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BROOKDALE CHAPEL HILL AL (NC)	2220 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 10/13/26 to 10/14/26.	{D 000}		
{D 067}	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B was not abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure 4 of 4 exit doors had a continuously sounding device that was operational and audible throughout the facility and were accessible to a resident who was	{D 067}		

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{D 067}	Continued From page 1 intermittently disoriented (Resident #1). The findings are: Observation of the facility's front entrance door on 10/13/26-10/14/26 at various times between 8:00am-5:00pm revealed: -The door opened and closed without the sound of a continuous alarm. -There was a receptionist area at the front door; staff were intermittently present and on multiple occasions staff were not at the desk. Observation of the A-hall on 10/13/26 at 10:18am revealed: -There was an exit door in the physical therapy (PT) room. -The door exited to an enclosed courtyard. -The door opened and closed without the sound of a continuous alarm. Observation of the B-hall on 10/13/26 at 10:21am revealed: -There was a common area/sitting room for the residents. -There was an exit door in the common area/sitting room. -The door exited to an enclosed courtyard. -The door opened and closed without the sound of a continuous alarm. Observation of the C-hall on 10/13/26 at 10:26am revealed: -The door exited to the residents' enclosed smoking area. -The door opened and closed without the sound of a continuous alarm. Review of Resident #1's current FL2 dated 07/01/26 revealed:	{D 067}		

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{D 067}	Continued From page 2 -Diagnoses included dementia, seizure disorder, hypertension, and atrial fibrillation. -Resident #1 was intermittently disoriented. Interview with Resident #1 on 10/13/26 at 9:10am revealed: -He had lived at the facility with his dog for about four months. -He took his dog outside to walk and use the bathroom by himself. -He walked around the parking lot and the sidewalks around the building when he walked his dog. -He asked the state surveyor if there were any convenience food/gas stores in the area that he could walk to. -He did not know if he was allowed to walk to a convenience store or if he could walk off the property on his own. Interview with a personal care aide (PCA) on 10/13/26 at 3:05pm revealed: -Resident #1 went outside with his dog without any problem. -Resident #1 did not seem to be confused. Observation of a PCA on 10/13/26 at 3:05pm revealed: -The PCA was in a dining room. -There were no doors visible from the dining room but the courtyard was visible from the dining room window. -She had a pager clipped to her belt. -The pager made a low buzzing sound. -The PCA looked at the pager and continued working. -The PCA did not go to any doors, look down a hallway or out of the window and she did not leave the dining room.	{D 067}		

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{D 067}	Continued From page 3 Interview with a PCA on 10/13/26 at 3:05pm revealed: -There were three exit doors the residents could use to go outside. -One of the doors went out to the courtyard where the residents could smoke. -She had a pager she kept with her while she worked. -When a door was opened her pager would buzz; the screen on the pager indicated which door was open. -The pager buzzed but then cancelled itself and stopped buzzing. -The front door had a chime that sounded when it was opened; she could not always hear the chime on the front door. -There were some residents who had memory issues and would get a little confused. -There was one resident who thought the front desk was the front desk at a hotel. -She could see the front door from one of the hallways. -There was not always someone at the front desk. Interview with a second shift medication aide (MA) on 10/14/26 at 3:20pm revealed: -Every exit door had an alarm on it that notified all the staff pagers when one of them was opened. -When an exit door was opened the alarm would go to the pagers and the pagers would buzz. -The pagers would also indicate which door was open; when the door closed the buzzing would stop and would be cancelled on the pager. -The alarms on the pagers were just to let the staff know someone came in the door. -The doors had a chime on it that sounded like a "ding-dong"; the chime would sound twice when the door was opened. -The alarms were not continuous and did not	{D 067}		

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{D 067}	Continued From page 4 have to be turned off by staff. -There was no staff assigned to sit the front desk in the evenings but there was usually staff at the front desk working on the computer or in the area of the front desk. -He did not go to the front door to check if a resident had exited the facility unless he was in the area because staff were usually in the front area. -He tested the alarms and locked the exit doors at 9:30pm. -There were some residents with insomnia at night but none of the residents wandered or were exit seeking. Interview with the Business Office Manager (BOM) on 10/14/26 at 9:44am revealed: -All staff were assigned pagers that alerted staff when the doors were opened. -Staff were seated at the receptionist desk all day. -She and the Administrator could see the front door from their offices. -The front door was supposed to be locked at 7:00pm and opened at 7:00am daily. -The MAs were responsible for locking and unlocking the doors. Interview with the Health and Wellness Coordinator (HWC) on 10/14/26 at 10:54am revealed: -When the outside doors were opened, the pager alerted staff to which door was opened. -Staff closest to that door would check the door. -Staff cleared the pager after they checked the door. -If an alert was not cleared, staff would use the radio to request a door to be checked. -The BOM could see the front door from her office window.	{D 067}		

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{D 067}	Continued From page 5 -She would sit at the receptionist desk as needed. -Resident #1 walked his dog outside by himself. -He walked his dog on the sidewalks that lead to the sister facility next door and back. -Resident #1 had not walked away from the facility and did not talk about leaving the facility. -She was not concerned about Resident #1 walking his dog outside by himself because he had a routine. Interview with the Administrator on 10/13/26 at 3:04pm revealed: -Residents signed in and out of the facility, but not when they were sitting on the porch. -All staff were assigned radios and pagers. -The doors chimed when opened and staff were alerted on their pagers. -The alert included the location of the door that was opened, and staff had to respond to the door that was opened to clear the alert. -Whoever was closest to the exit door would respond, staff were not assigned to a hallway. -If an alert was not cleared, staff would use the radio to ask someone to check the exit door. Second interview with the Administrator on 10/13/26 at 4:23pm revealed: -After 7:00pm, the doors were locked by the second shift MA and unlocked at 7:00am by the third shift MA. -The Administrative staff (BOM, and HWC) monitored the exit doors until 5:oopm; staff were assigned to monitor the door after 5:00pm. -She and the BOM could see the front door from their office windows and would look out of the window when the door chimed. -On the weekends, a manager worked from 8:00am to 5:00pm at the front desk. -The PCAs and MAs were responsible for checking the doors when staff were not seated at	{D 067}		

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{D 067}	Continued From page 6 the front desk. Attempted telephone interview with Resident #1's power of attorney (POA) on 10/13/26 at 2:25pm was unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 10/14/26 at 8:50am was unsuccessful. The facility failed to ensure the alarms on the exit doors to the facility had a continuous and audible sounding device when the doors opened which placed Resident #1 who was intermittently disoriented at risk for elopement. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/16/26 for this violation.	{D 067}		
{D 195}	10A NCAC 13F .0608 (c-f) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (c) The aide shall provide personal care services and supervision needed by the residents. (d) Aides shall not provide housekeeping duties except: (1) Between the hours of 7:00 a.m. to 9:00 p.m.: (A) to prevent an accident or injury; (B) when occasionally attending to an individual resident housekeeping need; and (C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this	{D 195}		

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{D 195}	Continued From page 7	{D 195}		

Rule.
(2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not:
(A) hinder the aide's care of residents or immediate response to resident calls;
(B) do not disrupt the residents' normal lifestyles and sleeping patterns; and
(C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty.
(e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents.
(f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties.

Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section.

Bed Count	Position Type	First Shift	Second Shift	Third Shift
21 - 30	Aide	16	16	8
	Supervisor	Not Required	Not Required	Not Required
	Administrator	In the building, or within 500 feet and immediately available.		
31-40	Aide	16	16	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**

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{D 195}	Continued From page 8	{D 195}		

Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8

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{D 195}	Continued From page 9	{D 195}		

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64

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{D 195}	Continued From page 10 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure personal care aides were not routinely assigned to perform food service duties such as setting the dining tables, clearing used place settings from the tables, cleaning dining room tables, washing dining room linen and cleaning the dining room floors. The findings are: Observations of three dining rooms on the first floor on 10/13/26 at various times from 11:00am to 2:30pm revealed: -At 11:00am, there was a personal care aide (PCA) and a medication aide (MA) placing beverage glasses and cloth placemats on the tables. -The PCA placed additional cloth placemats and silverware rolled into cloth napkins on the tables. -The PCA and the MA cleared the residents plates and silverware when they were done eating and were stacking them on a cart after scrapping them off. -The MA and the PCA cleared the beverage glasses and remaining plates off the tables as	{D 195}		

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{D 195}	Continued From page 11	{D 195}		

most of the residents left the dining rooms.
-The PCA removed the cloth placemats and napkins from the tables.
-At 2:30pm, the PCA mopped the kitchenette, moved chairs in the dining room and began to sweet the floors.

Interview with a cook on 10/13/26 at 12:40pm revealed:
-He was the only cook in the kitchen.
-There were no diet aides working in the kitchen.
-He did not come out of the kitchen during meals; he did not work in the dining rooms.
-The PCAs and MAs cleared the tables, cleaned the dining rooms and brought the dishes into the kitchen.
-The cooks washed the dishes.

Interviews with a PCA on 10/13/26 at 12:50pm and 2:30pm revealed:
-She cleared dirty dishes off the residents' tables after they were done.
-She scrapped and stacked the dishes and staff in the kitchen washed them.
-After every meal she removed the soiled table linen including napkins, and cloth placemats and if a tablecloth was soiled she would remove it from the table.
-She washed all the soiled table linen after breakfast and lunch because it had to be reused to set up for the next meal.
-She rolled silverware into cloth napkins after the breakfast for the lunch meal and after lunch for the dinner meal.
-She had to roll silverware after each meal because there was not enough silverware and napkins to roll for all three meals at one time.
-She set the tables before lunch with a clean tablecloth if needed, a cloth placemat, silverware rolled into napkins and beverage glasses.

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{D 195}	Continued From page 12 -She set up the beverage glasses on the table for the dinner meal. -Second shift set everything else on the dining room tables and for the dinner meal and cleaned up afterwards. -Third shift rolled silverware and set up the tables for the breakfast meal. -She swept the dining rooms and the kitchenette after every meal. -She mopped the floors if they needed it because there was a spill or the floor was sticky. -She also had to attend to residents' needs before and after lunch; including any personal care needs. -When a resident required personal care or assistance with something like going to the bathroom, transferring, getting out of bed or laying down in the bed while she was setting up or cleaning the dining room she would be notified on her pager. -She would stop what she was doing and go to the resident. -Sometimes after lunch it could be a challenge to get everything done in the dining rooms and help the residents. Interview with another PCA on 10/13/26 at 2:24pm revealed: -She was responsible for setting up the dining room and cleared the dishes after she served the residents their meals. -The MA assisted her during mealtimes but did not receive help from the kitchen staff. Interview with a MA on 10/13/26 at 12:59pm revealed: -She helped to set the tables before meals; she placed silverware and beverage glasses on them. -She helped to clear the dishes from the tables in the three dining rooms.	{D 195}		

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{D 195}	Continued From page 13 -She scrapped the dishes and the cook washed them. -She rolled silverware after breakfast and lunch every day. -She helped to remove and wash napkins and cloth placemats after breakfast and lunch. -No staff from the kitchen came to help in the dining room because there was only the cook. -She had to stop and could not help the PCA when a resident needed a medication or to help a resident use the bathroom. Interview with another MA on 10/13/26 at 12:12pm revealed: -She would help the PCA in the dining room during mealtimes after she had administered medications. -The PCA rolled silverware in napkins and cleaned the dining room after mealtime. Telephone interview with the Administrator on 10/14/26 at 11:50am revealed: -The PCAs broke down the dining room tables after meals including scrapping dishes and dumping fluid from beverage glasses; the cooks washed the dishes, glassed and silverware. -The first shift PCAs removed the napkins, placemats, and tablecloths from the tables after the breakfast and lunch meals and took them to the laundry and washed them. -The first shift PCAs rolled silverware into cloth napkins for the lunch meal, second shift PCAs rolled the silverware for dinner, and the third shift PCAs rolled silverware for breakfast. -The third shift PCAs set the breakfast tables with place mats, silverware and beverage glasses, the first shift PCAs cleared breakfast and lunch tables, and the second shift PCAs set up and cleared the dinner tables. -The third shift PCAs mopped the kitchenette and	{D 195}		

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{D 195}	Continued From page 14 the dining rooms at night. -The MAs helped the PCAs when they had the time. -The management team including the business office manager, Resident Care Coordinator (RCC) and the Health and Wellness Coordinator (HWC) were available to help the PCAs so the PCAs could answer call bells. -She thought the facility was compliant with the rule because she had two PCAs and two MAs scheduled and they were above the required staffing hours.	{D 195}		
{D 375}	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents (#1, and #2) had a physician's order to self-administer medications observed in	{D 375}		

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{D 375}	Continued From page 15	{D 375}		

the residents' rooms.

The findings are:

Review of the facility's Self-Administration of Medication policy dated 03/2026 revealed:
-A resident who desired to self-manage medications must successfully complete the Self-Administration of Medications Review form, which would be completed by the Health and Wellness Director (HWD).
-Once the resident successfully passed the Self-Administration of Medications Review form, the HWD would obtain an order allowing the resident to self-administer medications from the resident's Primary Care Provider (PCP).
-The resident would be assessed quarterly for the ability to safely self-administer medications.
-This applied to over the counter and prescription medications.

1.Review of Resident #1's current FL2 dated 07/01/26 revealed:
-Diagnoses included dementia, seizure disorder, hypertension, and atrial fibrillation.
-There was no order for self-administration of any medication.

Observation of Resident #1's room on 10/13/26 at 9:10am revealed:
-There was a bottle of over the counter (OTC) aspirin 325 (used to relieve pain) tablets on the nightstand.
-There was a tube of OTC butenafine hydrochloride 1% cream (an antifungal cream) on the nightstand.

Review of Resident #1's record revealed:
-There was no order for aspirin 325.
-There was no order for butenafine hydrochloride

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{D 375}	Continued From page 16 1% cream. -There was no Self-Administration of Medications Review form, which would be completed by the Health and Wellness Director (HWD). -There was no order for Resident #1 to self-administer medications or to keep medications at the bedside from his primary care provider (PCP) Review of Resident #1's electronic medication administration records (eMAR) for August 2026, and September 2026 revealed: -There was no entry for aspirin 325. -There was no entry for butenafine hydrochloride 1% cream. Review of Resident #1's eMAR for October 2026 from 10/01/26 to 10/13/26 revealed: -There was no entry for aspirin 325. -There was no entry for butenafine hydrochloride 1% cream. Interview with Resident #1 on 10/13/26 at 9:10am revealed: -A family member took him to a local pharmacy where he purchased the aspirin and butenafine hydrochloride cream a couple of weeks ago. -He applied the butenafine hydrochloride cream between his toes every day. -He used the aspirin for headaches; he had only taken the aspirin one time and that was about a week ago. -He did not have an order for the aspirin or the butenafine hydrochloride from his PCP because they were OTC medications. -He had not told staff that he had the new medications in his room. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/13/26 at	{D 375}		

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{D 375}	Continued From page 17 3:28pm revealed: -Resident #1 did not have an order to self-administer medications. -Resident #1's PCP should be notified if he was taking any OTC medications without orders. -The OTC butenafine hydrochloride cream would not cause a problem if he applied it too often and there were no medication interactions with his medications but the PCP should know he was using it. -None of his current medications interacted with aspirin but aspirin thinned the blood and should be avoided when taking blood pressure and anti-seizure medications, both of which Resident #1 was ordered. -Resident #1 had a diagnoses of dementia and he could accidentally take the aspirin over and over again without remembering; taking too much aspirin could cause a bleeding ulcer. -One of the main reasons residents diagnosed with dementia were living in an assisted living was because they needed medication management from the facility. Interview with a housekeeper on 10/13/26 at 2:55pm revealed she had not seen any bottles of medication or creams in Resident #1's room. Interview with a personal care aide (PCA) on 10/13/26 at 3:10pm revealed she had never seen bottles of medications or creams in Resident #1's room. Interview with a medication aide (MA) on 10/14/26 at 3:20pm revealed he had not seen OTC medications in Resident #1's room. Interview with a second MA on 10/14/26 at 11:23am revealed: -She administered Resident #1 his medications in	{D 375}		

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{D 375}	Continued From page 18	{D 375}		

his room.
-She had not seen the aspirin or the OTC butenafine hydrochloride cream in Resident #1's room.
-Resident #1 did not have an order to self-administer any medications.

Interview with the Health and Wellness Director (HWC) on 10/14/26 at 10:55am revealed:
-Resident #1 did not have an order to self-administer medications and should not have been taking aspirin or apply OTC butenafine hydrochloride cream himself.
-She was not sure Resident #1 could self-administer his medications.
-Resident #1 had never asked if he could self-administer his medications.
-He did not have an order for aspirin or OTC butenafine hydrochloride cream.
-She had removed the medications from his room yesterday when she was told they were in there.
-She was not sure how much of the aspirin Resident #1 had taken.

Telephone interview with the Administrator on 10/14/26 at 11:45am revealed:
-Resident #1 did not have an order to self-administer medications.
-Resident #1 had not expressed an interest in self-administering his own medications.
-Resident #1 would not be able to administer his own medications.

Attempted telephone interview with Resident #1's power of attorney (POA) on 10/13/26 at 2:25pm was unsuccessful.

Attempted telephone interview with Resident #1's PCP on 10/14/26 at 8:50am was unsuccessful.

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{D 375}	Continued From page 19 Refer to the interview with the housekeeper on 10/13/26 at 2:55pm. Refer to the interview with a PCA on 10/13/26 at 3:10pm. Refer to the interview with a MA on 10/14/26 at 3:20pm. Refer to the interview with a second MA on 10/14/26 at 11:23am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/14/26 at 10:30am. Refer to the interview with the HWC on 10/14/26 at 10:55am. Refer to the telephone interview with the Administrator on 10/14/26 at 11:45am. 2. Review of Resident #2's current FL2 dated 08/26/26 revealed diagnoses included acute kidney failure, hypertension, and rheumatoid arthritis. Observation of Resident #2's room during the initial tour on 10/13/26 at 9:03am revealed there was a bottle of extra strength acetaminophen tablets (used to treat pain) tablets sitting on the bedside table. Review of Resident #2's electronic medication administration records (eMAR) for August and September revealed there was no entry for extra strength acetaminophen tablets. Review of Resident #2's eMAR for June from 10/01/26-10/13/26 revealed there was no entry for extra strength acetaminophen tablets.	{D 375}		

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{D 375}	Continued From page 20 Interview with Resident #2 on 10/13/26 at 9:08am revealed: -She had an order to self-administer her medications. -She did not have a self-administration order for extra strength acetaminophen. -Her family member gave her the tablets, and she thought she could keep them at bedside. Interview with another PCA on 10/13/26 at 12:12pm revealed she had not seen medications in the Resident #2's room; if she had, she would have told the medication aide (MA). Interview with the Housekeeper on 10/13/26 at 2:41pm revealed: -She would report to the Health and Wellness Director (HWD) or Health and Wellness Coordinator (HWC) if she saw medication in a resident's room. -She had not noticed any medications in the resident's room. Interview with a medication aide (MA) on 10/13/26 at 2:51pm revealed: -Resident #2 had an order to self-administer her medications. -The HWC was responsible for checking her room for medications. Interview with the HWC on 10/14/26 at 10:54am revealed: -Resident #2 had an order to self-administer her medications. -She was not aware Resident #2 had extra strength acetaminophen in her room. -When the MA's notified her of medication in a resident's room, she would remove the medication and call the family to let them know about the self-administration policy.	{D 375}		

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{D 375}	Continued From page 21 -She completed room sweeps weekly checking for medications in the resident's room. Attempted telephone interviews with Resident #2's PCP on 10/13/26 at 2:39pm and 10/14/26 at 8:41am were unsuccessful. Attempted telephone interview with Resident #2's family member on 10/13/26 at 11:03am was unsuccessful. Refer to the interview with the housekeeper on 10/13/26 at 2:55pm. Refer to the interview with a PCA on 10/13/26 at 3:10pm. Refer to the interview with a medication aide (MA) on 10/14/26 at 3:20pm. Refer to the interview with a second MA on 10/14/26 at 11:23am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/14/26 at 10:30am. Refer to the interview with the Health and Wellness Coordinator (HWC) on 10/14/26 at 10:55am. Refer to the telephone interview with the Administrator on 10/14/26 at 11:45am. _____ Interview with the housekeeper on 10/13/26 at 2:55pm revealed: -She was in and out of the residents' rooms at least once a week or more. -Sometimes she would see bottles of medications or creams in the residents' rooms or in their bathrooms.	{D 375}		

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{D 375}	Continued From page 22 -When she saw medications in the residents room she would notify the Administrator. Interview with a personal care aide (PCA) on 10/13/26 at 3:10pm revealed: -She had seen medications in residents' rooms. -Some of the residents had bottles of acetaminophen tablets and rash creams in their rooms. -She had not been told what to do if she saw medications in a resident room. -She was told she could not touch or handle medications because she was not a medication aide (MA). -Some of the residents were allowed to take their medications on their own. -If she saw medication in a resident's room and she knew that resident was not allowed to take medications on their own, she would tell the MA, the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWC) about the medication. Interview with a MA on 10/14/26 at 3:20pm revealed: -Residents were not allowed to have medications in their rooms if the MAs did not administer their medications. -When he found or saw medications in a resident's room he pulled the medication and locked it on the medication cart. -Residents who self-administered medications could not have medications in their room if they did not have an order on the eMAR. -He notified the HWC so an order for the medication could be added to the eMAR, but even with an order the resident could not have it in their room. Interview with a second MA on 10/14/26 at	{D 375}		

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{D 375}	Continued From page 23 11:23am revealed: -She checked residents rooms and bathrooms for medications when she was in a resident's room. -When she found a medications she would check the eMAR to see if the resident had an order for the medication and to see if they had an order to self-administer medication. -She would remove the medication from the room after explaining it to the resident if they did not have an order to self-administer. -She would notify the RCC or the HWC when she found medication in a resident's room. -Residents had to have an order to self-administer medications and they had to have an order for all medications, even residents with an order to self-administer medications. Interview with the RCC on 10/14/26 at 10:30am revealed: -Residents were not allowed to have medication in their rooms if they did not have an order for self-administration; including over the counter (OTC) medications. -Residents with an order to self-administration needed to have an order for all medications; even OTC. -The MAs were supposed to always watch for medications in the residents rooms when they went into the rooms. -She did a sweep to looked for medications in residents' rooms on one hall a week while the HWC and the Administrator did other rooms on other hallways. -They would check certain residents' rooms more frequently when they knew the resident or the resident's family could purchase OTC medications and bring them into the facility. -PCAs were supposed to look for medications in the residents rooms when they went into the room to provide care; the PCA would let the MA	{D 375}		

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{D 375}	Continued From page 24	{D 375}		

know about the medication and the MA would inform her, the HWC or the Administrator.
-When medications were found in a room and the resident did not have an order for the medication or an order to self-administer the HWC or the Administrator were notified, the medication was removed from the room, the resident told and the PCP told; sometimes they would get an order for the medication.
-All medication required an order from the PCP, even if the resident had an order to self-administer medication.

Interview with the HWC on 10/14/26 at 10:55am revealed:
-An order for a resident to self-administration medications was up to the resident's PCP to decide.
-She completed the resident self-administration assessment at the facility to determine if the resident was competent enough to self-administer their own medications.
-If the resident did not have the order from the physician to self-administer medications they were not even allowed to have OTC medications in their rooms.
-Resident who had an order to self-administer medications could not have medications in their room if they did not have an order for the medication.
-The MA, and PCAs were supposed to report any medications a resident was self-administering to her or the Administrator.
-The RCC, the Administrator and herself did room sweeps once a week to check rooms for medications.

Telephone interview with the Administrator on 10/14/26 at 11:45am revealed:
-There were two steps required for a resident to

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{D 375}	Continued From page 25 be able to self-administer medications. -The resident's physician wrote the order for the resident to self-administer medications. -The resident would have to pass the facility's assessment to see if they could safely administer their own medications. -The MAs, PCAs and housekeepers were in the residents' rooms every day and should pay attention for medications in the residents' rooms and bathrooms. -When they saw a medication in a resident's room they were to report it to the RCC or the HWC as soon as they saw it. -The RCC, HWC or herself would remove the medication from the resident's room, tell the resident why the medication was being removed, notify the family, and the PCP to possibly get an order for the found medication. -The HWC would look once a month in drawers and cabinets for medications in resident's room. -Families brought OTC medications to the residents without the facility staff's knowledge; it was a constant battle. -She did monthly educational meetings with the residents and included information about medications in their rooms and about self-administered medications required an order from a physician. -So many things could go wrong when a resident had medication in their room and they were taking it without the self-administering order and assessment like accidentally overdosing.	{D 375}		