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
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 21, 2026 through July 23, 2026.	D 000	ID Prefix Tag: D125 Rule 10A NCAC 13F .0403 (a): Qualifications of Medication Staff	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 medication aides (MA) sampled (Staff B) who administered medications to residents completed the state MA examination test prior to administering medications. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 02/14/25. -There was a medication aide (MA) job description for Staff B dated 04/16/26. -There was documentation Staff B completed a 5-hour and 10-hour medication aide training on 11/27/25. -There was documentation of Staff B's medication clinical skills competency validation	D 125	Team Member who had incorrect Med Tech Certification was removed from cart until NC Adult Care Home testing is complete. Test was passed on August 8, 2026 and verified on NCDSR Adult Care Licensure Section Inservice conducted for Business Office Manager on July 22, 2026, regarding the correct credentialing website for Adult Care Home Medication Technicians (Med Techs). On July 23, 2026 a comprehensive review of all Med Tech personnel files was conducted. This audit verified that all active Med Techs have successfully passed the required exam and completed their clinical skills validation check-offs. Upon hire the Business Office Manager or Designee will verify Med Tech Credentials are on the approved NC Adult Care Home Website: NC Adult Care Medication Aide Testing Search	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Kiesinger — TITLE: Executive Director — (X6) DATE: 9-2-2026

Received via email on September 2, 2026.
Reviewed and acknowledged with addendum on September 8, 2026. Heather L. Leonard, Consultant

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D 125	Continued From page 1 checklist on 12/29/25. -There was no documentation Staff B passed the state MA test. -There was no documentation for an employment verification form for Staff B. Observation of Staff B on 07/22/26 from 8:03am to 8:15am revealed: -At 8:03am, Staff B unlocked a medication cart and prepared medications for administration to a resident. -At 8:13am, Staff B administered 3 medication and 11 crushed medication tablets mixed in applesauce to the resident. -At 8:15am, Staff B donned gloves and administered a prescription eye drop and nasal spray to the resident. Interview with Staff B on 07/21/26 at 3:26pm revealed: -She was a medication aide (MA) at the facility. -She had been a MA since 01/2026 (no specific date provided). -She began her employment at the facility as a PCA. Second interview with Staff B on 07/23/26 at 3:06pm revealed: -She had been administering medications at the facility since 01/2026. -She had not passed the state MA test required for medication administration in an adult care home. -She had taken a medication aide test required to work in a skilled nursing facility. -She did not know until 07/23/26 that there was a different MA test she needed to pass before being allowed to administer medications in an adult care home.	D 125	ID Prefix Tag: D125 Continued: To ensure ongoing compliance, the Resident Care Director and Executive Director will conduct weekly meetings with the Business Office Manager every Tuesday for the next three months. These meetings will serve to audit and verify the credentials of all newly hired Medication Technicians, with all tracking data maintained on a dedicated Excel spreadsheet Audit will be maintained in community and available upon request Addendum as per telephone conversation with Barbara Liepiga, Administrator on 09/08/2026 at 2:30 p.m.: - The date of correction will be August 8, 2026. - M. Fortis, RN Licensure Consultant.	

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D 125	Continued From page 2 Review of a resident's electronic medication administration records (eMARs) for 05/2026 revealed: -Staff B documented administration of medication on 05/04/26, 05/07/26, 05/08/26, 05/10/26, 05/21/26, and 05/24/26-05/26/26. -Staff B documented administration of a medication on 05/04/26 at 8:00pm which was supposed to be held according to the primary care provider (PCP) ordered blood pressure parameters. Review of a resident's eMARs for 06/2026 revealed: -Staff B documented administration of medication on 06/02/26, 06/06/26-06/08/26, 06/13/26, 06/17/26, 06/18/26, 06/24/26, 06/28/26, and 06/29/26. -On 06/08/26 at 8:00pm, there was no documentation for administration of a medication used to treat high blood pressure when Staff B documented a blood pressure reading for which the PCP had prescribed the administration of the blood pressure medication. Review of a resident's eMARs for 07/2026 revealed: -Staff B documented administration of medication on 07/02/26, 07/03/26, 07/09/26, 07/11/26-07/15/26, and 07/17/26-07/19/26. -On 07/13/26, 07/14/26 and 07/17/26 at 8:00pm, there was no documentation for administration of a medication used to treat high blood pressure when Staff B documented a blood pressure reading for which the PCP had prescribed the administration of the blood pressure medication. Interview with the Business Office Manager (BOM) on 07/23/26 at 2:38pm revealed: -Staff B scheduled herself for the medication aide	D 125		

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D 125	Continued From page 3 training course she took. -She was responsible for receiving staff training documents from managers and placing those training documents in the staff personnel record. Interview with the Assisted Living Director (ALD) on 07/23/26 at 2:50pm revealed: -Prior to her hire, Staff B was already employed at the facility. -Staff B scheduled herself for the medication aide testing that she passed and bought the certificate to the facility. -She did not know until 07/23/26 that the NC medication aide registry did not apply to medication aides working in adult care homes. -She had not seen any documentation for Staff B passing the NC medication aide testing for adult care homes. Interview with the Administrator on 07/23/26 at 2:40pm revealed: -Staff B have not passed the medication aide test specific to adult care homes. -The facility did not see that the information printed on the registry referring to medication aide listing indicated those qualifications were not applicable to adult care home medication aide qualifications. Second interview with the Administrator on 07/23/26 at 3:23pm revealed: -She expected the ALD or Resident Care Director (RCD) to know that MAs were qualified upon interviewing. -She would expect the ALD or RCD to have verified MA qualifications were accurate before scheduling the staff to administer medications. -She did not have an employee record audit process in place at present.	D 125		

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D 344	Continued From page 4	D 344		
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 observations, interviews, and record reviews, the facility failed to clarify treatment orders for 1 of 5 sampled residents (#3) for compression stockings used to prevent blood clots. The findings are: Review of Resident #3's current FL-2 dated 03/06/26 revealed diagnoses included dementia, anxiety dysphagia, generalized muscle weakness and difficulty walking. Review of Resident #3's physician's order dated 06/01/26 revealed there was an order to apply TED (Thrombo-Embolic Deterrent) hose every morning and remove every night. (TED hose are compression stockings used to prevent blood	D 344	ID Prefix Tag: D344 Rule 10 NCAC 13F .1002: Medication Orders Resident #3 Physician Orders were verified on 7/22/2026 Medication Technicians were in serviced on 7/22/2026 and 7/23/2026 regarding Medication Administration Record, Medication Errors, Medication Administration Practice Habits. All Med Techs will be inserviced regarding new ordering system by September 10, 2026. Implementation will be on September 11, 2026. Upon receipt of an order the community will verify receipt of order and then 1. Verify Pharmacy received new order 2. Verify Order in QMAR system from original order 3. Follow up with PCP regarding clarification or discrepancies in the order	

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D 344	Continued From page 5 clots.) Review of Resident #3's physician's order dated 07/16/26 revealed there was an order to apply Tubigrip socks to bilateral legs daily every morning and remove daily at bedtime. (Tubigrips are an elastic tubular support bandage that provides pressure to the legs.) Review of Resident #3's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Anti-embolism Knee-high stockings, apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 8:00pm. -Anti-embolism Knee-high stockings were documented as applied daily at 6:00am from 07/02/26 through 07/22/26. -Anti-embolism Knee-high were documented as removed daily at 8:00pm from 07/01/26 through 07/14/26 and from 07/16/26 through 07/21/26. -There was an entry for Tubigrips, apply to bilateral legs every morning and removed at bedtime scheduled for 8:00am. Observation of Resident #3 on 07/22/26 at 12:02pm and 4:21pm revealed she was wearing Tubigrips on both legs. Observation of Resident #3 on 07/23/26 at 11:02am revealed she was wearing Tubigrips on both legs. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/23/26 at 8:34am revealed: -Resident #3 had active orders for both TED hose and Tubigrips. -The pharmacy sent a note to the facility on	D 344	ID Prefix Tag: D344 continued The Assisted Living Director or Designee will verify the accuracy of approved new medication orders three times weekly Resident Care Director or Designee will audit order tracking system weekly to ensure accuracy of orders Audit will be maintained in community and available upon request Addendum as per telephone conversation with Barbara Lieginger, Administrator on 09/08/2026 at 2:39pm: - The date of correction will be September 11, 2026. - H. Forte, RN Licensure Consultant	

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D 344	Continued From page 6	D 344		

07/16/26 requesting clarification on whether the TED hose order should remain active but received no follow up from the facility.
-There was no discontinue order received for Resident #3's TED hose.
-The pharmacy added orders to the eMAR based on orders received from providers.
-Orders could not be removed from the eMAR without a discontinue order

Interview with a medication aide (MA) on 07/22/26 at 3:45pm revealed:
-Resident #3 had an order for both TED hoses and Tubigrips.
-According to the orders, Resident #3 would be wearing the TED hose and Tubigrips at the same time.
-He applied both the TED hose and Tubigrips but had only applied the Tubigrips once, on Friday (07/17/26).
-On Friday, 07/17/26, Resident #3 was wearing both the TED hose and Tubigrips.
-MAs were responsible for clarifying orders by speaking with the Assisted Living Director (ALD) and calling the pharmacy and the primary care provider (PCP).

Interview with a second medication aide on 07/23/26 at 11:26am revealed:
-Resident #3 had an order for both TED hose and Tubigrips.
-He had been a MA for a while so he knew the TED hose and Tubigrips could not be put on at the same time as both provide a tight grip and would have been uncomfortable.
-MAs administered medication and treatments based on the eMAR.
-If an order on the eMAR did not look right, the MA was to call the PCP for clarification.
-MAs and upper management could call the PCP

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D 344	Continued From page 7	D 344		

for clarification.
-PCAs could apply Tubigrips if they were kept in the resident's room.
-MAs applied the Tubigrips if they were kept on the medication cart.
-Resident #3's Tubigrips were kept on the medication cart.

Interview with the RCD on 07/23/26 at 11:06am revealed:
-She, the MAs and the ALD approved orders.
-The staff member that approved the order in question was responsible for clarifying the order.
-She was aware Resident #3 had an order for TED hose but was unsure about the order for the Tubigrips.
-She did not review eMARs.
-There was no one in the facility responsible for eMAR audits.
-Once the pharmacy uploaded the orders, the orders appeared for staff to verify the order by comparing the electronic order to the physical order before approval.
-If there was an order that did not match up, staff were to contact the pharmacy for clarification.
-She was not aware both the TED hose and Tubigrips were on Resident #3's eMAR.
-Resident #3's PCP should have been contacted for clarification.
-Pharmacy requests for clarification went to concierge and placed in the ALD's box.
-The ALD was then responsible for clarifying the order.

Interview with the Assisted Living Director (ALD) on 07/23/26 at 7:53am revealed:
-Resident #3 had an order for TED hose.
-Tubigrips were later ordered for Resident #3, and the TED hose order was not discontinued.
-The TED hose and Tubigrips were ordered for

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D 344	Continued From page 8 Resident #3 by 2 different PCPs from the same practice. -MAs were supposed to ask her if they had any questions about orders. -She could not say all MAs knew Resident #3 should not wear TED hose and Tubigrips at the same time. -Resident #3's TED hose should have been discontinued and removed from the eMAR. -She and the MAs were responsible for clarifying orders. -She was not aware both the TED hose and Tubigrips were on Resident #3's eMAR. -She and the MAs did not do eMAR audits. -A nurse consultant completed eMAR audits once a week. -The last eMAR audit was done 05/01/26. -Wearing both the TED hose and Tubigrips at the same time was too much pressure. Interview with the Administrator on 07/23/26 at 8:15am and 3:29pm revealed: -She was not familiar with the orders on the eMARs. -All clinical information was handled by the ALD. -The ALD was responsible for clarifying orders. -MAs were not nurses and would follow orders as written. -She could not say there was a process in place for review of the eMAR. -If there was a concern, she looked at the eMAR. Interview with Resident #3's PCP on 07/23/26 at 12:56pm revealed: -Resident #3 was originally ordered TED hose and later switched to Tubigrips. -TED hose and Tubigrips both provide compression and should not be worn at the same time. -Wearing the TED hose and Tubigrips at the	D 344		

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D 344	Continued From page 9 same time would not hurt but both were not needed because they have the same function. -She was aware Resident #3 had an order for TED hose when she ordered the Tubigrips. -Resident #3's TED hose order should have been discontinued or put on hold. -Facility staff were responsible for letting her know the TED hose order needed to be discontinued. -Facility staff were responsible for clarifying orders. -When a clarification was needed, facility staff called her (if it was urgent) or left a request for clarification in a book for her in the medication room of the facility. -She visited the facility twice a week. -No one requested an order clarification for Resident #3 for the TED hose and Tubigrips. -She had only seen Resident #3 with Tubigrips on recently. -She had not seen Resident #3 wearing both TED hose and Tubigrips. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable.	D 344		
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.	D 358		

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D 358	Continued From page 10 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a prescribing practitioner for two of three residents (#6, #7) observed during the medication pass including errors with a medication related to low blood pressure (#6, #7) and a medication related to calming and sleep effects (#7), and for 1 of 6 sampled residents (#6) related to blood pressure medications with parameters. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am medication pass on 07/22/26. Review of Resident #6's current FL-2 dated 04/15/26 revealed diagnoses included unspecified dementia, Parkinson's disease, bacteremia, urinary tract infection, history of falling, and fracture of ribs. Review of Resident #6's current physician orders dated 06/25/26 revealed an order for Midodrine (used to treat low blood pressure) 2.5 milligram (mg) tablet every twelve hours, hold for systolic blood pressure greater than 100. Observation of the 8:00am medication pass on 07/22/26 revealed: -The medication aide (MA) prepared and administered Resident #6 seven medications at 7:46am, including a Midodrine 2.5mg tablet. -The MA observed Resident #6 swallow the	D 358	ID Prefix Tag: D358 Rule 10A NCAC 13F .1004 (a) Medication Administration On July 22, 2026 Medication Technician was reassigned to a non-medication duty pending incident review and competency re-education. On July 22 -23, 2026 All Med Techs were in serviced by Director of Resident Services on Medication Administration Rights, 6 Rights, review of BP parameters. All Med Tech's will verify that the medication being administered is consistent with the current provider order, including medication: • Medication name • Strength and dose • Route • Frequency • Administration Instructions • Hold parameters or other clinical parameters • PRN Indication and required follow-up documentation, when applicable	

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D 358	Continued From page 11 medications before returning to the medication cart and disposing of the empty medication cups. -The MA returned to Resident #6, after administering the Midodrine, with a digital blood pressure machine and obtained a blood pressure reading from the resident's left arm of 161/104 at 7:49am, while the resident remained seated. (According to the National Institute of Health, a person is considered hypertensive if the systolic blood pressure (top number) is 140 or higher and diastolic blood pressure (bottom number) is 90 or higher.) Review of Resident #6's July 2026 electronic medication administration record (eMAR) revealed there was an entry for Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100, scheduled for administration at 8:00am and 8:00pm daily that included obtaining a blood pressure reading. Interview with the MA on 07/22/26 at 9:50am revealed: -She did not know why she did not hold Resident #6's Midodrine 2.5mg tablet on 07/22/26 scheduled for 8:00am. -She checked Resident #6's blood pressure after she administered the Midodrine 2.5mg tablet. -She would have known to hold the Midodrine 2.5mg tablet if she had checked the residents' blood pressure first. -She thought she may have read the instructions printed on the eMAR too fast. -She was "going off the bottom number" of the blood pressure reading to determine if the Midodrine needed to be held. Interview with the Administrator on 07/22/26 between 10:30am and 11:17am revealed Resident #6's blood pressure should have been	D 358	ID Prefix Tag: D358 Cont. Any unclear, incomplete, conflicting, or inconsistent medication order will be held for clarification in accordance with applicable regulations and community policy, and the clarification will be documented in the resident's record. Medication staff will be reminded that medications must be administered according to the current provider's order and that a medication may not be administered outside of ordered parameters. Monitoring for Sustained Compliance: The Resident Care Director/Director of Resident Services will conduct weekly medication administration audit for four consecutive weeks. The audit will include a review of medication orders against the MAR and medication administration documentation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 12 taken before administering the Midodrine 2.5mg tablet. Telephone interview with the PCP on 07/22/26 at 1:55pm revealed: -Midodrine was used to treat hypotension. -She had concerns if medication order instructions were not followed and not being read. -Resident #6's blood pressure needed to be obtained before administering the Midodrine to determine if the Midodrine needed to be held. -It was important to obtain a blood pressure reading for Resident #6 to know what was happening with the residents' blood pressure. -Resident #6's blood pressures were "on the higher side" and were "all over the place". -Midodrine elevated and stabilized the blood pressure. -By administering the Midodrine with a high blood pressure, the resident's blood pressure could possibly become higher. -A high blood pressure makes the heart work harder. -With high blood pressure, the resident could complain of headache, experience heart palpitations, have increased risk for blood clots, or have a stroke. Refer to the interview with the Administrator on 07/23/26 at 3:14pm. 2. Review of Resident #7's current FL-2 dated 04/30/26 revealed diagnoses included paroxysmal atrial fibrillation, orthostatic hypotension, imbalance gait instability, anxiety and depression, hypothyroidism, hyperlipidemia, and cardiac pacemaker. a. Review of Resident #7's physician orders on the FL-2 dated 04/30/26 revealed an order for	D 358	ID Prefix Tag: D358 Cont. Following the initial four-week monitoring period, the community will continue monthly medication administration audits for an additional three months to demonstrate sustained compliance. Audit will be maintained in community and available upon request. Addendum as per telephone conversation with Barbara Lieninger, Administrator on 09/08/2026 at 2:30pm: - The date of correction will be September 3, 2026. H. Forte, RN Licensure Consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 13 Midodrine 5mg tablet prn (as needed) at 8:00am, 12:00pm, and 4:00pm for blood pressure less than 120/80. Review of Resident #7's physician orders dated 05/20/26 revealed an order for Midodrine (used to treat low blood pressure) 5 mg tablet at 8:00am, 12:00pm, 4:00pm for blood pressure less than 120/80. Review of a physician assistant (PA-C) signed history and physical dated 06/09/2026 revealed there were instructions for Midodrine 5mg tablet three times a day as needed listed under the "medications additional text" heading. Observation of the 8:00am medication pass on 07/22/26 revealed: -The medication aide (MA) prepared and administered Resident #7 medications (capsules and tablets) at 7:57am, including a Midodrine 5mg tablet. -The MA did not obtain a blood pressure reading for Resident #7 before or after administering the Midodrine 5mg tablet. Review of Resident #7's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Midodrine 5mg tablet scheduled to be administered at 8:00am, 12:00pm, 4:00pm for blood pressure less than 120/80 and scheduled for "PRN" (as needed), including an entry for a blood pressure reading. -There was no documentation for administration of Midodrine 5mg tablet or blood pressure readings for the month of July 2026. Interview with the MA on 07/22/26 at 12:45pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 -She did not remember administering the Midodrine 5mg tablet to Resident #7 on 07/22/26 with the 8:00am morning medications. -If the printed eMAR instructions were for the Midodrine 5mg tablet to be given at 8:00am, 12:00pm, and 4:00pm, then the resident should have been administered the Midodrine 5mg tablet at those times. -When she prepared medications for administration to a resident, as she removed the medication containers from the medication cart she clicked off each medication on the eMAR as she compared the medication to the eMAR to make sure she had the correct medication for the resident. -She was not used to working on the medication cart that included Resident #7's medications, which she thought "might have something to do with it." Interview with Resident #7 on 07/22/26 at 4:08pm revealed: -She had just woken up. -She denied any dizziness. -She did not remember the last time she felt lightheaded. Observations of Resident #7 on 07/22/26 at 4:15pm revealed the MA obtained a blood pressure reading of 174/92 from the resident's left arm while she was seated in a chair. Telephone interview with the PCP for Resident #7 on 07/23/26 at 12:55pm revealed: -She had recently been assigned as a new provider for Resident #7 and had not seen the resident as of yet. -Resident #7's Midodrine 5mg was prescribed as prn at 8:00am, 12:00pm, and 4:00pm if the blood pressure was less than 120/80.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 15	D 358		

-The resident's blood pressure would need to be obtained to determine need for administration of the Midodrine 5mg tablet.
-She thought the Midodrine 5mg tablet order was confusing and had questions as to how staff were being prompted to check Resident #7's blood pressure if ordered as prn (as needed).
-If the resident's blood pressure was not checked, she would be concerned for symptoms of an elevated blood pressure which included dizziness, headache, and nausea which puts the resident at risk for hypertension.

Refer to the interview with the Administrator on 07/23/26 at 3:14pm.

b. Review of Resident #7's physician orders dated 05/20/26 revealed an order for Mag Glycinate (used to treat anxiety and sleep disorders) 100 mg capsule take 2 capsules (=200mg) by mouth every evening.

Review of a physician assistant (PA-C) signed history and physical dated 06/09/2026 revealed there were instructions for Magnesium (Mag) Glycinate 100mg 2 capsules daily listed under the "medications additional text" heading.

Observation of the 8:00am medication pass on 07/22/26 revealed the medication aide (MA) prepared and administered Resident #7 medications (capsules and tablets) at 7:57am, including one Mag Glycinate 100mg capsule.

Review of Resident #7's July 2026 electronic medication administration record (eMAR) printed on 07/22/26 following the 8:00am medication pass revealed:
-There was an entry for Mag Glycinate capsule 100mg take 2 capsules (=200mg) by mouth every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 16	D 358		

evening, scheduled at 8:00pm.
-There was no documentation for administration of the Mag Glycinate 100mg capsule administered on 07/22/26 with the 8:00am medications.

Review of a second copy of Resident #7's July 2026 eMAR printed on 07/23/26 revealed:
-There was an entry for Mag Glycinate capsule 100mg take 2 capsules (=200mg) by mouth every evening, scheduled at 8:00pm.
-The MA initials documenting the administration of the Mag Glycinate 100mg two capsules (=200mg) on 07/22/26 at 8:00pm did not match the initials for the MA observed administering Resident #7 the dosage of Mag Glycinate 100mg capsule on 07/22/26 at 7:57am.

Interview with the MA on 07/22/26 at 12:45pm revealed:
-She did not remember administering the Mag Glycinate 100mg capsule to Resident #7 on 07/22/26 with the 8:00am morning medications.
-When she prepared medications for administration to a resident, as she removed the medication containers from the medication cart she clicked off each medication on the eMAR as she compared the medication to the eMAR to make sure she had the correct medication for the resident.
-She was not used to working on the medication cart that included Resident #7's medications, which she thought "might have something to do with it."

Telephone interview with the PCP for Resident #7 on 07/23/26 at 1:08pm revealed:
-Resident #7's current order was Mag Glycinate 200mg in the evening.
-She would have concerns for gastrointestinal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 17	D 358		

symptoms such as nausea, vomiting, abdominal pain, and loose stool if Resident #7 was administered the Mag Glycinate twice on 07/22/26.

Refer to the interview with the Administrator on 07/23/26 at 3:14pm.

3. Review of Resident #6's current FL-2 dated 04/15/26 revealed diagnoses included unspecified dementia, Parkinson's disease, bacteremia, urinary tract infection, history of falling, and fracture of ribs.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 04/30/26.

a. Review of physician orders for Resident #6 dated 04/29/26 revealed an order for Midodrine (used to treat low blood pressure) 2.5 milligram (mg) tablet every twelve hours, hold for systolic blood pressure (SBP) greater than 100.

Review of subsequent physician orders for Resident #6 revealed:
-On 05/19/26, there was a signed physician's order Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100.
-On 06/25/26, there was a signed physician's order Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100.

Review of Resident #6's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100, scheduled for administration at 8:00am and 8:00pm daily that included obtaining a blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 18	D 358		

pressure reading.
-At 8:00am, there were documented SBP readings greater than 100 ranging from 126 to 148 on 13 occasions when the Midodrine 2.5mg tablet was documented as administered by the MAs.
-At 8:00pm, there were documented SBP reading greater than 100 ranging from 121 to 146 on 8 occasions when the Midodrine 2.5mg tablet was documented as administered by the MAs.

Review of Resident #6's June 2026 eMAR revealed:
-There was an entry for Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100, scheduled for administration at 8:00am and 8:00pm daily that included obtaining a blood pressure reading.
-At 8:00am, there were documented SBP readings greater than 100 ranging from 110 to 156 on 18 occasions when the Midodrine 2.5mg tablet was documented as administered by the MAs.

Review of Resident #6's July 2026 eMAR revealed:
-There was an entry for Midodrine 2.5mg tablet every 12 hours, hold for SBP greater than 100, scheduled for administration at 8:00am and 8:00pm daily that included obtaining a blood pressure reading.
-At 8:00am, there were documented SBP readings greater than 100 ranging from 120 to 197 on 22 occasions when the Midodrine 2.5mg tablet was documented as administered by the MAs.

Interview with a medication aide (MA) on 07/22/26 at 9:50am revealed:
-If a medication was held, the MA initials would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 19	D 358		

circled on the eMAR.
-She did not know why the Midodrine 2.5mg tablet was not held according to the physician orders.

Interview with the Assisted Living Director (ALD) on 07/23/26 at 7:56am revealed:
-She and MAs did not perform eMAR audits.
-A nurse consultant performed eMAR audits weekly.
-If a MA had a question about a medication entry on the EMAR, the MA was supposed to call the ALD.

Interview with the Resident Care Director (RCD) on 07/23/26 at 11:25am revealed:
-She expected the MAs to read the entire printed instructions on the eMAR before preparing the administration of Resident #6's Midodrine.
-The resident's blood pressure should be taken to determine if the Midodrine needed to be administered.

Interview with Resident #6's primary care provider (PCP) on 07/22/26 at 1:55pm revealed:
-She had concerns if the MAs were not following the physician orders and not reading the orders.
-The goal for Resident #6 was for his blood pressure not to fall too low that the resident would fall or pass out.
-If the Midodrine was being administered outside the prescribed parameters, the blood pressure could become elevated.
-High blood pressure was called a "silent killer".
-Sometimes signs what is happening with the blood pressure cannot be seen.
-The resident could experience headaches, heart palpitations, increased risk for blood clots, and stroke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20 Refer to the interview with the Administrator on 07/23/26 at 3:14pm. b. Review of a physician order for Resident #6 dated 04/15/26 revealed an order for Hydralazine (used to treat high blood pressure) 25 milligram (mg) tablet every eight hours as needed for systolic blood pressure (SBP) greater than 175. Review of subsequent physician orders for Resident #6 revealed: -On 05/19/26, there was a signed physician's order for Hydralazine 25mg tablet every 8 hours as needed for SBP greater than 175. -On 06/25/26, there was a signed physician's order for Hydralazine 25mg tablet every 8 hours as needed for SBP greater than 175. Review of Resident #6's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 25mg tablet take one tablet by mouth every 8 hours as needed for SBP greater than 175. -There were no scheduled blood pressure checks for every 8 hours. -There were blood pressure readings for 8:00am and 8:00pm. -There was a documented systolic blood pressure reading of 184 on 05/22/26 at 8:00am. -There was no documentation for administration of the Hydralazine 25mg tablet on 05/22/26 for the SBP of 184. Review of Resident #6's June 2026 eMAR revealed: -There was an entry for Hydralazine 25mg tablet take one tablet by mouth every 8 hours as needed for SBP greater than 175. -There were no scheduled blood pressure checks	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 21 for every 8 hours. -There were blood pressure readings for 8:00am and 8:00pm. -There was a documented systolic blood pressure reading of 179 on 06/08/26 at 8:00pm. There was no documentation for administration of the Hydralazine 25mg tablet on 06/08/26 for the SBP of 179. -There was a documented systolic blood pressure reading of 186 on 06/21/26 at 8:00am. There was no documentation for administration of the Hydralazine 25mg tablet on 06/21/26 for the SBP of 186. Review of Resident #6's July 2026 eMAR revealed: -There was an entry for Hydralazine 25mg tablet take one tablet by mouth every 8 hours as needed for SBP greater than 175. -There were no scheduled blood pressure checks for every 8 hours. -There were blood pressure readings for 8:00am and 8:00pm. -There was a documented systolic blood pressure reading of 197 on 07/03/26 at 8:00am. There was no documentation for administration of the Hydralazine 25mg tablet on 07/03/26 for the SBP of 197. -There was a documented systolic blood pressure reading of 202 on 07/13/26 at 8:00pm. There was no documentation for administration of the Hydralazine 25mg tablet on 07/13/26 for the SBP of 202. -There was a documented systolic blood pressure reading of 177 on 07/16/26 at 8:00pm. There was no documentation for administration of the Hydralazine 25mg tablet on 07/16/26 for the SBP of 177. -There was a documented systolic blood pressure reading of 178 on 07/17/26 at 8:00pm. There was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 22 no documentation for administration of the Hydralazine 25mg tablet on 07/17/26 for the SBP of 178. Observations of medications on hand for Resident #6 on 07/23/26 at 12:15pm revealed there was a pharmacy labeled medication package for Hydralazine 25mg tablet take one tablet by mouth every 8 hours as needed for SBP greater than 175, quantity of 30 tablets, with a dispense date of 04/29/26. There were 30 tablets remaining on hand. Interview with a medication aide (MA) on 07/22/26 at 9:50am revealed: -She initialed on the eMAR when a medication was administered. - She did not normally work on the medication cart where Resident #6's medications were stored. Interview with the Assisted Living Director (ALD) on 07/23/25 at 7:56am revealed: -The licensed health professional support nurse (LHPS) consultant performed eMAR audits and quarterly LHPS reviews. -The MAs and ALD were responsible to complete medication cart audits (no specific timeframe provided). Interview with Resident #6's primary care provider (PCP) on 07/22/26 at 1:55pm revealed: -She had concerns if the MAs were not following the physician orders and not reading the orders. -The resident was prescribed another medication (Midodrine) that could elevate the blood pressure which would concern her. -Resident #6 could have used a dose of the Hydralazine when the resident's blood pressure readings were greater than 179.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 23 -High blood pressure was called a "silent killer". -Sometimes signs of what is happening with the blood pressure cannot be seen. -The resident could experience headaches, heart palpitations, increased risk for blood clots, and stroke. Refer to the interview with the Administrator on 07/23/26 at 3:14pm. Interview with the Administrator on 07/23/26 at 3:14pm revealed: -She expected the MAs to look at the instructions printed on the eMARs and verify accuracy against the medication labels to ensure the correct dosage of a medication was administered. -If there were parameters, such as blood pressure checks, the parameters were supposed to be completed prior to prepping a medication with parameters for administration. -Medications were to be administered to residents based on the physician orders/directions. The facility failed to administer medications used to treat blood pressures as ordered and failed to perform blood pressure checks prior to the administration of blood pressure medications with parameters to 2 of 3 residents (#6, #7) observed on the 07/22/26 medication pass resulting in a 10% medication error rate. The facility documented the administration of a blood pressure medication on 61 occasions to a resident (#6) in a three month timeframe when the resident's systolic blood pressure readings were greater than the physician prescribed parameters which had the potential to elevate the residents' blood pressure. This failure placed the resident at risk for headaches, dizziness, blood clots, and strokes and was detrimental to the health, safety, and welfare of the resident and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092234	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 24 constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2026.	D 358		

Forte, Hope

From: Barbara Riexinger <Barbara.Riexinger@ridgecare.com>
Sent: Wednesday, September 2, 2026 2:17 PM
To: Forte, Hope
Cc: Shawnda Overton
Subject: [External] Falls River Village - Revised Plan of Correction
Attachments: Falls River Village - Plan of Correction Revised 9.2.2026.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Report suspicious emails with the Report Message button located on your Outlook menu bar on the Home tab.

Good Afternoon Ms. Forte,

Please find attached the revised Plan of Correction for Falls River Village Assisted Living.

Please let me know if you have any questions or require any additional information.

Kind Regards,

FALLS RIV

Barbara Riexinger
Executive Director

Phone (919) 844-9747 **Mobile** (716) 525-7268
Barbara.Riexinger@ridgecare.com
www.RidgeCare.com
1110 Falls River Avenue, Raleigh, NC 27614