| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BROOKDALE CONCORD PARKWAY | 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual and follow-up survey on 06/23/26 through 06/25/26. | D 000 | The following is the plan of correction for Brookdale Concord Parkway. This Plan of Correction is in regards to the State of Deficiencies dated 6/23/26-6/25/26. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as a confirmation of our ongoing efforts to comply with the statuatory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation provided. | |
| D 238 | 10A NCAC 13F .0703 (f) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations<br>(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure the information provided related to the resident's condition was appropriate and could meet the individual's needs for 1 of 5 sampled residents (#1), who had a higher level of care recommendation listed on the resident's FL2.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 10/02/25 revealed:<br>-Diagnoses included Alzheimer's disease, asthma and type 2 diabetes. | D 238 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matt Fitzwater | TITLE: Executive Director II | (X6) DATE: 7/24/26



AS Reviewed and Acknowledged 08/03/26

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| D 238 | Continued From page 1<br>-She was ambulatory.<br>-The recommended level of care was skilled nursing facility (SNF).<br><br>Review of the Resident #1's Resident Register revealed an admission date of 09/06/23.<br><br>Review of Resident #1's care plan dated 06/17/26 revealed she was independent with all activities of daily living.<br><br>Interview with the medical assistant for Resident #1's Primary care Provider (PCP) on 06/23/26 at 1:12pm revealed:<br>-The facility had faxed Resident #1's FL2 to the office with SNF level of care already filled out on the FL2.<br>-The PCP, "probably just signed the FL2 without looking at it."<br><br>Interview with Resident #1's Hospice Registered Nurse on 06/24/26 at 2:05pm revealed:<br>-Resident #1 was admitted under Hospice services on 09/06/25.<br>-Resident #1 was completely independent.<br>-Resident #1 was appropriate for Assisted Living Facility (ALF) level of care due to her independence with ADL's.<br><br>Interview with the Health and Wellness Director on 06/25/26 at 12:42pm revealed:<br>-She knew Resident #1's FL2 had a recommended SNF level of care due to there being an issue with payment to the facility.<br>-She knew the facility had sent out Resident #1's information for SNF placement but did not receive any bed offers.<br>-She did not feel Resident #1 was appropriate for SNF level of care due to the resident being independent. | D 238 | The HWD or designee will review each FL-2 prior to resident move in, change in conditon, or discharge from the hospital/rehab to verify that the approrpriate level of care is checked and the form is signed by the doctor.<br><br>The HWC (Health and Wellness Coordinator) or designee will double check the FL-2 prior to fililng it in the resident chart.<br><br>The HWD or designee will have FL-2 documents corrected, as needed, by the physician or the resident will transfer to the appropriate level of care within thirty (30) days.<br><br>The Executive Director or designee will review all of the aforementioned FL-2s monthly for 12 months. | 6/26/26 |

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| D 238 | Continued From page 2<br>-The facility should have completed a new FL2 with the appropriate level of care after the facility did not receive SNF bed offers.<br><br>Interview with the Administrator on 06/24/26 at 2:20pm revealed:<br>-The facility completed the FL2 with a recommended SNF level of care due to Resident not having funds or a financially reasonable party in place to pay the facility for room and board.<br>-He thought Resident #1 could qualify for SNF Medicaid.<br>-No bed offers were received when Resident #1's 10/02/25 FL2 was referred to SNF.<br>-The facility should have completed a new FL2 with the appropriate ALF level immediately after no SNF bed offers were received.<br>-He was trying to do what he could to help with the resident's financial situation due to the facility not accepting Medicaid. | D 238 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#3) related to a medication to treat | D 358 | The HWD or designee will review all new medication orders to verify accuracy. Upon medication arrival, the HWD or designee will verify the medication matches the order. This will include name, dosage, and directives.<br><br>The HWC/RCC or designee will review the orders in the system to verify they match and utilize a new order tracking sheet.<br><br>The Medication Technitians will compare the medication packaging with the order prior to dispensing the medication to the resident.<br><br>To assist with ongoing compliance, the Resident Care Coordinator or designee will complete monthly medication cart audits to verify accuracy every month for twelve (12 ) months. | 6/26/26 |

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| D 358 | Continued From page 3 | D 358 | | |

constipation.

The findings are:

Review of the facility's General Guidelines for Medication Administration policy dated 11/2011 revealed medication directions on the physician order and pharmacy label should correlate with the medication direction on the electronic medication administration record (eMAR).

Review of Resident #3's current FL2 dated 03/12/26 revealed:
-Diagnoses included traumatic retroperitoneal hematoma (blunt or penetrating injury causing bleeding in the area behind the abdominal cavity), atrial fibrillation, coronary artery disease, recurrent falls and dementia.
-Resident #1 was intermittently disoriented and semi-ambulatory.
-There was an order for senna (a medication to treat constipation) 8.6mg, one tablet daily.

Review of Resident #3's Resident Register revealed there was no documented admission date.

Review of Resident #3's record revealed an admission date of 04/18/24.

Review of Resident #3's Nurse Practitioner's (NP) orders dated 05/07/26 revealed there was an order for senna 8.6mg, one tablet every morning.

Review of Resident #3's April 2026 eMAR revealed:
-There was an entry for senna 8.6mg, one tablet daily scheduled at 8:00am.
-There was documentation senna 8.6mg one tablet was administered to Resident #3 daily at

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| D 358 | Continued From page 4<br>8:00am from 04/01/26 through 04/30/26.<br><br>Review of Resident #3's May 2026 eMAR revealed:<br>-There was an entry for senna 8.6mg, one tablet daily scheduled at 8:00am.<br>-There was documentation senna 8.6mg one tablet was administered to Resident #3 daily at 8:00am from 05/01/26 through 05/31/26.<br><br>Review of Resident #3's June 2026 eMAR revealed:<br>-There was an entry for senna 8.6mg, one tablet daily scheduled at 8:00am.<br>-There was documentation senna 8.6mg one tablet was administered to Resident #3 daily at 8:00am from 06/01/26 through 06/23/26.<br><br>Observation of medications on hand for Resident #3 on 06/24/26 at 12:10pm revealed:<br>-There was a bubble pack containing Senexon-S (a medication containing a stimulant laxative (senna) with a stool softener to treat constipation) 8.6-50mg tablets, with 20 tablets remaining.<br>-The label indicated Senexon-S 8.6-50mg 28 tablets were dispensed to the facility with a "start date" of 06/17/26.<br><br>Interview with a medication aide (MA) on 06/24/26 at 2:49pm revealed:<br>-She administered the Senexon-S 8.6-50mg one tablet to Resident #3 that morning.<br>-The order on Resident #3's eMAR was senna 8.6mg one tablet daily in the morning.<br>-She administered Senexon-S 8.6-50mg one tablet to Resident #3 because it matched the "dispensed supply" note on the same screen as the senna 8.6mg, one tablet daily in the morning order. | D 358 | | |

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| D 358 | Continued From page 5<br><br>Telephone interview with a representative with the facility's contracted pharmacy on 06/25/26 at 10:04am revealed:<br>-Resident #3 had an order for Senexon-S 8.6-50mg one tablet daily from a FL2 dated 07/29/25.<br>-The facility entered resident medications orders into the eMAR system.<br>-On 03/12/26 the pharmacy received Resident #3's hospital discharge paperwork but did not receive the FL2 dated 03/12/26.<br>-The pharmacy did not enter the order for senna 8.6mg, one tablet daily from the hospital discharge paperwork dated 03/12/26 because the paperwork did not indicate the senna order was "new" or "changed".<br>-Senexon-S 8.6-50mg 28 tablets were dispensed to the facility on 03/18/26, 04/15/26, 05/13/26 and 06/10/26.<br>-If Resident #3 received Senexon-S 8.6-50mg one tablet daily instead of senna 8.6mg one tablet daily he could experience runny stools.<br><br>Interview with Resident #3's NP on 06/25/26 at 12:03pm revealed:<br>-She expected the facility to review resident hospital discharge orders and ensure they were entered accurately in the eMAR system.<br>-She expected the MAs to administer medications as ordered.<br><br>Interview with the Health and Wellness Director (HWD) on 06/25/26 at 12:43pm revealed:<br>-She or the Health and Wellness Coordinator (HWC) were responsible to review all resident hospital discharge paperwork for medication changes or new medications.<br>-Resident #3's order for senna 8.6mg, one tablet daily order on his hospital FL2 dated 03/12/26 was overlooked. | D 358 | | |

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| D 358 | Continued From page 6<br>-The MAs were responsible to administer medications according to the orders on the residents eMAR.<br>-If a resident's medication on hand did not match the medication in the eMAR system, the MA should contact the HWD, HWC, Resident Care Coordinator (RCC) or call the pharmacy.<br>-She had not been notified Resident #3's Senexon-S 8.6-50mg medication on hand did not match the order in the eMAR system.<br><br>Interview with the Administrator on 06/25/26 at 1:30pm revealed:<br>-The HWD, HWC, RCC and MAs were all responsible to enter resident medication orders into the eMAR system.<br>-The HWC or the HWD were responsible to review all orders entered into the eMAR system for accuracy.<br>-The MAs were responsible to administer medications according to the orders on the resident's eMAR. | D 358 | | |
| D 367 | 10A NCAC 13F .1004 (j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; | D 367 | THe HWD or designee will review all new medication orders to verify accuracy. Upon medication arrival, the HWD or designee will verify the medication matches the order. This will include name, dosage, and directives.<br><br>The HWC/RCC or designee will review the orders in the system to verify they match and utilize a new order tracking sheet.<br><br>The Medication Technitians will compare the medication packaging with the order prior to dispensing the medication to a resident.<br><br>To assist with ongoing compliance, the RCC or designee will complete a medication cart audit monthly for twelve (12) months to verify for accuracy. | 6/26/26 |

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| D 367 | Continued From page 7<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(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).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 1 of 5 residents related to documentation of a medication to treat pain (#5).<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 10/14/25 revealed:<br>-Diagnoses included femur (hip) fracture and chronic pain.<br>-There was an order for tramadol (a medication to treat pain) 100mg, one tablet at bedtime.<br><br>Review of Resident #5's Nurse Practitioner's (NP) order dated 02/10/26 revealed there was an order for tramadol 100mg, one tablet at bedtime.<br><br>Review of Resident #5's NP's order dated 06/11/26 revealed there was an order to decrease Resident #5's tramadol 100mg to tramadol 50mg, one tablet at bedtime.<br><br>Review of Resident #5's June 2026 electronic medication administration record (eMAR) | D 367 | | |

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| D 367 | Continued From page 8 | D 367 | | |

revealed:
-There was an entry for tramadol 100mg, one tablet at bedtime.
-Tramadol 100mg, one tablet was documented administered to Resident #5 at 7:00pm from 06/01/26 to 06/22/26.

Review of Resident #5 tramadol 100mg control substance count sheet (CSCS) revealed:
-Tramadol 100mg, 30 tablets was received on 05/15/26 for Resident #5.
-Tramadol 100mg, one tablet was signed out daily for the resident from 05/16/26 through 06/14/26.
-The last tramadol 100mg tablet was signed out on 06/14/26 at 7:00pm.

Review of Resident #5's tramadol 50mg CSCS revealed:
-Tramadol 50mg, 30 tablets was received on 06/11/26 for Resident #5.
-Tramadol 50mg, one tablet was signed out daily for Resident #5 from 06/15/26 through 06/23/26.
-There were 21 tablets of tramadol 50mg remaining after one tablet was signed out on 06/23/26 at 7:00pm.

Observation of medication on hand for Resident #5 on 06/24/26 at 11:20am revealed:
-There was a bubble pack of tramadol 50mg with 21 tablets remaining.
-The label indicated tramadol 50mg, 30 tablets were dispensed to the facility on 06/11/26 for Resident #5.

Interview with the Health and Wellness Director (HWD) on 06/24/26 at 3:05pm revealed:
-Resident #5's NP orders were received by facility staff by email or fax.
-The pharmacy received the order to decrease Resident #5's tramadol to 50mg because it was a

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controlled substance and the NP had to send a hard script directly to the pharmacy.
-She spoke with Resident #5's NP and it was believed the tramadol 50mg, one tablet daily order faxed to the facility was "tied up" in the fax machine and was not delivered to the facility.
-Because the facility did not receive the order for Resident #5's tramadol 50mg, one tablet daily, the order was not updated in his eMAR.
-The MAs should have identified the discrepancy when they began administering tramadol 50mg, one tablet to Resident #5 on 06/15/26.
-She was not aware Resident #5's tramadol dosage had been changed and not updated in the eMAR system.

Interview with a MA on 06/25/26 at 11:25am revealed:
-The MAs were responsible to ensure resident medications were administered according to the orders on the eMAR.
-The MAs were responsible to accurately document medications administered on the residents' eMARs.

Telephone interview with a representative with the facility's contracted pharmacy on 06/24/26 at 4:13pm revealed:
-The facility was responsible for adding new medication orders to the residents' eMARs.
-Resident #5 had a new order dated 06/11/26 for tramadol 50mg, one tablet daily at bedtime.
-Tramadol 50mg, 30 tablets was dispensed for Resident #5 on 06/11/26.

Interview with the Administrator on 06/25/26 at 1:30pm revealed:
-The MAs were responsible for accurately documenting medications administered on the eMAR.

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| D 367 | Continued From page 10<br>-He did not know how often but the RCC was responsible to audit resident medications.<br>-He was unsure if the RCC reviewed the eMARs for accuracy. | D 367 | | |
| D 463 | 10A NCAC 13F .1306 Admission To The Special Care Unit<br><br>10A NCAC 13F .1306 Admission To The Special Care Unit<br>In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:<br>(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.<br>(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.<br>(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure the requirements were met for admission to the special care unit (SCU) for 3 of 3 sampled residents related to documentation of a pre-admission screening for the appropriateness of an individual's placement in the SCU (#2 and #8), documentation of an | D 463 | The HWD or designee will complete the follwing prior to any new admission or internal transfer to the Special Care Unit (SCU).<br><br>1) The SCU box is checked on each FL-2<br>2) The SCU prescreening form is completed<br>3) The resident has a diagnosis of Alzheimers, Dementia, or cognitive impairment.<br>4) The NC Special Care Unit Disclosure Form is completed and signed.<br><br>The HWD or designee will review SCU documentation weekly for three (3) months. | 6/26/26 |

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| | HAL013019 | A. BUILDING: _____ B. WING _____ | R 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE CONCORD PARKWAY | 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 |

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appropriate diagnosis to meet criteria for admission to the SCU (#8), and failed to ensure disclosures were completed upon admission for a resident (#3) who resided in the SCU.

The findings are:

Review of the facility's SCU policy revised in August 2008 revealed:
-The pre-admission review process considers the residents' care needs, service planning, and associate capabilities to meet these needs.
-The review process should occur as soon as possible after the referral has been received so a timely and prompt decision can be made.

1. Review of Resident #2's current FL2 dated 04/09/26 revealed:
-Diagnoses included Alzheimer's disease, ulcerative colitis, major depressive disorder, anxiety disorder, altered mental status, urinary tract infection, hypertension, and disorder of bone density and structure.
-She was constantly disoriented and non-ambulatory.

Review of Resident #2's Resident Register revealed an admission date of 01/27/23.

Review of Resident #2's Care Plan dated 03/13/26 revealed she required total care for eating, toileting, ambulation, bathing, dressing, grooming, and was 2-person assist for transferring.

Review of Resident #2's resident record revealed there was no SCU pre-screening.

Telephone interview with Resident #2's Power of Attorney (POA) on 06/25/26 at 12:22pm revealed:

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-Resident #2 had some decline recently related to her nearing the end-of-life stage.
-Resident #2 had cognitive decline and was unable to talk like she used to and Resident #2 could not remember who she was.
-She remembered the health and wellness director doing some of the SCU paperwork but did know if the pre-screening was completed.

Interview with the health and wellness director (HWD) on 06/25/26 at 12:42pm revealed:
-She did not know the pre-screening had not been completed on Resident #2.
-It was her responsibility and the health and wellness coordinator's (HWC) responsibility to ensure pre-screenings were completed on all admissions to the SCU.
-She thought it got overlooked.

Interview with the Administrator on 06/25/26 at 1:28pm revealed:
-He did not know Resident #2 did not have a pre-screening in her resident record.
-He thought all SCU paperwork was up to date for Resident #2.

Based on observation, record review and interviews with staff, it was determined that Resident #2 was not interviewable.

Refer to the interview with the HWD on 06/25/26 at 12:42pm.

Refer to the Administrator on 06/25/26 at 1:28pm.

2. Review of Resident #8's current FL2 dated 03/03/26 revealed:
-Diagnoses included chronic kidney disease-stage 2, sleep apnea, spinal stenosis, overactive bladder, acute cystitis, and nonrheumatic mitral

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valve stenosis.
-There was no information on orientation.
-She was semi-ambulatory and was incontinent of bowel and bladder.

Review of Resident #8's Resident Register revealed an admission date of 02/28/26.

Review of Resident #8's Care Plan dated 04/04/26 revealed:
-She was independent with eating.
-She required limited assistance with ambulation.
-She required extensive assistance with toileting, bathing, dressing, grooming, and transferring.

a. Review of Resident #8's resident record revealed there was no SCU pre-screening.

Interview with the health and wellness director (HWD) on 06/25/26 at 12:42pm revealed:
-She did not know the pre-screening had not been completed on Resident #8.
-It was her responsibility and the health and wellness coordinator's (HWC) responsibility to ensure pre-screenings were completed on all admissions to the SCU.
-She thought it got overlooked.

Interview with the Administrator on 06/25/26 at 1:28pm revealed:
-He did not know Resident #8 did not have a pre-screening in her resident record.
-Resident #8 started in the assisted living (AL), then was transferred to SCU after returning from a hospital visit on 03/31/26.
-He thought all of Resident #8's SCU paperwork had been completed.

Refer to the interview with the HWD on 06/25/26 at 12:42pm.

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| D 463 | Continued From page 14<br><br>Refer to the Administrator on 06/25/26 at 1:28pm.<br><br>b. Review of Resident #8's resident record revealed no diagnoses documented on FL2 or hospital discharge summary to meet criteria to the SCU.<br><br>Review of Resident #8's hospital FL2 dated 03/25/26 revealed diagnoses included extended-spectrum beta-lactamase (ESBL) cystitis (urinary tract infection caused by bacteria that resist many common antibiotics), falls, dysphagia, and type 2 diabetes.<br><br>Interview with the health and wellness director (HWD) on 06/25/26 at 12:42pm revealed:<br>-She did not know the FL2 with a diagnosis that was appropriate for the SCU was not in Resident #8's resident record.<br>-She thought a corrected FL2 with an admitting diagnosis had been updated and placed in Resident #8's resident record, but she could not locate the corrected FL2.<br><br>Interview with the Administrator on 06/25/26 at 11:30am revealed:<br>-He did not know Resident #8 did not have an FL2 with an appropriate diagnosis in her resident record.<br>-Resident #8 started in the assisted living (AL), then was transferred to SCU after returning from a hospital visit on 03/31/26.<br>-Resident #8 went out to the hospital again on 04/10/26 and never returned to the facility after that.<br>-He thought all SCU paperwork had been completed for Resident #8.<br><br>Refer to the interview with the HWD on 06/25/26 | D 463 | | |

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| D 463 | Continued From page 15<br>at 12:42pm.<br><br>Refer to the interview with the Administrator on 06/25/26 at 1:28pm.<br><br>3. Review of Resident 3's current re-admission FL2 dated 03/12/26 revealed:<br>-Diagnoses included traumatic retroperitoneal hematoma, atrial fibrillation and recurrent falls.<br>-Resident #3 was intermittently disoriented.<br>-The recommended level of care was memory care unit.<br><br>Review of Resident #3's Resident Register revealed the date of admission field was blank.<br><br>Review of Resident #3's record revealed:<br>-He was initially admitted to the facility on 04/18/24.<br>-There was no Special Care Unit (SCU) signed disclosure statement available for review.<br><br>Interview with the Health and Wellness Director (HWD) on 06/25/26 at 12:43pm revealed the Sales Manager or the Administrator was responsible for ensuring the SCU disclosure was completed and signed by the responsible party for residents residing in the SCU.<br><br>Telephone interview with Resident #3's family member on 06/25/26 at 11:08am revealed:<br>-He was Resident #3's Power of Attorney (POA).<br>-He signed a SCU disclosure statement yesterday (06/24/26) for Resident #3.<br>-He did not know if he had signed a SCU disclosure statement when Resident #3 was transferred to the SCU from the assisted living.<br><br>Interview with the Administrator on 06/25/26 at 1:30pm revealed: | D 463 | | |

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| D 463 | Continued From page 16<br>-He was responsible for ensuring SCU disclosure statements were signed by the resident's responsible party prior to admission to the SCU.<br>-Resident #3 was an internal transfer from the assisted living unit to the SCU and he overlooked completing the SCU disclosure.<br><br>Refer to the interview with the HWD on 06/25/26 at 12:42pm.<br><br>Refer to the Administrator on 06/25/26 at 1:28pm.<br>_____<br>Interview with the HWD on 06/25/26 at 12:42pm revealed:<br>-It was her responsibility and the health and wellness coordinator's (HWC) responsibility to make sure paperwork was up to date.<br>-She and the HWC did audits quarterly to 6 months on resident records to make sure paperwork was completed.<br><br>Interview with the Administrator on 06/25/26 at 1:28pm revealed:<br>-It was the responsibility of the HWD and the HWC to ensure all paperwork was completed.<br>-It was his responsibility to check behind the HWD and HWC to ensure everything was completed and in the resident records.<br>-He expected audits to be done monthly, but he was not sure if audits were being done. | D 463 | | |