was sleepy and she told staff to keep an eye on him. -The MA called her at 3:00am and reported Resident #3 did not want to go to the hospital but she encouraged him too. -Resident #3's PCP gave guidance on her after-visit summaries but no order to do anything for Resident #3's skin tear.	D 273		

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D 273	Continued From page 7 Interview with the Administrator on 07/02/26 at 12:43pm revealed: -She knew Resident #3 had a skin tear on his leg. -The PCP did not give any follow-up order from her visit on 06/25/26. -The RCC reviewed after-visit summaries and she "skimmed" them. -She expected staff to review the Assessment and Plan section of the after-visit summary and she thought staff did. -The documentation to keep the skin tear covered was a plan, not an order, and Resident #3 was competent to keep the skin tear covered. -She had instructed the PCP not to put orders in the body of the after-visit summary. Telephone interview with Resident #3's PCP on 07/02/26 at 1:35pm revealed: -Resident #3 was capable of applying his own band-aid. -Staff could not monitor whether Resident #3 kept the skin tear covered. -If Resident #3 could not communicate for himself she would have expected staff to know if there was an issue, but he was capable of telling staff if there was a problem. Telephone interview with the hospital nurse assigned to Resident #3 on 07/02/26 at 12:30pm revealed: -Resident #3 was admitted to the hospital with a wound to his left leg. -Resident #3 stated he had bumped his leg and caused a scratch. -Resident #3's left leg was swollen with redness and painful upon admission. -Resident #3 was diagnosed with cellulitis. -Resident #3 was taken to the operating room on 07/01/26 to clean out the infection.	D 273		

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D 273	Continued From page 8 -Resident #3 returned from the operating room with a dressing over the wound to his left leg. -Resident #3's dressing had not been removed since surgery; he was waiting on the surgical team to make their rounds before the dressing was removed. -Resident #3 was receiving intravenous antibiotics; the last day was scheduled for 07/12/26. Telephone interview with a representative from the surgical team at the hospital on 07/02/26 at 1:15pm revealed: -The bottom of Resident #3's foot to just below his knee was red and swollen. -Resident #3 had severe cellulitis. -Resident #3 was taken to the operating room for debridement of the infection. -He did not recall the size of the wound after the debridement. Attempted telephone interview with Resident #3's family member on 07/01/26 at 2:38pm was unsuccessful. _____ The facility failed to ensure monitoring and follow-up care for a resident's (#3) skin tear that he sustained after a fall. Staff relied on the resident to manage his own wound care and did not assess the wound to ensure it was covered and to recognize the wound had become infected, resulting in the resident complaining of leg pain and having to be hospitalized with an infection. The facility's failure resulted in serious neglect and physical harm which constitutes a Type A1 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/02/26	D 273		

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D 273	Continued From page 9 THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 1, 2026.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all food items stored by the facility were protected from food related contamination in the kitchen, refrigerator, and freezer, and that nonperishable food items were properly stored.	D 283	See attached	

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D 283	Continued From page 10 The findings are: Observation of the kitchen on 06/30/26 at 8:41am revealed: -There were four uncovered trays of stuffed baked potatoes on a rack in the kitchen. -There were 5 trays with 12 to 15 individual cups on marshmallows on each tray. -The marshmallows were uncovered and the 5 trays were stacked on top of each other. -There was an uncovered container of broccoli on the preparation table. -There were two rolling carts containing cups ½ full of lemonade and water that were uncovered. -There were 7 individual bowls of cereal stacked on top of each other and uncovered. Observation of the dry storage closet on 06/30/26 at 8:42am revealed there was a large box of rice in a blue bag that was not sealed. Observation of the refrigerator on 06/30/26 at 8:45am revealed: -There were two cups of liquid in the refrigerator that were uncovered. -There were 20 individual servings of pears on a tray that were uncovered. -There were 4 trays with 10 to 20 individual servings of grapes on each tray that were uncovered. -The four trays were stacked on top of each other. Interview with the cook on 07/02/26 at 9:33am revealed: -She forgot to cover the food on 06/30/26. -She knew the food was to be covered and not exposed. -She was very busy that morning, 06/30/26.	D 283		

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D 283	Continued From page 11 -The food could have become contaminated. Interview with the dietary aide (DA) on 07/01/26 at 1:56pm revealed: -She prepared the marshmallows and the drinks that were left uncovered in the kitchen. -She forgot to cover the food after she prepped it. -It was important to cover the food to keep it from getting contaminated. Interview with a second DA on 07/02/26 at 9:45am revealed the food in the kitchen and the refrigerator should be covered when waiting to be cooked or served to the residents. Interview with the Dietary Manager (DM) on 07/01/26 at 1:39pm revealed: -The DAs were responsible for prepping snacks and desserts for each meal. -The opened bag rice in the dry storage room should have been sealed by tying a knot in the bag. -There was saran wrap to place over the exposed food and drinks sitting in the kitchen and in the refrigerator. -The food could become contaminated if it was not covered or sealed properly. Interview with the Administrator on 07/02/26 at -She expected all food to be covered. -She was concerned of a mitigation risk.	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	D 358	See allegation	

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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 2 of 7 sampled residents (#1 and #4) for record review including errors with an inhaler, a medication for sleep, and a supplement (#1) and a mood stabilizer and a medication for cholesterol (#4).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/20/26 revealed diagnoses included exacerbation of chronic obstructive pulmonary disease (COPD) on 04/02/26, shortness of breath, muscle weakness, and aortic aneurysm.

a. Review of Resident #1's FL-2 dated 04/20/26 revealed there was an order for budesonide/formoterol 160-4.5 (a combination inhaler used to reduce swelling, inflammation in the airways and to relax the muscles around the airways) two puffs twice daily.

Review of Resident #1's June 2026 electronic medication administration record (eMAR) from 06/08/26 to 06/29/26 revealed:
-There was an entry for budesonide/formoterol 160-4.5 inhaler two puffs twice daily.
-There was documentation budesonide/formoterol was administered 88 of 88 opportunities.

Observation of the medication on hand for

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Resident #1 on 06/30/26 at 11:12am revealed:
-There was a box containing a budesonide/formoterol 160-4.5 inhaler on the medication cart.
-There was an opened date documented on the box of 06/07/26.
-There was an inhaler in the box that contained 50 of 120 inhalations.
-There was a second box of budesonide/formoterol 160-4.5 inhaler dispensed on 06/24/26 in Resident #1's medication bin that was sealed.

Telephone interview with a representative from the facility's contracted pharmacy on 06/30/26 at 2:42pm revealed:
-Resident #1 had an order for budesonide/formoterol 160-4.5 inhaler two inhalations twice daily.
-The pharmacy dispensed one inhaler of budesonide/formoterol 160-4.5 on 04/23/26, 05/18/26, and 06/24/26.
-One inhaler had 120 inhalations which would last Resident #1 30 days if administered 2 puffs twice daily.

Interview with a medication aide (MA) on 07/01/26 at 3:50pm revealed:
-She reordered inhalers when there were 5 inhalations remaining in the inhaler.
-She did not know why there were more inhalations remaining in the inhaler than had been documented on the eMAR.

Interview with a second MA on 07/01/26 at 4:30pm revealed a MA had not been administering the inhaler as ordered.

Interview with the MA supervisor on 07/02/26 at 9:08am revealed:

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D 358	Continued From page 14 -Resident #1 was in the hospital in April 2026 with breathing problems. -Resident #1 needed her inhaler to help with shortness of breath. Interview with the RCC on 07/02/26 at 10:39am revealed she was concerned that the MAs were only administering one inhalation instead of two inhalation at each scheduled administration time. Telephone interview with the Primary Care Physician (PCP) on 07/02/26 at 1:45pm revealed: -Resident #1 used her inhaler for COPD and emphysema. -She was recently hospitalized with an exacerbation of COPD. -She was concerned about non-compliance. -She expected the inhaler to be administered as ordered. b. Review of Resident #1's FL-2 dated 04/20/26 revealed there was an order for melatonin 3mg (used to treat insomnia) one at bedtime. Review of Resident #1's April 2026 eMAR from 04/23/26 to 04/30/26 revealed: -There was an entry for melatonin 3mg at bedtime. -There was documentation melatonin was administered 8 of 8 opportunities. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for melatonin 3mg at bedtime. -There was documentation melatonin was administered 62 of 62 opportunities. Review of Resident #1's June 2026 eMAR from 06/01/26 to 06/29/26 revealed:	D 358		

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D 358	Continued From page 15 -There was an entry for melatonin 3mg at bedtime. -There was documentation melatonin was administered 58 of 58 opportunities. Observation of the medication on hand for Resident #1 on 06/30/26 at 11:12am revealed there was a punch card containing 21 of 30 melatonin tablets available for administration with a dispensed date of 05/27/26. Telephone interview with a representative from the facility's contracted pharmacy on 06/30/26 at 2:42pm revealed: -Resident #1 had an order for melatonin 3mg at bedtime. -The pharmacy dispensed 30 tablets of melatonin on 03/24/26, 04/23/26, and 05/27/26. -Each dispensing would last Resident #1 30 days. -The pharmacy had not dispensed any melatonin in June 2026. Telephone interview with the PCP on 07/02/26 at 1:45pm revealed she had not been notified of Resident #1 having any difficulties sleeping. c. Review of Resident #1's FL-2 dated 04/20/26 revealed there was an order for vitamin D-3 2000 units (used as a supplement) one daily. Review of Resident #1's April 2026 eMAR 04/24/26 to 04/30/26 revealed: -There was an entry for vitamin D-3 2000 units daily. -There was documentation vitamin D-3 was administered 7 of 7 opportunities. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for vitamin D-3 2000 units	D 358		

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daily.
-There was documentation vitamin D-3 was administered 30 of 31 opportunities.

Review of Resident #1's June 2026 eMAR from 06/01/26 to 06/29/26 revealed:
-There was an entry for vitamin D-3 2000 units daily.
-There was documentation vitamin D-3 was administered 30 of 30 opportunities.

Observation of the medication on hand for Resident #1 on 06/30/26 at 11:12am revealed:
-There was a punch card containing 23 of 30 vitamin D-3 tablets available for administration with a dispensed date of 06/23/26.
-There was a second punch card in Resident #1's medication bin containing 28 of 30 vitamin D-3 tablets available for administration with a dispensed date of 05/20/26.

Telephone interview with a representative from the facility's contracted pharmacy on 06/30/26 at 2:42pm revealed:
-Resident #1 had an order for vitamin D-3 2000 units daily.
-The pharmacy dispensed 30 tablets of vitamin D-3 2000 on 04/27/26, 05/19/26, and 06/23/26.
-Each dispensing would last Resident #1 30 days.

Telephone interview with the Primary Care Physician (PCP) on 07/02/26 at 1:45pm revealed Resident #1 received a loading dose of vitamin D and was decreased to 1000 units yesterday because her vitamin D levels were good.

Attempted telephone interview with the Registered Nurse (RN) on 07/02/26 at 10:05am.

Refer to the interview with a medication aide (MA)

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D 358	Continued From page 17 on 07/01/26 at 3:50pm. Refer to the interview with a second MA on 07/01/26 at 4:30pm. Refer to the interview with a third MA on 07/02/26 at 7:57am. Refer to the interview with the MA supervisor on 07/02/26 at 9:08am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. Refer to the telephone interview with the PCP on 07/02/26 at 1:45pm. 2. Review of Resident #4's current FL-2 dated 02/17/26 revealed diagnoses included mental retardation and hypercholesterolemia. a. Review of Resident #4's FL-2 dated 02/17/26 revealed there was an order for divalproex 125mg (used as a mood stabilizer) twice daily. Review of Resident #4's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for divalproex 125mg twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that divalproex had been administered 60 of 60 opportunities. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for divalproex 125mg twice	D 358		

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daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that divalproex had been administered 62 of 62 opportunities.

Review of Resident #4's June 2026 eMAR from 06/01/26 to 06/29/26 revealed:
-There was an entry for divalproex 125mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that divalproex had been administered 58 of 58 opportunities.

Observation of the medication on hand for Resident #4 on 06/30/26 at 3:30pm revealed there was a punch card containing 11 of 52 divalproex available for administration with a dispensed date of 05/29/26.

Telephone interview with a representative from the facility's contracted pharmacy on 07/01/26 at 2:28pm revealed:
-Resident #4 had an order for divalproex 125mg twice daily.
-The pharmacy dispensed 60 tablets on 04/27/26 and 06/23/26 which would last 30 days, and 52 tablets on 05/29/26 which would last 26 days.

Telephone interview with the Primary Care Physician (PCP) on 07/02/26 at 1:45pm revealed Resident #4 took simvastatin for his cholesterol.

b. Review of Resident #4's FL-2 dated 02/17/26 revealed there was an order for simvastatin 20mg (used to lower cholesterol) at bedtime.

Review of Resident #4's April 2026 eMAR revealed:
-There was an entry for simvastatin 20mg every night with a scheduled administration time of

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D 358	Continued From page 19 9:00pm. -There was documentation simvastatin was administered 30 of 30 opportunities. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for simvastatin 20mg every night with a scheduled administration time of 9:00pm. -There was documentation simvastatin was administered 31 of 31 opportunities. Review of Resident #4's June 2026 eMAR from 06/01/26 to 06/29/26 revealed: -There was an entry for simvastatin 20mg every night with a scheduled administration time of 9:00pm. -There was documentation simvastatin was administered 29 of 29 opportunities. Observation of the medication on hand for Resident #4 on 06/30/26 at 3:30pm revealed there was a punch card containing 10 of 30 simvastatin tablets available for administration with a dispensed dated of 05/29/26. Telephone interview with a representative from the facility's contracted pharmacy on 07/01/26 at 2:28pm revealed: -Resident #4 had an order for simvastatin 20mg every night. -The pharmacy dispensed 30 tablets on 04/02/26 and 05/29/26 which was a 30-day supply. -The pharmacy had not dispensed any simvastatin in the month of June 2026. Telephone interview with the Primary Care Physician (PCP) on 07/02/26 at 1:45pm revealed she had not been notified of Resident #4 having changes in his mood.	D 358		

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D 358	Continued From page 20 Attempted telephone interview with the Registered Nurse (RN) on 07/02/26 at 10:05am. Refer to the interview with a medication aide (MA) on 07/01/26 at 3:50pm. Refer to the interview with a second MA on 07/01/26 at 4:30pm. Refer to the interview with a third MA on 07/02/26 at 7:57am. Refer to the interview with the MA supervisor on 07/02/26 at 9:08am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. Refer to the telephone interview with the PCP on 07/02/26 at 1:45pm. Interview with a medication aide (MA) on 07/01/26 at 3:50pm revealed: -She worked second shift and covered some third shifts when someone was out. -She reordered medications when the tablets got to the blue line on the punch card, which was 5 tablets remaining in the punch card. -The numbers on these medications do not add up. -There were more medications on hand than there should be. -It looked like somebody was not administering medications as ordered. Interview with a second MA on 07/01/26 at	D 358		

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D 358	Continued From page 21 4:30pm revealed she reordered medications by clicking the reordered button on the computer or calling the pharmacy. Interview with a third MA on 07/02/26 at 7:57am revealed: -She did not know why there were more medication on hand than was documented on the eMARs. -She administered medications as ordered; she could not speak for the other MAs. Interview with the MA supervisor on 07/02/26 at 9:08am revealed: -She ensured the MAs had everything they needed to administer medications. -She worked as a MA when there were call-outs. -She trained new MAs on the medication cart. -She did not know why there were more medications on hands than were documented on the eMAR. -There was a MA who worked at the facility 1.5 months ago who was not administering medications. -She was concerned that something could happen to the residents if they were not getting their medications as ordered. -The residents paid for the medications, they should receive them as ordered. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed: -The RN audited medication for 6 to 8 residents 1 to 2 days a week. -The RN mainly checks the medications of the residents who have dementia. -The RN did a pill count for each medication that the residents were being administered. -The RN looked at the dispensed date on the punch card.	D 358		

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D 358	Continued From page 22 -She tried to be creative by checking medications to ensure they were being administered as ordered. -The RN rarely found a problem with medications being administered as ordered. Interview with the Administrator on 07/02/26 at 12:43pm revealed: -The RCC assigned medication cart audits to the MAs. -The medication carts were also audited by the RN, the RCC, a representative from the pharmacy. -The medication cart audit was completed weekly. -The purpose of the medication cart audit was to check proper storage of medications, cleanliness of the medication cart, any pill spillage, and discontinued medications. -She would review each medication and do her own investigation. -Her staff would investigate each individual medication in question. Telephone interview with the PCP on 07/02/26 at 1:45pm revealed she would like for medications to be administered as ordered.	D 358		
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;	D 367	see attached	

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D 367	Continued From page 23 (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 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 the electronic medication administration records (eMAR) were accurate for 2 of 7 sampled residents (#1 and #2) related to oxygen as needed (PRN). The findings are: 1. Review of Resident #1's current FL-2 dated 04/20/26 revealed diagnoses included exacerbation of chronic obstructive pulmonary disease on 04/02/26, shortness of breath, muscle weakness, and aortic aneurysm. Review of Resident #1's signed physician orders dated 05/28/26 revealed there was an order for oxygen 2L/M PRN for shortness of breath. Review of Resident #1's May 2026 eMAR from 05/28/26 to 05/31/26 revealed:	D 367		

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D 367	Continued From page 24 -There was an entry for oxygen 2L/M PRN shortness of breath. -There was no documentation that Resident #1 had used her oxygen from 05/28/26 to 05/31/26. Review of Resident #1's June 2026 eMAR from 06/01/26 to 06/29/26 revealed: There was an entry for oxygen 2L/M PRN shortness of breath. -There was no documentation that Resident #1 had used her oxygen from 06/01/26 to 06/29/26. Observation of Resident #1 on 06/30/26 at 9:30am revealed: -Resident #1 was sitting in her chair in her bedroom. -She had placed her nasal cannula in her nostrils. -The oxygen tubing was connected to an oxygen concentrator. -The oxygen concentrator was not turned on. Observation of Resident #1 at various times on 06/30/26-07/02/26 revealed she was using her oxygen at 2L/M while in her bedroom. Interview with Resident #1 on 06/30/26 at 9:30am revealed: -She was on 2L/M PRN. -It did not feel like she was getting any oxygen. -She realized her concentrator was turned off. -She only wore her oxygen when she was in her room. -She used her oxygen every day. Interview with the medication aide (MA) supervisor on 07/02/26 at 9:08am revealed: -She did not document on the eMAR when Resident #1 wore her oxygen. -She had not seen the entry on the eMAR for the PRN oxygen for Resident #1. -She had not been instructed to document the	D 367		

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D 367	Continued From page 25 PRN oxygen on the eMAR for Resident #1. -It was important because the Primary Care Provider (PCP) would look at the eMAR. -The PCP may not know Resident #1 was using her oxygen every day. -Resident #1 used her oxygen every day she worked. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed: -She knew the PRN order for the oxygen was on the eMAR. -Resident #1 used her oxygen when she was in her room. -It would be difficult for the MAs to document on the eMAR since Resident #1 wore her oxygen at different times of the day. -She was not concerned that the MAs were not documenting on the eMAR when Resident #1 was using her oxygen. -Resident #1's son, PCP, and anyone involved in Resident #1's care knew how the facility managed the oxygen. Interview with the Administrator on 07/02/26 at 12:43pm revealed: -There was no way to click on and off the PRN order on the eMAR. -Resident #1 took her oxygen off and would replace the oxygen independently when she needed it. 2. Review of Resident #2's current FL2 dated 03/22/26 revealed: -Diagnoses included obstructive sleep apnea, hypertension, chronic obstructive pulmonary disease, recurrent falls, depression, thrombocytopenia. -There was an order for oxygen via nasal cannula (NC) 3 liters per minute (LPM) as needed (PRN)	D 367		

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D 367	Continued From page 26 for shortness of breath. Review of Resident #2's electronic medication administration record (eMAR) for April 2026 revealed: -There was no entry for oxygen via NC 3 LPM. -There was no documentation oxygen via NC 3 LPM was administered. Review of Resident #2's eMAR for May 2026 revealed: -There was no entry for oxygen via NC 3 LPM. -There was no documentation oxygen via NC 3 LPM was administered. Review of Resident's #2 eMAR for June 2026 revealed: -There was no entry for oxygen via NC 3 LPM. -There was no documentation oxygen via NC 3 LPM was administered. Observation of Resident #2 at various times on 06/29/26-07/02/26 revealed he was wearing an oxygen NC connected to an oxygen concentrator that was delivering oxygen at 3 LPM. -The resident was observed with oxygen on except when eating throughout the survey from 06/29/26-07/02/26. Interview with Resident #2 on 06/30/26 at 2:07pm revealed he nodded his head to yes, that he wore his oxygen. Telephone interview with Resident #2's family member on 06/30/26 3:11pm revealed: -He wore oxygen all the time except when eating and showering. -He did not want to wear his oxygen when eating. -He was more exhausted without his oxygen after eating a meal.	D 367		

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

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D 367	Continued From page 27 Interview with a medication aide (MA) on 06/30/26 at 4:23pm revealed: -Resident #2 always wore his oxygen except when eating. -She was not aware of the need to chart his use of oxygen PRN on the eMAR. Interview with the MA supervisor on 07/02/26 at 8:19am revealed: - Resident #3 always wore his oxygen except when eating or showering. - She was not aware of the need to chart Resident #2's use of oxygen PRN on the eMAR. Interview with the resident care coordinator (RCC) on 07/02/26 at 10:38 am revealed: -The MA did not document PRN oxygen on the eMAR's. -She was not concerned that Resident #2's PRN oxygen was not documented on the eMAR. Telephone interview with Resident #2's primary care physician (PCP) on 07/01/26 at 1:35pm revealed: -Resident #2's oxygen should be used PRN.	D 367		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and	D 375	See attached	

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D 375	Continued From page 28 documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 2 sampled residents (#3, #8) had a physician's order to self-administer medications observed in the residents' rooms. The findings are: Review of the facility's medication administration policy dated 01/02/23 revealed: -Self-administering medications required pre-approval by the Administrator and the Resident Care Coordinator (RCC), and a physician's order. -If medications were ordered to be maintained bedside, residents must store the medication in a manner that prevented other residents from using the medication. -Families were not allowed to bring medications to the residents directly but must deliver the medication to a medication aide (MA), or the RCC. 1. Review of Resident #3's FL2 dated 02/12/26 revealed: -Diagnoses included lung carcinoma. -He was intermittently disoriented. -The original date the FL2 was signed was 02/12/26; however, documentation indicated it was reviewed and signed by the physician on	D 375		

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D 375	Continued From page 29 04/01/26. -There was an order for Neosporin (a triple-antibiotic ointment used to prevent infection and keep the wound hydrated). -There was no self-administer order for Neosporin. Review of Resident #3's Resident Register revealed: -The date of admission was 04/02/26. -Resident #3 was forgetful and needed reminders. Review of Resident #3's care plan dated 04/07/26 revealed: -He required limited assistance from staff with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -He was always disoriented. -He had a significant loss and required direction. Observation of Resident #3's room on 06/30/26 at 9:10am revealed a tube of Neosporin ointment on his bedside table. Review of Resident #3's record revealed there were no orders for self-administration of any medications. Review of Resident #3's physician's orders dated 06/02/26 revealed an order for Neosporin with the directions to clean minor skin tears with saline as needed and apply ointment and sterile dressing daily per standing order. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Neosporin with the directions to clean minor skin tears with saline as	D 375		

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D 375	Continued From page 30	D 375		

needed and apply ointment and a sterile dressing daily per standing order.
-There was no documentation that Neosporin had been administered from 06/01/26 through 06/30/26.
-There was no documentation that the Neosporin could be kept at the bedside.

Interview with Resident #3 on 06/30/26 at 9:10am revealed:
-He used Neosporin on his leg once a day.
-No one told him to use Neosporin on his leg.
-He had fallen, which caused a sore on his leg, which he was applying Neosporin.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/26 at 1:37pm revealed:
-Resident #3 did not have an order to self-administer Neosporin.
-If Resident #3 had an infection and the Neosporin was not used correctly, the infection could worsen and would not heal as quickly.

Interview with a MA on 07/01/26 at 3:50pm revealed:
-Resident #3 did not have an order to self-administer any medication, to her knowledge.
-Resident #3 could self-administer Neosporin if staff reminded him.
- Resident #3 should not self-administer any medication without an order.
-If she observed medication in plain view, she would notify the Resident Care Coordinator (RCC).

Interview with the MA Supervisor on 07/02/26 at 8:19am revealed:
-There was a standing order for Neosporin.
-She did not know whether Resident #3 had an

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D 375	Continued From page 31	D 375		

order to self-administer the Neosporin.
-Resident #3 had not told her he was using Neosporin.

Interview with the RCC on 07/02/26 at 10:39am revealed:
-Resident #3 did not have an order to self-administer antibiotic cream.
-They had a problem with Resident #3 bringing items into the facility on his own.
-They checked his room once (she did not recall the date) and he had Band-Aids, Neosporin, Tums and eye drops, which were removed.
-Resident #3 did not understand why he could not keep these items in his room.
-Staff might not recognize Neosporin was a medication, and she would need to educate the staff.

Interview with the Administrator on 07/02/26 at 12:43pm revealed Resident #3 would need an order to self-administer Neosporin.

Telephone interview with Resident #3's primary care provider (PCP) on 07/02/26 at 1:35pm revealed:
-She was unaware that Resident #3 had Neosporin at his bedside.
-No one had requested an order for Resident #3 to self-administer the Neosporin.

Refer to the interview with a housekeeper on 07/02/26 at 9:52am.

Refer to the interview with a personal care aide (PCA) on 07/02/26 at 9:59am.

Refer to the interview with the MA Supervisor on 07/02/26 at 8:19am.

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D 375	Continued From page 32 Refer to the interview with the RCC on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. 2. Review of Resident #8's current FL2 dated 03/05/26 revealed: -Diagnoses included congestive heart failure and respiratory failure. -There was no order for Systane eye drops (used to provide temporary relief from burning, irritation, and dryness). -There was no authorizing Resident #8 to self-administer Systane eye drops. Review of Resident #2's Resident Register revealed the date of admission was 06/03/24. Review of Resident #8's care plan dated 04/07/26 revealed: -She required extensive assistance from staff with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -She was forgetful and required reminders. Observation of Resident #8's room on 06/30/26 at 9:15am revealed a box of Systane eye drops on the table beside of her chair. Review of Resident #8's record revealed there were no orders authorizing self-administration of medications. Review of Resident #8's physician's orders dated 06/02/26 revealed there was no order for Systane eye drops. Review of Resident #3's June 2026 electronic medication administration record (eMAR)	D 375		

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D 375	Continued From page 33 revealed there was no entry for Systane eye drops and no documentation Systane eye drops were administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/26 at 1:37pm revealed: -Resident #8 did not have an order for Systane eye drops. -Resident #8 would need an order to self-administer the Systane eye drops. Interview with Resident #8 on 07/01/26 at 10:00am revealed she used the Systane eye drops once a day for dry eyes. Interview with Resident #8's family member on 07/01/26 at 10:00am revealed he provided Resident #8 with the Systane eye drops; she let him know when she was out and needed a new bottle. Interview with a MA on 07/01/26 at 3:50pm revealed: -Resident #8's memory was "terrible". -Resident #8 did not have an order to self-administer any medications. -Resident #8 would not be able to self-administer any medications because her memory was "not good at all". Interview with the MA Supervisor on 07/02/26 at 8:19am revealed: -Resident #8's memory "comes and goes." -Resident #8 could physically apply eye drops, but she would not remember that she "just done it". -The eye drops should not have been in Resident #8's room without an order, and she did not even have an order for eye drops.	D 375		

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D 375	Continued From page 34 Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed: -Resident #8 could self-administer eye drops. -Resident #8 would not remember if she administered the eye drops and, therefore, should not self-administer them. Interview with the Administrator on 07/02/26 at 12:43pm revealed Resident #8 would need an order to self-administer eye drops. Refer to the interview with a housekeeper on 07/02/26 at 9:52am. Refer to the interview with a personal care aide (PCA) on 07/02/26 at 9:59am. Refer to the interview with the MA Supervisor on 07/02/26 at 8:19am. Refer to the interview with the RCC on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. Interview with a housekeeper on 07/02/26 at 9:52am revealed: -She was taught if she saw any type of medication in a resident's room to tell the MA. -She had not seen any medications in residents' room. Interview with a PCA on 07/02/26 at 9:59am revealed: -If she saw eye drops or creams in a residents' room, she would notify the RCC. -She had not seen any eye drops or creams in a residents' room.	D 375		

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D 375	Continued From page 35 Interview with the MA Supervisor on 07/02/26 at 8:19am revealed: -Sometimes residents purchased items on their own, and staff were not always aware they had the medication in their rooms. -If a resident was going to self-administer any medications, the PCP would need to write an order authorizing self-administration. -If a medication was found in a resident's room, staff would remove it and contact the PCP to obtain an order for the medication to be self-administered. -All staff, including housekeeping and PCAs, knew to let the MAs know if medications were seen in a residents' room. Interview with the RCC on 07/02/26 at 10:39am revealed: -Staff attempted to check resident rooms at least once a month to see in the residents had anything in their room without an order. -Staff notified her if they saw medication in a resident's room. Interview with the Administrator on 07/02/26 at 12:43pm revealed: -Residents were told upon admission to the facility that they could not keep medications in their room without an order. -Staff conducted weekly room sweeps, and staff were in resident rooms daily. -Staff were instructed that if medications were found in a residents' room, they were to give the medication to the MAs.	D 375		
D 387	10A NCAC 13F .1007 (b) Medication Disposition 10A NCAC 13F .1007 Medication Disposition	D 387	see attached	

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D 387	Continued From page 36 (b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure discontinued medications were stored separately from actively used medications for 3 of 7 sampled residents (#1, #3, and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 04/20/26 revealed diagnoses included exacerbation of chronic obstructive pulmonary disease on 04/02/26, shortness of breath, muscle weakness, and aortic aneurysm. Review of Resident #1's signed physician order dated 05/07/26 revealed there was an order to discontinue trazodone 50mg ½ tablet every 12 hours as needed for sleep. Observation of Resident #1's medication on hand on 06/30/26 at 11:10am revealed there was a punch card containing 14 of 14 one-half tablets of trazodone 50mg tablets in Resident #1's bin with active medications. Interview with the medication aide (MA) Supervisor on 07/02/26 at 8:19am revealed she did not know Resident #4's punch card for benzonatate was still on the medication cart; it was overlooked.	D 387		

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D 387	Continued From page 37 Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed she was not aware that Resident #4's benzonatate remained in the medication cart. Refer to the interview with a MA on 07/01/26 at 3:50pm revealed: Refer to the interview with the MA on 07/01/26 at 4:30pm. Refer to the interview with the MA Supervisor on 07/02/26 at 8:19am. Refer to the interview with the RCC on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. 2. Review of Resident #4's current FL-2 dated 02/17/26 revealed diagnoses included mental retardation and hypercholesterolemia. Review of Resident #4's medication review dated 02/12/26 revealed: -Resident #4 had two as needed (PRN) medications ordered for cough. -The pharmacist recommended discontinuing one of the two PRN cough medications. -The Primary Care Physician agreed and discontinued benzonatate 100mg (used to suppress cough) three times daily PRN. -The medication review was signed by the PCP on 02/12/26. Observation of medication on hand for Resident #4 on 06/30/26 at 3:30pm revealed there was a punch card containing 2 of 30 benzonatate	D 387		

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D 387	Continued From page 38 100mg tablets with a dispensed date of 01/09/26. Interview with the medication aide (MA) Supervisor on 07/02/26 at 8:19am revealed she did not know Resident #4's punch card for benzonatate was still on the medication cart; it was overlooked. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed she was not aware that Resident #4's benzonatate remained in the medication cart. Refer to the interview with a MA on 07/01/26 at 3:50pm revealed: Refer to the interview with the MA on 07/01/26 at 4:30pm. Refer to the interview with the MA Supervisor on 07/02/26 at 8:19am. Refer to the interview with the RCC on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. 3. Review of Resident #3's FL2 dated 02/12/26 revealed: -Diagnoses included lung carcinoma. -There was an order for Senna (used to treat constipation) 8.6mg, take two tablets, twice daily as needed (PRN) for constipation. Review of Resident #3's pharmacy review dated 04/28/26 revealed: -Resident #3 had two PRN orders for medications used to treat constipation and suggested one of the medications be discontinued.	D 387		

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D 387	Continued From page 39 -The primary care provider (PCP) wrote an order to discontinue the Senna on 04/30/26. Review of Resident #3's April 2026 electronic medication administration review (eMAR) for 04/30/26 revealed: -There was an entry for Senna 8.6mg, take two tablets twice daily, as needed. -There was no documentation that Senna had been administered from 04/01/26-04/30/26. -There was documentation the Senna was discontinued on 04/30/26. Observation of Resident #3's medications on hand on 06/30/26 at 2:10pm revealed: -There was a punch card for Senna 8.6mg, take two tablets twice daily, as needed with a dispense date of 04/01/26. -There were 44 of 60 tablets remaining on the punch card. Interview with the medication aide (MA) Supervisor on 07/02/26 at 8:19am revealed she had seen Resident #3's punch card for Senna in the medication cart, but she thought he had a PRN order for the Senna; it was overlooked that it was not removed. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 10:39am revealed she was not aware that Resident #3's Senna remained in the medication cart. Refer to the interview with a MA on 07/01/26 at 3:50pm revealed: Refer to the interview with the MA on 07/01/26 at 4:30pm. Refer to the interview with the MA Supervisor on	D 387		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 387	Continued From page 40 07/02/26 at 8:19am. Refer to the interview with the RCC on 07/02/26 at 10:39am. Refer to the interview with the Administrator on 07/02/26 at 12:43pm. Interview with a MA on 07/01/26 at 3:50pm revealed: -Discontinued medications were pulled from the medication cart on first shift. -If a discontinued medication was not pulled, she would remove the medication from the medication cart and notify the RCC. -If she documented that she gave a medication that was not available she would notify the RCC and let her know. -The medication cart was audited by a Registered Nurse (RN) once or twice a week. -If the RN notices a medication on the medication cart that had not been given as ordered she would speak to the MA. Interview with the MA on 07/01/26 at 4:30pm revealed: -Medication that was discontinued would be removed from the medication cart and returned to the pharmacy. -She would know a medication had been discontinued because she would see it on the eMAR. Interview with the MA supervisor on 07/02/26 at 8:19am revealed: -The RCC, RN and the MA supervisor was responsible for removing discontinued medications from the medication carts. -The MA could remove discontinued medication if one had been missed.	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032001	A. BUILDING: _____ B. WING _____	07/02/2026

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D 387	Continued From page 41 -The RN comes 3 days a week for cart audits. -She did not know there were discontinued medications on the medication carts. Interview with the RCC on 07/02/26 at 10:39am revealed: -She removed medications that had been discontinued from the medication cart after the PCP had discontinued the medication. -The MAs also knew to remove a medication from the medication cart if the medication had been discontinued. -Discontinued medications were removed from the cart and placed in a box to be returned to the pharmacy. -The RN audited medication for 6 to 8 residents 1 to 2 days a week. -She would remove discontinued medication if she saw it on the medication cart. -They try to be efficient, but some meds slip through. Interview with the Administrator on 07/02/26 at 12:43pm revealed: -Medication that had been discontinued should have been removed from the medication cart by the MA or the RCC and returned to the pharmacy. -The discontinued medication would not have been administered because the MAs would not administer a medication without an active order.	D 387		

Telephone contact was made with the Administrator on 08/04/26, and information not pertinent to the Plan of Correction (POC) was redacted. kg

Eno Pointe Assisted Living, HAL032001
POC for Survey exit 07/02/26

10A NCAC 13F .0902(b) Health Care D 273

It is the community's standard practice to ensure referral and follow-up is made to meet routine and acute health care needs of residents. On 7/10/26, RN in-serviced all Med Tech staff on protocols for documentation, communication and follow-up monitoring of Incidents. Review of provider notes and After Visit Summaries are reviewed by the Resident Care Coordinator within 24 hours and on-going compliance reviewed by RN, PharmD, Executive Director, QA Personnel, or Med Tech Supervisor at least weekly. Shift Communication Sheet was updated and Post-Incident Event Monitoring Log was implemented to provide documentation and to ensure on-going and timely monitoring of health care needs; these were put in place on 07/23/26 after In-servicing Med Tech staff by ED. Post-Incident Event Monitoring Logs will be completed by Med Techs and reviewed at least weekly by RCC, RN, ED, QA Personnel, Med Tech Supervisor or PCP to ensure on-going compliance.

[redacted]

Completion Date: 07/23/26

[redacted]

10A NCAC 13F .0904(a)(2) Nutrition and Food Service D283

It is the community's standard practice to store, prepare and serve food and beverages under sanitary conditions. The Food Service Manager in-serviced each Dietary staff on proper storage, cross contamination prevention and temperature danger zones on 07/03/26 including covering prepped trays and beverages. To ensure on-going compliance, monitoring will be completed at least daily by the FSM, Executive Director, or designated department manager.

Completion Date: 07/03/26

10A NCAC 13F .1004(a) Medication Administration D358

It is the community's standard practice to ensure medications are administered as the physician ordered. RN in-serviced Med Tech staff on 07/10/26 on med administration, including proper use of inhalers. Additionally, to ensure accurate auditing, Med Tech staff were instructed to use the oldest filled med card first and to note the start date on the card, to ensure auditing back stock and out of facility days result in accurate audits. To ensure on-going compliance, at least weekly, med carts (stock) are audited by PharmD, Resident Care Coordinator, QA Personnel, Executive Director, or Med Tech Supervisor.

Completion Date: 07/10/26

10A NCAC 13F .1004(j) Medication Administration D367

It is the community's standard practice to ensure eMAR records are accurate including as related to PRN oxygen orders. RN in-serviced Med Tech staff on 07/10/26 on monitoring and proper usage of PRN oxygen. The eMAR software does not provide the means for Med Tech staff to document electronically for PRN oxygen use therefore we did not have omissions on MAR (missed, blanks or incomplete entries on MAR). Our pharmacy audited all PRN oxygen electronic orders for N.C. customers and order set-up was consistent across the state. To ensure on-going compliance, the pharmacy developed a new method for Med Techs to document electronically the monitoring of PRN oxygen proper usage and equipment functionality.

Completion Date: 07/24/26

10A NCAC 13F .1005(a) Self-Administration of Medications D375

It is the community's standard practice to ensure there are physician's orders to self-administer medications in resident rooms. RN in-serviced Med Tech staff on 07/10/26 to verify physician orders for any medications observed in resident rooms. Additionally, as our resident contract prohibits any meds from being brought into or left in resident rooms, these two residents were reminded of our policy. Community staff are aware to remove meds from rooms and give to Med Techs to verify orders. To ensure on-going compliance, at least weekly, room audits are completed by Med Techs, Housekeepers, Aides, Housekeeper Supervisor, Resident Care Coordinator, QA Personnel, or Executive Director.

Completion Date: 07/10/26

10A NCAC 13F .1007(b) Medication Disposition D387

It is the community's standard practice to ensure discontinued medications are stored separately from active medications. RN in-serviced Med Tech staff on 07/10/26 on proper disposition. Resident Care Coordinator, Med Tech, or designee will remove discontinued medications from cart upon receipt of discontinued orders. Full cart audits were completed on 07/06/26. To ensure on-going compliance, weekly cart audits are completed by PharmD, Med Techs, Med Tech Supervisor, RN, QA Personnel, or Resident Care Coordinator.

Completion Date: 07/10/26

07/31/26