STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034112	A. BUILDING: _____ B. WING _____	C 10/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

(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 License Section conducted a complaint investigation from 10/13/26 to 10/16/26. The complaint investigation was initiated by the Forsyth County Department of Social Services on 08/14/26 and 09/30/26.	D 000		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 7 sampled residents (#7) had an FL2 completed annually.	D 235		

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D 235	Continued From page 1 The findings are: Review of Resident #7's FL2 dated 01/09/26 revealed diagnoses included congestive heart failure (CHF), chronic kidney disease (CKD), atrial fibrillation (Afib), chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of Resident #7's Resident Register revealed an admission date of 03/01/25. Review of Resident #7's record revealed: -There was an FL2 dated 01/09/25. -There was no FL2 available for review completed between 01/09/25 and 10/14/26. Interview with the Director of the secured assisted living on 10/16/26 at 6:09pm revealed: -The facility's contracted nurse reviewed residents' records and sent emails to the Health Care Director (HCD) about FL2s that were due. -She knew residents must have a FL2 completed annually. -She did not know Resident #7 did not have an updated FL2 completed annually between 01/09/25 and 10/14/26. -She was not responsible to audit residents' records. -The resident's Primary Care Provider (PCP) was responsible for completing the FL2. Interview with the HCD on 10/16/26 at 7:50pm revealed: -The facility's contracted nurse reviewed residents' records and sent emails to the HCD about FL2s that were due. -She knew residents must have a FL2 completed annually.	D 235		

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D 235	Continued From page 2 -She was responsible for ensuring FL2 were current. -She knew Resident #7's FL2 needed to be updated. -Resident #7 was under the care of an outside PCP and she faxed it to that PCP for a signature in January 2026. Interview with the Regional Director of Operation on 10/16/26 at 8:54pm revealed: -She was the current Administrator. -Residents' records were expected to be audited by the HCD routinely. -She knew residents must have a FL2 completed annually. -She did not know Resident #7 had no updated FL2 completed annually between 01/09/25 and 10/14/26. -Residents' records were expected to be audited by the HCD routinely. -The HCD was responsible for ensuring the FL2 was current.	D 235		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Infomation on Facility and Resident Register (a) An adult care home administrator or their management designee shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has	D 243		

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D 243	Continued From page 3 been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the facility. The information shall consist of the following: (1) the resident contract to which the following applies: (A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet; (C) the contract shall be signed and dated by the administrator or management designee and the resident or the resident's authorized representative, a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record; (D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended contract or an amendment to the contract for review and confirmation of receipt; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients as established by the North Carolina Social Services Commission and the North Carolina General Assembly. This Rule is not met as evidenced by: Based on record review and interviews, the	D 243		

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facility failed to provide the resident's authorized representative a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees for 2 of 3 sampled residents (#2, and #3).

The findings are:

Review of the facility financial agreement revealed the community will provide 30 days advanced written notice before any increase to the monthly rent and/or miscellaneous charges.

1. Review of Resident #2's current FL2 dated 05/28/26 revealed:
-Diagnoses included mild dementia with psychotic disturbance, generalized anxiety disorder, insomnia, Vitamin B deficiency, and anosognosia.
-The resident current level of care was documented as assisted living facility.
-The resident was intermittently disoriented.

Review of Resident #2's Signed Contract revealed:
-The contract was signed by Resident #2's Power-of-Attorney (POA) on 05/29/26.
-Resident #2's monthly level-of-care (LOC) services was documented as $625.00 on the Proration Fee Worksheet portion of the contract.
-Level 1 Care was documented under the section for miscellaneous charges for an amount of $625.00 in the Attachment A Schedule of Costs with Resident #2's Signed Contract Resident #2 was indicated for Level 1 miscellaneous costs.
-Level 2 Care was documented under the section for miscellaneous charges for an amount of $1040.00 in the Attachment A Schedule of Costs.

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Review of the Resident Register for Resident #2 revealed she was admitted to the facility on 06/03/26.

Review of the Facility's NC Health and Service Evaluation Results for Resident #2 dated 06/05/26 revealed:
-Resident #2's care needs were determined for a higher monthly LOC at Level 2.
-There were no signatures for Resident #2 or for Resident #2's POA.

Review of Resident #2's facility assessment and care plan dated 06/19/26 revealed:
-The resident was assessed for supervision assistance in activities of daily living (ADL) with bathing and for no assistance with grooming, dressing, toileting, eating (nutrition), ambulation, and mobility and transfers.
-The assessment and care plan was signed by the Health Care Director (HCD) on 06/13/26 and was signed by the primary care physician (PCP) on 06/19/26.
-There was no subsequent care plan available for review.

Review of Resident #2's Account Ledger Sheet revealed:
-There was an entry on 06/16/26, Resident #2's level of care was documented as Level 2 with a rate of $1040.00.
-There was an entry on 06/24/26. Resident #2's level of care was documented as Level 2 with a rate of $1040.00 for dates 07/01/26 to 07/31/26.
-There were no entries for any level of care rates prior to the 06/16/26 entry on Resident #2's account ledger sheet.

Review of Resident #2's progress notes from 06/04/26 to 10/05/26 revealed:

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-There was an entry on 06/04/26, the HCD document resident moved into the community, all move-in assessments were completed, a care meeting was held prior to move-in, and Resident #2 required assistance with showers.
-There was an entry on 06/06/26, the HCD documented there were no issues or concerns and noted Resident #2 was adjusting to the community well.
-There was an entry on 06/17/26, the HCD spoke with the Resident #2's POA about level of care changes for the secured assisted living and about the possible option of the family providing a daytime and evening sitter.

Observation of Resident #2 at various times from 10/13/26 to 10/16/26 revealed:
-She was pleasant and very oriented in discussions related to staff and other residents.
-She attended and participated in various activities throughout the daytime.
-She walked with other residents around the community and took trips to the lower outside levels of the facility to talk and sit in the front area of the facility.

Interview with Resident #2 on 10/15/26 at 9:15am revealed:
-She took her own showers but sometimes the staff reminded her to take her showers because she would get busy doing other things.
-She required no other assistance from the staff and she just liked staying busy with her friends at the facility.

Interview with the HCD on 10/16/26 at 2:05pm revealed:
-She was not aware Resident #2's LOC changed because she completed the assessment on 06/05/26 for a LOC 2 care plan.

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D 243	Continued From page 7 -The initial assessment was completed by someone else while she was on leave from the facility and there was no record of the initial assessment. -She was not aware if Resident #2 or Resident #2's POA was notified 30 days in advance before the care charges increased from June 2026. -She was not aware Resident #2's care charges increased because she was not involved in the resident's finances. Interview with the Director of the secured assisted living (AL) on 10/16/26 at 6:10pm revealed: -She was not sure who initially assessed Resident #2 from May 2026 but the HCD completed another assessment for Resident #2 in June 2026. -She was aware Resident #2's LOC changed because she was present for the meeting between the previous Administrator and the Resident #2's POA in June 2026. -She was not aware if Resident #2 or Resident #2's POA were notified 30 days in advance before the care charges increased from June 2026. -She was not aware Resident #2's care charges increased because she was not involved in the resident's finances. Interview with the Regional Director of Operations on 10/16/26 at 8:05pm revealed she was not aware Resident #2 and Resident #2's POA were not notified 30 days in advance about an increase in level of care costs from June 2026 until she started in the 2nd week of September 2026. Attempted telephone interview with Resident #2's POA on 10/15/26 at 10:22am was unsuccessful. Refer to the interview with the Director of the secured AL on 10/16/26 at 6:10pm.	D 243		

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D 243	Continued From page 8 Refer to the interview with the HCD on 10/16/26 at 6:50pm. Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:05pm. 2. Review of Resident #3's current FL2 dated 10/22/25 revealed: -Diagnoses included metabolic encephalopathy, vascular dementia, and gait instability. --The resident current level of care was documented as assisted living facility. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 10/22/25. Review of Resident #3's Signed Contract revealed: -The contract was signed by Resident #3's Power-of-Attorney (POA) on 10/22/25. -Resident #3's monthly level-of-care (LOC) services was documented as blank on the Proration Fee Worksheet portion of the contract. -Level 1 Care was documented blank under the section for miscellaneous charges for an amount of $600.00 in the Attachment A Schedule of Costs with Resident #3's Signed Contract Resident #3 was indicated for Level 1 miscellaneous costs. -Miscellaneous charges listed LOC charges as Level 1 was $600.00 per month, and Level 2 was $1000.00 per month. Review of Resident #3's facility assessment and care plan dated 12/04/25 revealed: -The resident was assessed for independent assistance in activities of daily living (ADLs) with eating, toileting, ambulation/locomotion, dressing, grooming/personal hygiene, and transferring. -He was assessed for supervision assistance with	D 243		

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bathing.
-The assessment and care plan was signed by the Director of secured assisted living (AL) on 12/05/25 and was signed by the Primary Care Provider (PCP) on 12/04/25.
-There was no subsequent care plan available for review.

Review of the Facility's NC Health and Service Evaluation Results for Resident #3 dated 10/31/25 revealed:
-Resident #3's care level needs were determined for a monthly LOC at Level 1 based on setup as of the assessment completion date of 10/31/25.
-There was notation the assessment was the initial assessment.
-There were no signatures for Resident #3 or for Resident #3's POA on the copy provided for Resident #3's results.

Review of the Facility's NC Health and Service Evaluation Results for Resident #3 dated 06/25/26 revealed:
-Reason for assessment was documented as no change of condition.
-Resident #3's care level needs were determined for a monthly LOC at Level 2 based on setup as of the assessment completion date of 06/25/26.
-There were no signatures for Resident #3 or Resident #3's POA.

Review of Resident #3's Account Ledger Sheet on 10/16/26 revealed:
-There were no entries for any level of care rates prior to the 11/21/25 entry on Resident #3's account ledger sheet.
-On 11//22/25, there was an entry for care from 10/27/25 to 10/31/25 with Resident #3's level of care documented as Level 1 with a rate of $600.00.

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-On 11//22/25, there was an entry for care from 11/01/25 to 11/30/25 with Resident #3's level of care documented as Level 1 with a rate of $600.00.
-On 11//22/25, there was an entry for care from 12/01/25 to 12/31/25 with Resident #3's level of care documented as Level 1 with a rate of $600.00.
-On 12/23/25, 01/23/26, 02/24/26, 03/23/26, 04/21/26, and 05/22/26 there were entries with Resident #3's level of care documented as Level 1 with a rate of $600.00.
-On 06/30/26, there was an entry for care from 06/28/26 to 06/30/26 with Resident #3's level of care documented as Level 2 with a rate of $1040.00.
-On 06/30/26, there was an entry for care from 07/01/26 to 07/31/26 with Resident #3's level of care documented as Level 2 with a rate of $1040.00.
-On 07/21/26, 08/27/26, and 09/21/26 there were entries with Resident #3's level of care documented as Level 2 with a rate of $1040.00.

Continued review of Resident #3's Account Ledger Statement revealed on 09/21/26, Resident #3's ledger had a billing correction to credit LOC billed at Level 2 costs of $1040.00 billed on 06/30/26, 07/21/26, 08/27/26, and 09/21/26 and adjust to bill only $625.00 for Level 1 care for the monthly cost of care for Level 1 care.

Review of Resident #3's progress notes from 06/26/26 to 09/25/26 revealed there was no documentation Resident #3's Power of Attorney was contacted for a change of LOC reassessment or cost of care increase.

Observation of Resident #3 at various times from

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10/13/26 to 10/16/26 revealed:
-He ambulated from the third floor of the facility to dining room independently.
-He was pleasant and interactive with other residents.
-He conversed with residents at his dining table.

Review of electronic mail (email) documentation dated 09/17/26 from Resident #3's family and POA revealed:
-The POA had met with the Regional Director of Operations last Friday (09/11/26) related to Resident #3's billing for cost of care and having not received an updated assessment, LOC increase , and cost of LOC increase prior to the withdrawal of funds and other issues.
-He noted he had spoken with facility billing staff and emailed numerous occasions for the increased billing.
-It was explained the facility had undated the facility computer system and experienced some lapses in correspondence tracking.
-He questioned why there was billing increase without authorization from the POA (payee).

Review of email dated 09/18/26 from the Regional Director of Operations to Resident #3's POA revealed:
-There was a summary of items discussed during a meeting on 09/18/26 with the POA.
-The LOC was discussed.
-A credit would be issued for LOC increase from 06/28/26 through 09/30/26.
-Level 2 care rate would begin 10/01/26.
-Monthly follow-up meetings were to be scheduled with notification via email.

Telephone interview with Resident #3's POA on 10/15/26 at 10:41am revealed:
-He took Resident #3 to most of his outside

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appointments.
-He visited Resident #3 frequently, sometimes every day.
-The facility had a new facility Manager currently and he hoped things would get better.
-He met with the Regional Director of Operations last month (09/11/26) to discuss billing for Resident #3's LOC.
-He was not notified of the LOC changes prior to receiving increased billing for June 2026.
-He had not been informed of LOC changes and had not signed a LOC assessment change when the cost of care changed in June 2026.
-The facility had credited charges for care in June 2026 through September 2026 after their meeting.

Interview with the Health Care Director (HCD) on 10/16/26 at 2:05pm revealed:
-She performed the Facility's NC Health and Service Evaluation Results for Resident #3 dated 06/25/26 for Resident #3.
-She was not aware Resident #3's LOC changed because she completed the assessment on 06/05/26 and the initial assessment was completed by the Director of the secured assisted living (AL).
-The assessment on 06/25/26 was prompted by a change or upgrade to the facility's computer system which affected all assessments, billing, and health care monitoring.
-She was not aware Resident #3's care charges increased because she was not involved in the resident's finances, only completing the Facility's NC Health and Service Evaluation and passing the results to the facility's administration.

Interview with Resident #3 on 10/16/26 at 5:00pm revealed:
-He had no current health issues.

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HARMONY AT BROOKBERRY FARM	512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106

(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 243	Continued From page 13 -He was doing great at the present time and had lunch with his family member earlier today. -His family member helped with his appointments with outside providers and medications. Interview with the Regional Director of Operations on 10/16/26 at 8:00pm revealed: -She was not aware Resident #3 and his POA was not notified 30 days in advance about an increase in level of care costs from June 2026 until she started in the 2nd week of September 2026. -She spent the first week or more talking with residents' POA and family members related to the new Level of Care rates applied without contacting the family members or payees. -She had scheduled a meeting with Resident #3's POA on 09/11/26 to review the assessment made in June at which time Resident #3's Level of Care rate increased. -There would be routine monthly, or more frequently if needed, meetings with Resident #3's POA. -Resident #3's billing had been adjusted to reflect Level of Care 1 until she had a meeting with the POA to discuss the increased Level of Care and the increase in cost to be charged. -There had been increases in the facility's LOC rates since Resident #3 was admitted. -She had a meeting scheduled with Resident #3's POA scheduled today (10/16/26) but the POA rescheduled the meeting. Refer to the interview with the Director of the secured assisted living (AL) on 10/16/26 at 6:10pm. Refer to the interview with the HCD on 10/16/26 at 6:50pm.	D 243		

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D 243	Continued From page 14 Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:05pm. _____ Interview with the Director of secured assisted living (AL) on 10/16/26 at 6:10pm revealed: -She was not aware a resident or the resident's responsible party must receive 30 days notice prior before their costs were increased by the facility. -She was responsible for the assessments of the secured AL residents and the Health Care Director (HCD) was responsible for the assessments of the 2nd and 3rd floor AL residents. -She covered the assessments for all the residents in the event the HCD was on leave from the facility and the HCD was responsible for all the resident in the event she was on leave from the facility. -She was not aware a resident or the resident's responsible party must receive 30 days notice prior before their costs were increased by the facility. -The Administrator, the Business Office Manager (BOM), and Sales Manager were responsible for discussing financial information with the resident's or the resident's responsible party. Interview with the Health Care Director (HCD) on 10/16/26 at 6:50pm revealed: -She and the Director of the secured AL coordinator were responsible for assessing and scheduling care plan meetings for the resident's and the resident's responsible party. -The Administrator, the BOM, and Sales Manager were responsible for discussing financial information with the resident's or the resident's responsible party. -She was not aware a resident or the resident's responsible party must receive 30 days notice	D 243		

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D 243	Continued From page 15 prior before their costs were increased by the facility. Interview with the Regional Director of Operations on 10/16/26 at 8:05pm revealed: -She assumed responsibility as the Administrator during the second week of September 2026 and had addressed various resident's financial concerns. -She expected the HCD to notify the resident or the resident's responsible party once the HCD completed an assessment for a change to a level of care to schedule a care plan meeting with the resident or the resident's responsible party, the Administrator, and the HCD. -She expected the resident or a resident's responsible party to be notified by either the Administrator or the HCD according to the company policy prior to a resident's change of condition affecting a possible change to level of care costs.	D 243		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on the observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 7 sampled residents (#5) who had orders for blood pressure (BP) checks for seven days and for blood sugar monitoring two times per day for seven days. The findings are:	D 273		

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D 273	Continued From page 16 Review of #5's current FL2 dated 03/04/26 revealed diagnoses included hypertension, hyperlipidemia, diabetes mellitus, Alzheimer's disease, and depression. a. Review of Resident #5's physician order dated 08/06/26 revealed an order for BP checks two times per day for 7 days and call the Primary Care Provider (PCP) for a systolic blood pressure greater than 160 or less than 90, or for a diastolic blood pressure greater than 90 or less than 60. Review of Resident #5's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for BP checks twice daily with a start date of 08/07/26 and end date of 08/13/26. -There was documentation of 11 BP checks out of 14 opportunities. Interview with a pharmacist with the facility's contracted pharmacy on 10/16/26 at 2:22pm revealed: -The pharmacy received an order to check a BP two times per day for 7 days for Resident #5. -The order was entered on Resident #5's eMAR by the pharmacy staff to start BP checks from 08/07/26 through 08/13/26. Interview with Resident #5's PCP on 10/15/26 at 12:27pm revealed: -She ordered BP checks because Resident #5 had complaints of dizziness. -She planned to taper medications for Resident #5 based on the BP values. -She expected the BPs to be checked two times per day for 7 days as ordered. -She was not aware the BP checks were not	D 273		

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D 273	Continued From page 17 done twice daily. Interview with a medication aide (MA) on 10/14/26 at 10:13am revealed: -She did not remember a BP order for Resident #5 from 08/07/26 through 08/13/26. -The Health Care Director (HCD) or Director of the secure assisted living (AL) would communicate to the MAs when there were new orders. -Any new order to check BP would be placed on the eMAR and checked by the HCD or Director of the secure AL unit. -Resident #5 had last complained of dizziness to her in June 2026. Interview with a family member of Resident #5 on 10/15/26 at 2:45pm revealed: -She was aware of Resident #5's complaints of dizziness. -She was aware the PCP was tapering her medications to see if the dizziness would improve. -She had not been told any BP values. Interview with the Director of the secured AL on 10/16/26 at 6:15pm revealed: -She did not remember BP checks being ordered for Resident #5 from 08/07/26 through 08/13/26. -All new orders were placed on the eMAR by the contracted pharmacy. -New orders were verified by herself or the HCD on the eMAR. -She did not know why the BPchecks were missed. Interview with the HCD on 10/16/26 at 6:55pm revealed: -The Director of the secured AL was responsible for checking orders in the secure assisted living.	D 273		

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-The HCD would assist if the Director of the secured AL was not available.
-She did not know about BP checks that were missed on Resident #5.

Interview with the Regional Director of Operations on 10/16/26 at 8:20pm revealed:
-She became the Administrator during the second week of September 2026.
-It was the responsibility of the HCD and the Director of the secured AL to audit the charts randomly.
-The chart audits should include comparing the PCP orders against the eMARs.
-It was expected new orders be implemented and follow up occur with the PCP when there were parameters or when tasks like BP checks were not carried out as ordered.

Based on observation and record review it was determined Resident #5 was not interviewable.

b. Review of Resident #5's physician order dated 08/21/26 revealed an order to monitor fingerstick blood sugar (FSBS) two times per day for 7 days, 30 minutes before breakfast and 30 minutes before bedtime, and to call the PCP for FSBS less than 100 or greater than 400.

Review of Resident #5's August 2026 eMAR revealed:
-There was an entry for FSBS checks scheduled twice daily at 8:00am and 8:00pm.
-On 8/21/26 at 8:00am and 8:00pm, no FSBS was documented on the eMAR.
-On 08/22/26 at 8:00am and 8:00pm, no FSBS was documented on the eMAR.
-On 08/23/26 at 8:00am, no FSBS was documented on the eMAR.
-On 08/24/26 at 8:00am, no FSBS documented

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was on the eMAR.
-On 08/25/26 at 8:00am and 8:00pm, no FSBS was documented on the eMAR.
-On 8/27/26 at 8:00am and 8:00pm, no FSBS was documented on the eMAR.
-Blood sugars ranged from 132 to 577.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/26 at 2:22pm revealed Resident #5's order to check FSBS two times per day for 7 days was placed on the eMAR by the pharmacy staff to start 08/21/26 through 8/27/26.

Interview with Resident #5's PCP on 10/15/26 at 12:27pm revealed:
-She ordered FSBS checks for Resident #5 because she was changing her insulin.
-She planned to change insulin doses based on the blood sugar values.
-She was not notified of the missed FSBS checks or the reason why they were missed.
-She expected the FSBS to be checked two times per day for 7 days.

Interview with a MA on 10/14/26 at 10:13am revealed:
-She did not remember a FSBS order for Resident #5 from 08/21/26 through 08/27/26.
-Any new orders to check blood sugars would be placed on the eMAR by the pharmacy.

Interview with a family of Resident #5 on 10/15/26 at 2:45pm revealed:
-Resident #5's blood sugars had been out of control since she had been admitted to the facility.
-She would ask the MAs the values of her blood sugars.
-She did not know the schedule that her mother's

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D 273	Continued From page 20 blood sugar was monitored. Interview with the Director of the secured AL on 10/16/26 at 6:15pm revealed: -She did not remember FSBS checks being ordered for Resident #5 from 08/21/26 through 08/27/26. -All new orders were placed on the eMAR by the contracted pharmacy. -New orders were verified by the Director of the secured AL or HCD on the eMAR. -She did not know why the FSBS checks were missed or why the PCP was not notified. Interview with the HCD on 10/16/26 at 6:55pm revealed: -The Director of the secured AL was responsible for checking orders in the secure assisted living unit. -The HCD would assist if the Director of the secured AL was not available. -She did not know about FSBS checks that were missed on Resident #5. Interview with the Regional Director of Operations on 10/16/26 at 8:20pm revealed: -It was the responsibility of the HCD and the Director of the secured AL to audit the charts randomly. -The chart audits should compare the PCP's orders against the eMARs. -The HCD should audit the eMARs for missed entries. -The HCD should audit for missed notifications to the PCP. -It was expected new orders be implemented and communications occur with the PCP when there were parameters or when orders were not completed as ordered.	D 273		

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D 273	Continued From page 21 Based on observation and record review it was determined Resident #5 was not interviewable.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 7 sampled residents (#2), for an order to administer a one-time dose of medication used to treat anxiety disorders. The findings are: Review of Resident #2's current FL2 dated 05/28/26 revealed diagnoses included mild dementia with psychotic disturbance, generalized anxiety disorder, insomnia, vitamin B deficiency, and anosognosia. Review of the Resident Register for Resident #2 revealed she was admitted to the facility on 06/03/26. Review of Resident #2's signed physician's order dated 06/19/26 revealed there was an order for a one-time dose of lorazepam (a medication used to treat anxiety) 0.5mg, 1 tablet by mouth.	D 276		

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D 276	Continued From page 22 Review of Resident #2's June 2026 electronic medication administration record (eMAR) from 06/01/26 to 06/30/26 revealed there was no entry to administer a one-time dose of lorazepam (a medication used to treat anxiety) 0.5mg, 1 tablet by mouth. Interview with Resident #2 on 10/15/26 at 9:15am revealed she recalled having some anxiety issues within the first couple weeks she moved into the facility but did not recall the medication aide (MA) giving her any additional medication to help calm her nerves. Telephone interview with Resident #2's Primary Care Provider (PCP) on 10/15/26 at 12:17pm revealed: -Resident #2 had an order for a one-time dose of lorazepam on 06/19/26 because the Health Care Director (HCD) had requested the medication to calm her nerves related to adjusting to living at the facility. -She was not aware the order had not been started for Resident #2's one-time dose of lorazepam for 06/19/26. -She expected the staff to implement the orders that were written since they contacted her for the order to calm Residents #2's anxiety issues. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/26 at 12:05pm revealed: -The pharmacy staff were responsible for entering orders into the facility's eMAR once the facility staff or a residents physician sent the order to the pharmacy. -The facility staff were responsible for verifying and approving the eMAR entries once the orders were entered into the eMAR by the pharmacy staff.	D 276		

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D 276	Continued From page 23 -The pharmacy did not have an order for a one-time dose of lorazepam from 06/19/26 for Resident #2. Interview with the HCD on 10/16/26 at 2:05pm revealed: -She was aware of the order for a one-time dose of lorazepam for Resident #2 from 06/19/26 because she requested the verbal order from the PCP. -She was not aware the lorazepam was entered on the eMAR and had not been started for Resident #2 because she thought Resident #2 received the medication. -The PCP was normally responsible for sending medications over to the pharmacy but she and the Director of the secured assisted living (AL) were responsible for sending verbal orders to the pharmacy. -Once the orders were sent, the pharmacy staff entered resident's orders into the eMAR and she and the Director of the secured AL were responsible for verifying and approving the eMAR entry. -She, the Director of the secured AL, and the lead medication aide (MA) were responsible for reviewing orders. -She and the Director of the secured AL were responsible for auditing eMARs weekly with the PCP but she was not sure why Resident #2's lorazepam was overlooked. Interview with the lead MA on 10/16/26 at 5:38pm revealed: -She was not aware of an order for a one-time dose of lorazepam from 06/19/26 for Resident #2. -The PCP sent resident's medication orders electronically to the pharmacy and she, the Director of the secured AL, and the HCD received the orders from the PCP by email.	D 276		

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D 276	Continued From page 24 -The HCD, the Director of the secured AL, and she were responsible for reviewing physician orders and the HCD and the Director of the secured AL were responsible for completing eMAR audits. -She was not sure what details were involved in the eMAR audits since she was not responsible for the audits. Interview with the Director of the secured AL on 10/16/26 at 6:10pm revealed: -The PCP sent resident's medication orders electronically to the pharmacy and she, the lead MA, and the HCD received the orders from the PCP by email. -She and the HCD were responsible for sending verbal orders to the pharmacy. -She was not aware of an order for a one-time dose of lorazepam from 06/19/26 for Resident #2 because she was not involved with the request for the lorazepam from Resident #2's PCP. -She, the HCD, and the lead MA were responsible for reviewing physician orders. -She and the HCD were responsible for completing eMAR audits weekly with the PCP which consisted of reviewing missed, expired, and discontinued medications. Interview with the Regional Director of Operations on 10/16/26 at 8:05pm revealed: -The HCD was responsible for ensuring a resident's medication orders were faxed to the pharmacy and the pharmacy staff entered the order into the eMAR for the facility. -The HCD was responsible for verifying and approving the eMAR entry for the facility once the pharmacy entered the order into the eMAR system. -She expected the HCD to verify orders and to ensure orders were started for residents in the	D 276		

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D 276	Continued From page 25 eMAR to receive their medications as ordered by the physician. -She expected the HCD to complete eMAR audits weekly to ensure administration of resident's medications were not missed by the MAs. -The HCD was able to delegate eMAR responsibilities to the lead MA, the Director of the the secured AL, and the MAs but she the HCD was ultimately responsible to ensure all follow-up tasks were completed for the eMAR. Attempted telephone interview with Resident #2's power-of-attorney (POA) on 10/15/26 at 10:22am was unsuccessful.	D 276		
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 medication orders for 1 of 3 sampled residents (#2) including	D 344		

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orders for an antidepressant medication.

The findings are:

Review of Resident #2's current FL2 dated 05/28/26 revealed diagnoses included mild dementia with psychotic disturbance, generalized anxiety disorder, insomnia, vitamin B deficiency, and anosognosia.

Review of Resident #2's physician orders dated 06/05/26 revealed:
-There was an order for trazadone (a medication used to treat depression) 50mg, take half a tablet every night.
-There was an order for trazadone 50mg, take half a tablet as an additional dose around 2:00-3:00pm as needed.

Review of Resident #2's physician orders dated 06/18/26 revealed there was an order for trazadone 50mg, take half a tablet at 2:00pm and take an additional half tablet in the evening at 7:00pm.

Review of Resident #2's physician orders dated 06/25/26 revealed:
-There was an order for trazadone 50mg, take half a tablet every night.
-There was an order for trazadone 50mg, take half a tablet as an additional dose around 2:00-3:00pm as needed.

Review of Resident #2's physician orders dated 06/29/26 revealed there was an order for trazadone 50mg, take half a tablet at 2:00pm and take an additional half tablet in the evening at 7:00pm.

Review of Resident #2's physician orders dated

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07/23/26 revealed there was an order to discontinue trazadone 50mg, take half a tablet as an additional dose around 2:00-3:00pm as needed.

Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for trazadone 50mg take half a tablet in the evening scheduled for administration at 7:00pm from 06/07/26 to 09/19/26.
-There was documentation trazadone 50mg take half a tablet every evening was administered 06/01/26 to 06/19/26.
-There was a second entry for trazadone 50mg take half a tablet as an additional dose around 2:00-3:00pm as needed.
-There was documentation trazadone 50mg take half tablet half tablet as an additional dose around 2:00-3:00pm was administered twice on 06/10/26 and on 06/20/26.
-There was a third entry for trazadone 50mg take half a tablet at 2:00pm and at 7:00pm from 06/20/26 to 06/30/26.
-There was documentation trazadone 50mg take half tablet at 2:00pm and at 7:00pm was administered from 06/20/26 to 06/30/26.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for trazadone 50mg take half a tablet as an additional dose around 2:00-3:00pm as needed from 07/01/26 to 07/23/26.
-There was documentation trazadone 50mg take half tablet half tablet as an additional dose around 2:00-3:00pm was administered once on 07/01/26.
-There was a second entry for trazadone 50mg take half a tablet at 2:00pm and at 7:00pm from

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07/01/26 to 07/31/26.
-There was documentation trazadone 50mg take half tablet at 2:00pm and at 7:00pm was administered from 07/01/26 to 07/31/26.

Observation of Resident #2's medications on hand on 10/15/26 at 9:27am revealed there was a bubble pack of trazadone 50mg, take half tablet every night, dispensed 10/08/26 with 17 of 30 tablets available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/26 at 12:05pm revealed:
-The pharmacy received the current order on 06/18/26 and on 06/29/26 for Resident #2's trazadone 50mg take half a tablet at 2:00pm and at 7:00pm.
-The previous order for Resident #2's trazadone 50mg was to take tablet at 7:00pm and take half a tablet as an additional dose around 2:00-3:00pm as needed and should have been discontinued from the eMAR on 06/19/26.
-The pharmacy staff had not discontinued the previous order due to an entry error for the half tablet as an additional dose around 2:00-3:00pm as needed but the facility had not contacted the pharmacy to discontinue the order until 07/23/26.
-The pharmacy entered the orders into the eMAR for the facility but the facility staff were responsible for reviewing and approving the eMAR once the pharmacy entered the orders.

Interview with Resident #2's mental health provider (MHP) on 10/15/26 at 2:40pm revealed:
-Resident #2 had an order for trazadone 50mg take half tablet at 2:00pm and at 7:00pm daily.
-She discontinued the order for Resident #2's trazadone 50mg take half tablet as an additional dose around 2:00-3:00pm as needed on

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D 344	Continued From page 29 06/18/26. -She had received no correspondence from the facility staff since 06/28/26 related to Resident #2's as needed trazadone order and she expected the as needed order to be discontinued and not on the eMAR. -She expected medications to be administered as ordered and for the facility staff to clarify with her if there was confusion with a resident's medication orders. Telephone interview with Resident #2's Primary Care Provider (PCP) on 10/16/26 at 8:22am revealed: -She signed an incorrect, old medication list for Resident #2 the facility provided her for her visit notes with Resident #2 on 06/25/26. -She had not realized the discrepancy for the discontinued trazadone as needed dose until the pharmacy contacted her on 06/29/26 related to Resident #2's MHP order for trazadone scheduled at 2:00pm and at 7:00pm. -The facility had not clarified the discontinued as needed order with her until 07/23/26. -Resident #2's MHP order from 06/18/26 for trazadone 50mg at 2:00pm and at 7:00pm was the correct order and the facility should have discontinued the as needed trazadone for Resident #2. -She expected medications to be administered as ordered and for the facility staff to clarify with her and any other resident providers if there was confusion with a resident's medication orders. Interview with Resident #2 on 10/15/26 at 9:15am revealed: -She relied on the medication aides (MA) to administer her medications. -She had not recalled any issues with her medications from the past several months.	D 344		

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D 344	Continued From page 30 Interview with a MA on 10/16/26 at 10:30am revealed: -The PCP sent new medication orders directly to the facilities contracted pharmacy electronically. -The Health Care Director (HCD) and Director of the secured assist living (AL) were responsible for clarifying orders with the PCP and other physicians. -She was not aware of any discrepancies for Resident #2's trazadone orders from June 2026. -She administered residents' medications according to the entries in the eMAR and the HCD and the Director of the secured AL were responsible for medication cart audits to identify any discrepancies. Interview with the lead MA on 10/15/26 at 9:37am revealed: -She and the HCD were responsible for reviewing physician orders for the 2nd and 3rd floor assisted living residents. -The Director of the secured AL was responsible for reviewing the physician's orders for the secured AL residents. -She, the HCD, and Director of the secured AL reviewed physician's orders for all residents when either one of the HCD, the Director of the secured AL, or her was on leave from the facility. -She, the HCD and Director of the secured AL were responsible for weekly medication cart audits to identify any discrepancies. -She was not aware of Resident #2's order to discontinue her as needed trazadone until the HCD talked with Resident #2's responsible party on 07/23/26. Interview with the HCD on 10/16/26 at 2:05pm revealed: -The physician was responsible for sending a	D 344		

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resident's order to the pharmacy through an electronic format.
-She, the MAs, the Director of the secured AL, and the lead MA were responsible for requesting a copy of the order from the pharmacy.
-She and the Director of the secured AL were responsible for approving eMAR entries once the pharmacy entered a resident's order.
-She, the lead MA, and Director of the secured AL were responsible for weekly medication cart audits to identify any discrepancies.
-She was not aware of Resident #2's order to discontinue her as needed trazadone until she talked with Resident #2's responsible party on 07/23/26.
-On 07/23/26, she reached out to the PCP regarding clarification of Resident #2's trazadone order and gained a verbal order to send to the pharmacy.

Interview with the Director of the secured AL on 10/16/26 at 6:10pm revealed:
-The physician was responsible for sending a resident's order to the pharmacy through an electronic format and the physician sent a copy of the resident's order to the facility through email communication.
-She, the lead MA, and the HCD were responsible for reviewing all physicians' orders once the order was emailed to the facility.
-She and the HCD were responsible for verbal orders from the physicians and were responsible for faxing the verbal orders to the pharmacy.
-The pharmacy entered the physician's orders into the resident's eMAR and she or the HCD were responsible for reviewing and approving the eMAR entry.
-She was not aware of Resident #2's order to discontinue her as needed trazadone from June 2026 and was not aware the discontinued as

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D 344	Continued From page 32 needed trazadone was on the eMAR until 07/23/26. Interview with the Regional Director of Operations on 10/16/26 at 8:05pm revealed: -The HCD was primarily responsible to ensure physicians orders are clarified when there is a discrepancy even when the HCD delegated other staff for medication clarification tasks. -The HCD was responsible for receiving, reviewing physician's orders to send the orders to the pharmacy even when a physician would send the order electronically to the pharmacy. -The MAs, the HCD, Director of secured AL, and the lead MA were responsible for contacting the pharmacy for a copy of a physician's order if the physician had not provided the order upon the completion of a visit with a resident. -The HCD was responsible for auditing medication carts weekly and the medication cart audits involved clarifying orders and eMARs to the medications in the cart with expired and discontinued medications. -She was not aware of Resident #2's physician order to discontinue her as needed trazadone from June 2026 because she started as the interim Administrator in the second week of September 2026. -She expected all physician's orders to be clarified, administered, and discontinued as ordered. Attempted telephone interview with Resident #2's power-of-attorney (POA) on 10/15/26 at 10:22am was unsuccessful.	D 344		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 349		

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D 349	Continued From page 33 (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure self-administration orders were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 7 residents (#7). The findings are: Review of the facility's medication policy dated 04/2021 revealed the healthcare director observed the resident and utilized the assessment of medication self-management to determine if the resident could safely manage his/her own medication. Review of Resident #7's FL2 dated 01/09/26 revealed diagnoses included congestive heart failure (CHF), chronic kidney disease (CKD), atrial fibrillation (Afib), chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of Resident #7's Resident Register revealed an admission date of 03/01/25. Observation of Resident #7's room on 10/16/26 at 3:18pm revealed:	D 349		

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-Medications were stored inside a lockbox mounted on the wall in the bathroom.
-The lockbox contained acetaminophen 650mg, ambien 10mg, vitamin D3 25mg, diltiazem hcl 120mg, pantoprazole 40mg, levothyroxine 75 mg, metoprolol ER 24hr 25mg, multivitamin, tramadol 50mg, buprenorphine 15 mg, drysol 20% cream, and entresto 24-26mg.
-An oxygen concentrator and nasal tubing were at the bedside.

Interview with Resident #7 on 10/16/26 at 3:18pm revealed:
-She was independent in taking her medication.
-She used the oxygen at bedtime.
-She saw Primary Care Provider (PCP) in July 2026 and there were no changes to her ability to self-administer her medications.
-Her family member scheduled all her medical appointments.

Review of Resident #7's record revealed
-There was an FL2 dated 01/09/25 with self-administration order included.
-There was no FL2 available for review completed between 01/09/25 and 10/14/26.

Review of Resident #7's records revealed:
-There was a self-administration assessment completed by the facility's third-party provider 08/21/26.
-There was no current order for self-administration of medications.
-The last physician order was completed by resident's PCP on 10/25/25 with no current order for self-administration written.
-A medication review was completed by the facility's pharmacy on 9/15/26 noting self-administration.
-There was an order for acetaminophen 650mg

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(used to treat pain) 2 tablets twice a day, as needed (prn), for pain or discomfort.
-There was an order for aller-chlor 4mg (used as an antihistamine) 1 tablet twice a day for antihistamine.
-There was an order for ambien 10mg (used to treat insomnia) 1 tablet every 24 hours daily prn for insomnia.
-There was an order for apixaban 2.5mg (used to treat stroke and blood clots) 1 tablet twice a day.
-There was an order for ascorbic acid 500mg (used to treat vitamin C deficiency) 1 tablet daily.
-There was an order for baza 12% cream (used to treat skin infection) apply topically three times a day to buttock.
-There was an order for vitamin D3 25mg (used to treat vitamin D deficiency) 2 tablets daily.
-There was an order for diltiazem hcl 120mg (used to treat blood and oxygen to the heart) 1 cup daily.
-There was an order for entresto 24-26mg (used to treat CHF) 1 tablet twice a day.
-There was an order for sodium chloride nasal sol 0.65% (used for stuffy nose) 1 spray in both nostrils every 24 hours prn.
-There was an order for tramadol 50mg (used to treat pain) 1 tablet daily.
-There was an order for 2 liters oxygen prn.
-All of the medications were stand alone orders.

Review of Resident #7's August 2026, September 2026, and October 2026 electronic medication administration records (eMAR) revealed there were no eMARs available for review.

Interview with the Health Care Director (HCD) on 10/16/26 at 11:30am revealed the facility did not maintain eMARs for residents who self-administered their medications.

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D 349	Continued From page 36 Attempted telephone interview with Resident #7's PCP on 10/14/26 at 11:30am and 10/15/26 at 9:30am was unsuccessful. Interview with the lead medication aide (MA) on 10/16/26 at 5:45pm revealed: -The facility's contracted nurse completed residents' self-administer assessments. -Resident #7 did not have any eMARs on file because she self-administered her own medications. -Resident #7 did not receive any assistance from staff with her medication administration. -She was not aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months and that Resident #7 did not have current six-month signed medication self-administration physician's orders. Interview with the Director of the secured assisted living (AL) on 10/16/26 at 6:09pm revealed: -The facility's contracted nurse reviewed residents' records and sent emails about FL2s that were due the PCP. -Resident #7 did not have any eMARs on file because she self-administered her own medications. -Resident did not receive any assistance from staff with her medication administration. -She was not aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months and that Resident #7 did not have current six-month signed medication self-administration physician's orders. -Residents' records were audited by the facility medical provider.	D 349		

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D 349	Continued From page 37 Interview with the HCD on 10/16/26 at 7:50pm revealed: -She was not aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months. -She was not aware Resident #7 did not have current six-month signed medication self-administration physician's orders. -The facility's contracted nurse reviewed residents' records and sent emails about FL2s that were due to the HCD. -Self-administration assessments were completed by the facility's contracted nurse. Interview with the Regional Director of Operations on 10/16/2026 at 8:54pm revealed: -She was not aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months. -She was not aware Resident #7 did not have current six-month signed medication self-administration physician's orders. -She stated the charts are expected to be audited by the HCD routinely. -The HCD is responsible for obtaining the self administer orders from the resident's PCP.	D 349		
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	D 358		

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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:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents (#3 and #5) related to medications used to treat elevated blood sugars (#5), and a blood thinner, a blood pressure medication, a medication used to treat gastro-esophageal reflux, and a diuretic for fluid retention (#3).

The findings are:

Review of the facility's medication administration policy implemented April 2021 revealed the facility intended to provide assistance with all aspects of medication services in a manner that provided for a safe, timely and standardized approach in medication administration.

1. Review of Resident #3's current FL2 dated 10/22/25 revealed diagnoses included metabolic encephalopathy, vascular dementia, and gait instability.

Review of Resident #3's Resident Register revealed an admission date of 10/22/25.

Interview with Resident #3 on 10/16/26 at 5:00pm revealed:
-His family member helped with his appointments with outside providers and medications.
-He did not know his medications.

a. Review of Resident #3's hospital FL2 and

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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 39 discharge summary dated 07/24/26 revealed: -Current diagnoses listed the principal problem was acute or chronic anemia with active problems including atrial fibrillation, hyperlipidemia, and vascular dementia. -Active and resolved diagnoses included principal problem chronic upper gastro-intestinal (GI) bleeding, which was resolved, acute or chronic anemia, atrial fibrillation, and vascular dementia. Review of Resident #3's hospital discharge summary from a subsequent hospitalization dated 08/07/26 revealed: -Resident #3 was admitted on 08/05/26 for anemia and melena (black tarry stool suggesting bleeding from an internal source) and discharged on 08/07/26. -Resident #3 was found to have a large hiatal hernia and cameron lesions (a type of erosion of the stomach lining that bleeds) with gastroenterology suggesting dosing with a proton pump inhibitor twice a day. Review of Resident #3's hospital encounter after visit summaries on 10/15/26 revealed: -Resident #3 had a hospital encounter after visit summary from 07/14/26 to 07/15/26 for volume overload. (According to the American Heart Association, volume overload is a medical condition where the body has an excessive accumulation of fluid in the extracellular fluid space, including the bloodstream and tissues) -He was treated for chronic anemia but refused admission to the hospital. (Anemia is defined by the Mayo Clinic as a medical condition where your body does not have enough healthy red blood cells or hemoglobin to carry oxygen to your organs and tissues. Chronic anemia is anemia lasting more than 3 months).	D 358		

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D 358	Continued From page 40 Review of Resident #3's hospital discharge after visit summary dated 07/24/26 revealed there was an order for omeprazole 40mg (a medication used to decrease stomach acid secretion and treat stomach ulcer and reflux to aid in deceasing bleeding from a esophagus or stomach ulceration) daily at 6:00am. Review of Resident #3's documented history of present illness on encounter visit summaries from his primary care provider (PCP) dated 07/31/26 revealed: -Resident #3 was hospitalized the week of 07/15/26 and discharged against medical advice (AMA) on 07/15/26. He refused infusion (for anemia) and refused admission. -He was admitted to the hospital on 07/22/26 for anemia with a hemoglobin of 5.9 (normal range is 14.0-17.5 g/dL) upon admission, received 2 units of blood for anemia and was discharged on 07/24/26. His blood thinner was discontinued at discharge. Review of Resident #3's hospital discharge summary from a subsequent hospitalization dated 08/07/26 revealed: -Resident #3 was admitted on 08/05/26 for anemia and melena (black tarry stool suggesting bleeding from esophagus or stomach ulcers) and discharged on 08/07/26. -Resident #3's laboratory results for hemoglobin were documented as 10.7 (normal range is 14.0-17.5 g/dL), and his hematocrit was 33.1 (normal range 41.5-50.4%) at admission on 07/22/26. (Hemoglobin and hematocrit laboratory results are used to monitor anemia). -There was an order for a medication to treat stomach acid secretion inhibitor and stop omeprazole 40mg.	D 358		

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Review of Resident #3's documented history of present illness on encounter visit summaries from his PCP dated 08/13/26 revealed:
-He was seen for hospital follow-up.
-His hemoglobin was 9.9 and hematocrit was 31.7.

Review of Resident #3's July 2026 electronic medication administration record (eMAR) revealed:
-There was no entry for omeprazole 40mg daily at 6:00am.
-There was no documentation omeprazole 40mg was administered to Resident #3 in July 2026.

Review of Resident #3's August 2026 eMAR revealed:
-There was no entry for omeprazole 40mg daily at 6:00am.
-There was no documentation omeprazole 40mg was administered to Resident #3 from 08/01/26 to 08/07/26 when the medication was discontinued.

Observation of Resident #3's medication on hand for administration on 10/16/26 at 2:54pm revealed there was no omeprazole 40mg on hand for administration.

Telephone interview with Resident #3's PCP on 07/15/26 at 12:40pm revealed:
-She was very concerned about Resident #3's chronic anemia.
-She had been trying to get a hold on Resident #3's chronic anemia and had sent the resident to the hospital on previous occasions due to his low hemoglobin probably coming from bleeding somewhere in his body.
-She was monitoring his hematocrit and hemoglobin weekly from 07/06/26 to 09/04/26.

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D 358	Continued From page 42 -His last value (no date given) was hemoglobin of 12.9. -Her main concern was the negative effect of chronic anemia with very low hemoglobin and hematocrit could damage his kidneys and add to his heart load which was a problem since he had heart failure and saw a cardiologist. -It would be very important for Resident #3 to receive omeprazole or other stomach acid secretion inhibitors as ordered. -Resident #3's chronic anemia could have been negatively affected by not receiving omeprazole. Telephone interview with Resident #3's family member on 10/15/26 at 10:41am revealed: -He took Resident #3 to most of his outside appointments. -He visited Resident #3 frequently, sometimes every day. -He was present at the hospital discharge on 07/24/26 when the hospital physician told the family Resident #3 was going to be ordered a medication to take daily. -He left the paperwork with the order for omeprazole 40mg daily in the resident's room on 07/24/26. -He visited Resident #3 on 07/28/26, after the hospital discharge on 07/24/26, found discharge paperwork under the Resident's bed, and discovered Resident #3 was not being administered omeprazole daily from the eMAR. -He alerted medication staff that the resident stopped his blood thinner and started omeprazole daily when the resident was discharged. -The resident was back in the hospital from 08/05/26 to 08/07/26 and received orders for a different stomach medication. -He had repeated problems with the facility staff administering his family member's medications as ordered.	D 358		

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D 358	Continued From page 43 Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/16/26 at 1:55pm revealed: -Resident #3's hospital discharge FL2, admission notes and after visit summary for a hospital visit from 07/22/24 to 07/24/26 were faxed to the pharmacy by the facility on 07/28/26. -He acknowledged omeprazole 40mg was on the hospital FL2 and discharge summary notes dated 07/24/26. -The pharmacy staff never entered omeprazole 40mg on Resident #3's July 2026 or August 2026 eMAR but he did not know why. -There was no documentation Resident #3's omeprazole was dispensed from the pharmacy. -The facility was responsible for reviewing all medications orders compared to the eMAR information sent to the facility and contacting the pharmacy for any corrections or omissions. -There was no information in the pharmacy computer related to the facility contacting the pharmacy regarding Resident #3's omeprazole. Interview with the Health Care Director (HCD) on 10/20/26 at 7:15pm revealed: -The HCD, Director of the secured Assisted Living (AL) or medication aides (MAs) could write new orders on a paper medication administration (MAR) to document administration in some circumstances. -Resident #3's omeprazole 40mg could have been on a paper MAR. -She offered no additional information or documentation for Resident #3's omeprazole 40mg. Refer to the interview with the lead medication aide (MA) on 10/16/2026 at 5:20pm.	D 358		

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D 358	Continued From page 44 Refer to the interview with the Director of the secured Assisted Living (AL) on 10/16/26 at 5:25pm. Refer to the interview with the Health Care Director (HCD) on 10/16/26 at 7:15pm. Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm. b. Review of Resident #3's physician's orders from Resident #3's PCP dated 07/03/26 revealed and order for apixaban 5mg (a blood thinner used to treat atrial fibrillation) twice a day. Review of Resident #3's hospital admission note dated 07/22/26 revealed: -The resident was admitted on 07/22/26 for reported low hemoglobin and hypotension with a blood pressure of 91/55. -There was documentation of a recent hospital admission from 07/14/26 to 07/15/26 for abnormal hemoglobin and significant iron deficiency. He received one unit of packed red blood cells during the hospital visit on 07/14/26. -Resident #3's laboratory results for hemoglobin were documented as 5.9 (normal range is 14.0-17.5 g/dL), and his hematocrit was 18.4 (normal range 41.5-50.4%) at admission on 07/22/26. Review of Resident #3's laboratory results on hospital discharge on 07/24/26 revealed Resident #3's laboratory results for hemoglobin were documented as 7.9 and his hematocrit was 25.1. Review of Resident #3's hospital visit from 07/22/26 to 07/24/26 after visit summary revealed apixaban 5mg was to be held (paused) until the medication was resumed by the resident's provider.	D 358		

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D 358	Continued From page 45 Review of Resident #3's hospital discharge FL2 dated 07/24/26 revealed apixaban 5mg was not included in medications ordered on the discharge FL2. Review of Resident #3's hospital discharge summary from a subsequent hospitalization dated 08/07/26 revealed Resident #3 was admitted on 08/05/26 for anemia and melena (black tarry stool suggesting bleeding from esophagus or stomach ulcers) and discharged on 08/07/26. Review of Resident #3's physician's order from his PCP dated 07/28/26 revealed an order to discontinue apixaban 5mg. Review of Resident #3's PCP encounter details of present illness notes dated 07/31/26 revealed: -Resident #3 was admitted to a local hospital on 07/22/26 and discharged on 07/24/26 for anemia. -The resident had a history of heart failure with preserved ejection fraction and was on apixaban, which was discontinued at discharge on 07/24/26. -Apixaban 5mg was discontinued on 07/28/26 by the PCP. Review of Resident #3's progress note revealed: -On 07/22/26 at 6:41pm, the HCD documented Resident #3's PCP requested, due to low hemoglobin levels, the resident should be sent out to a local hospital emergency department. The resident's family member was contacted and agreed to meet the resident at the hospital. -On 07/24/26 at 11:45pm, a medication aide (MA) documented the resident returned from the hospital and all paperwork was faxed to the facility's contracted pharmacy and the resident's PCP. -On 07/28/26 at 5:39pm, the HCD documented	D 358		

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she spoke with Resident #3's family member who revealed the cardiologist had recommended during the hospital stay that apixaban be stopped but did not give him an order. The HCD reached out to Resident #3's PCP for an order to discontinue apixaban 5mg.

Review of Resident #3's July 2026 eMAR revealed:
-There was an entry for apixaban 5mg twice a day scheduled for administration at 8:00am and 8:00pm.
-Apixaban 5mg was documented as administered at 8:00am and 8:00pm from 07/01/26 to 0714/26, 07//15/26 at 8:00pm, 07/16/26, 07/17/26, 07/18/26, 07/20/26, 07/21/26, and 07/22/26.
-Apixaban 5mg was not administered at 8:00am on 07/15/26 with documented leave of absence, 07/19/26 at 8:00am and 8:00pm with out of facility for reason, from 07/23/26 at 8:00am to 07/24/26 at 8:00pm with leave of absence for reason.
-Apixaban was documented as administered from 07/25/26 at 8:00am to 07/28/26 at 8:00am.
-Apixaban 5mg was discontinued on the eMAR on 07/28/26 at the 8:00pm dose.
-There were 7 doses of apixaban 5mg administered after the medication was ordered to be held/paused on 07/24/26.

Observation of Resident #3's medication on hand for administration on 10/16/26 at 2:54pm revealed there was no apixaban 5mg on hand for administration.

Telephone interview with Resident #3's family member on 10/15/26 at 10:41am revealed:
-He was Resident #3's Power of Attorney (POA).
-He took Resident #3 to most of his outside appointments.
-He visited Resident #3 frequently, sometimes

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every day.
-He was present at the hospital discharge on 07/24/26 when the hospital physician told the family member that the blood thinner (apixaban) was going to be held/pause for the blood in the resident stool.
-He visited Resident #3 on 07/28/26, after the hospital discharge on 07/24/26, found discharge paperwork under the Resident's bed, and discovered Resident #3 was still receiving apixaban 5mg with his medications.
-He alerted medication staff that the apixaban was supposed to be stopped.

Telephone interview with Resident #3's PCP on 10/15/26 at 12:00pm revealed:
-She saw Resident #3 on routine visits to the facility.
-She was monitoring Resident #3's laboratory test for chronic anemia and low hemoglobin.
-Blood loss could add to low hemoglobin levels and anemia.
-The facility routinely placed after visit summaries in her facility box for reviewing with her weekly visit on Thursdays.
-She did not have access to the facility's eMARs for a few months due to the facility changing their computer system and not providing her with a password.
-This caused her concern with monitoring medication administration.
-She did not routinely check residents' medications in the facility's medication cart unless she had a concern for a particular medication.
-Resident #3's apixaban 5mg was listed on the medication list under "Pause taking these medications" followed by "take these medication" where several medications were listed on the hospital discharge and after visit for the hospital visit dated from 07/22/26 to 07/24/26.

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D 358	Continued From page 48 -She would not have seen the hospital paperwork until the following week as she had visited the facility on Thursday, 07/23/26 and next on Thursday, 07/30/26. -She signed a verbal order on 07/28/26 to discontinue Resident #3's apixaban 5mg faxed to her by the HCD on 07/28/2026 at 5:37pm. -Since she did not have access to the facility's eMAR computer, she did not know Resident #3 received apixaban 5mg from 07/25/26 until 07/28/26. -The facility should have reviewed Resident #3's hospital paperwork when he came back to the facility and reached out to her on the on-call provider for an order to discontinue apixaban 5mg per the discharge and after visit paperwork. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/16/26 at 1:55pm revealed: -Resident #3's hospital discharge FL2, admission notes and after visit summary for hospital visit from 07/22/24 to 07/24/26 were received by fax at the pharmacy on 07/28/26. -The pharmacy staff highlighted to pause apixaban 5mg on the paperwork but there was no documentation for the pharmacy's action for the medication. -The facility was responsible for reviewing all medications orders compared to the eMAR information sent to the facility and contact the pharmacy for any corrections or omissions. The pharmacy received an order to discontinue apixaban from Resident #3's PCP on 07/28/26. -Apixaban 5mg was discontinued by the pharmacy on 07/28/26 for the 8:00pm dose. Interview with the HCD on 10/16/26 at 5:00pm revealed: -Resident #3's hospital paperwork from 07/24/26	D 358		

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did not have an order to discontinue apixaban 5mg, only pause the medication.
-When she was made aware of the resident's family member's concern related to the discharge paperwork, she consulted the paperwork for further review.
-She contacted Resident #3's PCP on 07/28/26 for an order to discontinue Resident #3's apixaban 5mg.

Refer to the interview with the lead MA on 10/16/2026 at 5:20pm.

Refer to the interview with the Director of the secured AL on 10/16/26 at 5:25pm.

Refer to the interview with the HCD on 10/16/26 at 7:15pm.

Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm.

c. Review of Resident #3's current FL2 dated 10/22/25 revealed an order for furosemide 20mg (used to treat fluid buildup) once daily.

Review of Resident #3's after visit encounter details with Resident #3's PCP dated 06/25/26 revealed:
-There were electronically signed medication orders including furosemide 20mg daily.
-Resident #3 was noted to have shortness of breath and increased fatigue with minimal exercise.
-Resident #3 had a cardiology appointment scheduled on 07/01/26.

Review of Resident #3's cardiology visit summary note revealed:
-There was an order faxed to the facility with a

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time stamp of 07/01/26 at 4:41pm.
-The fax received was an order for daily weights with a goal weight of 185 (pounds) or less.
-If the weight was less than 185, take 20mg of Lasix (furosemide is the generic).
-If the weight was 185 to 190, take 40mg of Lasix.
-If the weight was greater than 190, take 60mg of Lasix.

Review of Resident #3's subsequent faxed cardiology notes dated 07/06/26 with a time stamp of 2:31pm revealed:
-"Per our previous conversation about Lasix, please see updated order to follow".
-Take 40mg of Lasix daily.
-If there was a 3-pound weight gain in 24 hours or five pound weight increase in a week, increase to 80mg daily. Goal daily weight was 185 pounds.

Review of Resident #3's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for furosemide 20mg one tablet daily, scheduled for administration at 8:00am.
-Furosemide 20mg was documented administered on 07/01/26 at 8:00am and 07/02/26 at 9:00am.
-The order was discontinued on 07/03/26 at 9:52am.

Continued review of Resident #3's July 2026 eMAR revealed:
-There was entry for daily weight scheduled for 9:00am beginning 07/03/26.
-There was a second entry for furosemide 20mg tablet if weight greater than 190 take 3 tablets=60mg, if weight 185-190 take 2 tablets = 40mg, if weight less than 185 take one tablet= 20mg for edema with time scheduled prn (as

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needed) with a start date of 07/02/26.
-On 07/03/26, Resident #3's weight was documented as 199.8 pounds and furosemide 20mg was documented administered at 1:29pm, but no amount of furosemide was documented.
-On 07/04/26, Resident #3's weight was documented as 199.2 pounds and furosemide 20mg was blank for administration.
-On 07/05/26, Resident #3's weight was documented as 199.3 pounds and furosemide 20mg was blank for administration.
-On 07/06/26, Resident #3's weight was documented as 199.1 pounds and furosemide 20mg was blank for administration.
-On 07/07/26, Resident #3's weight was 195 pounds and furosemide 20mg was documented administered at 9:03am, but no amount of furosemide was documented.
-On 07/08/26, Resident #3's weight was documented as 193.2 pounds and furosemide 20mg was blank for administration.
-On 07/09/26, Resident #3's weight was blank for documented weight and furosemide 20mg was blank for administration.
-On 07/10/26, Resident #3's weight was blank for documented weight and furosemide 20mg was blank for administration.
-On 07/11/26, Resident #3's weight was documented as 193 pounds and furosemide 20mg was blank for administration.
-On 07/12/26, the eMAR entry was discontinued.
-There was a third entry for furosemide 40mg one tablet daily scheduled for administration at 8:00am daily beginning 07/12/26.
-There was a fourth entry for furosemide 20mg take 2 tablets=40mg in addition to scheduled dose as needed, if there is a 3-pound weight gain in 24 hours or a 5-pound weight over 1 week. Goal weight 185 pounds with scheduled time of administration as prn (as needed).

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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 52 -Furosemide 40mg was documented as administered daily from 07/12/26 to 07/31/26 at 8:00am except on 07/15/26, 07/23/26 and 07/24/26 when the resident was out of the facility. -There were 9 of 9 opportunities for administering furosemide 20mg tablets from 07/03/26 to 07/12/26 with no documentation for administration. -Resident #3's weight decreased daily from 193 pounds on 07/12/26 to 183 pounds on 07/30/26. Review of Resident #3's eMAR for August eMAR 2026 revealed: -There was entry for daily weight scheduled for 9:00am beginning 07/03/26. -There was an entry for furosemide 40mg one tablet daily scheduled for administration at 8:00am daily. -Furosemide 40mg documented as administered at 8:00am daily. -Resident #3's weight ranged from 184 pounds on 08/01/26 down to 179.6 pounds on 08/31/26. -There was an entry for furosemide 20mg take 2 tablets=40mg in addition to scheduled dose as needed, if there is a 3-pound weight gain in 24 hours or a 5-pound weight over 1 week. Goal weight 185 pounds with scheduled time of administration as prn. -On 08/21/26 at 9:11am, there was one 3-pound weight gain in 24 hours with the resident's weight documented as 177 pounds on 08/20/26 and 180.1 on 08/21/26. Furosemide 20mg with 2 tablets to equal 40mg dose in addition to the 40mg scheduled dose was documented as administered. Review of Resident #3's eMAR for September eMAR 2026 revealed: -There was entry for daily weight scheduled for 9:00am beginning 07/03/26.	D 358		

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D 358	Continued From page 53 -There was an entry for furosemide 40mg one tablet daily scheduled for administration at 8:00am daily. -There was an entry for furosemide 20mg take 2 tablets=40mg in addition to scheduled dose as needed, if there is a 3-pound weight gain in 24 hours or a 5-pound weight over 1 week. Goal weight 185 pounds with scheduled time of administration as prn. -Resident #3's weight ranged from 179 pounds on 09/01/26 to 179 pounds on 09/30/26 with no 3-pound weight gain in 24 hours. -Furosemide 40mg documented as administered at 8:00am daily. Review of Resident #3's eMAR for October 2026 from 10/01/26 to 10/14/26 revealed: -There was entry for daily weight scheduled for 9:00am beginning 07/03/26. -There was an entry for furosemide 40mg one tablet daily scheduled for administration at 8:00am daily. -Furosemide 40mg was documented as administered at 8:00am from 10/01/26 to 10/14/26. -There was an entry for furosemide 20mg take 2 tablets=40mg in addition to scheduled dose as needed, if there is a 3-pound weight gain in 24 hours or a 5-pound weight over 1 week. Goal weight 185 pounds with scheduled time of administration as prn. -Resident #3's weight ranged from 178 pounds on 10/01/26 to 182 pounds on 10/14/26 with one 3-pound weight gain in 24 hours. (on 10/14/26 at 10:16am, Resident #3's weight was documented as 182 pounds). -On 10/06/26, there was one 3-pound weight gain in 24 hours with the resident's weight documented as 178 pounds on 10/05/26 and 182.6 on 10/06/26. Furosemide 20mg with 2	D 358		

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D 358	Continued From page 54 tablets to equal 40mg dose in addition to the 40mg scheduled dose was not documented as administered. Observation of Resident #3's medication on hand for administration on 10/16/26 at 2:54pm revealed: -There were 83 tablets remaining of a quantity of 90 tablets of furosemide 20mg tablets dispensed on 07/01/26. -There were 17 of 30 tablets of furosemide 40mg tablets dispensed on 10/02/26 with directions to take on tablet daily. Review of Resident #3's progress notes dated 07/02/26 revealed: -The HCD documented she reached out to the cardiologist office requesting the cardiology nurse contact the HCD regarding the order for Resident #3's furosemide 20mg dosing with weight parameters for possible change to the order. -There were no additional notes related to furosemide documented in the progress notes. Telephone interview with Resident #3's PCP on 10/15/26 at 12:00pm revealed: -Resident #3 had heart failure as well as other diagnoses. -She was aware Resident #3 had orders for daily weights and changes to his furosemide 20mg for fluid retention from his cardiology clinic on 07/01/26. -The HCD had been reluctant to have staff try to follow the furosemide 20mg order based on daily weights and contacted the cardiology clinic for an order change to be simpler. -On 07/06/26, the furosemide order was changed to 40mg daily and an additional 40mg if 3-pound weight gain in 24 hours or 5-pound weight gain in one week.	D 358		

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-She was aware of the new furosemide order written on 07/06/26.
-She reviewed the residents' eMARs for documentation of medication administration when she had a scheduled visit with a resident.
-She noticed Resident #3 had missing documentation for furosemide administration the first few days in July 2026.
-She would expect Resident #3 to have received furosemide 20mg daily from his old order even if the facility was trying to contact the cardiology clinic for a different furosemide order.
-Resident #3 could experience more fluid retention causing increased shortness of breath if he did not receive furosemide.

Telephone interview with a nurse at Resident #3's cardiology clinic on 10/15/26 revealed:
-The cardiologist was not available for interview.
-He had Resident #3's office notes available for review.
-Resident #3 had a furosemide order dated 07/01/26 for furosemide 20mg tablets to be dosed according to weight with a goal dry weight of 185 pounds.
-This type order was routine for residents with congestive heart failure and fluid retention around the heart causing shortness of breath and fatigue.
-There was a second order dated 07/06/26 for furosemide 40mg daily, with additional 40mg to equal 80mg for weight gain of 3 pounds in 24 hours, or 5 pounds gain in a week.
-Resident #3 should be receiving furosemide daily.
-If the resident did not receive furosemide his fluid weight could increase worsening his shortness of breath and fatigue for minimal exercise and increased load on the heart.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 10/16/26 at 1:30pm revealed:
-Resident #3 received medications from the pharmacy, including furosemide 20mg ordered daily.
-The pharmacy received a new order faxed from the facility on 07/01/26 for Resident #3's
-The fax received was an order for daily weights with a goal weight of 185 (pounds) or less.
-If weight was less than 185, take 20mg of Lasix (furosemide is the generic).
-If weight was from 185 to 190, take 40mg of Lasix.
-If weight was greater than 190, take 60mg of Lasix.
-The pharmacy entered the order in their computer system on 07/01/26 and pushed the order to the facility for approval.
-Once the facility approved (and released) the order, the order was synchronized electronically with the facility's eMAR system.
-The facility did not use an eMAR system that was able to be subsequently viewed by the pharmacy for additional information, including administration documentation.
-The pharmacy received another order for Resident #3's furosemide dated 07/06/26 but not faxed to the pharmacy on 07/09/26 at 5:21pm.
-The 07/09/26 order was "Per our previous conversation about Lasix, please see updated order to follow". Take 40mg of Lasix daily. If 3-pound weight gain in 24 hours or 5-pound weight increase in a week, increase to 80mg daily. Goal weight was 185.
-That order was entered on 07/10/26 into the pharmacy computer system for approval by the facility.
-The pharmacy dispensed furosemide 20mg in a one time quantity of 90 tablets on 07/01/26 with directions for furosemide 20mg tablet if weight

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greater than 190 take 3 tablets=60mg, if weight 185-190 take 2 tablets = 40mg, if weight less than 185 take one tablet= 20mg for edema with time scheduled prn (as needed).
-The pharmacy dispensed furosemide 40mg labeled one tablet daily for a quantity of 30 tablets on 07/10/26, 08/04/26, 09/01/26, and 10/02/26.

Interview with Resident #3's family member on 10/15/26 at 10:41am revealed:
-Resident #3 had a cardiologist for monitoring his heart function.
-On a visit to the cardiologist in July 2026, the cardiologist expressed concerns to the family member that the facility was not administering his diuretic (furosemide) as ordered.
-He informed the HCD of the resident not receiving furosemide as directed and the cardiologist's concern (no date given).

Interview with the HCD on 10/16/26 at 7:00pm revealed:
-Resident #3 was the first resident the facility had with an order for furosemide to be administered by "sliding scale" meaning weight the resident and adjust the furosemide dose according to the weight.
-She did not feel the MAs were qualified to administer medications via a sliding scale.
-The facility did not admit residents with sliding scale medications, an example was sliding scale insulin.
-Resident #3 had been in the facility since October 2025 and she did not want to discharge the resident because of the furosemide order.
-She contacted the resident's cardiology clinic to change the order to a more familiar order.
-The furosemide order was changed on 07/06/26 and faxed to the contracted pharmacy (no date provided for date faxed and no fax confirmation

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presented).
-She had not audited Resident #3's eMAR and was not aware Resident #3 had documented administration of furosemide only 2 of 9 times from 07/03/26 to 07/12/26.

Interview with the Regional Director of Operations on 10/16/26 at 8:10pm revealed:
-She had been working with Resident #3's family member to resolve medication concerns and complaints for Resident #3.
-She was aware Resident #3 did not receive furosemide as ordered from 07/02/26 to 07/12/26 from emails and conversations with Resident #3's family member.

Refer to the interview with the lead MA on 10/16/2026 at 5:20pm.

Refer to the interview with the Director of the secured AL on 10/16/26 at 5:25pm.

Refer to the interview with the HCD on 10/16/26 at 7:15pm.

Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm.

d. Review of Resident #3's hospital discharge summary dated 07/24/26 revealed an order for metoprolol succinate 24-hour ER (extended release) (used to regulate heart rate and lower blood pressure) 25mg daily.

Review of Resident #3's hospital discharge summary dated 08/07/26 revealed:
-Resident #3 was admitted on 08/05/26 for anemia and melena (black tarry stool suggesting bleeding from esophagus or stomach ulcers) and discharged on 08/07/26.

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D 358	Continued From page 59 -Discharge medications included metoprolol succinate ER (extended release) 25mg daily. Review of the After Visit Summary dated 08/07/26 revealed an appointment scheduled at an electrophysiology clinic for atrial fibrillation . Review of Resident #3's after visit summary from the electrophysiology clinic dated 08/17/26 revealed: -He was seen for atrial fibrillation. -His blood pressure was documented as 84/60 and weight as 180 pounds. -Metoprolol Succinate 25mg was ordered to be stopped on 08/17/26. -There was a scheduled follow-up appointment with a Cardiology clinic on 09/25/26. Review of Resident #3's Physician Order Review dated 09/25/26 and signed by Cardiology Nurse Practitioner (NP) on 09/25/26 revealed: -Resident #3's metoprolol succinate ER 25mg one daily was listed and schedule for administration at 8:00pm. -There was an order to stop metoprolol, continue the other medications. -Follow up in 3 months was ordered. -The order was time-stamped as faxed to the facility's contracted pharmacy on 09/25/26 at 3:08pm. Review of Resident #3's progress notes 09/25/26 revealed: -At 12:33pm, the lead MA called the facility's contracted pharmacy regarding metoprolol succinate ER 25mg. She was told by a pharmacy staff that the pharmacy received the order to discontinue the medication on 08/17/26 and no additional medication was sent to the facility after that date.	D 358		

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-She expressed that the medication was still showing up for staff to administer, and he said it was an eMAR issue.
-At 5:09pm, the HCD reached out to the cardiologist to clarify the metoprolol and left a message for the doctor's office to contact the HCD to give an update.
-The HCD noted she spoke with Resident #3's PCP and verified Resident #3's medication that the cardiologist had a concern about.Review of Resident #3's August 2026 eMAR revealed:
-There was entry for metoprolol succinate ER 25mg one daily schedule for administration at 8:00pm.
-Metoprolol succinate ER 25mg was documented as administered daily at 8:00pm from 08/01/26 to 08/31/26.
-There were 14 doses of metoprolol succinate ER 25mg documented as administered in August 2026 after the medication was discontinued on 08/17/26.

Review of Resident #3's September 2026 eMAR revealed:
-There was entry for metoprolol succinate ER 25mg one daily schedule for administration at 8:00pm.
-Metoprolol succinate ER 25mg was documented as administered daily at 8:00pm from 09/01/26 to 09/24/26.
-Metoprolol succinate ER 25mg was discontinued on 09/25/26 on the eMAR.
-There were 24 doses of metoprolol succinate ER 25mg documented as administered in September 2026 after the medication was discontinued on 08/17/26.

Observation of Resident #3's medication on hand for administration on 10/16/26 at 2:54pm revealed there was no metoprolol succinate ER 25mg on

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D 358	Continued From page 61 hand for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/16/26 at 1:55pm revealed: -The pharmacy received the order to discontinue Resident #3's metoprolol succinate ER 25mg on 08/17/26. -The pharmacy staff discontinued metoprolol in the pharmacy's computer system on 08/17/26 but it appeared the pharmacy staff did not complete the pharmacy entry to appear as deleted for the facility. -Resident #3's metoprolol succinate ER 25mg was dispensed on the cycle fills dated for a 30 days' supply on 06/04/26, 07/02/26, and 08/04/26. -Depending on when the 08/04/26 cycle fill metoprolol succinate ER 25mg was started, the medication card could have lasted until at least 09/04/26. -There was no metoprolol succinate ER 25mg dispensed on Resident #3's cycle filled medications on 09/04/26. -If a medication was removed from the medication cart, it should be sent back to the pharmacy for destruction with the next pharmacy delivery to the facility. -There was no documentation at the pharmacy for return of metoprolol succinate ER 25mg for Resident #3 available for review, but it was possible the facility sent a partial card back to be destroyed and the pharmacy had not processed the paperwork. -The pharmacy received an order on 09/24/26 from Resident #3's PCP to discontinue metoprolol succinate ER 25mg and it was discontinued on the September 2026 eMAR on 09/25/26. Telephone interview with Resident #3's PCP on 10/15/26 at 12:00pm revealed:	D 358		

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-She saw Resident #3 on routine visits to the facility.
-She was monitoring Resident #3's laboratory test for chronic anemia and low hemoglobin.
-The facility routinely placed after visit summaries in her facility box for reviewing with her weekly visit on Thursdays.
-She did not have access to the facility's eMARs for a few months due to the facility changing their computer system and not providing her with a password.
-This caused her concern with monitoring medication administration.
-She did not routinely check residents' medications in the facility's medication cart unless she had a concern for a particular medication.
-Resident #3's metoprolol was first discontinued on 08/17/26 by cardiology as reviewed on the after visit summary dated 08/17/26.
-Facility staff told her Resident #3's was not stopped until 08/26/26 but she did not recall who told her.
-She wrote an order on 09/24/26 to discontinue metoprolol succinate ER 25mg per the facility's request for the order to send to the pharmacy so the medication would be discontinued on the eMAR.

Interview with Resident #3's family member on 10/15/26 at 10:41am revealed:
-He took Resident #3 to an appointment on 08/17/26 at the electrophysiology clinic for testing.
-Resident #3 (and the family member) were instructed to stop metoprolol.
-He took Resident #3 to a cardiology appointment on 09/29/26 and the resident's eMAR was reviewed.
-The resident's blood pressure was 90/63.
-The cardiology provider was upset and concerned for the resident's welfare that Resident

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D 358	Continued From page 63 #3's metoprolol succinate ER 25mg was ordered to be stopped but was documented as still administered through 09/24/26. Interview with the HCD on 10/16/26 at 5:05pm revealed: -The pharmacy should have discontinued metoprolol succinate ER 25mg on the eMAR from the order faxed to the pharmacy on 08/17/26 from the electrophysiology clinic. -She might have documentation that Resident #3's metoprolol was pulled from the medication cart by one of the medication aides (MA) but she was not sure where it was. -The medications pulled from the medication cart should be written up on a pharmacy return sheet and returned to the pharmacy on the next delivery. -The return sheets were in boxes in a storage room and not easily retrievable. -No return to pharmacy information was available for review for when or if metoprolol succinate ER 25mg was return for Resident #3. Refer to the interview with the lead MA on 10/16/2026 at 5:20pm. Refer to the interview with the Director of the secured AL on 10/16/26 at 5:25pm. Refer to the interview with the HCD on 10/16/26 at 7:15pm. Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm. 2. Review of Resident #5's current FL2 dated 03/04/26 revealed: -Diagnoses included Alzheimer's disease, diabetes mellitus, hypertension, atrial fibrillation, depression and hyperlipidemia.	D 358		

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D 358	Continued From page 64 -She was intermittently disoriented. a. Review of Resident #5's physician order dated 09/06/26 revealed an order for Novolog (a fast-acting insulin used to control blood sugar) 3 units(u) with meals. Review of Resident #5's physician order dated 09/23/26 revealed an order to discontinue Novolog 3u with meals and start Novolog 6u with meals. Review of Resident #5's After Visit Summary from a local hospital emergency department visit on 09/16/26 revealed: -The resident was seen at the hospital with a diagnosis of hyperglycemia due to diabetes mellitus, poorly controlled diabetes mellitus, and hypokalemia. -Her Hemoglobin A1C (a measurement of longterm blood glucose control with normal range, according to the American Diabetes Association, being under 7) was 13.1. -Resident #5 was ordered a potassium supplement for 5 days. Review of Resident #5's After Visit Summary from a local hospitalization from 09/28/26 to 10/02/26 revealed: -The resident was admitted due to dizziness with diagnoses including acute cystitis with hematuria, dehydration with hyponatremia, Alzheimer's disease, hypertension, hypokalemia, and Type 2 diabetes mellitus. -Resident #5's blood sugar upon admission was 359. (The American Diabetes Association recommends blood sugar levels be maintained at 90 mg/dL to 130mg/dL before meals and less than 180 mg/dL one to two hours after meals when using a blood sample drawn from a	D 358		

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D 358	Continued From page 65 fingertip.) -There was a discharge order to discontinue Novolog and start taking a long-acting insulin. Review of Resident #5's September 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 3u with meals with a start date of 09/11/26 scheduled at 7:30am, 11:30am, and 4:30pm. -There was documentation Novolog 3u was administered three times daily at meal times from 09/11/26 through 9/28/26. -There was no entry for Novolog 6u with meals or documentation Novolog 6u were administered from 09/23/26 through 09/30/26. -There was no documentation Novolog was administered from 09/28/26 through 09/30/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/26 at 2:22pm revealed: -Resident #5 had an order on file for Novolog 3u beginning 09/06/26. -The pharmacy dispensed 5 pens of Novolog on 09/07/26 and they were delivered to the facility on 09/08/26. -Orders had been entered on the eMAR by pharmacy staff to start Novolog 3u at breakfast on 09/08/26. -It was expected that Novolog 3u would be administered to Resident #5 on 09/08/26 at breakfast. -No orders had been received by the pharmacy on 09/23/26 to increase the dose from 3u to 6u. -Whenever a new dosage for insulin was written by the primary care provider (PCP), the medication aide (MA) should administer the new dose from the existing insulin on the medication cart.	D 358		

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-The Health Care Director (HCD) or the Director of the secured assisted living (AL) should change the new insulin order on the eMAR.
-The HCD or the Director of the secured AL received all PCP orders and should fax new orders to the pharmacy.

Interview with Resident #5's PCP on 10/15/26 at 12:27pm revealed:
-She had written an order to start Novolog 3u with meals on 09/06/26.
-She had written an order on 09/23/26 to discontinue Novolog 3u with meals and increase Novolog to 6u with meals.
-She had asked one of the MAs if Novolog was being administered.
-She was concerned that Resident #5's insulin had not been administered because her FSBS values remained high.
-She sent Resident #5 to the emergency room on 09/16/26 due to hyperglycemia and blood glucose greater than 600.
-She sent Resident #5 to the emergency room on 09/28/26, which resulted in a 5-day admission for increased somnolence, hyperglycemia, dehydration, acute cystitis with hematuria and new visual changes.
-She called the facility's contracted pharmacy and spoke with a pharmacist and reviewed all insulin orders and determined the initial order dated 09/06/26 for insulin 3u started 5 days after the order was written, and the order dated 09/23/26 for Novolog 6u at meal times was never entered on the eMAR and never administered to Resident #5.

Interview with Resident #5's family member on 10/16/26 at 5:01pm revealed:
-She knew Resident #5 was on insulin.
-Resident #5's blood glucose had been over 600

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D 358	Continued From page 67 when she had an emergency room visit on 09/16/26. -She was concerned that Resident #5 had 2 different hospitalizations within a month. Interview with a MA on 10/14/26 at 10:13am revealed: -She had administered Novolog 3u with meals to Resident #5. -She had not seen orders to increase Novolog to 6u before meals. -She had not been told by the HCD or the Director of the secured AL to change the insulin dose. -New orders were reviewed and changed on the eMAR by the HCD or the Director of the secured AL. Interview with another MA on 10/16/26 at 4:30pm revealed: -She had administered Novolog 3u with meals to Resident #5. -She had not seen orders to increase Novolog to 6u before meals. -She had not been told by the HCD or the Director of the secured AL to change the insulin dose. Interview with a third MA on 10/16/26 revealed: -She had administered Novolog 3u with meals to Resident #5. -She had not seen orders to increase novolog to 6u before meals. -She had not been told by the HCD or the Director of the secured AL to change the insulin dose. -New orders were reviewed and changed on the eMAR by the HCD or the Director of the secured AL. -She did not make any changes to the eMAR.	D 358		

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D 358	Continued From page 68 Interview with the the Director of the secured AL on 10/16/26 at 5:25pm revealed: -She did not know why there was a delay in starting Resident #5's Novolog 3u until 09/11/26 when the order was written on 09/06/26. -She did not know about the change in Novolog from 3u to 6u because she was on vacation during that time. -She expected insulin changes would occur within 2 days. Interview with the HCD on 10/20/26 at 7:35pm revealed: -She did not know why there was a delay in starting Resident #5's Novolog 3 units. -She did not remember the new orders written 09/23/26 for Novolog 3u to change to 6u. -She did not remember an email with the new PCP orders on 09/23/26. -She expected new or changed insulin orders to start within 2 days of the new or changed order. Interview with the Regional Director of Operations on 10/16/26 at 8:15pm revealed the reasonable time frame for insulin changes would be immediately. Based on observation and record review it was determined Resident #5 was not interviewable. Refer to the interview with the lead medication aide (MA) on 10/16/2026 at 5:20pm. Refer to the interview with the Director of the secured Assisted Living (AL) on 10/16/26 at 5:25pm. Refer to the interview with the HCD on 10/16/26 at 7:15pm.	D 358		

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D 358	Continued From page 69 Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm. b. Review of Resident #5's physician order dated 03/30/26 revealed there was an order for Toujeo (a long-acting insulin to lower blood sugar) 10u every morning. Review of Resident #5's physician order dated 08/21/26 revealed an order for Toujeo 5u to be administered before breakfast. Review of Resident #5's physician order dated 08/27/26 revealed an order for Toujeo 10u to be administered before breakfast. Review of Resident #5's August 2026 eMAR revealed: -There was an entry for Toujeo 10u daily with a scheduled administration time of 9:00am and a discontinue date of 08/17/26. -There was documentation Toujeo 10u was administered to Resident #5 from 08/01/26 through 08/17/26. -There was a second entry for Toujeo 5u before breakfast with a scheduled administration time of 7:30am with a start date of 08/23/26 and discontinue date of 08/28/26. -There was documentation Toujeo 5u was administered to Resident #5 from 08/23/26 through 08/27/26. -There was a third entry for Toujeo 10u daily with a scheduled administration time of 7:30am and start date of 08/28/26. -There was documentation Toujeo 10u was administered to Resident #5 from 08/28/26 through 08/30/26. -There was no documentation Toujeo was administered before breakfast on 08/18/26	D 358		

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D 358	Continued From page 70 through 8/22/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/26 at 2:28 pm revealed: -Toujeo insulin injector containing 300u was dispensed to the facility for Resident #5 on 08/18/26. -New medications were dispensed with each cycled delivery. -The amount of Toujeo on hand reflected the cycled medication for October because the facility returned any remaining supply on hand to the pharmacy at the end of each cycle. -Dose changes for Toujeo were expected to be administered within 24 hours of the new written order. Interview with Resident #5's PCP on 10/16/26 at 12:27pm revealed: -She expected the new insulin orders for Toujeo be started within 24 hours of the written order. -She was not aware of the missed morning doses from 08/18/26 through 08/22/26. Interview with an MA on 10/14/26 at 10:13am revealed: -She did not remember Resident #5's Toujeo orders from August 2026. -Resident #5 always had insulin order changes. -New orders were reviewed and changed on the eMAR by the HCD or the Director of the secured assisted living (AL). Interview with a second MA on 10/16/26 revealed: -She had administered Toujeo to Resident #5. -She did not remember the dates of the insulin changes from August 2026. -New orders are reviewed and changed on the eMAR by the HCD or the Director of the secured	D 358		

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D 358	Continued From page 71 AL. -She did not make any changes to the eMAR. Interview with the Director of the secured AL on 10/16/26 at 5:25pm revealed: -She did not know Toujeo morning insulin was not administered 08/18/26 through 08/22/26. -She did not know why there was a delay of 2 days to start the Toujeo 5u. -She expected insulin changes would occur within 2 days. -She did not audit the charts. Interview with the HCD on 10/16/26 at 7:35pm revealed: -She did not audit the chart for new orders. -She did not know Toujeo morning insulin was not administered 08/18/26 through 08/22/26. -She did not know why there was a delay of 2 days to start the Toujeo 5u. -She expected insulin changes would occur within 2 days. Interview with the Regional Director of Operations on 10/16/26 at 8:15pm revealed the reasonable time frame for insulin changes would be immediately. Based on observation and record review it was determined Resident #5 was not interviewable. Refer to the interview with the lead medication aide (MA) on 10/16/2026 at 5:20pm. Refer to the interview with the Director of the secured Assisted Living (AL) on 10/16/26 at 5:25pm. Refer to the interview with the HCD on 10/16/26 at 7:15pm.	D 358		

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D 358	Continued From page 72 Refer to the interview with the Regional Director of Operations on 10/16/26 at 8:00pm. _____ Interview with the lead MA on 10/16/2026 at 5:20pm revealed: -She became the lead MA a couple of months ago and was responsible for assisting MAs with medication issues. -Previously, she was a scheduled MA working shifts on all the medication carts. -The facility started the current eMAR system February 2026 or March 2026. -All orders appearing on the current eMAR system were entered by the facility's contracted staff. -The HCD or the Director of the secured AL were the only staff authorized to approve orders entered into the eMAR system, pended until approval, then released for the MA to administer medications. -The MAs did not have routine access to medication orders for questions but referred question to her or the HCD or the Director of the secured AL to be reviewed. -The MA were trained to administer medications according to the eMAR, at the scheduled time the medications appeared on the eMAR. Interview with the Director of the secured AL on 10/16/26 at 5:25pm revealed: -Normally, the HCD and/or she received new primary care provider (PCP) orders by email from the PCP. -She or the HCD waited until the order was entered on the eMAR by the pharmacy. -She or the HCD then checked the order box as verified and the order was returned to the pharmacy. -The medication order became visible on the	D 358		

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eMAR once the pharmacy could see the order had been verified by the HCD or the Director of the secured AL.
-She or the HCD would write new orders on the MAR to be administered on new medications with weekend admissions.

Interview with the HCD on 10/20/26 at 7:15pm revealed:
-She did not routinely check the residents' records for new orders.
-Records were reviewed by a contracted nurse randomly weekly with a sample of records reviewed (maybe 10 records).
-Normally, the HCD and Director of the secured AL received new PCP orders by email from the PCP.
-The PCP routinely electronically ordered or faxed medications to the facility's contracted pharmacy.
-The HCD or Director of the secured AL waited until the order was keyed on the eMAR by the pharmacy.
-She or the Director of the secured AL checked the reviewed medication order box as verified and the order was returned to the pharmacy.
-The order was visible on the eMAR once the pharmacy could see the order had been verified by the HCD or the Director of the secured AL.
-The HCD or the Director of the secured AL would write new orders on a paper MAR sometimes, to be administered.

Interview with the Regional Director of Operations on 10/16/26 at 8:00pm revealed:
-She assumed manager of the facility about 4 weeks ago due to the Administrator's medical leave.
-She was acting as the Interim Administrator.
-The HCD and the Director of the secured AL were responsible for ensuring PCP orders were

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D 358	Continued From page 74 implemented. -The HCD and the Director of the secured AL were responsible for approving and clarifying PCP orders. -The HCD and the Director of the secured AL should fax any PCP orders they received to the contracted pharmacy. -The HCD and the Director of the secured AL should contact the pharmacy if there was not an order received back from the pharmacy to verify and before approving any order for the eMAR. -She stated the residents' records were expected to be audited by the HWD routinely every week.. -The HCD had the responsibility to audit the MARs and a few charts randomly every week. _____ The facility failed to administer medications as ordered to Resident #3 who had diagnoses including chronic anemia and congestive heart failure related to not stopping a blood thinner and starting a medication for decreasing stomach acid or stomach ulceration which could have decrease stomach bleeding and anemia with a subsequent hospitalization for blood in the stool, not stopping a blood pressure medication that resulted in the resident having a very low blood pressure reading on subsequent cardiology visits, and not administering a diuretic for fluid retention which placed the resident at risk for increased shortness of breath; and not increasing Novolog insulin from 3 units to 6 units for Resident #5 resulting in her being hospitalized for five days to treat elevated blood sugar (hyperglycemia) and acute visual changes. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/16/26.	D 358		

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D 358	Continued From page 75 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 15, 2026.	D 358		