STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: _____ B. WING _____	R 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigation on July 7, 2026 through July 8, 2026. The complaint investigation was initated by Mecklenburg Department of Social Services on June 25, 2026.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an	D 254		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Resident Care Director — (X6) DATE: 8/17/2026

Reviewed and acknowledged by, Melissa J. Jones 8/13/26.

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D 254	Continued From page 1 identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others; (E) no response by the resident to the intervention for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without	D 254		

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D 254	Continued From page 2 intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated following a significant change in condition for 2 of 2 sampled residents (#2 and #6) who were admitted to Hospice services. The Findings are: 1. Review of Resident #2 's current FI-2 dated 05/25/26 revealed: -Diagnoses included depression unspecified, unspecified dementia without behavioral disturbance. -She was semi-ambulatory with a wheelchair. -The recommended level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register	D 254		

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D 254	Continued From page 3 revealed an admission date of 12/09/24. Review of Resident #2's progress note dated 05/22/26 revealed she was admitted under Hospice services due to a fall with injury, on 05/22/26. Review of Resident #2's care plan dated 06/18/26 revealed: -The care plan was initiated due to change in condition. -She required one person assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfers. -The personal care aides (PCAs) assisted her with bowel and bladder incontinent care. -Resident #2 was noted as a Fall risk due to her physical condition. -She used a wheelchair for mobility and transfers. -To reduce fall risk, a hospital bed was ordered and lowered to the floor with a fall mat and wedges were placed in the bed. -Staff were required to check on Resident #2 at frequent intervals in the middle of the night and early morning hours. -There was no mention that Resident #2 was admitted to Hospice services. Telephone interview with Resident #2's Responsible Party (RP) on 07/08/26 at 12:36pm revealed: -Resident #2 had several falls in May when she sustained a fractured pubic ramus (a crack or break in the pubic bone, which is part of the pelvis) that was diagnosed as inoperable. -She was discharged back to the facility and referred to Hospice services. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 1:03pm revealed she did	D 254		

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D 254	Continued From page 4 not send Resident #2's care plan to her PCP to review and sign due to she only thought the family needed to sign it. Refer to the interview with the SCC on 07/08/26 at 1:02pm. Refer to the interview with the Administrator on 07/08/26 at 11:43am. 2. Review of Resident #6's current FL2 dated 03/30/26 revealed: -Diagnoses included heart disease, glaucoma, falls, pressure ulcer stage 2, severe cognitive impairment, stage 3 kidney disease, hypertension, and vascular dementia. -She was non-ambulatory. -The recommended level of care was Special Care Unit (SCU). Review of Resident #6's Resident Register revealed a financial admission date of 04/01/26. Review of Resident #6's record revealed a physical admission date of 04/15/26. Review of Resident #6's care plan dated 06/03/26 revealed: -It was an initial care plan initiated on 04/27/26. -She required one person assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfers. -There was no updated care plan when she began hospice with a significant change on 05/08/26. Review of Resident #6's Primary Care Physician (PCP) order dated 05/08/26 revealed an order for Hospice due to severe protein calorie malnutrition.	D 254		

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D 254	Continued From page 5 Telephone interview with Resident #6's Power of Attorney (POA) on 07/08/26 at 11:04am revealed: -Resident #6's health and cognition were declining. -Resident #6 had anxiety and she was unable to sleep at night and often would get out of bed and would fall. Telephone interview with the hospice Registered Nurse (RN) on 07/08/26 at 11:21am revealed: -Hospice services began for Resident #6 in May 2026 due to severe protein calorie malnutrition. -Resident #6 also started having multiple falls during the night and would have increased anxiety. -Resident #6 would have "screaming fits" and would attempt getting out of bed which usually resulted in a fall. -Resident #6 had increased agitation within the last week and they were trying to control it with medications. -Resident #6 also had increased pain, which could have contributed to the behaviors she was exhibiting. Interview with the Administrator on 07/08/26 at 11:43am revealed she did not know Resident #6's care plan was not updated with a significant change. Refer to the interview with the Special Care Coordinator (SCC) on 07/08/26 at 1:02pm. Refer to the interview with the Administrator on 07/08/26 at 11:43am. Interview with the SCC on 07/08/26 at 1:02pm revealed: -She completed care plans within a week of the	D 254		

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D 254	Continued From page 6 residents' move in dates. -She did not know hospice would be considered a significant change, and a new care plan would need to be established. -She did not know hospice needed to be on the care plan. -She updated care plans in the system online but did not print them or have physician sign them. Interview with the Administrator on 07/08/26 at 11:43am revealed: -Care plans were generated once assessments were completed. -The SCC was responsible for completing assessments for residents on the SCU. -When a significant change occurred, the SCC should have updated the care plan, printed the care plan, and had the physician sign the care plan. -She did not know care plans were not being completed for significant changes. -The SCC should have been auditing care plans quarterly. -They completed initial audits earlier in June 2026. -She was not sure why it was not caught during the audit.	D 254		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's	D 259		

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D 259	Continued From page 7 current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.	D 259		

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D 259	Continued From page 8 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 6 sampled residents had a care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (#2 and #6). The findings are: 1. Review of Resident #2 's current FI-2 dated 05/25/26 revealed: -Diagnoses included depression unspecified, unspecified dementia without behavioral disturbance. -She was semi-ambulatory with a wheelchair. -The recommended level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 12/09/24. Review of Resident #2's care plan dated 06/18/26 revealed: -Resident #2 required assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfers. -There was no signatures from the Primary Care Provider (PCP) on the care plan. Interview with Special Care Coordinator (SCC) on 07/08/26 at 1:03pm revealed: -She did not send Resident #2's care plan to Resident #2's Primary Care Provider (PCP) to review and sign. -She thought she only needed to get the RP to sign. Interview with the Special Care Coordinator	D 259		

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D 259	Continued From page 9 (SCC) on 07/08/26 at 1:03pm revealed she forgot to get a provider signature for Resident #2's care plan. Refer to the interview with the SCC on 07/08/26 at 11:43am. Refer to the interview with the Administrator on 07/08/26 at 1:02pm. 2. Review of Resident #6's current FL2 dated 03/30/26 revealed: -Diagnoses included heart disease, glaucoma, falls, pressure ulcer stage 2, severe cognitive impairment, stage 3 kidney disease, hypertension, and vascular dementia. -She was non-ambulatory. -The recommended level of care was special care unit (SCU). Review of Resident #6's Resident Register revealed a financial admission date of 04/01/26. Review of Resident #6's record revealed a physical admission date of 04/15/26. Review of Resident #6's care plan dated 06/03/26 revealed: -The care plan was an initial care plan that was initiated on 04/27/26. -Resident #6 required assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfers. -The care plan was signed by the physician on 06/03/26. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 9:52am and at 1:02pm revealed: -She was new to her role and was still in training	D 259		

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D 259	Continued From page 10 around April 2026. -She had to fax the care plan for Resident #6 multiple times to get the physician signature and that was why it was late. -There was no documentation available where the care plan was faxed to the PCP. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She remembered the SCC having to fax the care plan for Resident #6 multiple times to the physician and that was why he signed it late. -It was hard to get Hospice physician signatures sometimes. -She did not realize Resident #6's care plan was signed late. Refer to the interview with the SCC on 07/08/26 at 11:43am. Refer to the interview with the Administrator on 07/08/26 at 1:02pm. _____ Interview with the SCC on 07/08/26 at 1:02pm revealed: -She was responsible for completing care plans on the SCU. -She completed care plans within a week of Residents moving into the facility. -She thought care plans needed to signed by the physician within 3 days of completion. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She knew physicians had to sign care plans within 15 days of the assessment. -The SCC was responsible for making sure care plans were signed by the physicians on the SCU. -Care plan audits were completed during the first of June 2026.	D 259		

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D 259	Continued From page 11 -She was told by the SCC that all care plans were up to date. -She expected audits to be conducted quarterly on all care plans.	D 259		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to clarify medication orders for 1 of 7 sampled residents (Resident #5) related to an order for short-acting insulin that was not included on the hospital discharge medications list. The findings are: Review of Resident #5's current FL2 dated 06/06/26 revealed: -Diagnoses included type 1 diabetes. -Resident #5's current level of care was hospital, and his recommended level of care was assisted	D 344		

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D 344	Continued From page 12 living facility. Review of Resident #5's Nurse Practitioner's (NP) orders dated 02/19/26 revealed an order to check the residents finger stick blood sugar (FSBS) with meals and inject insulin lispro 100units/ml per sliding scale; FSBS 201-250 = 2 units, FSBS 251-300 = 3 units, FSBS 301-350 = 4 units, FSBS 351-400 = 5 units, FSBS greater than 400 = 6 units and call NP. Review of Resident #5's hospital discharge summary dated 06/06/26 revealed there was no order for insulin lispro 100units/ml inject per sliding scale. Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro 100unit/ml inject per sliding scale with meals; FSBS 201-250 = 2 units, FSBS 251-300 = 3 units, FSBS 301-350 = 4 units, FSBS 351-400 = 5 units, FSBS greater than 400 = 6 units and call NP. -There was documentation Resident #5's FSBS was checked before meals at 7:30am, 11:30am and 4:30pm and insulin lispro 100unit/ml per sliding scale administered from 06/06/26 at 4:30pm through 06/30/26. Review of Resident #5's July 2026 eMAR revealed: -There was an entry for insulin lispro 100unit/ml inject per sliding scale with meals; FSBS 201-250 = 2 units, FSBS 251-300 = 3 units, FSBS 301-350 = 4 units, FSBS 351-400 = 5 units, FSBS greater than 400 = 6 units and call NP. -There was documentation Resident #5's FSBS was checked before meals at 7:30am, 11:30am and 4:30pm and insulin lispro 100unit/ml per	D 344		

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D 344	Continued From page 13 sliding scale administered from 07/01/26 at 7:30am through 07/07/26 at 11:30am. Telephone interview with a representative with the facility's contracted pharmacy on 07/08/26 at 9:42am revealed: -Resident #5 had an order dated 02/09/26 upon his admission to the facility for insulin lispro 100unit/ml inject per sliding scale with meals; FSBS 201-250 = 2 units, FSBS 251-300 = 3 units, FSBS 301-350 = 4 units, FSBS 351-400 = 5 units, FSBS greater than 400 = 6 units and call NP. -The pharmacy received Resident #5's hospital discharge summary dated 06/06/26. -There was no order for insulin lispro per sliding scale on Resident #5's hospital discharge summary. -Pharmacy staff did not reconcile resident medications from hospital discharge summaries. -Pharmacy staff looked only for new, changed or discontinued medications when they received a hospital discharge summary. Interview with the Administrator on 07/08/26 at 11:43am revealed: -The Wellness Nurse was responsible for reviewing the hospital discharge summaries and clarifying with the resident's Primary Care Provider (PCP) any previous medication orders that were not on the discharge summary. -She was not aware Resident #5's order for insulin lispro 100unit/ml inject per sliding scale with meals was not on the discharge summary. -Resident #5's order for insulin lispro 100unit/ml inject per sliding scale with meals should have been clarified with his NP after his discharge from the hospital.	D 344		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 14	D 358		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (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 3 of 7 residents (#5, #6, and #7) for medications to lower blood sugar levels (#5 and #7), raise blood sugar levels (#5) and a medication for sleep and/or anxiety (#6). The findings are: 1. Review of Resident #5's current FL2 dated 06/06/26 revealed diagnoses included diabetes mellitus type 1. Interview with Resident #5 on 07/08/26 at 1:15pm revealed: -His FSBS fluctuated, sometimes the readings were high and sometimes they were low. -He did not know how much insulin he received. -He did not know when he was to be administered glucose. -The medication aides (MA) checked his FSBS and administered his medications according to the reading. a. Review of Resident #5's hospital discharge summary dated 06/06/26 revealed:	D 358		

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D 358	Continued From page 15 -There was an order for insulin lispro (a medication to lower blood sugar levels) inject 6 units three times daily with meals according to parameters. -Resident #5's insulin lispro 6 units with meals was to be held if the resident ate less than 25% of the meal. -Resident #5 was to receive insulin lispro 3 units with meals if the resident ate 25% to 50% of the meal. -Resident #5 was to receive insulin lispro 6 units with meals if he ate greater than 50% of the meal. Review of Resident #5's signed Nurse Practitioner's (NP) order dated 06/30/26 revealed: -There was an order to discontinue Resident #5's insulin lispro 6 units before meals. -There was an order to start insulin lispro inject 8 units before each meal and to hold if Resident #5's finger stick blood sugar (FSBS) was less than 120. Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro, inject 8 units with meals scheduled at 7:30am, 11:30am and 4:30pm and to hold for FSBS less than 120. -Insulin lispro 8 units was documented administered to Resident #5 on 07/05/26 at 7:30am when his FSBS was 96. Observation of medications available for administration for Resident #5 on 07/07/26 at 4:42pm revealed there was an insulin lispro kwikpen available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 07/08/26 at 9:42am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 16 -Resident #5 had an order dated 06/30/26 for insulin lispro 8 units before meals. -Resident #5's insulin lispro 8 units before meals was to be held if his FSBS was less than 120. -Two insulin lispro kwikpens containing 3ml each, were dispensed for Resident #5 on 06/06/26 and 06/08/26. -If insulin lispro 8 units was administered to Resident #5 when his FSBS was less than 120, his blood sugar levels could drop and he could experience sweating, shakiness, confusion, increased heart rate and seizures. Interview with a MA on 07/08/26 at 10:53am revealed: -The MAs were responsible to administer medications as ordered and according to any parameters stated in the orders. -She did not know if any audits were completed of resident eMARs for medications administered outside of parameters. Interview with Resident #5's NP on 07/08/26 at 12:10pm revealed: -The MAs were responsible for accurately administering medications according to orders. -The MAs should be reading the orders and ensuring medications were held when outside of parameters. -She was not aware Resident #5 was administered insulin lispro 8 units when his FSBS was less than 120. -Resident #5 could have experienced confusion and shakiness if insulin lispro 8 units was administered when his FSBS was less than 120. Interview with the Administrator on 07/08/26 at 11:43am revealed: -The MAs were responsible for administering resident medications according to the order,	D 358		

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D 358	Continued From page 17 including any parameters. -She or the wellness nurses were responsible for completing weekly audits of residents FSBS reading. -She was not aware Resident #5 was administered insulin lispro 8 units when his FSBS was less than 120. Refer to the interview with the Administrator on 07/08/26 at 11:43am. b. Review of Resident #5's NP's orders dated 01/28/26 revealed there was an order for glucose 4grams, chew 4 tablets as needed for FSBS less than 70. Review of Resident #5's hospital discharge summary dated 06/06/26 revealed there was an order for glucose 4grams, chew 4 tablets as needed for low blood sugar. Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for glucose 4grams, chew 4 tablets as needed for FSBS less than 70. -On 07/04/26 at 7:30am Resident #5's FSBS was 62 and there was no documentation glucose 4grams, 4 tablets was administered to the resident. Observation of medications available for administration for Resident #5 on 07/07/26 at 4:42pm revealed there was glucose 4grams available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 07/08/26 at 9:42am revealed: -Resident #5 had an order dated 02/09/26 for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 18 glucose 4grams, chew 4 tablets as needed for FSBS less than 70. -Glucose 4grams 10 tablets were dispensed for Resident #5 on 02/09/26 and 03/02/26. -If glucose 4grams, 4 tablets was not administered to Resident #5 when his FSBS was less than 70, he could experience sweating, shakiness, confusion, increased heart rate, seizures and was at risk of being hospitalized due to his blood sugar being low. Interview with a MA on 07/08/26 at 10:53am revealed: -The MAs were responsible to administer medications as ordered and according to any parameters stated in the orders. -Resident #5's glucose 4grams, 4 tablets for FSBS less than 70 was a PRN (as needed) medication and did not show on his list of routine medications to administer. -MAs would need to be aware of Resident #5's PRN glucose order since it did not show on the medications that were to be administered to Resident #5. -She did not know if any audits were completed of resident eMARs for accuracy. Interview with Resident #5's NP on 07/08/26 at 12:10pm revealed: -The MAs were responsible for accurately administering medications according to orders, including PRN medications. -She was not aware Resident #5 was not administered glucose 4grams, 4 tablets when his FSBS was less than 70. -Resident #5 could have experienced confusion and shakiness if he did not receive glucose 4grams, 4 tablets when his FSBS was less than 70.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 19 Interview with the Administrator on 07/08/26 at 11:43am revealed: -The MAs were responsible for administering resident medications according to the order, including PRN medications. -She was not aware Resident #5 was not administered glucose 4grams, 4 tablets when his FSBS was less than 70. Refer to the interview with the Administrator on 07/08/26 at 11:43am. 2. Review of Resident #7's current FL2 dated 05/19/16 revealed: -Diagnoses included diabetes mellitus type 2 and dementia. -There was an order for insulin lispro (a medication to lower blood sugar levels) kwikpen 100unit/ml, inject 8 units before lunch and supper if finger stick blood sugar (FSBS) was greater than 200. Review of Resident #7's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro kwikpen 100unit/ml, inject 8 units before lunch and supper if FSBS was greater than 200, scheduled at 11:30am and 4:30pm -There were two instances between 06/22/26 and 06/30/26 insulin lispro 100unit/ml 8 units was administered to Resident #7 when her FSBS was less than 200. -Resident #7's FSBS on 06/23/26 at 11:30am was 183 and insulin lispro 100unit/ml 8 units was documented administered. -Resident #7's FSBS on 06/28/26 at 4:30pm was 168 and insulin lispro 100unit/ml 8 units was documented administered.	D 358		

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D 358	Continued From page 20 Review of Resident #7's July 2026 eMAR revealed: -There was an entry for insulin lispro kwikpen 100unit/ml, inject 8 units before lunch and supper if FSBS was greater than 200, scheduled at 11:30am and 4:30pm -There was one instance between 07/01/26 and 07/07/26 insulin lispro 100unit/ml 8 units were administered to Resident #7 when her FSBS was less than 200. -Resident #7's FSBS on 07/07/26 at 11:30am was 176 and insulin lispro 100unit/ml 8 units was documented administered. Observation of medications available for administration for Resident #7 on 07/08/26 at 10:56am revealed there was a insulin lispro 100unit/ml kwikpen available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 07/08/26 at 9:42am revealed: -Resident #7 had an order dated 04/14/25 for insulin lispro kwikpen 100unit/ml 8 units before lunch and supper if her FSBS was greater than 200. -Three insulin lispro kwikpens containing 3ml each, were dispensed for Resident #7 on 03/01/26 and 05/24/26. -If insulin lispro 8 units was administered to Resident #7 when her FSBS was less than 200, her blood sugar levels could drop, and she could experience sweating, shakiness, confusion, increased heart rate and seizures. Interview with a MA on 07/08/26 at 10:53am revealed: -The MAs were responsible to administer medications as ordered and according to any parameters stated in the orders.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 21 -On 06/28/26 at 4:30pm Resident #7 FSBS was 168 and she administered insulin lispro 100unit/ml 8 units to the resident. -She overlooked that she should have held Resident #7 insulin lispro on 06/28/26 at 4:30pm. -She did not know if any audits were completed of resident eMARs for medications administered outside of parameters. Interview with Resident #7's NP on 07/08/26 at 12:10pm revealed: -The MAs were responsible for accurately administering medications according to orders. -The MAs should be reading the orders and ensuring medications were held when outside of parameters. -She was not aware Resident #7 was administered insulin lispro 8 units when her FSBS was less than 200. -Resident #7 could have experienced confusion and shakiness if insulin lispro 8 units was administered when her FSBS was less than 200. Interview with the Administrator on 07/08/26 at 11:43am revealed: -The MAs were responsible for administering resident medications according to the order, including any parameters. -She or the wellness nurses were responsible for completing weekly audits of residents FSBS reading. -She was not aware Resident #7 was administered insulin lispro 8 units when her FSBS was less than 200. Refer to the interview with the Administrator on 07/08/26 at 11:43am. 3. Review of Resident #6's current FL2 dated 03/30/26 revealed diagnoses included heart	D 358		

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D 358	Continued From page 22 disease, glaucoma, falls, pressure ulcer stage 2, severe cognitive impairment, stage 3 kidney disease, hypertension, and vascular dementia. Review of Resident #6's signed physician order dated 06/19/26 revealed there was an order for trazadone (used as a sleep aid for insomnia and can be used to decrease anxiety and agitation) 50mg one tablet at bedtime. Review of Resident #6's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for trazadone 50mg one tablet at 8:00pm. -Trazadone 50mg, one capsule was documented administered daily from 06/20/26 through 06/30/26 between 7:00 to 8:00pm. -Trazodone 50mg was documented as administered a total of 11 doses. Review of Resident #6's July 2026 eMAR revealed: -There was an entry for trazadone 50mg one tablet at 8:00pm. -Trazadone 50mg, one capsule was documented administered daily from 07/01/26 through 07/06/26 between 7:00 to 8:00pm. -Trazodone 50mg was documented as administered a total of 6 doses. Observation of medications on hand on 07/07/26 at 4:24pm revealed trazadone 50mg was not available for administration. Telephone interview with the facility's contracted pharmacy on 07/07/26 at 4:42pm revealed: -Resident #6 had an active order for trazadone 50mg one tablet at bedtime. -Trazodone was filled on 06/19/26 with a quantity	D 358		

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D 358	Continued From page 23 of 15 dispensed. -There were no refill requests from the facility and no other dispense dates. A second telephone interview with the facility's contracted pharmacy on 07/08/26 at 9:03am revealed: -The facility requested a refill yesterday (07/07/26) at 5:45pm. -The facility got the medication yesterday from the back up pharmacy so Resident #6 would get the medication before her nighttime dose yesterday. -Resident #6 could have increased insomnia due to not receiving trazadone as ordered. -Resident #6 was prescribed trazadone to keep her calm and help her sleep. Telephone interview with the hospice Registered Nurse (RN) on 07/08/26 at 11:21am revealed: -She did not know Resident #6 did not have trazodone 50mg available for administration. -The medication aides (MAs) did not notify her that the resident needed a refill or she would have ordered it herself. -Resident #6 was prescribed trazadone due to her not being able to sleep at night. -Resident #6 would "scream and yell" and she would get out of bed and have falls. -Trazadone helped her sleep. -She had increased agitation a week ago and had issues with being in pain. -They were trying to control her sleep and pain management through medications. -If Resident #6 did not receive her trazodone as prescribed it could result in her not be able to sleep at night. Telephone interview with Resident #6's Power of Attorney (POA) on 07/08/26 at 11:04am revealed:	D 358		

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D 358	Continued From page 24 -Resident #6's health and cognition were declining. -Resident #6 had anxiety and she was unable to sleep at night and often would get out of bed and would fall. -She thought Resident #6 was prescribed trazodone to keep her calm at night and help her sleep so she would not get upset, attempt to get out of bed, and fall. -She did not know Resident #6 had missed doses of trazodone. Telephone interview with a MA on 07/08/26 at 9:22am revealed: -She did not know Resident #6's trazadone was not available for administration. -She last gave trazadone on 07/05/26 and noticed Resident #6 only had one tablet left. -She did not reorder trazadone because she thought someone else already reordered it. -She did not check to see if it was reordered because she did not know how to check on the computer. -She thought only the Resident Care Director (RCD) could check to see if it needed to be reordered. -The MA's were supposed to reorder when 10 tablets were left. -The sticker had been pulled off the medication card, so she assumed someone else reordered it because once you reorder, you pull the sticker off the card. Telephone interview with another MA on 07/08/26 at 9:40am revealed: -She remembered giving Resident #6 trazadone on 07/06/26. -She did not realize she had given Resident #6's last dose on 07/06/26. -She had never reordered medications before.	D 358		

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D 358	Continued From page 25 -She had been an MA at the facility for about a month, and she was still learning how to order medications. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 1:02pm revealed: -She did not know Resident #6 did not have trazadone available for administration. -She did not monitor medication cart audits or medication orders. -The Administrator and MAs were responsible for ensuing medications were available and administered. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She did not know the trazodone was not available for administration for Resident #6. -She did not know the last date Resident #6's audit occurred. Refer to the interview with the Administrator on 07/08/26 at 11:43am. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She was the Resident Care Director (RCD) and filling in as the Administrator since the previous Administrator left. -She expected MAs to reorder medications when the residents were down to 7 tablets. -Medication orders were conducted online and MAs were expected to reach out to pharmacy to make sure they received the orders. -MAs were expected to do weekly medication cart audits. -She was responsible for doing monthly medication cart audits and checking behind everyone.	D 358		

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D 367	Continued From page 26	D 367		
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 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 Record (eMAR) was accurate for 2 of 7 sampled residents related to a medication used to treat infections (#5) and a medication used to treat sleep (#6). The findings are:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: _____ B. WING _____	R 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 367	Continued From page 27 1. Review of Resident #5's current FL2 dated 06/06/26 revealed diagnoses included dementia and benign prostatic hyperplasia (enlarged prostate gland) with urinary retention. Review of Resident #5's hospital discharge medication list dated 06/25/26 revealed there was an order for cephalexin (a medication to treat infections) 500mg, one capsule twice daily for seven days. Review of Resident #5's staff progress notes revealed: -Resident #5 was sent to the emergency department (ED) on 06/25/26 when his fingerstick blood sugar (FSBS) before lunch was 594. -Resident #5 returned to the facility on 06/25/26 at 11:55pm. -Resident #5 received additional insulin in the ED and was diagnosed with a urinary tract infection and prescribed an antibiotic. Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for cephalexin 500mg, one capsule twice daily for 7 days with a start date of 06/26/26. -Cephalexin 500mg, one capsule was documented administered between 7:00pm and 9:00pm on 06/26/26 and twice daily from 06/27/26 through 06/30/26. Review of Resident #5's July 2026 eMAR revealed: -There was an entry for cephalexin 500mg, one capsule twice daily for 7 days with a start date of 06/26/26. -Cephalexin 500mg, one capsule was documented administered twice daily from	D 367		

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D 367	Continued From page 28 07/01/26 through 07/04/26. Telephone interview with a representative with the facility's contracted pharmacy on 07/08/26 at 9:42am revealed: -Resident #5 had an order dated 06/25/26 for cephalexin 500mg, one capsule twice daily for seven days. -Cephalexin 500mg, 14 capsules were dispensed for Resident #5 on 06/26/26. -Facility staff signed for Resident #5's cephalexin 500mg, 14 capsules on 06/26/26 at 11:54pm. Interview with a MA on 07/08/26 at 10:53am revealed: -The MAs were responsible for documenting medications administered to the residents on their eMARs. -If a medication was not administered for any reason, the MA should not document it was administered. Interview with the Administrator on 07/08/26 at 11:43am revealed she was not aware cephalexin 500mg, 17 capsules was documented administered to Resident #5 when 14 capsules were dispensed from the pharmacy. Refer to the interview with the Administrator on 07/08/26 at 11:43am. 2. Review of Resident #6's current FL2 dated 03/30/26 revealed diagnoses included heart disease, glaucoma, falls, pressure ulcer stage 2, severe cognitive impairment, stage 3 kidney disease, hypertension, and vascular dementia. Review of Resident #6's signed physician order dated 06/19/26 revealed there was an order for trazadone (used as a sleep aid for insomnia and	D 367		

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D 367	Continued From page 29 can be used to decrease anxiety and agitation) 50mg one tablet at bedtime. Review of Resident #6's June 2026 electronic medication administration (eMAR) revealed: -There was an entry for trazadone 50mg one tablet at 8:00pm. -Trazadone 50mg, one capsule was documented administered daily from 06/20/26 through 06/30/26 between 7:00pm to 9:00pm. -Trazodone was documented as administered for a total of 11 doses. Review of Resident #6's July 2026 eMAR revealed: -There was an entry for trazadone 50mg one tablet at 8:00pm. -Trazadone 50mg, one capsule was documented administered daily from 07/01/26 through 07/06/26 between 7:00pm to 9:00pm. -Trazodone was documented as administered for a total of six doses. Observation of medications on hand on 07/07/26 at 4:24pm revealed trazadone 50mg was not available for administration. Telephone interview with the facility's contracted pharmacy on 07/07/26 at 4:42pm revealed: -Resident #6 had an active order for trazadone 50mg one tablet at bedtime. -Trazodone was filled on 06/19/26 with a quantity of 15 dispensed. -There were no refill requests from the facility and no other dispense dates. Telephone interview with Resident #6's Power of Attorney (POA) on 07/08/26 at 11:04am revealed: -Resident #6's health and cognition were declining.	D 367		

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D 367	Continued From page 30 -Resident #6 had anxiety and she was unable to sleep at night and often would get out of bed and would fall. -She thought Resident #6 was prescribed trazodone to keep her calm at night and help her sleep so she would not get upset, attempt to get out of bed, and fall. -She did not know Resident #6 had missed doses of trazodone. Telephone interview with a medication aide (MA) on 07/08/26 at 9:22am revealed: -She did not know Resident #6's trazadone was not available for administration. -She last gave trazadone on 07/05/26 and noticed Resident #6 only had one tablet left. -She only signed off on medications given if they were administered. -She did not sign off on medication given if they were not administered. -She did not realize the eMAR had trazodone administered 17 times, when the pharmacy only gave 15 doses. -She did not know why the eMAR was inaccurate. Telephone interview with another MA on 07/08/26 at 9:40am revealed: -She remembered giving Resident #6 trazadone on 07/06/26. -She did not realize she had given Resident #6's last dose on 07/06/26. -She only signed off on medications given if they were administered. -She did not sign off on medication given if they were not administered. -She did not know why the eMAR was inaccurate. Interview with the Special Care Coordinator (SCC) on 07/08/26 at 1:02pm revealed: -She did not know Resident #6's eMAR was	D 367		

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D 367	Continued From page 31 inaccurate. -She did not monitor medication cart audits or medication orders. -The Administrator and MAs were responsible for ensuring medications were available and administered. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She did not know Resident #6 did not have trazodone available for administration. -She did not know Resident #6's trazodone was documented as administered a total of 17 times when the pharmacy only dispensed a total of 15 tablets. -She did not know Resident #6's eMAR was inaccurate. Refer to the interview with the Administrator on 07/08/26 at 11:43am. Interview with the Administrator on 07/08/26 at 11:43am revealed: -She was responsible for checking medications on the medication cart monthly. -She expected MAs to only document on the eMAR that a medication was administered only when it was administered. -She expected MAs to document the medication was not administered if it was not administered. -MAs were responsible for auditing medication carts weekly. -She was responsible for auditing medication carts monthly.	D 367		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Garden Of Charlotte
Address of Community: 6000 Park South Drive, Charlotte, NC 28210
License number: HAL-060-019
Inspection date(s): July 7- 2026 – July 8-2026
Name/Title of Legal Entity Representative Signing the Plan of Correction:

Signature of Sunrise Representative: **Jennifer Gorczyca**
Date of Submission: **8/4/2026**

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 254 10A NCAC 13F .0801 Resident Assessment This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated following a significant change in condition for 2 of 2 sampled residents (#2 and #6) who were admitted to Hospice services.	*7/17/2026* *7/9/2026* *7/23/2026* *7/9/2026* *7/30/26*	***A. With respect to the specific resident/situation cited:*** Resident #2's assessment and care plan were completed and signed by physician on 7/17/26. Resident #6's assessment and care plan were completed and signed by physician on 7/8/26. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** Sr. Executive Director conducted audit on residents' assessments and care plans to confirm compliance with rule. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** New move-ins (30 days) and changes of condition (3 days) will be discussed at the stand-up meeting until assessment and care plan are signed by the physician. ***D. With respect to how the plan of correction will be monitored:*** The ED, RCD, BOC or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D259 10A NCAC 13F .0802 (a) (c) Resident Care Plan This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 6 sampled residents had a care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (#2 and #6). .	7/17/2026 7/9/2026 7/23/2026 7/24/2026 and ongoing 7/24/2026 and ongoing	***A. With respect to the specific resident/situation cited:*** Resident #2's care plan was completed and signed by physician on 7/17/26. Resident #6's care plan was completed and signed by physician on 7/8/26. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** Sr. Executive Director conducted audit on residents' care plans to confirm compliance with rule. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** New move-ins (30 days) and changes of condition (3 days) will be discussed at the stand-up meeting until care plan is signed by the physician. *D.* ***With respect to how the plan of correction will be monitored:*** The ED, RCD, BOC, SR RCD or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D 344 10 A NCAC 13F .1002 (a) Medication Orders the resident's record. This Rule is not met as evidenced by:	7/15/2026 7/15/2026	**A. With respect to the specific resident/situation cited:** Resident # 5 orders were clarified by the physician and the order to continue sliding scale per the current order obtained on 7/15/2026. **B. With respect to how the facility will identify residents/situations for the identified concerns**: Resident Care Director and/or designee audited residents who were sent to the hospital in the last 30 days to confirm that the previous MAR matches the discharge summary. Any discrepancy will be clarified with the primary care physician.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 344 Based on record review and interviews, the facility failed to clarify medication orders for 1 of 7 sampled residents (Resident #5) related to an order for short-acting insulin that was not included on the hospital discharge medications list.	7/15/2026 And ongoing 7/24/2026	**C. With respect to what systemic measures have been put into place to address the stated concern:** Discharge summary orders will be reviewed and reconciled by wellness nurses or designee upon residents' return to the community. Any clarifications needed will be obtained from the physician and sent to pharmacy to be added to the MAR. **D. With respect to how the plan of correction will be monitored:** The ED, RCD, or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D 358 10A NCAC 13F .1004 (a) Medication Administration This Rule is not met as evidenced by: D 358 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 residents (#5, #6, and #7) for medications to	7/9/2026 7/9/2026 7/24/2026	**A. With respect to the specific resident/situation cited:** Resident # 5 received medication administration as ordered Resident # 6 received medications administration as ordered Resident #7 received medications administration as ordered **B. B. With respect to how the facility will identify residents/situations for the identified concerns** Resident care director conducted an audit of residents' eMAR to confirm medications are administered as ordered and parameters are followed. **C. With respect to what systemic measures have been put into place to address the stated concern:** Weekly audits will be completed by the wellness nurses or designee to confirm medication administration accuracy as ordered and parameters are followed.

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lower blood sugar levels (#5 and #7), raise blood sugar levels (#5) and a medication for sleep and/or anxiety (#6).	7/24/2026	**D. With respect to how the plan of correction will be monitored:** The ED, RCD, BOC, SR RCD or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and a
D 367 10A NCAC 13F .1004 (j) Medication Administration This Rule is not met as evidenced by: D 367 Based on observations, interviews, and record reviews, the facility failed to ensure the electronic Medication Administration Record (eMAR) was accurate for 2 of 7 sampled residents related to a medication used to treat infections (#5) and a medication used to treat sleep (#6).	7/9/2026 7/9/2026 7/24/2026 7/24/2026	**A. With respect to the specific resident/situation cited:** Resident # 5's electronic Medication Administration Record was correct. Resident #6's electronic Medication Administration Record was correct. **B. With respect to how the facility will identify residents/situations for the identified concerns** Resident Care Director conducted an audit of residents' electronic Medication Administration Record for accuracy. **C. With respect to what systemic measures have been put into place to address the stated concern:** Weekly audit of the residents' electronic Medication Record will be conducted by the wellness nurse or designee to confirm accuracy. **D. With respect to how the plan of correction will be monitored:** The ED, RCD, BOC, SR RCD or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.

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