STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 07/08/25 to 07/11/25 and 07/14/25.	D 000		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors were kept clean in the hallways, common areas, and in residents' rooms in the Assisted Living (AL) and the hallways and day room in the Special Care Unit (SCU). The findings are: Review of the environmental inspection report	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 074	Continued From page 1	D 074		

from the local county health department dated 04/09/25 revealed:
-The facility received one demerit.
-There was documentation of soiled linen stored on the floor.

Review of an undated housekeeping cleaning schedule revealed:
-The floors were to be swept and mopped on Sunday, Tuesday, Friday, and Saturday; there was nothing indicating the location of the floors.
-Deep cleaning was on Monday, Wednesday, and Thursday.
-All furniture was moved and cleaned under in each of the residents' rooms during deep cleaning.

1. Observations of hallways and the common areas during the initial tour in AL on 07/08/25 from 8:05am to 8:40am revealed:
-There were three hallways (100 hall, 200 hall, and 300 hall) where the resident rooms were.
-There was dirt and debris on the floors in the hallways.
-There was dirt and debris on the floors of some residents' rooms.

Observation of the 100-hall living room in AL on 07/08/25 at 8:43am revealed:
-The floor was dirty and needed sweeping.
-There was a build up of dirt and two dead bugs in the corner and along the baseboard.
-There was dirt next to one of the chairs.
-There was dirt and a dead moth next to the table.

Observation of the 100-hall living room in AL on 07/08/25 at 3:08pm revealed:
-The floor continued to be dirty with the buildup of dirt in the corner and along the baseboard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 2 -The area of the floor with dirt next to the chair and the table, and the dead moth had been cleaned. Observation of the 200-hall living room in AL on 07/08/25 at 8:47am revealed: -There was a dead cricket in the center of the floor. -There was trash and dirt under the table on the right side of the fireplace. -There was an empty spray bottle on the floor next to the table. Observation of the 200-hall living room in AL on 07/09/25 at 9:47am revealed: -The trash and dirt remained under the table on the right side of the fireplace. -The empty spray bottle and the dead cricket had been removed. Observation of the 200-hall living room in AL on 07/14/25 at 11:50am revealed the trash and dirt remained under the table on the right side of the fireplace. Observation of the hallway at the 200-hall exit door in AL on 07/09/25 at 9:50am revealed: -The rug at the door was dirty and in need of vacuuming. -There was a dead cricket in the corner of the hallway, next to the door. Interview with a resident on 07/10/25 at 8:42am revealed: -The facility had been going downhill for the last two months. -It was a new facility and it should not be so dirty. -The floors were always dirty. -She had not seen housekeeping cleaning the hallways until yesterday.	D 074		

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	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 3	D 074		

-Housekeeping staff went to her room to clean her bathroom once a week but did not thoroughly clean her toilet.
-The housekeepers swept her floors once a week but did not mop the floors.

Interview with a second resident on 07/10/25 at 9:01am revealed:
-Her family came to the facility weekly to visit and swept her floors.
-Her family did not visit last week and she asked a personal care aide (PCA) to get housekeeping to sweep her floor but the housekeeper never came.
-The housekeepers did not sweep or mop her floors on a consistent basis.
-She had not seen the housekeeping staff clean the hallway floor like they had done this week.

Interview with a resident's family member on 07/09/25 at 1:52pm revealed:
-She purchased a broom and dustpan for the resident's room.
-She cleaned the resident's room three days each week.
-Housekeeping cleaned the resident's room once a week and did not mop the floors.
-She mentioned it to the Administrator and he told her the residents were responsible for keeping their rooms cleaned.
-She had never seen anyone clean the resident's room.
-She purchased cleaning products and deep cleaned the resident's room weekly.

Interview with a PCA on 07/10/25 at 9:19am revealed:
-The residents complained about not having their floors swept and mopped.
-She would tell a housekeeper and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 4	D 074		

housekeeper would sweep or mop the room if it was needed.
-She could not recall how often housekeeping cleaned the residents' rooms.
-Housekeeping swept and mopped the residents' rooms once a week.

Interview with a housekeeper on 07/10/25 at 10:33am revealed:
-He worked 5 days each week and alternated working on weekends.
-He was responsible for sweeping and mopping the common areas of the facility and the residents' rooms and their bathrooms.
-He cleaned the residents' rooms three days each week; swept .
-When two housekeepers were working, the residents' rooms were deep cleaned.
-Deep cleaning occurred twice each week which included sweeping.
-Deep cleaning involved removing the furniture out of the room, sweeping and mopping the floors, and cleaning the bathroom.
-Some residents complained about their rooms not being cleaned daily.
-He explained to the residents that all rooms had to be cleaned three times each week.

Interview with the facility's Maintenance Supervisor on 07/10/25 at 10:54am revealed:
-There were two housekeepers in the facility.
-The housekeepers were responsible for cleaning the residents' rooms daily.
-The rooms were swept and mopped, and trash was removed daily.
-The PCAs were responsible for removing the trash, but the housekeepers would remove the trash when needed.
-Deep cleaning of the residents' rooms occurred three times each week when two housekeepers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 074	Continued From page 5	D 074		

worked.
-Deep cleaning the rooms consisted of cleaning the bathroom and removing furniture in the room to sweep, mop, and buff the floor.
-The hallways and common areas were swept and mopped daily.

Interview with the interim Resident Care Coordinator (RCC) 07/10/25 at 11:49am revealed:
-Housekeeping was responsible for ensuring the residents' rooms were cleaned.
-The housekeepers deep cleaned the residents' rooms once a week.
-When the residents complained about not having their rooms cleaned, she informed the housekeepers.
-The housekeeper would clean the residents' room.

Interview with the Administrator on 07/11/25 at 8:26am revealed:
-Housekeeping was responsible for cleaning the common areas and floors in the facility.
-The hallways were swept and mopped once a week.
-The residents' rooms were cleaned once a week.
-Some residents complained about their floors not being cleaned.
-He would let a housekeeper know that a resident's floor needed cleaning.
-The doors and windowsills were cleaned when the rooms were deep cleaned.

2. Observations of hallway floors and the dayroom floors in the SCU on 07/08/25 at various times between 8:15am to 3:00pm revealed:
-At 8:15am, there were large black pieces of debris, long black streaks like a tire track, dust,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 6	D 074		

dead bugs and debris in the hallway.
-There were several long black track marks, large black pieces of debris, clumps of dirt, food, dried spills and dust on the floor in the day room.
-There was material from the artificial planter and large dried rings with dust and debris stuck to the rings on the floor in the dayroom.
-At 9:57am, there were large black pieces of debris with dust and down the hallway.
-There were clumps of dust on the floors in the corners of the doorways into resident rooms.
-There was a dead bug in the entrance to a resident room.
-At 12:25pm and 3:00pm, the day room and the hallway in the SCU had not been swept or mopped and the same amount of debris, dust, and track marks were still on the floors.

Observations of the hallway floors and the dayroom floors in the SCU on 07/09/25 at various times between 8:16am to 11:05am revealed:
-At 8:16am, there were track marks, large pieces of debris, clumps of dirt, food, dried spills, a dead bug and dust from the previous day in the hallway and the day room.
-At 8:59am, the housekeeper was pushing an automated machine to mop and dry the floors in the hallway.
-At 11:05am, the day room had dried spills, food, and black chunks of debris on the floor.

Observations of the hallway floors and the dayroom floors in the SCU on 07/10/25 at various times between 6:30am to 10:00am revealed:
-At 6:30am, there were dried spills, dust, crumbs, track marks and dirt on the floor in the day room.
-There were large pieces of a black substance with hair and dust up and down the hallway.
-There were clumps of dust and dead beetles in the hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 7	D 074		

-At 6:58am, the housekeeper pushed the housekeeping cart through the hallway but did not sweep or mop the floors.
-At 7:20am, the housekeeper took a broom and a dustpan and walked around the hallway spot sweeping areas.
-At 10:00am, there were black pieces of debris, clumps of dust, small bits of balled up paper, dried spills and crumbs on the floor in the day room.

Telephone interview with a resident's family member on 07/10/25 at 10:34am revealed:
-The floors in the hallways and in the dayroom were always dirty.
-There were marks on the floors from the residents' wheelchairs.
-She had seen dead bugs, hair and dust in the hallways.
-There were times she had seen food and urine on the floors in the dayroom.
-She had not seen staff attempting to clean the floors.
-She had complained to the personal care aides (PCAs) and to the previous Administrator, but nothing had been done.

Interview with a PCA on 07/09/25 at 11:56am revealed there were two housekeepers at the facility and one of them swept and mopped the floors every other day if not every day in the SCU.

Telephone interview with a PCA on 07/10/25 at 7:41am revealed:
-The housekeeper swept the floors on the first shift from 7:00am to 3:00pm.
-The housekeeper swept the floors once a day.

Interview with a housekeeper on 07/10/25 at 3:11am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 8	D 074		

-There were two housekeepers for the entire building.
-He was responsible for the SCU including the floors in the hallways and the day room.
-When the other housekeeper was off, he was responsible for the AL and the SCU.
-He was the only housekeeper on the weekends; he worked every other weekend.
-He mopped the hallways and the common areas once a week with the floor machine.
-He did not use a hand mop because of the risk of a resident slipping and falling.
-Once a day he used a dust mop to sweep the hallways and the day room in the SCU and a broom to reach the areas the dust mop did not reach.
-He spot swept with a broom and a dustpan during the day to see what he missed or if there was more dirt on the floor.
-There were no housekeepers at night.

Interview with the facility's Maintenance Supervisor on 07/10/25 at 10:54am revealed:
-He oversaw the housekeepers.
-There were two housekeepers in the facility.
-The hallways and common areas were swept and mopped daily.

Interview with the Special Care Coordinator (SCC) on 07/14/25 at 8:47am revealed:
-The housekeeper was responsible for cleaning the floors in hallways and the day room.
-She did not routinely check on the hallways or the day room floors to see if they were cleaned.
-If she noticed the floors needed to be cleaned, she called the housekeeper to come and clean them.
-She would sweep or mop something up if it were small.
-She did not know if there was a schedule or how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 9 often the floors were swept and mopped. -She saw the housekeeper sweeping or using the floor cleaning machine in the mornings. -The floors in the SCU were swept and mopped all day long to keep them clean. -If she had seen dirty floors in the hallways or the day room she would have had the housekeeper clean them. -She did not know of any complaints about dirty floors in the hallways or the day room. Interview with the Administrator on 07/14/25 at 12:56pm revealed: -He went into the SCU and walked around once a day. -He looked at the floors to make sure they were clean. -The floors in the hallways and the day room were swept and mopped once a day and deep cleaned every two days. -The floors should be spot swept and mopped as needed. -If he saw the floors needed to be cleaned, he got housekeeping or a PCA to clean the area. -He had not heard of any complaints about the floors in the SCU being dirty.	D 074		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed;	D 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 118	Continued From page 10 (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living (AL) was maintained in an operating condition. The findings are: Interview with a resident who resided in resident room #310 on 07/08/25 at 8:15am revealed: -There was a problem with the call bell system. -The system had been out for months. Interview with a resident who resided in resident room #211 on 07/08/25 at 8:28am revealed the call bell system had not worked for three weeks. Interview with a resident who resided in resident room #301 on 07/08/25 at 8:42am revealed: -The call bell system had not been working in over a month. -The personal care aides (PCA) told residents the call bell system was not needed because staff made rounds and checked on the residents.	D 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 118	Continued From page 11	D 118		

-She talked about the call bell system during a resident council meeting and was told by the Administrator the facility was not a hospital, and the call bell system was not a necessity.

Interview with a resident who resided in resident room #308 on 07/08/25 at 9:05am revealed:
-She was observed sitting in her recliner with oxygen in use at 2 liters.
-The call bells did not work; they had not worked correctly for the past month.
-She wanted her medications last night so she could go to bed and she did not have any way to call the staff.
-She walked into the hallway and yelled for assistance around 9:00pm, but no one came.
-The medication aide (MA) brought her medications around 10:00pm.
-Everyone knew the call bell system was not working.
-She knew some residents were given a whistle or a bell.
-She did not have a whistle or a bell; the staff did not offer her a whistle or bell.

Observation of resident room #109 on 07/08/25 at 9:20am revealed:
-The resident pulled the cord in the resident's bathroom and bedroom, but it did not work.
-The was no audible alarm from the call bell panel at the nurses' station.
-There was no other sounding device to alert staff in the resident's room.

Interview with the resident who resided in resident room #109 on 07/08/25 at 9:20am revealed:
-The call bell did not work correctly.
-The call bell would light up in his bedroom but there was no response from staff.
-He had to go into the hallway to alert staff when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 118	Continued From page 12	D 118		

he needed assistance.
-He was unsure how long the call bell had not been working properly.

Observation of resident room #310 on 07/08/25 at 10:08am revealed:
-The resident pulled the cord in the resident's bedroom, but it did not work.
-There was no audible alarm from the call bell panel at the nurses' station.
-The resident had a whistle as a sounding device.

Interview with the resident who resided in resident room #310 on 07/08/25 at 10:08am revealed:
-The call bell system had not been working for about three weeks.
-She pulled the call bell string, but no staff was alerted.
-The facility did not provide her with a sounding device to alert staff for assistance.
-She used a wheelchair for ambulation and needed assistance with toileting.
-She called her family member to call the facility to get assistance from staff.
-The PCAs gave her their phone numbers to call when she needed assistance.
-Her family member purchased a whistle for her to use.
-Other residents in the facility asked for a whistle and her family member purchased additional whistles and gave them to some of the residents.
-The Administrator told her that the call bell was not mandatory.

Interview with the resident who resided in resident room #115 on 07/08/25 at 10:42am revealed:
-The call bell system had not worked for at least three weeks.
-She was given a whistle by a resident but had not used it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 118	Continued From page 13 Observation of resident room #301 on 07/08/25 at 4:33pm revealed: -The resident pulled the cord in the resident's bedroom, but it did not work. -There was no audible alarm from the call bell panel at the nurses' station. -The resident had a whistle for a sounding device in her bedroom. Interview with the resident who resided in resident room #301 on 07/08/25 at 4:33pm revealed: -The call bell system had not worked for three or more weeks. -She had to wait until staff came to do rounds to get assistance. -When the call bell system was working, it took staff 30 minutes to respond. -She had edema in her legs and it took her a while to move around. -She required assistance with transferring in and out of bed and with getting out of her lift chair. -She needed assistance with showering and toileting. -She hired a private sitter for two hours, five days each week for assistance. -She needed the sitter in the event she needed assistance while the call bell system was down. -She may not keep the sitter after the call bell system was up and working properly again. Observation of resident room #211 on 07/08/25 at 4:45pm revealed: -The resident pulled the cord in the resident's bedroom, but it did not work. -The was no audible alarm from the call bell panel at the nurses' station. -The resident had a whistle as a sounding device. Interview with the resident who resided in resident	D 118		

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D 118	Continued From page 14 room #211 on 07/08/25 at 4:45pm revealed: -She moved to the facility from another AL and only moved there because the facility had a call bell system. -The call bell system had not worked for three weeks. -She was given a whistle by another resident, and it was taken away by a PCA. -She was not sure why her whistle was taken. -She was given a second whistle from another resident. -The Administrator told her that the call bell system was not required because the facility was not a hospital. -The call bell system was brought up during resident council meetings, but nothing was done. -She needed help while in the shower. -She had not used her whistle. -She was concerned that if she had a fall, staff would not respond because staff could not hear the whistle. Interview with the resident who resided in resident room #102 on 07/09/25 at 10:40am revealed: -The call bell had not worked for 6 weeks. -A resident's family member purchased whistles and gave them to some of the residents. -She asked the Administrator why the call bell system was not working and he did not provide her with an answer. -The Administrator told her that the facility was not a hospital, and the residents did not need a call bell. -She blew her whistle once and staff did not know which room to go to. -She took her cell phone into the bathroom in the event she had a fall and needed to reach someone. -She did not feel safe not having a working call bell system.	D 118		

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D 118	Continued From page 15 -She chose to move into the facility because of the call bell system. Interview with the resident who resided in resident room #215 on 07/11/25 at 8:15 am revealed: -The Administrator gave him a whistle that day that did not work. -He blew the whistle and it did not make a sound. -He did not need help but was testing the whistle out. Interview with the resident who resided in resident room #105 on 07/11/25 at 8:20 am revealed: -He was given a whistle that did not work. -He blew the whistle to alert staff and no staff member came to his room. -A PCA came to check on him while she was doing rounds. -The PCA did not hear the whistle. Interview with the resident who resided in resident room #301 on 07/11/25 at 12:09pm revealed: -She needed assistance with toileting and had told a PCA she needed to go to the bathroom before she went to lunch. -After 10 minutes the PCA had not returned so she blew her whistle. -When the staff did not respond she blew her whistle again; she could not wait because she was going to have a bowel movement. -She said she blew her whistle three times, and no one came. Interview with the resident who resided in resident room #307 on 07/11/25 at 3:46pm revealed: -She did not have a way to call for assistance because the call bell system was not working. -She was given a kazoo on 07/09/25 by the Administrator. (she showed the surveyor a 1 to 1.5 inch yellow toy kazoo.)	D 118		

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D 118	Continued From page 16 -She did not know how to blow the kazoo, and no one showed her how to blow it. Observation of the resident using the toy kazoo to summons help on 07/11/25 at 3:46pm revealed: -She blew the toy kazoo and a soft sound was heard by the surveyor while standing in the resident's room next to her. -The surveyor opened the resident's bedroom door and the resident blew the toy kazoo a second time. -At 3:53pm, a PCA entered the resident's room. Interview with a PCA on 07/11/25 at 3:53pm revealed: -She was working second shift today, 07/11/25, and was making rounds to check on the residents. -She did not hear the resident blowing the toy kazoo. -She knew the call bells were not working, so she tried to check on the residents as much as possible. Observation of the 300 hall on 07/11/25 at 11:58am revealed: -The 300 hall was located at the back of the AL. -Two long back-to-back whistle blows could be heard from the end of the 300 hall near the entrance to the dining room and the activity room. -At 12:00pm, the whistle blows could be heard again in the same hall. -There were no staff in the hallway. -At 12:01pm, there was a resident leaning out of her doorway looking up and down the hallway and asked who blew the whistle. -At 12:03pm, two more residents came into the hallway from different rooms and asked where the whistle blows came from. -There were no staff in the hallway.	D 118		

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D 118	Continued From page 17 -At 12:09pm, the set of whistle blows could be heard for a third time on the 300 hall. -There was a resident in resident room 301 who was seated in her wheelchair in her bathroom with her whistle. Observation of resident room #308 on 07/11/25 at 3:02pm revealed: -There was a call bell not in the bedroom that did not work. -There was no whistle or bell in the resident's room. Observation of resident room residing in room #213 on 07/11/25 at 3:12pm revealed: -There was a resident in the room sitting in a wheelchair wearing oxygen. -There was a call bell in the room but did not work. -There was a whistle on a table next to the resident. Telephone interview with a resident's family member on 07/08/25 at 8:10am revealed: -The call bells were not working; they had not worked in the past week. -The call bells worked "on and off" the past 5 weeks. -She was told the facility was waiting on a part to repair the call bell system. -Her family member did not have a way to contact the staff when she needed assistance. -Some residents were given a whistle to blow or a tabletop bell to ring; her family member was not given a bell or whistle. Interview with a second resident's family member 07/08/25 at 9:02am revealed: -The call bell system had not been working for months.	D 118		

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D 118	Continued From page 18 -The resident required assistance with toileting and was unable to alert staff when she needed assistance. -The facility did not provide the resident with a sounding device to alert staff when the resident needed assistance. -The resident would call her, and she would call the facility to let the staff know that the resident needed assistance. -She purchased a whistle for the resident to alert staff. -Other residents complained about not being able to alert staff so she purchased additional whistles for other residents in the facility. -She contacted the front desk, and no one could tell her when the call bell system would be fixed. Interview with a third resident's family member 07/09/25 at 11:03am revealed: -Her family member called her to alert the facility staff when she needed assistance. -She had no way of alerting staff when her family member called her for assistance. -She called the front office and was not able to reach anyone because the staff would not answer the phone. Interview with another PCA on 07/09/25 at 10:10am revealed: -She could not recall how long the call bell system had not been working. -The call bell system was working two weeks ago and then it went out. -When the call bell system was working, the call bell screen at the nurses' station would sound and the resident's room number would show on the screen. -A resident's family member purchased whistles two weeks ago and gave them to the residents. -Staff did 2-hour checks on all of the residents	D 118		

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D 118	Continued From page 19	D 118		

after the call bell system stopped working.
-When the residents blew the whistle, she would go into a few bedrooms to discover which resident blew the whistle.
-The residents complained about not having the call bell system.

Interview with a third PCA on 07/09/25 at 10:26am revealed:
-The call bell system was working last week and stopped working.
-A resident's family member purchased whistles and gave them to the residents.
-When a resident blew the whistle, she would go from room to room to find out which resident blew the whistle.
-Some of the residents called the front office when the residents were in need of assistance.
-Staff performed 30-minute checks on the residents that did not have whistles.
-Some of the residents complained about not having a working call bell system.
-She would report the complaints to the MA.

Interview with a MA on 07/09/25 at 11:17am revealed:
-The call bell system had not been working for a month.
-The residents were given a whistle by a resident's family member.
-Most of the residents had the PCA's and MA's cell phone numbers to call for assistance.
-When the residents blew the whistle, staff would walk the halls to ask the residents who blew the whistle.
-If a resident did not have a whistle, staff would check on the resident every 30 minutes.
-Rounds were increased from 2-hour to 1-hour after the call bell system went down.

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D 118	Continued From page 20 Interview with a second MA on 07/11/25 at 9:35am revealed the call bell system was not working; she was not aware how long the system had not been working. Interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 11:40 am revealed: -The call bell system had not been working for three weeks. -It worked for two days and stopped working again. -Staff asked the residents to keep their doors open. -Supervision was increased from every 2-hour rounds to every 1-hour rounds. -An additional staff was added to every shift to provide more supervision as their primary assignment. -A resident's family member purchased whistles for some of the residents. -Staff would walk the halls to see who blew the whistle when the whistles were blown. -All of the residents complained about not having a working call bell system. -She was concerned for the residents who needed assistance while the call bell system was not working. Interview with the Maintenance Supervisor on 07/09/25 at 11:58am revealed: -The call bell system had not been working for three weeks. -The Regional Maintenance Director oversaw 75 buildings. -He contacted the Regional Maintenance Director on 06/18/25 to inform him that the call bell system was not working. -The Regional Maintenance Director did not provide a date as to when he would fix the call	D 118		

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D 118	Continued From page 21	D 118		

bell system.
-A third shift MA would unplug the call bell system causing it to lose memory and required it to be reprogrammed.
-He reported that the MA unplugged the system to his previous supervisor.
-He reported it to the interim RCC and the Administrator.
-The MA that unplugged the system no longer worked at the facility.

Interview with the interim RCC on 07/09/25 at 12:15pm revealed:
-She was told by the Regional Maintenance Director who repaired the call bell system that someone unplugged the call bell system.
-When the call bell system was unplugged.
-She suspected a particular PCA was responsible for unplugging the call bell system.
-The PCA no longer worked at the facility.

Interview with the Operations Specialist on 07/11/25 at 9:11am revealed:
-She was first notified that the call bell system was not working a couple of weeks ago.
-The Regional Maintenance Director fixed the call bell system and it was working for a couple of days and stopped working again.
-She contacted the Regional Maintenance Director on 07/07/25 to make him aware that the call bell system stopped working.
-The Regional Maintenance Director could not provide her with a date as to when he would repair the system.

Interview with the Regional Vice President of Operations on 07/11/25 at 8:51am revealed:
-She was contacted on 06/26/25 by the Administrator to say that the call bell system was not working.

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D 118	Continued From page 22 -She contacted the Regional Maintenance Director and he fixed the call bell system on 07/01/25. -The call bell system stopped working two days later. -She contacted the Regional Maintenance Director again on 07/08/25 to inform him that the call bell system was not working. -The Regional Maintenance Director said he would be at the facility next week to repair the call bell system. Interview with the Regional Maintenance Director on 07/14/25 at 12:43pm revealed: -He was contacted at the end of June 2025 by the Regional Vice President of Operations that the call bell system was not working. -He fixed the call bell system on 07/01/25. -He was notified again on 07/06/25 by the Regional Vice President of Operations that the call bell system stopped working. -There were storms in the area that caused the call bell system to stop working. -He reprogrammed the call bell system today 07/14/25 and it took 15 minutes to have the system working. -He would have purchased bells for all the residents in the facility to alert staff when the call bell system stopped working. Interview with the Administrator on 07/09/25 at 2:13pm revealed: -The call bell system stopped working after a storm three weeks ago. -He called the Regional Maintenance Director and the call bell system was fixed. -It took the Regional Maintenance Director eight hours to fix the call bell system. -Three days later the call bell system went out again.	D 118		

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D 118	Continued From page 23 -He contacted the Regional Maintenance Director two weeks ago to let him know the call bell system stopped working. -He was not provided a date as to when the system would be repaired. -He was not sure why the call bell system stopped working. -All residents had bells or whistles. -The facility did not provide the residents with bells or whistles. -The resident's family members purchased the bells and whistles. -He told the residents to see him if they needed a whistle. -Staff walked the halls to see who rang the bells or blew the whistles. -The RCC added additional staff to the schedule on every shift to ensure the residents were receiving care. -Some residents complained about not having a working call bell system. -He never told residents that the call bell system was not required in the facility. -He was not made aware that anyone unplugged the call bell system. Interview with the Administrator on 07/11/25 at 8:26am revealed: -He contacted the Regional Maintenance Director by text message but could not recall when. -He did not speak to the Regional Maintenance Director directly because it was hard to reach him. -The Regional Vice President of Operations contacted the Regional Maintenance Director directly. -He was hoping that the Regional Maintenance Director would be in the facility today 07/11/25 to fix the call bell system.	D 118		

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D 118	Continued From page 24 The facility failed to ensure all residents had a sounding device to alert staff for assistance. There were multiple residents who were dependent on staff for toileting and transferring. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 2025.	D 118		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating;	D 254		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 254	Continued From page 25 (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others; (E) no response by the resident to the intervention for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with	D 254		

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D 254	Continued From page 26 Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change in condition for 1 of 1 sampled residents (#4) who was no longer ambulatory and required 2 to 3 staff assistance with standing and providing incontinence care. The findings are: Review of Resident # 4's current FL-2 dated 02/11/25 revealed: -Diagnoses included gait instability, lymphedema of lower extremity, diabetes mellitus type 2 with diabetic neuropathy, venous insufficiency,	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 254	Continued From page 27	D 254		

hypertension, and arthritis of both knees.
-She was semi-ambulatory.
-She was incontinent of bladder.
-The orientation, personal care assistance, and the skin assessment were blank.

Review of Resident #4's pre-admission assessment dated 02/26/25 revealed:
-Resident #4 was independent with mobility, transfers, and toileting, and required limited staff assistance with bathing and dressing.
-Resident #4 used a rolling walker when ambulating.
-Resident #4 had a wound on her buttocks; the previous Administrator was uncertain of the stage of the wound.

Review of Resident #4's Resident Register revealed:
-Resident #4 signed the Resident Register on 02/26/25; she was admitted to the facility on 03/14/25.
-Resident #4 required assistance with dressing and sometimes with ambulation.
-Resident #4 used a walker for ambulation.
-Resident #4 was forgetful and needed reminding.

Review of Resident #4's care plan dated 03/13/25 revealed:
-The care plan was not signed by the Primary Care Provider (PCP).
-She was ambulatory with the assistance of a rollator walker.
-The skin assessment was blank.
-She had bladder incontinence daily.
-Her memory was adequate.
-She was independent with feeding.
-She required supervision from staff with ambulation, grooming and personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 254	Continued From page 28	D 254		

-She required limited assistance from staff with bathing and dressing.
-She required extensive assistance from staff with transferring.
-There was no other care plan to review.

Review of Resident #4's licensed health profession services (LHPS) evaluation dated 04/08/25 revealed:
-She required some assistance with transfer at times.
-She ambulated with a rollator in her room and required assistance propelling her wheelchair for long distances.

Review of Resident #4's electronic progress notes revealed:
-On 05/02/25, the Resident Care Coordinator (RCC) spoke with Resident #4's Power of Attorney (POA) regarding Resident #4 not being able to transfer to the bathroom
-On 05/02/25, Resident #4 became combative when 3 staff provided personal care and dressed her in her pajamas.
-On 05/18/25, a personal care aide (PCA) attempted to provide incontinent care and Resident #4 refused.
-On 05/31/25, a PCA notified Resident #4's Power of Attorney (POA) that Resident #4 could not stand, and that she refused a shower.

Interview with a PCA on 07/09/25 at 5:31pm revealed:
-Resident #4 was independent with personal care on admission.
-Sometime in May 2025, Resident #4 required assistance from staff with toileting, bathing, dressing and incontinence care.
-Resident #4 continued to decline and required assistance from 2 to 3 staff to stand her to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 254	Continued From page 29 provide incontinent care. Interview with another PCA on 04/11/25 at 11:21am revealed: -Resident #4 could ambulate to the bathroom and to the dining room when she was first admitted to the facility. -She declined over time; about a month before she was taken to the hospital, she had stopped ambulating to the bathroom and to the dining room. -She did not ambulate and stayed in her recliner all the time. -It would take 3 staff to provide incontinence care; 2 staff to stand her and hold her up, while the third staff cleaned her and changed her incontinent brief. Interview with a medication aide (MA) on 07/10/25 at 10:23am revealed: -Resident #4 required 2 to 3 person assistance during the last month she was resided in the facility. -Resident #4 stayed in her recliner and never got in her bed. -It would take two staff to stand Resident #4 while she changed the dressing. Telephone interview with a former MA on 07/11/25 at 3:05pm revealed: -Resident #4 was total care before she went to the hospital; it would take 2 to 3 staff to care for her. -Resident #4 did not like the staff to provide incontinent care and change her incontinent brief; she preferred to sit in a wet brief. -The staff would call her POA, he would talk with her, and then she would let the staff provide care to her. -The staff would call the POA several times a	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 254	Continued From page 30 week. Interview with Resident #4's PCP on 07/14/25 at 11:23am revealed: -The staff were responsible for completing the care plan. -She would review and sign the care plans when she visited the facility. -She did not know if she signed an initial care plan on admission or an updated care plan for Resident #4. Interview with the Interim RCC on 07/10/25 at 8:44am revealed: -Care plans were updated by the RCC when a resident had a significant change. -The RCC was responsible for updating the care plan when a resident's condition changed. -She did not know Resident #4's care plan was not updated when her condition declined. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The RCC was responsible for updating Resident #4's care plan when there was a change in condition. -The PCP would review and sign the care plan. -He expected the RCC to update care plans when there was a change in a resident's condition.	D 254		
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:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 31 TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 7 sampled residents (#3, #4) related to a resident who had weight loss (#3); and a resident who had a worsening pressure wound (#4). The findings are: Review of Resident #4's current FL-2 dated 02/11/25 revealed: -Diagnoses included gait instability, lymphedema of lower extremity, diabetes mellitus type 2 with diabetic neuropathy, venous insufficiency, hypertension, and arthritis of both knees. -She was semi-ambulatory. -She was incontinent of bladder. -The orientation, personal care assistance, and the skin assessment were blank. Review of Resident #4's pre-admission assessment dated 02/26/25 revealed: -The pre-admission assessment was completed by the previous Administrator. -She was independent with mobility, transfers, and toileting and required limited assistance with bathing and dressing. -She used a rolling walker when ambulating. -She had a wound on her buttocks; uncertain of the stage of the wound. -She had 3 falls last month and had a gait abnormality. Review of Resident #4's Resident Register revealed: -She signed the Resident Register to be admitted to the facility on 02/26/25; she was admitted to the facility on 03/14/25.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 32	D 273		

-She required assistance with dressing and sometimes with ambulation.
-She used a walker for ambulation.
-She was forgetful and needed reminding.

Review of Resident #4's care plan dated 03/13/25 revealed:
-The care plan was not signed by the Primary Care Provider (PCP).
-She was ambulatory with the assistance of a rollator.
-The skin assessment was blank.
-She had bladder incontinence daily.
-Her memory was adequate.
-She was independent with feeding.
-She required staff supervision with ambulation, grooming and personal hygiene.
-She required limited assistance from staff with bathing and dressing.
-She required extensive assistance from staff with transferring.

Review of Resident #4's skin assessment dated 03/13/25 revealed:
-The skin assessment was completed by the Resident Care Coordinator (RCC)
-There was a pressure wound was seen on her buttock.

Review of Resident #4's signed physician order dated 03/13/25 revealed there was an order to clean the sacral pressure wound with wound cleanser and cover with a dry dressing daily, until an order was received by the PCP.

Review of Resident #4's PCP after visit summary dated 03/24/25 revealed:
-She was seen for an evaluation and management visit as a new resident to the facility.
-The staff reported open wounds to her buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 33	D 273		

which were present upon admission to the facility.
-She was encouraged to shift her weight to relieve pressure from the sacral pressure wound.
-Staff reported she was unsteady with her rollator.
-There was an order for home health to evaluate and treat the sacral pressure wound.

Review of Resident #4's Home Health order dated 04/01/25 revealed:
-Cleanse the sacral pressure wound with wound cleanser daily, apply zinc oxide paste (used to treat skin irritation , and cover with a dressing.
-Apply skin barrier as needed to the peri-wound (the area of skin immediately surrounding the wound) to prevent maceration (skin that had been softened and broken down due to prolonged exposure to moisture) and protect the skin, and apply dressing as needed.
-The Home Health Nurse would visit once weekly for dressing changes and the staff would do the dressing changes on the days the Home Health Nurse did not visit.

Review of Resident #4's March 2025 electronic medication administration record (eMAR) from 03/17/25 to 03/31/25 revealed:
-There was an entry to clean the sacral pressure wound with wound cleanser and cover with a dry dressing daily, until an order was received by the PCP, scheduled between 7:00am and 3:00pm.
-There was documentation that the dressing was applied 10 of 15 opportunities from 03/17/25 to 03/31/25.
-There were exceptions documented; including waiting on wound care orders, and one exception was blank.

Review of Resident #4's April 2025 eMAR revealed:
-There was an entry to clean the sacral pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 34	D 273		

wound with wound cleanser and cover with a dry dressing daily, until an order was received by the PCP, scheduled between 7:00am and 3:00pm from 04/01/25 to 04/12/25.
-There was documentation that the dressing was applied 12 of 12 opportunities from 04/01/25 to 04/12/25.
-There was a second entry to clean the sacral pressure wound with wound cleanser and apply zinc oxide paste daily scheduled between 7:00am and 3:00pm from 04/13/25 to 04/30/25.
-There was documentation that the wound care was completed 18 of 18 opportunities from 04/13/25 to 04/30/25.

Review of Resident #4's May 2025 eMAR revealed:
-There was an entry to clean the sacral pressure wound with wound cleanser and apply zinc oxide paste daily scheduled between 7:00am and 3:00pm.
-There was documentation that the wound care was completed 29 of 31 opportunities from 05/01/25 to 05/31/25.
-There were two exceptions; when the resident refused.

Review of Resident #4's June 2025 eMAR from 06/01/25 to 06/02/25.
-There was an entry to clean the wound to buttocks and apply zinc oxide cream daily scheduled between 7:00am and 3:00pm.
-There was documentation that the wound care was completed 1 of 2 opportunities from 06/01/25 to 06/02/25.
-There was one exception; when the resident refused.

Review of Resident #4's shower list from 03/22/25 to 05/31/25 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 35	D 273		

-She was scheduled for a shower three times a week on Tuesday, Thursday, and Saturday.
-There was documentation that Resident #4 was showered 16 of 31 opportunities.
-There was documentation that on the 16 shower days that Resident #4 had no skin concerns.
-There was no documentation that a shower was given or attempted for 14 of 31 days.
-There was one exception on 05/31/25, when the resident refused.

Review of Resident #4's licensed health profession services (LHPS) evaluation dated 04/08/25 revealed she had an excoriated area on the sacrum that was treated with barrier cream and a chair cushion.

Review of Resident #4's electronic progress notes revealed:
-On 05/02/25, Resident #4 stated her wet clothes helped her stay cool.
-On 05/15/25, the Home Health Nurse spoke to the Resident Care Coordinator (RCC) and reported that Resident #4 refused wound.
-On 05/18/25, a personal care aide (PCA) attempted to provide incontinent care and Resident #4 refused.
-On 05/31/25, a PCA notified Resident #4's Power of Attorney (POA) that Resident #4 could not stand, that she refused a shower, and that her bottom was getting worse and the wound had an odor.

Review of Resident #4's Home Health assessment and admission note dated 04/01/25 revealed:
-Resident #4 had a stage 2 pressure wound to her sacral area.
-The pressure wound was photographed and measured 7cm x 7cm x 0.1cm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 36	D 273		

-The sacral pressure wound had a small amount of bloody drainage; there was no maceration, necrosis, or tunneling.
-The sacral pressure wound was cleansed with wound cleaner, zinc oxide paste was applied to the wound, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-The Home Health Nurse would visit Resident #4 weekly to provide wound care to the sacral pressure wound.
-The staff would change the wound dressing daily.

Review of Resident #4's Home Health note dated 04/07/25 revealed:
-Resident #4 was seen for wound care to the sacral pressure wound.
-The sacral pressure wound was cleansed with a wound cleaner, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound and covered with a bordered foam dressing.
-The wound had a scant amount of bloody drainage and measured 7.1cm x 6.9cm x 0.1cm; there was no maceration, necrosis, or tunneling.
-Demonstration and education was provided to the RCC on dressing changes and wound care to the sacral pressure wound.
-The Home Health Nurse provided education to Resident #4 on the importance of repositioning to relieve pressure to the buttocks; Resident #4 verbalized understanding.

Review of Resident #4's Home Health note dated 04/14/25 revealed:
-Resident #4 was sitting in her recliner and was seen for wound care to the sacral pressure wound.
-The sacral pressure wound was cleansed with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 37	D 273		

wound cleanser, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-The wound measured 7cm x 7cm x 0.1cm; there was no drainage, maceration, necrosis, or tunneling.
-The Home Health Nurse reinforced education with Resident #4 on repositioning frequently and incontinent care; Resident #4 verbalized understanding of teaching.

Review of Resident #4's Home Health note dated 04/21/25 revealed:
-Resident #4 was sitting in her recliner in her room.
-Resident #4 was observed wearing a soiled incontinence brief with a soiled pad beneath her.
-Staff assisted her with incontinent care.
-Resident #4 stated she was unable to make it to the bathroom because she needed increased assistance with ambulation.
-The sacral pressure wound was cleansed with a wound cleaner, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-There was no wound measurements or description of the wound documented.
-The Home Health Nurse reinforced education and importance of proper incontinence care and frequent repositioning to Resident #4 and the staff.

Review of Resident #4's Home Health note dated 04/28/25 revealed:
-Resident #4 was sitting in her recliner in her room.
-The sacral pressure wound was cleansed with a wound cleanser, zinc oxide paste was applied to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 38	D 273		

the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-The wound measured 7cm x 7cm x 0.1cm; there was no drainage, maceration, necrosis, or tunneling.
-The wound was slow to heal; Resident #4 continued to have soiled incontinence briefs for extended periods of time.
-Resident #4 was able to walk but maintained a sedentary lifestyle of watching television and reading.
-The Home Health Nurse educated Resident #4 on skin integrity and the destruction urine and feces had on open wounds.

Review of Resident #4's Home Health note dated 05/02/25 revealed:
-Resident #4 had a missed visit today.
-The Home Health Nurse was informed by the staff that Resident #4 had a fall that morning and was sent to the Emergency Department (ED).

Review of Resident #4's Home Health note dated 05/06/25 revealed:
-Resident #4 was sitting in the recliner in her room.
-The sacral pressure wound was cleansed with a wound cleanser, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-The wound measured 7cm x 7cm x 0.1cm; there was no drainage, odor, maceration, necrosis, or tunneling.
-Resident #4 was educated to reposition every 15 minutes while sitting in the recliner by the Home Health Nurse.
-Resident #4 verbalized understanding but stated that she could not get up on her own.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 39 Review of Resident #4's Home Health note dated 05/14/25 revealed: -Resident #4 was received sitting in her recliner. -Resident #4 refused to stand for wound care to the sacral pressure wound. -Resident #4 continued to have soiled incontinence briefs for extended periods of time. -The Home Health Nurse reinforced education on how urine and feces broke down the skin to Resident #4 and the staff. -The Home Health Nurse spoke with the RCC and informed her of Resident #4's refusal of wound care. -The RCC reported that Resident #4 was non-compliant with the staff providing incontinence care, repositioning, and dressing changes. Review of Resident #4's Home Health note dated 05/19/25 revealed: -Resident #4 was sitting in her recliner. -Resident #4 continued to sit in wet incontinence briefs; she had had a bowel movement also. -The PCA assisted the Home Health Nurse with incontinence care to Resident #4. -Resident #4 stood with assistance long enough for the dressing change but the Home Health Nurse was unable to obtain measurements of the wound. -The sacral pressure wound was cleansed with a wound cleanser, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing. -Resident #4 utilized a wheelchair daily and had decreased strength in her lower extremities. -The Home Health Nurse advised Resident #4 and the RCC that alternative living arrangement should be considered to meet Resident #4's	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 40	D 273		

needs.
-Resident #4 required assistance with all activities of daily living.
-Resident #4 verbalized she understood the need for a higher level of care and that Resident #4 would tell her POA.

Review of Resident #4's Home Health note dated 05/27/25 revealed:
-Resident #4 was seen for wound care to the sacral pressure wound.
-Resident #4 was sitting in the recliner in her room but refused to reposition for wound care.
-Resident #4 stated she was unable to stand because she was too weak.
-Two staff assisted Resident #4 in standing so wound care could be completed.
-The pressure wound was cleansed with normal saline, zinc oxide paste was applied to the wound bed, a skin barrier was placed on the peri-wound, and covered with a bordered foam dressing.
-The wound had moderate amount of bloody drainage and had an odor.
-Resident #4 could not stand long enough to obtain wound measurements.
-The Home Health Nurse spoke with the RCC to obtain updated wound orders.
-The RCC stated a message would be sent to the PCP; however, the PCP was out that week.
-The RCC stated she had spoken with Resident #4's POA and he was in agreement with moving Resident #4 to another facility due to needing a higher level of care.
-The Home Health Nurse informed the RCC that Resident #4 could benefit from antibiotics and wound care several times daily.
-The staff reported that Resident #4 was refusing care and becoming more resistant to care for activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 41	D 273		

Review of an electronic text message dated 05/28/25 between the RCC and the PCP at 11:57am revealed:
-The RCC requested an FL-2 for Resident #4 from the PCP; the POA was in the facility and wanted Resident #4 moved to another facility; Resident #4 had been refusing wound care.
-The PCP responded asking the RCC to fill out the FL-2 and should wound sign it.
-The RCC sent a picture of Resident #4's sacral pressure wound to the PCP.
-The PCP responded that Resident #4 "definitely needed skilled services."
-There were no new orders received.

Review of Resident #4's Home Health note dated 06/02/25 revealed:
-Resident #4 was seen today for wound care to the sacral pressure wound.
-Resident #4 was sitting on a saturated incontinence brief in her recliner in her room.
-Resident #4 was unable to stand and refused to get in the bed for wound care.
-Two staff assisted Resident #4 to stand long enough to visualize the wound.
-The wound was unstageable with adherent eschar (dead skin/tissue) and presented with a strong odor.
-The RCC was notified that Resident #4's wound could be infected.
-The RCC notified the PCP that Resident #4's wound could be infected.
-The RCC received orders to transport Resident #4 to the ED.

Review of Resident #4's ED assessment dated 06/02/25 revealed:
-She was brought to the ED by Emergency Medical Services (EMS) from an assisted living facility with a sacral pressure wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 42	D 273		

-On examination, Resident #4 had a large stage IV sacral pressure wound with a foul smelling odor that appeared infected; she complained of aching and pain in the sacral area.
-She was started on broad-spectrum antibiotics and pain medication.
-She was transferred to the surgical team and admitted to the hospital with diagnosis of acute sepsis and infected sacral wound.

Review of Resident #4's ED wound assessment dated 06/02/25 revealed:
-She had a sacral wound measuring 6cm x 7cm and 5cm deep with 4cm of tunneling at 12:00, 2cm at 9:00, and 2cm at 6:00; a wet to dry dressing was applied.
-She had a second pressure wound under her left buttock measuring 4cm x 2cm with tan eschar; a wet to dry dressing was applied.

Review of Resident #4's hospital daily assessment report dated 06/03/25 revealed at 10:40pm, Resident #4 was received into the intensive care unit from the operating room with a wound vac (a medical treatment that uses negative pressure to promote wound healing) intact to sacral wound.

Review of Resident #4's hospital discharge summary dated 06/12/25 revealed:
-Resident #4 was admitted to the hospital on 06/02/25 with a diagnosis of sepsis secondary to inferior coccygeal (a short section of small bones at the base of the spine) osteomyelitis.
-Resident #4 had an unstageable sacral pressure wound.
-Resident #4 had surgical excision of skin, subcutaneous tissue, and muscle of sacrum measuring 15cm x 16cm.
-Resident #4 had a coccygectomy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 43	D 273		

-She had surgical removal of skin, subcutaneous tissue, and the muscle of the left ischial wound measuring 6cm x 7cm.
-She was discharged to inpatient hospice care on 06/12/25 with diagnoses of sepsis secondary to infection of the lowest part of the coccyx or tailbone, a stage IV sacral wound wound and a stage IV left ischial wound. (A stage IV wound was a severe, full-thickness skin and tissue loss that exposed the bone, tedon and muscle.
-She was discharged to hospice in poor condition and for comfort measures.

Review of Resident #4's inpatient hospice admission summary dated 06/12/25 revealed:
-Resident #4 was treated for sepsis secondary to inferior coccygeal osteomyelitis.
-After 10 days of inpatient treatment, Resident #4's POA requested comfort measures for Resident #4.
-She was experiencing intractable pain related to a sacral pressure wound.
-She was started on a morphine drip (used to treat pain) and Ativan (used to treat anxiety) and atropine (used to decrease secretions) drops.
-The goal was to keep Resident #4 comfortable, free of pain, and with dignity.

Review of Resident #4's inpatient hospice discharge summary dated 06/13/25 revealed:
-Resident #4 was admitted to inpatient hospice on 06/12/25 due to a terminal illness with a diagnosis of sepsis from sacral osteomyelitis.
-Resident #4 expired on 06/12/25.

Interview with a PCA on 07/09/25 at 5:31pm revealed:
-She would place a cream on Resident #4's buttocks after incontinence care; the cream would help protect her skin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 44 -Resident #4 had about 3 dime sized broken skin areas on the inner side of her buttocks when she was admitted to the facility. -Over time the broken areas joined causing one larger wound. -The last time she saw Resident #4's wound was the week before she went to the hospital and the wound was about the size of her hand. -A week before Resident #4 was sent to the ED, she would be soiled from the bloody drainage from the wound, not urine. -Resident #4 did not complain of pain from the pressure wound. -Resident #4 sat in the recliner and never got in bed; sometimes she refused incontinence care and repositioning. -She told the medication aide (MA) that Resident #4's wound was draining and looked bad. Interview with a second PCA on 07/11/25 at 11:21am revealed: -She saw Resident #4's wound when she provided incontinence care, and the wound looked "horrible". -The sacral pressure wound was black, had an odor, and a big hole in the center of the wound that she could place her fist in; this was a week or two before Resident #4 went to the hospital. -She told the RCC that Resident #4's wound was black and had an odor. Telephone interview with a third PCA on 07/10/25 at 11:39am revealed: -She saw Resident #4 a few days before she went to the hospital. -She and another staff would hold Resident #4 up from sitting in her recliner so the MA could change the dressing to the pressure wound. -She saw Resident #4's sacral pressure wound when the MA was changing the dressing.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 45	D 273		

-The wound was about the size of her hand, the entire wound was black and had tea-colored drainage that saturated the dressing and the drainage would overflow into Resident #4's incontinence brief.

Interview with a fourth PCA on 07/11/25 at 10:59am revealed:
-The last time she saw Resident #4's wound was mid to late May 2025.
-The wound was the size of a grapefruit, and had pus coming from the center of the wound, and it had an odor.
-It looked like there was a second wound inside the wound that was the size of an orange.
-The outer edge of the wound looked bruised and there was black on the inside of the wound.
-She told the MA who was working what the wound looked like.
-The MAs would dress the wound daily.

Interview with the LHPS nurse on 07/11/25 at 2:48pm revealed:
-She would look at the Resident #4's wound if the dressing change was being done during her visit.
-She would read the Resident #4's Home Health Nurse's notes to see how the wound was progressing if she was unable to see the wound.
-She would look at Resident #4's wound if the staff had a concern about the wound.
-She had not been asked to assess the wound by the staff; she had not looked at Resident #4's since being admitted to the facility.
-A resident with a wound that progressed past stage II would be discharged to a higher level of care.
-She was not sure if she had been notified of Resident #4's wound worsening; she would have to look back at her notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 46 Interview with a MA on 07/10/25 at 10:23am revealed: -Resident #4 required 2 to 3 person assistance during the last month she was resided in the facility. -She changed the dressing to Resident #4's sacral pressure wound daily when she worked as the MA. -Resident #4 stayed in her recliner and never got in her bed. -It would take two staff to stand Resident #4 while she changed the dressing. -She would clean the area with normal saline, apply the zinc oxide paste, and cover with a non stick dressing and secure with tape. -The last time she saw Resident #4's sacral pressure wound (she could not remember when) it was about the size of an orange and red in color; she did not see any black areas on the wound. -She informed the RCC when she noticed the wound getting worse; she could not remember when she told the RCC the wound was getting worse. -She did not document that she notified the RCC; she was a new MA and was not sure she should. Telephone interview with a former MA on 07/11/25 at 3:05pm revealed: -Resident #4 was a total care before she went to the hospital; it would take 2 to 3 staff to care for her. -Resident #4 did not like for the staff to provide incontinent care and change her incontinence brief; she preferred to sit in a wet brief. -The staff would call her POA, he would talk with her, and then she would let the staff provide care to her. -The staff would call the POA several times a week.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 47	D 273		

-Resident #4's wound was discolored, black, and had a green discharge.
-The black area was about the size of a tennis ball.
-Resident #4 would pick at the wound.
-She reported to the RCC what Resident #4's wound looked like.
-She continued to clean the area with wound cleanser, applied zinc oxide paste, and covered with a dressing.
-She placed a skin barrier on the skin around the wound.
-Another MA told her how to apply a dressing to the wound.

Telephone interview with a representative at the facility's contracted Home Health agency on 07/10/25 at 2:23pm revealed:
-Resident #4 had been on their Home Health services for wound management since 04/01/25.
-There was an order to cleanse the sacral pressure wound with normal saline, apply zinc oxide paste, apply skin barrier on the peri-wound, and cover with a dressing.

Telephone interview with Resident #4's family member on 07/08/25 at 6:45pm revealed:
-Resident #4 had a stage II sacral wound when she was admitted to the facility on 03/14/25.
-Resident #4 started calling sometimes in May 2025, crying and saying she needed to get out of the facility.
-A relative went to visit Resident #4 and sent her a picture of Resident #4 sitting in a wheelchair and leaning to one side; the picture was sent sometimes in May, but she could not remember the date.
-Several phone calls were made to the facility; there was no answer or if a message was left, no one called back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 48	D 273		

-Resident #4's POA lived out of state and decided to travel to the facility to check on Resident #4 and to have her moved from the facility because she was so dissatisfied.

Telephone interview with Resident #4's POA on 07/10/25 at 6:40pm revealed:
-Resident #4 was unhappy at the facility.
-Resident #4 kept calling him, crying, and saying she needed to leave the facility.
-A family member went to see Resident #4 and sent him some pictures.
-Resident #4 was sitting in a slouched position in a wheelchair and leaning to the side.
-Resident #4 did not look good to him, so he planned a trip to the facility from out of state.
-He started researching facilities to see who would accept Resident #4.
-He received a phone call on 05/26/25 from the staff who said Resident #4 had wounds on her buttocks and Resident #4 refused to let the staff treat the wounds.
-He spoke with Resident #4 and he encouraged her to allow the staff to treat the wounds.
-He received a phone call on 06/02/25 that Resident #4 was being sent to the hospital ED because she had a pressure wound that required treatment.
-After he arrived at the ED, the ED Physician showed him the pressure wound on Resident #4's sacrum.
-There was a huge cavity in her buttocks with odor and drainage; it measured 6cm x 5cm x 4.5cm.
-The pressure wound was black with a yellowish area and a red area that looked like raw meat.
-Resident #4 was taken to surgery for wound debridement on 06/03/25.
-Resident #4's had a wound vac placed on the wound and was taken to the ICU.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 49	D 273		

-After a few days, Resident #4 was transferred to the surgical floor.
-Resident #4 was being treated for a wound infection and pain management.
-Resident #4 did well for a couple of days post operative but then started a gradual decline.
-The surgeon said Resident #4 needed a colostomy (a surgical procedure that creates an opening in the intestines allowing bowel to be collected in a pouch) to assist with keeping the wound clean, but Resident #4 could not go through another surgery because of her decline.
-The decision was made to keep Resident #4 comfortable and out of pain.
-Resident #4 passed away on 06/12/25.
-The surgeon said Resident #4 died from sepsis related to the infection from the wound.
-He did not remember being notified of Resident #4 refusing wound care or worsening of the pressure wound.
-He and his family did not understand how Resident #4 went from a stage II pressure wound to having major surgery to debride a wound to passing away.

Telephone interview with the Home Health Nurse on 07/14/25 at 9:51am revealed:
-She provided wound care to the sacral pressure wound to Resident #4.
-Resident #4 had refused wound care once or twice in May 2025.
-She saw Resident #4 on 05/19/25 to change the dressing, but she did not have a chance to measure the wound because Resident #4 could not stand long enough to measure the wound.
-The wound was a stage II, there was no necrosis and was about 5cm x 7cm on 05/19/25.
-She discussed with Resident #4 that she needed a higher level of care because of the wound, her inability to stand for wound care, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 50	D 273		

incontinence care.
-She discussed these issues with the RCC.
-On 06/02/25, she visited Resident #4 to provide wound care but Resident #4 refused care.
-Two staff assisted Resident #4 to stand for her to visualize the wound.
-The wound was unstageable with eschar and had a strong odor; the wound appeared to be infected.
-She notified the RCC, who notified the PCP and obtained orders for Resident #4 to be sent to the ED.

Telephone interview with another Home Health Nurse on 07/14/25 at 10:05am revealed:
-She saw Resident #4 for the first time on 05/27/25.
-Resident #4 refused treatment to the sacral pressure wound.
-She did notice an odor coming from the wound and notified the RCC.

Telephone interview with Resident #4's PCP on 07/10/25 at 2:44pm revealed:
-She ordered Home Health service for Resident #4 upon admission to the facility to manage stage II pressure wounds.
-She did not see the wound; the staff reported the findings to her.
-She was not informed Resident #4 was non-compliant with dressing changes and treatment.
-She was notified on 06/02/25 by the RCC who stated Resident #4's wound appeared infected.
-The Home Health Nurse was in the facility and showed her a picture of the wound on 06/02/25; she had Resident #4 transported to the ED.
-This was the first time she recalled being informed of Resident #4 refusing wound care.
-She saw Resident #4 in March 2025 and April

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 51	D 273		

2025; another PCP saw Resident #4 in May 2025.
-She could not make changes to treatments if she was not made aware of the wound worsening; she thought things were progressing well.
-She expected to be notified if Resident #4 was refusing dressing changes and if the wound was worsening.
-Arrangements could have been made earlier to send Resident #4 to a skilled nursing facility.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-She saw Resident #4 on 05/05/25 for an acute visit that was not related to the sacral pressure wound.
-Another provider saw Resident #4 in May 2025 for Resident #4's routine visit; she was out of town.
-The next time she saw Resident #4 was on 06/02/25 when she was notified the sacral pressure wound was necrotic and had an odor.
-She was shown a picture of the wound; she thought she saw the picture on 06/02/25, and she sent Resident #4 to the ED.
-She did not recall reviewing a picture of the wound prior to 06/02/25.
-She would have expected to have been notified if Resident #4 was refusing wound care.

Interview with the interim RCC on 07/10/25 at 8:44am revealed:
-She trained with the RCC from 05/13/25 to 06/02/25; she was the interim RCC position while the RCC was out.
-She worked as a MA and had cared for Resident #4 prior to training for the interim RCC.
-The Home Health Nurse saw Resident #4 once a week.
-Resident #4 refused wound care by the Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 52	D 273		

Health Nurse twice a month.
-The Home Health Nurse would speak to the RCC when Resident #4 refused wound care.
-She did not know if the RCC notified the PCP of Resident #4 refusing of wound care.
-Resident #4 got worse about a month after she was admitted to the facility.
-Resident #4 refused wound care and showers starting sometime in May 2025.
-Resident #4's wound worsened about a month after being admitted to the facility.

Interview with the interim RCC on 07/11/25 at 9:01am revealed:
-The staff had stood Resident #4 up and the Home Health Nurse had taken a picture of the pressure wound and texted the picture to her and the RCC.
-The wound in the picture appeared red with no drainage and was the size of a tennis ball; toward the bottom of the wound there was a black area about the size of a quarter.
-She received the picture between 05/13/25 to 06/02/25 because those were the days she was training with the RCC to fill in for her while she was out of work.
-She notified the RCC of the picture she received; the RCC received the same picture and she said she would handle it.
-She deleted the picture from her phone.
-The staff began making arrangements to transfer Resident #4 to a skilled nursing facility.
-She did not document what the wound looked like when she received the picture or the conversation with the RCC.
-Other than the picture she received, she was not notified of any changes to the wound.

Telephone interview with the RCC on 07/10/25 at 7:33pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 53 -Resident #4 could walk to the bathroom with assistance of her rollator walker when she was admitted then progressed to a wheelchair about a month later. -She sat and slept in her recliner every day. -She did a full body assessment of Resident #4 upon admission. -Resident #4 had a sacral pressure wound that was bruised, discolored and the skin was broken, but it was not a stage II pressure wound. -Resident #4 would not have been admitted to the facility if she had a stage II wound. -She notified the PCP of her skin assessment findings, and the PCP ordered Home Health nursing to manage the pressure wound. -Resident #4's had a wound order to cleanse the wound with normal saline and apply zinc oxide paste. -The MAs were to treat the wound daily when the Home Health Nurse did not visit. -She did not go with the Home Health Nurse when wound care was performed; she had not seen the wound. -The Home Health Nurse would come to her after the visit to inform her of any problems with the wound or if Resident #4 refused care. -Resident #4 started refusing Home Health dressing changes in mid-May. -On 06/02/25, she was notified by the Home Health Nurse that the wound appeared infected and there was an odor. -Resident #4's PCP was in the facility on 06/02/25, so she showed the PCP a picture of the wound and was instructed to send Resident #4 to the ED. -The PCP was not notified of Resident #4 refusing wound care prior to 06/02/25. Interview with the Administrator on 07/14/25 at 8:04am revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 54 -He had worked at the facility about 5 weeks and was not aware Resident #4 had a wound that had gotten worse and that she was refusing care. -The facility could only care for a wound that was a stage II or less. -The PCP should have been notified if Resident #4's wound was worsening and if she was refusing care. -He expected the staff to notify the PCP when the resident was refusing care and when the condition of a wound worsened. 2. Review of Resident #3's FL-2 dated 08/23/24 revealed diagnoses included hypertension and dementia. Review of Resident #3's care plan dated 06/04/25 revealed she required prompting to eat her meals. Review of Resident #3's weights from 01/13/25 to 05/15/25 revealed: -On 01/13/25, Resident #3's weight was 152.2 pounds. -On 02/16/25, Resident #3's weight was 165 pounds; a 13-pound weight gain and an 8% weight change. -On 03/15/25, Resident #3's weight was 147.5 pounds; an 18-pound weight loss and an 11% weight change. -On 04/15/25, Resident #3's weight was 142 pounds; a 5-pound weight loss and a 4% weight change. -On 05/15/25, Resident #3's weight was 175 pounds; a 33-pound weight gain and a 19% weight change. Review of Resident #3's hospital admission note dated 06/10/25 revealed she weighed 134 pounds when she was admitted.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 273	Continued From page 55 Resident #3 had a 12% change in her weight from January 2025 to June 2025. Review of Resident #3's progress notes from January 2025 to June 2025 revealed: -On 01/13/25, the primary care provider (PCP) was notified of Resident #3's weight variance. -On 04/21/25, the PCP was notified of Resident #3's weight variance. Telephone interview with Resident #3's power of attorney (POA) on 07/09/25 at 11:30am revealed: -Resident #3 weighed 187 pounds when she was admitted to the facility in August 2024; she had lost about sixty pounds since then. -Resident #3 had not eaten well since February 2025. -In April 2025, the facility staff called to report Resident #3 had lost weight; she did not know how much weight Resident #3 had lost. Interview with Resident #3's PCP on 07/14/25 at 12:06pm revealed: -She reviewed the residents' weights on the eMAR. -She tried to identify residents with changes in their weights, but she depended on the facility to catch the changes and notify her. -She should have been notified when a resident had a weight change of five pounds in a month. -Resident #3 weighed 160 pounds in November 2024, was 142 pounds on 12/11/24 and 154 pounds on 12/11/24. -Resident #3 had shown a steady decline and the family had requested the resident be placed on hospice. -She requested weights for Resident #3 because her weight had fluctuated and she wanted to get accurate weights.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 56	D 273		

-She needed accurate and precise weights to see if there was a change in weights and she depended on the facility to obtain those weights.
-She expected the facility to notify her of any weight changes for Resident #3.
-She was concerned because Resident #3 had overall decline and if she had known it could have changed her care.

Interview with a personal care aide (PCA) on 07/09/25 at 11:56am revealed:
-The PCAs weighed the residents once a month.
-They documented the residents' weight and gave the weights to the medication aide (MA).
-The residents were weighed on a scale while in their wheelchairs.
-The scale did not have a tare weight (a way to to automatically subtract the weight of the wheelchair from the total weight of the resident and the wheelchair); the PCAs had to manually calculate the weight of the resident by subtracting the weight of the wheelchair from the total weight of the resident and the wheelchair.
-The wheelchairs had a tag on the back with the weight of the chair.
-None of the residents were weighed more often than once a month.
-Resident #3 was weighed once a month while in her wheelchair.

Interview with a MA on 07/09/25 at 2:58pm revealed:
-The PCAs or the MAs weighed the residents once a month.
-The weights were documented in the eMAR by the MAs.

Interview with a second MA on 07/11/25 at 10:03am revealed:
-The PCAs weighed the residents on the 15th of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 57	D 273		

each month.
-Sometimes she helped with weighing residents.
-The facility only had the wheelchair scale.
-Residents were either weighed in their wheelchairs or standing up on the scale.
-The residents in wheelchairs were weighed in their wheelchairs and then the wheelchair was weighed without the resident.
-The weight of the wheelchair was subtracted from the total weight on the scale.
-The PCAs were trained by other PCAs on how to weigh residents.
-Most residents' weights went up and down.
-She only documented the weights in the eMAR.
-She had not been told what to do when a resident had a change in weight.

Interview with the Special Care Coordinator (SCC) on 07/14/25 at 10:02am revealed:
-The MAs and the PCAs weighed residents once a month.
-There was a standing scale and a wheelchair scale.
-Resident #3 was in a wheelchair so she was weighed on the wheelchair scale.
-Resident #3's wheelchair was weighed without her in it and the weight was subtracted from the total weight.
-Most residents were only weighed once a month.
-Resident #3 was only weighed once a month.
-She entered the residents' weights into the eMAR.
-She reviewed the residents' weights as she entered them into the eMAR.
-She looked for a drastic change in a resident's weight from month to month; a loss or gain of 15 pounds within two months was considered drastic.
-If a resident had a drastic weight change, she would have a care plan meeting with the PCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 273	Continued From page 58 -She noticed Resident #3 had some weight loss, but she did not recall how much and did not think it was drastic enough that a care plan meeting needed to be done. -Resident #3's POA was concerned about her weight loss. -The PCP reviewed the residents' monthly weights on the eMAR. -The PCP had not told her of any concerns with Resident #3's weight loss. -The facility did not have a policy about weights and weight loss. Interview with the Administrator on 07/14/25 at 12:56pm revealed: -The facility did not have a policy regarding weights. -Residents were weighted monthly. -If a resident had a weight loss or a weight gain of five pounds or 5% in a month it was a concern. -The MAs should report the residents' weight to the SCC. -The SCC should look at the last month's weight for any weight changes. -He was not sure if the PCP looked at the residents' weights every month for change. -It was the responsibility of the SCC to look at weights for changes too and be aware of changes and to notify the PCP when there was a change. _____ The facility failed to ensure referral and follow-up for a resident (#4), who had a stage II pressure ulcer wound, that became necrotic with drainage and odor, and the PCP was not notified of the worsening pressure wound. The resident was hospitalized, had surgery for debridement and partial removal of the muscle and coccyx, developed osteomyelitis and passed away due to sepsis related to sacral osteomyelitis. A second resident (#3) had significant weight loss and the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 273	Continued From page 59 physician was not notified. This failure resulted in serious physical harm and neglect which constitutes an A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on July 11, 2025. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 13. 2025.	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 observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#5) related to an order for checking blood sugars twice a day. The findings are: Review of Resident #5's current FL-2 dated 01/28/25 revealed diagnoses included seizures, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure, and deep vein thrombosis (DVT). Review of Resident #5's Primary Care Provider's	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 276	Continued From page 60 (PCP) after visit summary dated 05/05/25 revealed: -There was an order to discontinue daily blood sugar checks. -There was an order to increase blood sugar checks to twice daily. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for blood sugar checks daily with a scheduled time of 7:00am. -There was documentation the blood sugar was checked daily from 05/01/25 to 05/31/25. -The blood sugar values ranged from 97 to 188. -There was no entry to check Resident #5's blood sugar twice daily. Review of Resident #5's June 2025 eMAR revealed: -There was an entry for blood sugar checks daily with a scheduled time of 7:00am. -There was documentation the blood sugar was checked daily from 06/01/25 to 06/30/25. -The blood sugar values ranged from 91 to 225. -There was no entry to check Resident #5's blood sugar twice daily. Review of Resident #5's July 2025 eMAR revealed: -There was an entry for blood sugar checks daily with a scheduled time of 7:00am. -There was documentation the blood sugar was checked daily from 07/01/25 to 07/08/25. -The blood sugar values ranged from 120 to 166. -There was no entry to check Resident #5's blood sugar twice daily. Interview with Resident #5 on 07/10/25 at 3:48pm revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 276	Continued From page 61	D 276		

-The MAs checked her blood sugar once a day in the morning.
-The MAs did not check her blood sugar more than once a day.

Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed:
-The pharmacy did not receive an order to increase Resident #5's blood sugar checks from daily to twice daily.
-The facility staff had authorization to enter blood sugar checks into the eMAR if they wanted to.
-The order should have been faxed to the pharmacy so the order could have been entered on Resident #5's profile.

Interview with Resident #5's PCP on 07/14/25 at 11:23am revealed:
-Resident #5's blood sugar was being checked daily but the family requested twice a day blood sugar checks.
-She wrote an order several months ago for Resident #5 to increase blood sugar checks to twice a day.
-Resident #5's blood sugar was stable.
-She expected the staff to implement orders when she wrote them.

Interview with the interim Resident Care Coordinator (RCC) on 07/10/25 at 8:44am revealed:
-The after-visit summaries were reviewed by the RCC to see if new orders were written by the PCP.
-All new orders were faxed to the pharmacy; the RCC would enter the new blood sugar order onto the eMAR.
-She was not the Interim RCC when the order was written, but it was the responsibility of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 276	Continued From page 62 RCC to enter blood sugar checks into the eMAR. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The RCC was responsible for reviewing the PCP's after-visit summaries for new orders. -The new orders would be faxed to the pharmacy. -The RCC could enter blood sugar orders into the eMAR. -He expected the RCC to review the PCP's after-visit summaries and fax new orders to the pharmacy or enter the new order into the eMAR.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 283	Continued From page 63	D 283		

failed to ensure the sanitation of the Special Care Unit (SCU) dining room by not routinely sweeping and mopping the floors to remove debris, food and spills.

The findings are:

Observations of the dining room in the SCU on 07/08/25 at various times between 8:20am to 3:00pm revealed:
-At 8:20am, there were crumbs, dried drip spots, dried spills, and debris under the tables and chairs; the breakfast meal had not been served and there were no residents in the dining room.
-From 8:35am to 9:00am, seventeen residents ate breakfast in the dining room.
-At 9:08am, a dietary aide removed plates and wiped off the tables.
-At 10:31am, there were crumbs, chunks of eggs, balled up paper towels, used napkins, and liquids on the floors under the tables and chairs; there were no residents in the dining room.
-At 12:07pm, there were crumbs, chunks of eggs, used napkins, balled up paper towels, food, crumbs, debris, and dried spills under tables and chairs.
-There was material from the artificial planter on the floor at the opening to the dining room.
-At 3:00pm, there were crumbs, dried spills, dried pasta sauce and noodles on the floor under tables and chairs.

Observations of the dining room on 07/09/25 at various times between 8:16am to 10:27am revealed:
-At 8:16am, breakfast had not been served yet; there was a large area of dried spaghetti sauce and dried spaghetti noodles on the floor under two tables.
-There was debris, dried spills, large dark pieces

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 283	Continued From page 64	D 283		

of debris and food under the tables.
-There were dried spills, large clumps of dust and a one-inch brownish black dried lump stuck to the floor near the windows.
-At 10:27am, there was a dietary aide in the dining room with a broom and a mop.
-The tables and chairs had been moved to the perimeter of the dining room and the dietary aide was sweeping the floor.

Telephone interview with a resident's family member on 07/10/25 at 10:34am revealed:
-It seemed like the dining room floors in the SCU were always dirty.
-There was always food and dried spills on the dining room floors.
-The dining room floors were sticky.
-She had seen residents drop food on the floor during a meal and noticed it was still there the next day.
-She had complained to the previous Administrator.

Interview with a dietary aide on 07/08/25 at 12:09pm revealed the kitchen staff and housekeeping staff rotated cleaning the floors in the dining room.

Interview with a second dietary aide on 07/09/25 at 10:29am revealed:
-The dietary aides were responsible for sweeping and mopping the floors in the SCU dining room after breakfast.
-About every four days he moved the tables and chairs to the sides of the dining room to do a deep cleaning by sweeping and mopping.
-He did not have a schedule; he did a deep cleaning when he noticed it needed to be done like when the floors were sticky.
-In between the deep cleanings the personal care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 283	Continued From page 65	D 283		

aide (PCAs) swept the dining room floor in the SCU twice a day; after breakfast and dinner.
-He would spot sweep with a broom and a dustpan after lunch.
-He spot mopped sometime between breakfast and dinner if it was bad and needed it.
-He did not have a schedule for cleaning the dining room floors in the SCU; he did them on his own.
-No one had told him to clean the dining room floor in the SCU today; he noticed it needed to be done.

Interview with a housekeeper on 07/10/25 at 3:11am revealed:
-He swept the dining room floor in the SCU every morning at 7:00am when he came to work.
-He swept the dining room floor in the SCU every day after lunch.
-He used the floor machine to mop and dry the floor in the dining room twice a week.
-He would move the furniture to one side of the room and use the floor mopping machine and then move the furniture to the opposite side and do the other side of the floor in the dining room.
-Sometimes the floor looked good in the morning before breakfast and sometimes it looked bad.
-He did not know if the dining room floor in the SCU was cleaned at night after the residents ate dinner.

Interview with a PCA on 07/09/25 at 11:56am revealed:
-The dietary staff swept the dining room floors; she had not paid attention to how often they swept.
-Sometimes she noticed there was food on the floor in the dining room from the last meal.

Telephone interview with a second PCA on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 283	Continued From page 66 07/10/25 at 7:41am revealed: -The dietary staff were responsible for cleaning the floors in the dining room. -When she started working at the facility in August 2024 the dining room floors were swept and mopped once a day. -The dining room floors were supposed to be spot swept after each meal by the dietary staff. -The dining room floors were dirty when she came to work in the morning. -The food from the meals the day before would still be on the floor. -She did not see the dietary staff sweeping or mopping in the dining room between meals. Interview with the Kitchen Manager (KM) on 07/10/25 at 3:29pm revealed: -The dietary aides swept the dining room floor after each meal, and they spot mopped after each meal. -Housekeeping would also spot mop during the day. -She recently did an in-service training on sweeping and mopping the dining room floor due to a lot of complaints. -The Administrator told her there were complaints about the dining room floors and he had also seen dirty spots on the floors about a week ago. -She had not had a chance to look at the dining room floor to see if there was improvement. -She wanted to inspect them three times a week. -She had seen the floors about a week ago and there were crumbs on them, so she had a dietary aide come and sweep them. Interview with the Special Care Coordinator (SCC) on 07/14/25 at 8:47am revealed: -The floor in the dining room in the SCU should be cleaned by a dietary aide at least one hour after each meal.	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 283	Continued From page 67 -The dietary aides were responsible for cleaning the floors in the dining room. -She looked at the floor in the dining room about every other day. -If the floor looked dirty, she got the dietary aides to clean them. -She had not noticed the dirty floor in the dining room in the mornings. -The Administrator checked the floors in the dining room about 3 to 4 times a week. -She did not know of any complaints about dirty floors in the dining room. Interview with the Administrator on 07/14/25 at 12:56pm revealed: -The kitchen staff was responsible for cleaning the dining room floors in the SCU. -The dining room floors were swept after each meal because residents spilled and dropped food on the floor. -The floor should be mopped at least once a day unless there was a spill that needed to be cleaned up between mopping. -He had seen food and debris on the floor in the dining room in the SCU before and he had the kitchen staff come and clean it up. -He did rounds in the SCU once a day. -If there was food on the floor from the meal the previous day then the staff were not cleaning the floors between meals like they were supposed to. -The KM was responsible for making sure the dining room floor in the SCU was clean between meals and mopped daily.	D 283		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 68	D 312		

Homes:
(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure feeding assistance was provided for the residents in the Special Care Unit (SCU) when staff did not open individual cartons and bottles of milk for the residents at mealtimes and did not provide feeding assistance for 1 of 3 residents (#7).

The findings are:

1. Observations of the breakfast meal in the SCU on 07/08/25 from 8:35am to 9:00am.
-At 8:35am, there were 17 residents seated in the dining room.
-There were half pint cartons of 2% milk at 15 place settings and half pint bottles of fat free milk at four place settings; there were no cups to pour the milk into.
-There were two personal care aides (PCA) in the dining room; one of the PCAs was feeding a resident.
-The PCA feeding the resident never opened the resident's milk.
-One resident opened her carton of milk and another resident's carton of milk.
-Four residents opened their own cartons of milk.
-A PCA walked around and opened three residents' bottles of milk.
-The staff did not offer to open any other of the residents' milk and did not ask residents if they wanted their milk cartons opened.
-At 8:50am, staff began to remove residents from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 69	D 312		

the dining room.
-There were eight residents whose milk was never opened.

Observations of the lunch meal in the SCU on 07/08/25 from 12:10pm to 1:05pm revealed:
-At 12:10pm, the kitchen staff preset the tables with assorted beverages including unopened cartons and bottles of milk.
-Fifteen residents were given 2% milk in half-pint milk cartons and 3 residents were served fat free milk in half-pint bottles.
-At 12:18pm, there were two PCAs and 19 residents seated in the dining room.
-One PCA was feeding a resident and another PCA was walking around the dining room.
-The PCAs opened two residents' bottles of milk, a visitor opened a carton of milk for a resident, and four of the residents opened their own cartons of milk.
-At 12:38pm, there were 12 residents who had unopened milk cartons.
-At 12:40pm, the medication aide (MA) and the Special Care Coordinator (SCC) were in the dining room.
-The MA and the SCC did not offer to open any of the residents' milk cartons.
-At 12:45pm, the SCC was standing outside the SCU dining room at a half wall observing the dining room.
-At 1:05pm, the residents were leaving the SCU dining room; 12 residents still had unopened milk at their place settings.

Observations of the breakfast meal in the SCU on 07/09/25 from 8:28am to 9:10am revealed:
-At 8:28am, the kitchen staff preset the tables with assorted beverages including 14 unopened half-pint cartons of milk and 2 unopened half-pint bottles of milk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 70 -At 8:45am, there were 19 residents seated in the dining room. -There were two PCAs and a visitor in the dining room. -A visitor was feeding a resident, one PCA was encouraging a resident to eat and the second PCA was standing beside the first PCA. -Two residents did not get milk because they did not want milk, and four residents opened their own milk. -The visitor opened the resident's milk she was feeding. -At 9:07am, 12 residents' cartons of milk were not opened; the PCAs had not offered to open any of the residents' milk for them. -At 9:10am, the residents began to leave the dining room. Telephone interview with a resident's family member on 07/09/25 at 11:30am revealed: -She had been at the facility during mealtimes in the SCU. -She had not seen the PCAs or the MAs opening milk, asking the residents if they wanted their milk opened or encouraging residents to drink their milk. -She saw a lot of milk being thrown away after a meal. Telephone interview with another resident's family member on 07/10/25 at 10:34am revealed: -The dietary staff put the cartons of milk on the tables. -If the resident did not open the milk or drink it, the staff threw it in the trash can after the meal. -All the staff did not offer to open the milk for the residents; it depended on the staff that was working. -She did not see staff encouraging residents to drink their beverages, especially milk.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 71	D 312		

-The staff always seemed to be in a rush to get the residents out of the dining room and did not care if the residents ate or drank.
-She had not seen management in the dining room at mealtimes.

Interview with a PCA on 07/09/25 at 11:56am revealed:
-The dietary staff put the cartons of milk on the tables.
-Some of the residents got bottles of milk; she did not know why.
-Most of the residents could open their milk themselves; some of the residents could not open their milk cartons.
-Some of the residents asked staff to open their milk cartons.
-Some of the residents did not want milk.
-She did not ask residents if they wanted their milk because she was usually feeding a resident.
-They gave the cartons of milk back to the kitchen if the resident did not drink them.

Telephone interview with a second PCA on 07/10/25 at 7:41am revealed:
-Some of the residents in the SCU could not open their milk by themselves.
-The PCAs were supposed to walk around and help the residents during mealtimes.
-The PCAs should be opening milk cartons for the residents if they noticed the resident did not open them.
-She opened milk cartons for the residents when she was in the dining room.
-She noticed some of the PCAs did not help the residents during the meal because they were talking or sitting down.

Interview with a MA on 07/11/25 at 10:03am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 72	D 312		

-The dietary aides set the tables in the dining room.
-The milk was in small cartons.
-The PCAs and the MAs opened the milk cartons for the residents who could not open them.
-The residents did not have cups for their milk; they drank it right out of the milk carton.
-The PCAs went around and asked each resident if they needed help with anything, including opening their milk.
-She saw the PCAs helping the residents with their milk when she worked in the dining room.
-She could not always work in the dining room.

Interview with the Kitchen Manger (KM) on 07/14/25 at 11:30am revealed:
-The kitchen staff placed the cartons of milk at the place settings at meals for the residents in the SCU.
-They did not open the cartons of milk, and they did not provide a glass.
-There were two residents who did not like milk, but the rest of the residents got a carton of milk.
-The residents in the SCU got milk with all their meals.
-The residents or the PCAs opened the milk cartons and bottles.
-She saw a lot of the milk cartons come back unopened, so the residents were not drinking the milk.

Interview with the SCC on 07/14/25 at 8:47am revealed:
-The dietary aides put the milk cartons on the tables before the meal.
-Staff were supposed to assist the residents with anything they needed during meals, including opening cartons of milk.
-Some of the residents could open the milk cartons without help and some could not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 73	D 312		

-The PCAs opened about 9 to 10 cartons of milk at each meal.
-She did not know if there were cups for the PCAs to pour the milk into.
-The PCAs knew which residents liked milk and wanted their milk open.
-She observed breakfast every other morning, some of the lunch meals and some of the beginning of the dinner meals.
-She did not think the residents drank the milk.

Interview with the Administrator on 07/14/25 at 1:24pm revealed:
-The milk for the residents in the SCU should always be poured into a glass.
-The PCAs should have opened the milk cartons for the residents who could not open the cartons.
-The residents might have drank the milk if the cartons were opened and poured into a glass.
-He went into the dining room in the SCU at least four times a week.
-He looked to see if the residents were eating and drinking.
-He spent between 3 to 10 minutes interacting with residents and encouraging them to eat.
-He had not noticed the residents' milk cartons were not being opened for them.

2. Review of Resident #7's current FL-2 dated 08/26/24 revealed:
-Diagnoses included dementia, Alzheimer's disease and sundowning.
-She was constantly disoriented.

Observations of Resident #7 in the dining room in the Special Care Unit (SCU) on 07/08/25 from 8:35am to 9:00am revealed:
-There were two personal care aides (PCA) in the dining room and 17 residents.
-Resident #7 was served cinnamon roll casserole,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 74	D 312		

scrambled eggs, orange wedges, orange juice, water and 2% milk.
-Resident #7 was served her plate of food by a dietary staff and a PCA removed her silverware from the bag it was in and placed it next to her plate.
-The PCA walked away, and Resident #7 did not eat.
-Resident #7 did not pick up her fork or begin to eat her food.
-Staff did not return to Resident #7 to encourage or cue her to eat.
-At 8:58am, staff began to clear residents' plates from the tables and residents began to leave the dining room.
-Resident #7 had not eaten any of her breakfast when she left the dining room.

Observations of Resident #7 in the dining room in the SCU on 07/08/25 from 12:15pm to 1:00pm revealed:
-There were two PCAs in the dining room.
-Resident #7 was served a green salad with dressing, spaghetti with four meatballs and sauce, garlic toast, green beans, water, iced tea, milk and chocolate pudding.
-At 12:23pm, Resident #7 was sleeping at the table.
-The medication aide (MA) came into the dining room, and cued a few residents to eat.
-The Special Care Coordinator (SCC) stood on the perimeter of the dining room and observed the meal.
-At 12:29pm, Resident #7 was not eating, she was not cued to eat, and her milk was not opened.
-At 12:35pm, Resident #7 was not eating and was intermittently sleeping during the meal.
-At 12:39pm, the SCC woke Resident #7 up, cut her meatballs up and handed her a fork.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 75 -Resident #7 began to eat a meatball and stopped. -At 12:45pm, the MA went to Resident #7 and encouraged her to eat her meal; the resident began to eat her meatballs again. -At 12:49pm, Resident #7 was asleep. -At 12:55pm, Resident #7's was woken up by the SCC and she began to eat her meatballs again. -At 1:00pm, Resident #7's plate was removed, and she was served chocolate pudding. -Resident #7 ate 65% of her meatballs, and 100% of her pudding. -Resident #7 ate none of her spaghetti, salad, beans, garlic toast or milk. Observations of Resident #7 in the dining room in the SCU on 07/09/25 from 8:45am to 9:07am revealed: -Resident #7 was served a breakfast burrito with eggs, tomato, cheese and onions inside, salsa, orange slices, water, orange juice, and a bottle of skim milk. -A PCA removed Resident #7's silverware from the bag it was wrapped in and walked away. -Resident #7 was not eating and a PCA went to her and gave her her fork in her hand and told her to eat. -Her plate of food was cleared at 9:07am and she left the dining room. -Resident #7's milk was never opened for her. -Resident #7 did not eat her burrito; she ate 100% of her orange slices and left the dining room. Interview with Resident #7's primary care provider (PCP) on 07/14/25 at 12:06pm revealed: -Sometimes one of the MAs would tell her when a resident was not eating. -Sometimes she had to ask the staff if a resident was eating or not eating at meals.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 76	D 312		

-She wanted to be notified if a resident was not eating.
-The number of meals not eaten did not matter.
-She considered it as a change in a baseline for a resident not to eat.
-Not eating could indicate something was going on with the resident and she could look into what was going on.
-The resident could be in decline or have a urinary tract infection (UTI).
-Resident #7 currently had a UTI but she still would have liked to have been told she was not eating.

Interview with a PCA on 07/09/25 at 11:56am revealed:
-Resident #7 did not need to be encouraged or reminded to eat.
-Resident #7 would eat on her own.
-She had not noticed Resident #7 not eating her food.
-She may not have noticed because she was usually feeding a resident or encouraging a resident to eat.

Interview with a MA on 07/11/25 at 10:03am revealed:
-The PCAs were supposed to feed any residents who needed to be fed and to coach or encourage residents to eat.
-They were supposed to watch the dining room and see who needed help eating or who was not eating and see why they were not eating.
-She would encourage residents to eat when she was in the dining room.
-She would put a fork into a resident's hand to get them started.
-She would ask them why they were not eating and try to get them something else if they did not like the food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 77	D 312		

-The PCAs should have done all the same things she was doing.
-The PCAs would tell her when a resident was not eating, and she would let the SCC know.
-The PCA should let her know a resident did not eat after one meal.
-She thought the reason Resident #7 had not been eating was because she had a UTI and her mind was up and down.
-Resident #7 had started antibiotics and should be eating better.
-She had not told the SCC Resident #7 was not eating because the PCAs had not told her.

Interview with the SCC on 07/14/25 at 9:42am revealed:
-She had noticed Resident #7 not eating on and off.
-Resident #7 would eat a whole meal and then the next time she would not eat anything.
-If she did not eat at a meal the staff would encourage her to eat a snack between meals or encourage her to eat at the next meal.
-Within the past two-weeks Resident #7 had become increasingly more confused, and the staff had been directing her and prompting her to eat at meals.
-She had not notified the PCP about Resident #7 not eating and needing more direction at meals.
-The PCP was aware Resident #7 ate sporadically because the resident had been eating like that since she was admitted to the facility.

Interview with the Administrator on 07/14/25 at 12:41pm revealed:
-If a resident did not eat one meal it might have been because they were not hungry but after two meals or more the PCP should have been called.
-The PCP should have been made aware so she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 312	Continued From page 78 could observe the resident, do a "root cause" and figure out why the resident was not eating. -The PCAs should have let the MA know Resident #7 was not eating so she could have informed the SCC or the PCP. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.	D 312		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (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 interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 5 residents. The finding are: Review of Resident #22's current FL-2 dated 08/28/24 revealed: -Diagnoses included hypertension, hyperlipidemia, gastric esophageal reflux disease (GERD), depression, vitamin B12 deficiency, vitamin D deficiency, and bilateral	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 349	Continued From page 79	D 349		

carotid artery stenosis.
-There was an order for Lexapro 10mg (used to treat depression) daily.
-There was an order for hydrochlorothiazide 12.5mg (used to treat elevated blood pressure) daily.
-There was an order for pantoprazole 20mg (used to treat gastric reflux and indigestion) daily.
-There was an order for pravastatin 80mg (used to treat elevated cholesterol) daily.
-There was an order for benazepril 10mg (used to treat elevated blood pressure) daily.
-There was an order for diltiazem CD 240mg (used to treat elevated blood pressure) daily.
-There was an order for aspirin 81mg (used to reduce the risk of a heart attack or stroke) daily.
-There was an order for vitamin D3 1000 units (used as a supplement) daily.
-There was an order for vitamin B 12 1000mcg (used as a supplement) daily.
-There was an order for ferrous sulfate 325mg (used as a supplement) daily.
-There was an order for nitroglycerin 0.4mg sublingually (used for chest pain) as needed.

Review of Resident #22's record revealed there was no six-month signed physician's orders review of all medications and treatments.

A request for Resident #22's six month signed physician's orders was made on 07/09/25 at 9:15am and was not provided by survey exit.

Interview with Resident #22's PCP on 07/14/25 at 11:23am revealed:
-She did not recall signing 6 months orders at the facility until last week, week of 07/08/25.
-She did not recall signing six month orders for Resident #22 since her admission on 08/28/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 349	Continued From page 80 Interview with the interim RCC on 07/10/25 at 8:44am revealed: -She did not print residents' orders to be reviewed by the PCP every 6 months. -She did not know that orders had to be reviewed every 6 months. Interview with the Administrator on 07/14/25 at 8:04am revealed: -He knew 6 months orders should be reviewed and signed by the PCP. -He did not know if the RCC/SCC were printing the 6 months orders for the PCP to review and sign. -He expected the RCC/SCC to print the 6 month orders for physician review and signature immediately. -He expected the RCC/SCC to be knowledgeable about the reviewing and signing of the 6 month orders.	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 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	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 81	D 358		

medications as ordered for 2 of 5 residents (#8 and #10) observed during the morning medication pass including errors with a supplement (#8) and a medication to treat tremors related to Parkinson's disease (#10); and 3 of 5 sampled residents (#1, #5, and #19) for record review including errors with a stool softener (#1); two medications for allergies, a stool softener, a diuretic, a pain medication, and a medication for chronic obstructive pulmonary disease (COPD) (#5); and a medication for blood pressure (#19).

The findings are:

1. The medication error rate was 6.4% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00am medication pass on 07/09/25.

a. Review of Resident #10's current FL-2 dated 03/19/25 revealed:
-He resided in the Assisted Living (AL).
-Diagnoses included Parkinson's disease.
-There was an order for carbidopa-levodopa 25/100mg (used to treat tremors caused by Parkinson's disease) two tablets 3 times daily.

Observation of the morning medication pass on 07/09/25 at 8:45am revealed:
-The medication aide (MA) removed Resident #10's multi-dose pack from the medication cart.
-The multi-dose pack contained 9 pills; the name of each medication was listed on the multi-dose pack.
-The MA scanned the multi-dose pack, opened the multi-dose pack, placed the pills in a pill cup and administered the 9 medications to Resident #10.
-Carbidopa-levodopa 25/100mg was not in the multi-dose pack and was not administered to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 82 Resident #10. Review of Resident #10's July 2025 electronic medication administration record (eMAR) from 07/01/25 to 07/09/25 revealed: -There was an entry for carbidopa-levodopa 25/100mg with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that carbidopa-levodopa 25/100mg was administered on 07/09/25 at 8:00am. Telephone interview with a representative from the facility's contracted pharmacy on 07/09/25 at 11:49am revealed: -The pharmacy had an order for carbidopa-levodopa 25/100mg two tablets three times a day dated 05/08/25. -The pharmacy dispensed the carbodopa-levodopa in a punch card every week along with the multi-dose pack. -The pharmacy dispensed 42 carbidopa-levodopa 25/100mg tablets in a punch card that was delivered weekly with the multi-dose packs. -The carbodopa-levodopa was not placed in the multi-dose packs because the frequency for administration could change frequently and be administered as often as 5 or 6 times a day and the multi-dose packs could only hold medications for 4 times a day. -The pharmacy decided to place all carbidopa-levodopa orders in a punch card for this reason. Observation of medications on hand for Resident #10 revealed there was a punch card with 6 of 24 carbidopa-levodopa 25/100mg tablets available for administration dispensed on 07/03/25. Interview with the MA on 07/09/25 at 12:15pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 83	D 358		

revealed:
-She did not notice the carbidopa-levodopa was not in the multi-dose pack.
-She scanned the multi-dose pack but did not notice an error message pop up on the computer screen alerting her that the carbidopa-levodopa was not in the multi-dose pack.
-She just missed it; it was an oversight.

Interview with Resident #10 on 07/14/25 at 9:15am revealed:
-He took carbidopa-levodopa several times a day for tremors.
-He thought he took it every morning; he took what the MAs brought him.
-His tremors had not gotten any worse.

Interview with the Primary Care Provider (PCP) on 07/14/25 at 11:23am revealed:
-Resident #10 was ordered carbidopa-levodopa because Resident #10 had a diagnosis of Parkinson's disease and he experienced tremors.
-The medication was to help control the tremors.
-She was not concerned if Resident #10 only missed one dose, but she did expect the MAs to administer medications as ordered.
-If Resident #10 missed more doses, then the tremors could worsen.

Interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:47pm revealed:
-The MAs should compare medications in the medication cart to the medications listed on the eMAR.
-The MA should have realized the carbidopa-levodopa was not in the multi-dose pack and should have searched for a punch card; not all medications were in the multi-dose packs.
-Resident #10 had Parkinson's disease and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 84	D 358		

needed the medication for tremors.
-She expected the MA to administer medications as ordered and if the MA could not find a medication on the medication cart to let her know.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-The MA was not paying attention if she signed off on a medication that she did not administer.
-The MA should be scanning the multi-dose pack.
-If no error reading appeared on the computer screen then all the medications were in the multi-dose pack.
-If an error reading occurred, the MA would need to look for the medication that was not in the multi-dose pack.

Refer to the interview with the Administrator on 07/14/25 at 8:04am.

b. Review of Resident #8's current FL-2 dated 06/25/25 revealed:
-She resided in the Special Care Unit (SCU).
-Diagnoses included Alzheimer's disease, diabetes, and hypertension.

Review of a signed physician's order dated 07/03/25 revealed there was an order for Citracal-D3 extended release (ER) 600mg-12.5mg (used to prevent low calcium levels) two tablets daily.

Observation of the morning medication pass on 07/09/25 at 7:50am revealed:
-The medication aide (MA) removed 4 punch cards for Resident #8 from the medication cart and compared each punch card to the electronic medication administration record (eMAR).
-The MA punched one tablet from three punch cards and 1.5 tablets from the fourth punch card

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 85	D 358		

into a medication cup, for a total of 4.5 tablets to be administered.
-The MA administered 4.5 tablets to Resident #8.
-The MA only punched one tablet from the punch card that contained the Citracal-D3 ER 600mg-12.5mg.

Review of Resident #8's July 2025 eMAR from 07/05/25 to 07/09/25 revealed:
-There was an entry for Citracal-D3 ER 600mg-12.5mg two tablets daily.
-There was documentation two tablets of Citracal-D3 were administered daily from 07/05/25 to 07/09/25, including the medication pass that day, 07/09/25.

Observation of medications on hand for Resident #8 revealed:
-There was a punch card with 19 of 24 Citracal-D3 ER 600mg-12.5mg available for administration dispensed on 07/04/25.
-The 5th tablet was removed from the punch card today, 07/09/25, since the medication was dispensed on 07/04/25.

Based on eMAR documentation, medication dispensing records and medications on hand it was determined that Resident #8 was administered Citracal-D3 ER 600mg-12.5mg one tablet daily since the medication was started on 07/05/25, instead of 2 tablets as ordered.

Telephone interview with a representative from the facility's contracted pharmacy on 07/09/25 at 11:49am revealed:
-The pharmacy had an order for Citracal-D3 ER 600mg-12.5mg two tablets daily dated 07/03/25.
-The pharmacy dispensed 24 tablets of Citracal-D3 ER 600mg-12.5mg on 07/04/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 86 Interview with the MA on 07/09/25 at 2:34pm revealed: -She administered one tablet of Citracal-D3 ER 600mg-12.5mg at 8:00am. -She did not realize she should have administered two tablets of Citracal-D3 ER 600mg-12.5mg. -She was nervous because she was being observed and it was an oversight. Interview with the Primary Care Provider (PCP) on 07/14/25 at 11:23am revealed: -Citracal-D3 was ordered for Resident #8 last week on 07/03/25. -Citracal-D3 was used for bone health. -She expected medications to be administered as ordered, and to find out it had been administered incorrectly since it was ordered was frustrating. Interview with the Special Care Coordinator (SCC) on 07/09/25 at 4:27pm revealed: -The MA would click on Resident #8's eMAR and the medications to be administered would appear. -The MA should use the scanner to scan the medications into the eMAR. -The directions were on the eMAR and the prescription label to give two Citracal-D3 tablets. -The MA should have punched two Citracal-D3 tablets to administer. -She expected the MAs to administer the medications as ordered. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The MA should read the prescription label on the medication and compare to the entry on the eMAR when administering medications -The MA should have noticed the instructions were to give two tablets.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 87	D 358		

Based on observations, interviews, and record reviews, Resident #8 was not interviewable.

Refer to the interview with the Administrator on 07/14/25 at 8:04am.

2. Review of Resident #5's current FL-2 dated 1/28/25 revealed:
-Resident #5 resided in the Assisted Living (AL).
-Diagnoses included seizures, COPD, hypertension, congested heart failure, and deep vein thrombosis (DVT).

a. Review of Resident #5's signed physician orders dated 02/24/25 revealed there was an order for polyethylene glycol (used to treat constipation) 17gm in 8 ounces of water on Monday, Wednesday and Friday.

Review of Resident #5's Primary Care Provider's (PCP) after visit summary dated 06/26/25 revealed:
-Resident #5 had a history of constipation, which was managed by a combination of senna plus, polyethylene and dulcolax (these three medications are used to treat constipation).
-Resident #5 was changed from hydrocodone as needed (PRN) (a controlled substance used for pain) to a scheduled dose every evening, reducing the number of times hydrocodone was administered a day, to alleviate some constipation issues.
-Resident #5 was to continue using senna plus, polyethylene and dulcolax as ordered for constipation.

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol 17gm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 88	D 358		

in 8 ounces of water on Monday, Wednesday, and Friday.
-There was documentation that polyethylene glycol 17gm was administered 12 out of 13 opportunities.
-There was one exception; the resident refused.

Review of Resident #5's June 2025 eMAR revealed:
-There was an entry for polyethylene glycol 17gm in 8 ounces of water on Monday, Wednesday, and Friday.
-There was documentation that polyethylene glycol 17gm was administered 13 out of 13 opportunities.

Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/08/25 revealed:
-There was an entry for polyethylene glycol 17gm in 8 ounces of water on Monday, Wednesday, and Friday.
-There was documentation that polyethylene glycol 17gm was administered 3 out of 3 opportunities from 07/01/25 to 07/08/25.

Observation of the medication on hand for Resident #5 on 07/09/25 at 2:34pm revealed there was a bottle of polyethylene glycol 510gm dispensed on 02/24/25 that was ¼ to ½ full available for administration.

Review of Resident #5's PCP's after visit summary dated 07/06/25 revealed:
-Resident #5 complained of constipation and not having a bowel movement in three days.
-Resident #5 was currently taking senna plus 8.6/50mg twice daily.
-Resident #5 was ordered senna plus 8.6/50mg two tablets twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 89 Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed: -The pharmacy had an order for polyethylene glycol 17gm mix in 8 ounces of water on Monday, Wednesday and Friday dated 02/24/25. -The pharmacy dispensed one 510gm bottle of polyethylene glycol on 02/24/25. -A bottle of polyethylene glycol 510gm would last for 30 doses. -If administered three times weekly as ordered, the bottle would be empty in 70 days or on 05/05/25. -The pharmacy dispensed one bottle of polyethylene glycol on 02/24/25 and had not dispensed any since. Telephone interview with a Resident #5's family member on 07/08/25 at 8:10am revealed: -The facility had a problem getting medications in the facility to administer. -Resident #5 had an order for polyethylene glycol every other day. -Resident #5 needed the polyethylene glycol because she took a controlled substance and Resident #5 had constipation from the controlled substance. -A MA told her Resident #5 did not have an order for polyethylene glycol. -Resident #5 had not received the polyethylene glycol as ordered and she became constipated. -She discussed with the interim Resident Care Coordinator (RCC) about one to two weeks ago that Resident #5 was constipated and was not receiving the polyethylene glycol as ordered. -She thought Resident #5 started receiving polyethylene glycol within the past week or two. Interview with Resident #5 on 07/10/25 at 3:30pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 90	D 358		

-She took stool softeners, and she started taking polyethylene glycol every other day, but she could not remember when.
-She got constipated frequently and her stomach would hurt; she needed to take something for constipation regularly to keep from getting constipated.
-Her PCP increased one of her medications for constipation last week.

Interview with a medication aide (MA) on 07/10/25 at 10:23am revealed:
-She had not seen an order for polyethylene glycol on the eMAR for Resident #5.
-She had not administered polyethylene glycol to Resident #5.
-Resident #5's family member was asking for polyethylene glycol because she was constipated.
-She mentioned it to the interim RCC and the polyethylene glycol was added to the eMAR on Monday, 07/06/25.

Interview with a second MA on 07/10/25 at 3:43pm revealed:
-She administered polyethylene glycol to Resident #5, but she could not remember how long Resident #5 had been receiving the medication.
-Resident #5 had not complained of constipation to her.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-Resident #5 had an order for polyethylene glycol and senna plus to help with complaints of constipation.
-Resident #5 continued to complain of constipation and she increased Resident #5's senna plus on 07/06/25.
-She did not know Resident #5 was not receiving polyethylene glycol as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 91	D 358		

-If Resident #5 was receiving polyethylene glycol as ordered it may have taken care of the constipation and Resident #5 may not have needed the extra doses of senna plus that were ordered last week.

Interview with the Interim RCC on 07/10/25 at 8:44am revealed:
-Resident #5 complained of constipation frequently.
-The PCP increase her senna plus last week to help relieve the constipation.
-She did not realize Resident #5 was not getting polyethylene glycol as ordered.
-The MAs should administer medications as ordered.

Interview with the Administrator on 07/14/25 at 8:04am revealed the MA was not paying attention if she signed off on a medication that she did not administer.

b. Review of Resident #5's signed physician order dated 06/27/25 revealed there was an order for acetaminophen 325mg (used to treat pain) two tablets twice daily.

Review of Resident #5's June 2025 eMAR revealed:
-There was an entry for acetaminophen 325mg two tablets twice daily with a scheduled administration time of 8:00am and 2:00pm.
-There was documentation that acetaminophen was administered 4 out of 5 opportunities.
-There was one exception; the resident was unavailable.

Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/08/25 revealed:
-There was an entry for acetaminophen 325mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 92	D 358		

two tablets twice daily with a scheduled administration time of 8:00am and 2:00pm.
-There was documentation that acetaminophen was administered 15 out of 15 opportunities.

Observation of the medication on hand for Resident # 5 on 07/09/25 at 2:34pm revealed there was a punch card dispensed on 06/27/25 with 20 of 44 acetaminophen tablets remaining and available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed:
-The pharmacy had an order for acetaminophen 325mg two tablets twice daily dated 06/27/25.
-The pharmacy dispensed 44 tablets of acetaminophen 325mg in a punch card on 06/27/25.
-The 44 tablets in the punch card would last through Monday 07/07/25, until the medication was placed in the multi-dose pack to be administered starting on 07/08/25.
-There should be no acetaminophen 325mg tablets remaining in the punch card dispensed on 06/28/25 at the end of today, 07/08/25, if the medication was administered daily as ordered.

Review of Resident #5's PCP's after hours visit note dated 06/26/25 revealed:
-Resident #5 was experiencing pain that was currently being managed by hydrocodone-acetaminophen 5/325mg (a controlled substance used for pain) PRN and acetaminophen PRN.
-Resident #5 desired to reduce the hydrocodone usage during the day.
-There was an order to schedule hydrocodone-acetaminophen 5/325mg at bedtime, decreasing the amount of hydrocodone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 93	D 358		

administered during the day.
-Acetaminophen was changed from PRN to two tablets twice daily at 8:00am and 2:00pm to manage Resident #5's pain.

Interview with Resident #5 on 07/10/25 at 3:30pm revealed:
-The PCP recently changed her pain medication, acetaminophen, from PRN to scheduled.
-The pain medication was helping, but her legs still hurt.

Interview with a MA on 07/10/25 at 10:23am revealed:
-Resident #5 complained of pain in her legs daily.
-She was administered acetaminophen twice a day for the pain in her legs.
-She did not know why there were pills left in the punch cards after the medication was placed in the multi-dose pack, unless the pharmacy sent too many pills.
-The pharmacy would send punch cards for new medications until the new medication was placed in the multi-dose pack the following week.
-She would scan the multi-dose pack and if there was an alert on the computer that a medication was not in the multi-dose pack, she would look for the punch card in the medications cart for that medication.

Telephone interview with a second MA on 07/10/25 at 3:05pm revealed:
-Resident #5 complained of leg pain.
-She administered hydrocodone to Resident #5 when she complained of leg pain.
-Resident #5 used to have an order for acetaminophen for leg pain, but it had been discontinued.
-Resident #5 still had acetaminophen on the medication cart but she could not administer the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 94	D 358		

acetaminophen to Resident #5 because there was no order.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-Resident #5's medications for her leg pain were changed on 06/26/25 from PRN to scheduled to control the pain better and to decrease issues with constipation.
-She did not know Resident #5 was not receiving her acetaminophen as ordered.
-Resident #5 could continue to have pain if the medication was not administered as ordered.

Interview with the interim RCC on 07/10/25 at 8:44am revealed:
-Resident #5 complained of pain in her legs and took acetaminophen and a controlled substance for her pain.
-If there were acetaminophen tablets remaining, then the resident did not receive her medication as ordered.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-If the medication was not in the multi-dose pack, the MAs should look for a punch card.
-If the medication was not administered as ordered Resident #5 could have an increase in pain.

c. Review of Resident #5's current FL-2 dated 01/28/25 revealed there was an order for Trelegy Ellipta 100-6.25mcg (used to manage symptoms and prevent flare ups with COPD and asthma) inhale one puff daily.

Review of Resident #5's May 2025 eMAR revealed:
-There was an entry for Trelegy Ellipta

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 95	D 358		

100-6.25mcg inhale one puff daily with a scheduled administration time of 9:00am.
-There was documentation Trelegy Ellipta was administered daily from 05/01/25 to 05/31/25.

Review of Resident #5's June 2025 eMAR revealed:
-There was an entry for Trelegy Ellipta 100-6.25mcg inhale one puff daily with a scheduled administration time of 9:00am.
-There was documentation Trelegy Ellipta was administered daily from 06/01/25 to 06/30/25.

Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/08/25 revealed:
-There was an entry for Trelegy Ellipta 100-6.25mcg inhale one puff daily with a scheduled administration time of 9:00am.
-There was documentation Trelegy Ellipta was administered daily from 07/01/25 to 07/08/25.

Observation of the medication on hand for Resident # 5 on 07/09/25 at 2:34pm revealed there was a Trelegy inhaler dispensed on 12/24/24 with 11 of 30 inhalations remaining and available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed:
-The pharmacy had an order for Resident #5 for Trelegy Ellipta inhaler one puff daily dated 01/28/25.
-The pharmacy dispensed one Trelegy Ellipta inhaler on 04/09/25; there were no other Trelegy Ellipta inhalers dispensed.
-The Trelegy Ellipta inhaler had 30 inhalations and would last 30 days if administered as ordered.
-The pharmacy did not dispense the inhaler that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 96	D 358		

was currently being used with a dispensed date of 12/24/24.
-Inhalers were not on cycle-fill; the staff had t order inhalers when needed.

Interview with Resident #5 on 07/10/25 at 3:30pm revealed:
-She used her inhaler when the MAs brought it to her.
-She thought she used her inhaler daily.
-The past two days she had been "short-winded" when she walked to the dining room.
-She had not mentioned to anyone that she had been "short-winded" the past two days.

Interview with a MA on 07/10/25 at 10:23am revealed:
-She administered Trelegy Ellipta inhaler to Resident #5.
-She did not know why there was medication still remaining in the current inhaler dispensed on 12/24/24.
-The inhaler should be reordered monthly.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-Resident #5 had an order for Trelegy Ellipta one puff daily.
-Resident #5 was ordered Trelegy because she had COPD.
-Resident #5 could have an acute exacerbation of COPD if she was not administered her medications.
-She had not been notified of Resident #5 having any issues with shortness of breath.

Interview with the Interim RCC on 07/10/25 at 8:44am revealed:
-Resident #5 used an inhaler because of COPD or asthma.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 97	D 358		

-Resident #5 had not complained to her of any shortness of breath.
-She did not know that Resident #5's inhaler was not being ordered monthly and administered as ordered.
-Inhalers were not cycled filled; the MA had to order the inhaler every month.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-It appeared the inhaler was not being administered as ordered if the medication was not reordered and dispensed from the pharmacy monthly.
-If the medication was not administered as ordered Resident #5 could have an increase in shortness of breath.

d. Review of Resident #5's signed physician orders dated 05/08/25 revealed there was an order for torsemide 20mg (used to treat fluid retention) give 2 tablets (40mg) daily.

Review of Resident #5's May 2025 eMAR from 05/07/25 to 05/19/25 revealed:
-There was an entry for torsemide 20mg 2 tablets daily with a scheduled administration time of 9:00am.
-There was documentation that torsemide 20mg two tablets was administered daily from 05/08/25 to 05/19/25.

Observation of the medication on hand for Resident # 5 on 07/09/25 at 2:34pm revealed there was a punch card dispensed on 05/07/25 with 12 of 26 torsemide tablets remaining and available for administration

Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 98	D 358		

4:07pm revealed:
-The pharmacy had an order for torsemide 20mg take 2 tablets daily dated 05/07/25.
-The pharmacy dispensed 26 tablets of torsemide 20mg in a punch card on 05/07/25.
-The 26 tablets in the punch card would last through 05/19/25, until the medication was placed in the multi-dose pack to be administered starting on 05/20/25.
-There should be no torsemide 20mg tablets remaining in the punch card if the medication was administered daily as ordered.

Observation of Resident #5 on 07/10/25 at 3:30pm revealed she had non pitting edema to bilateral lower legs.

Interview with Resident #5 on 07/10/25 at 3:30pm revealed:
-She took two fluid pills every morning.
-She had swelling in her legs but the swelling was not as bad as it had been.
-She would sit in her recliner with her feet elevated every afternoon and that helped decrease the swelling in her legs.

Interview with a MA on 07/10/25 at 10:23am revealed:
-Resident #5 had swelling in her legs and received the fluid pill in the mornings.
-She did not know why there were pills left in the punch cards after the medication was placed in the multi-dose pack, unless the pharmacy sent to many pills.
-The pharmacy would send punch cards for new medications until the new medication was placed in the multi-dose pack the following week.
-She would scan the multi-dose pack and if there was an alert on the computer that a medication was not in the multi-dose pack, she would look

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 99	D 358		

for the punch card in the medications cart for that medication.

Telephone interview with a second MA on 07/10/25 at 3:05pm revealed:
-When new medications were ordered they were placed in the multi-dose packs.
-The only medications placed in punch cards were narcotics and antibiotics.
-She did not know that new medications were placed in punch cards to be administered until the medication was placed in the multi-dose pack.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-Resident #5 was ordered torsemide due to the swelling in her legs.
-She had not noticed any additional swelling in Resident #5's legs.
-This medication should have been administered as ordered when the order was written.

Interview with the Interim RCC on 07/10/25 at 8:44am revealed:
-When a new medication was ordered, the pharmacy would send a punch card of the new medication.
-There would be enough medication in the punch card available for administration until the medications were placed in the multi-dose pack by the pharmacy.
-The punch cards with the new medications would arrive the day after the medication was ordered.
-She did not know how long it took to set up a new medication to be dispensed in the multi-dose packs.
-The multi-dose packs would arrive on Fridays for the weekly administration day that started on Tuesdays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 100	D 358		

-The third shift MA was responsible for placing the weekly multi-dose packs on the medication cart every Monday night.
-The weekly multi-dose pack started every Tuesday morning.
-The medication punch cards dispensed in May 2025 with medications still available for administration were not administered as ordered.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-If the medication was not in the multi-dose pack, the MAs should look for a punch card.
-If the medication could not be located, the MA should contact the RCC or the pharmacy.

e. Review of Resident #5's signed physician orders dated 05/07/25 revealed there was an order for cetirizine 10mg (used to treat allergy symptoms) daily.

Review of Resident #5's May 2025 eMAR from 05/07/25 to 05/19/25 revealed:
-There was an entry for cetirizine 10 mg daily with a scheduled administration time of 8:00am.
-There was documentation that cetirizine 10mg was administered daily from 05/09/25 to 05/19/25.
-There was an exception on 05/08/25; the exception was the orders were approved for administration after the morning medication pass was completed, and 05/07/25 was blank.

Observation of the medication on hand for Resident #5 on 07/09/25 at 2:34pm revealed there was a punch card dispensed on 05/07/25 with 6 of 13 cetirizine tablets available for administration.

Telephone interview with a representative from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 101	D 358		

the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed:
-The pharmacy had an order dated 05/07/25 for cetirizine 10mg daily.
-The pharmacy dispensed 13 tablets of cetirizine 10mg in a punch card on 05/07/25.
-The 13 tablets in the punch card would last through 05/19/25, until the medication was placed in the multi-dose pack to be administered starting on 05/20/25.
-There should be no cetirizine 10mg tablets remaining in the punch card if the medication was administered daily as ordered.

Interview with Resident #5 on 07/10/25 at 3:30pm revealed:
-She took allergies pills every morning.
-She was not having any problems with a running nose, itchy eyes or congestion.

Telephone interview with a MA on 07/10/25 at 3:05pm revealed:
-When new medications were ordered they were placed in the multi-dose packs.
-The only medications placed in punch cards were narcotics and antibiotics.
-She did not know that new medications were placed in punch cards to be administered until the medication was placed in the multi-dose pack.

Interview with the Interim RCC on 07/10/25 at 8:44am revealed:
-When a new medication was ordered, the pharmacy would send a punch card of the new medication.
-There would be enough medication in the punch card available for administration until the medications were placed in the multi-dose pack by the pharmacy.
-The punch cards with the new medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 102	D 358		

would arrive the day after the medication was ordered.
-She did not know how long it took to set up a new medication to be dispensed in the multi-dose packs.
-The multi-dose packs would arrive on Fridays for the weekly administration day that started on Tuesdays.
-The third shift MA was responsible for placing the weekly multi-dose packs on the medication cart every Monday night.
-The weekly multi-dose pack started every Tuesday morning.
-The medication punch cards dispensed in May 2025 with medications still available for administration, were not administered as ordered.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-She was not aware Resident #5's cetirizine was changed from PRN to scheduled.
-She vacated in May 2025 and another provider saw Resident #5.
-Cetirizine was used for allergies.
-If cetirizine was not administered as ordered, the resident could have a runny nose, water, and itchy eyes.
-She had not been notified by the staff of any complaints of seasonal allergies for Resident #5.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-If the medication was not in the multi-dose pack, the MAs should look for a punch card.
-If the medication could not be located, the MA should contact the RCC or the pharmacy.

f. Review of Resident #5's signed physician orders dated 02/14/25 revealed there was an order for fluticasone nasal spray 25mcg (used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 103 treat allergies) 2 sprays to both nostrils daily. Review of Resident #5's May 2025 eMAR revealed: -There was an entry for fluticasone nasal spray 50mcg 2 sprays in each nostril daily. -There was documentation that fluticasone was administered daily from 05/01/25 to 05/31/25. Review of Resident #5's June 2025 eMAR revealed: -There was an entry for fluticasone nasal spray 50mcg 2 sprays in each nostril daily. -There was documentation that fluticasone was administered daily from 06/01/25 to 06/30/25. Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/08/25 revealed: -There was an entry for fluticasone nasal spray 50mcg 2 sprays in each nostril daily. -There was documentation that fluticasone was administered daily from 07/01/25 to 07/08/25. Observation of the medication on hand for Resident #5 on 07/09/25 at 2:34pm revealed there was one bottle of fluticasone nasal spray dispensed on 02/05/25 that was ½ full and available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed: -The pharmacy had an order for Resident #5 for fluticasone nasal spray 2 sprays to each nostril daily. -The pharmacy dispensed one bottle of fluticasone nasal spray on 02/05/25 and had not dispensed any since. -One bottle of fluticasone nasal spray would last 30 days when administering 2 sprays to each	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 104	D 358		

nostril daily.
-Fluticasone nasal spray was not cycle filled; the staff had to order the medication when it was needed.

-Interview with Resident #5 on 07/10/25 at 3:30pm revealed:
-She used the nasal spray most mornings.
-She was not having any problems with congestion.

Interview with a MA on 07/10/25 at 10:23am revealed:
-She administered fluticasone nasal spray to Resident #5.
-She did not notice the dispensing date on the prescription label and she did not know how long a bottle of nasal spray would last.
-There were some MAs who were not administering medications as ordered.

Interview with the PCP on 07/14/25 at 11:23am revealed:
-She was not aware fluticasone was changed from PRN to scheduled.
-She vacated in May 2025 and another provider saw Resident # 5.
-Fluticasone Nasal Spray was used for allergies.
-If fluticasone nasal spray was not administered as ordered, the resident could have increased congestion. if she did not received fluticasone as ordered

Interview with the Interim RCC on 07/10/25 at 8:44am revealed:
-Resident #5 should receive her nasal spray daily as ordered.
-It looked like the medication was not administered as ordered.
-Resident #5 could have headaches, a runny

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 105 nose, or itchy eyes. -The inhalers were not cycle filled; the MAs had to reorder the inhalers every month. Interview with the Administrator on 07/14/25 at 8:04am revealed: -It appeared the nasal spray was not being administered as ordered if the medication was not reordered and dispensed from the pharmacy monthly. -All medications were important and should be administered as ordered. _____ Telephone interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed: -The facility received a weekly multi-dose pack which was delivered to the facility on Fridays. -The multi-dose packs were a 7-day package of medications for each resident that contained most of the residents' pills. -The multi-dose pack started each week on Tuesday mornings. -When new medication orders were received, the pharmacy would send a punch card of the medication to the facility to last the resident until the medication was placed in the multi-dose pack; this could take 7 to 13 days depending on when the order was received. -The new medication order had to be received at least one week prior to the shipment date on Fridays, before it could be added to next week's multi-dose pack. -There were scheduled medications that could not be placed in the multi-dose pack; those medications were placed in a punch card and shipped weekly with the multi-dose packs. -Medications that were not cycle filled were re-ordered by the staff, such as inhalers, liquids, creams, eye drops, and nasal sprays.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 106 Interview with the Interim RCC on 07/10/25 at 8:44am revealed: -She was a MA for the facility but was filling in for the RCC while she was out of work. -The MAs on 3rd shift completed the medication cart audits weekly. -The MAs would print a copy of the orders and compare the orders with what was on the eMAR and the medications in the medication cart. -If there was a problem, the MA would highlight the medication on the order sheet and then gave it to her to follow up on. -The MA was responsible for pulling the expired and discontinued medications off the medication cart. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The MA should be scanning the multi-dose pack. -If no error reading appeared then all the medications were in the multi-dose pack. -If an error reading occurred the MA would need to look for the medication that was not in the multi-dose pack. -If the medications only lasted for 30 days, then the medications were not being administered as ordered. Refer to the interview with the Administrator on 07/14/25 at 8:04am. 3. Review of a Resident #19's current FL-2 dated 04/15/25 revealed diagnoses included dementia, diabetes, hypertension, and hyperlipidemia. Review of Resident #19's primary care provider (PCP) after visit report dated 06/16/25 revealed there was an order for amlodipine 5mg (used to treat high blood pressure) once daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 107 Review of Resident #19's electronic medication administration record (eMAR) for June 2025 from 06/16/25 to 06/30/25 revealed: -There was an entry for amlodipine 5mg once daily scheduled at 8:00am. -There was no documentation amlodipine was documented as administered from 06/16/25 to 06/30/25; there was no exception. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/14/25 at 10:01am revealed: -Resident #19 had an order for amlodipine 5mg once daily. -Eight tablets of amlodipine were dispensed on 06/16/25 and 7 tablets on 06/19/25. -Amlodipine was used to lower blood pressure. Observation of the medication cart, there were no medications for Resident #19. Based on observations, interviews, and record reviews, Resident #19 was discharged from the facility on 06/30/25. Interview with Resident #19's PCP on 07/14/25 at 12:20pm revealed: - Amlodipine was ordered for lowering blood pressure. -The effects of not receiving amlodipine as ordered would cause blood pressure to increase. -She expected the facility to administer medication as ordered. Interview with a medication aide (MA) on 07/14/25 at 09:09am revealed: -She administered medications using the eMAR and the medications on hand. -She did not recall not having amlodipine to	D 358		

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D 358	Continued From page 108 administer Resident #19. Interview with the Special Care Coordinator (SCC) on 07/14/25 at 11:01am revealed: -She was not aware Resident #19 did not have amlodipine to be administered. -The MA should have contacted the pharmacy to order medication that was not available to be administered. -She was not aware that the medication was dispensed from the pharmacy. -The MA should have administered the medication as ordered. -She could not locate the form used to record Resident #19's blood pressure readings. Interview with the Administrator on 07/14/25 at 1:31pm revealed: -He was not aware Resident #19 did not receive amlodipine. -He expected the MAs to administer medication as ordered. Refer to the interview with the SCC on 07/14/25 at 8:31am. Refer to the interview with the Administrator on 07/14/25 at 8:04am. 4. Review of Resident #1's current FL-2 dated 08/28/24 revealed: -Diagnoses included dementia, depression and insomnia. -She resided in the Special Care Unit (SCU). -There was an order for polyethylene glycol (used to treat and manage constipation) 17gm in 8oz fluid once daily.	D 358		

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D 358	Continued From page 109	D 358		

Review of Resident #1's physician's after visit report dated 03/31/25 revealed:
-Resident #1 had a history of recurrent constipation.
-Her constipation was acute and chronic.
-Her current bowel regimen consisted of a daily dose of polyethylene glycol.

Review of Resident #1's signed physician's order dated 07/08/25 revealed:
-Diagnoses included chronic idiopathic constipation.
-There was an order for polyethylene glycol 17gm once daily.

Review of Resident #1's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol 17gm in 8oz of fluid once daily scheduled at 8:00am.
-Resident #1's Polyethylene glycol was documented as administered 31 of 31 opportunities from 05/01/25 to 05/31/25.

Review of Resident #1's June 2025 eMAR revealed:
-There was an entry for polyethylene glycol 17gm in 8oz of fluid once daily scheduled at 8:00am.
-Resident #1's polyethylene glycol was documented as held on 06/01/25 and 06/02/25 due to loose stools and diarrhea.
-Resident #1's polyethylene glycol was documented as administered 28 of 28 opportunities from 06/03/25 to 06/30/25.

Review of Resident #1's July 2025 eMAR from 07/01/25 to 07/08/25 revealed:
-There was an entry for polyethylene glycol 17mg in 8oz fluid once daily scheduled at 8:00am.
-Resident #1's polyethylene glycol was

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D 358	Continued From page 110 documented as administered 8 of 8 opportunities from 07/01/25 to 07/14/25. Observation of Resident #1's medications on hand on 07/08/25 at 1:45pm revealed: -Thirty 17gm packets of polyethylene glycol were dispensed on 08/16/24; there were 18 packets available for administration. -There was a bottle of polyethylene glycol dispensed on 01/07/25; half the bottle was available for administration. -There was a second bottle of polyethylene glycol dispensed on 02/03/25; two thirds of the bottle was available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/10/25 at 2:49pm revealed: -Resident #1 had a current order for polyethylene glycol 17gm in 8oz fluid once daily. -A bottle of polyethylene glycol was dispensed on 11/05/24, 01/07/25 and 02/03/25; each bottle contained a thirty-day supply. -The pharmacy did not dispense polyethylene glycol in packets only in bottles. -Resident #1 may have had the packets when she was admitted. -Polyethylene glycol was not on a cycle fill; the facility needed to request a refill from the pharmacy. -The pharmacy had only dispensed three bottles of polyethylene glycol for Resident #1. -Polyethylene glycol was ordered for constipation. Telephone interview with Resident #1's hospice nurse on 07/11/25 at 10:47am revealed: -Resident #1's order for polyethylene glycol was correct and current. -Resident #1 had the order for polyethylene glycol once daily because she had a history of	D 358		

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	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

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D 358	Continued From page 111	D 358		

constipation.
-The main goal was to keep Resident #1 comfortable.
-If Resident #1 was not administered the polyethylene glycol as ordered she could become constipated and experience abdominal pain.

Interview with a personal care aide (PCA) on 07/09/25 at 11:56am revealed:
-Resident #1 was incontinent to bowel.
-Resident #1 had regular bowel movements.
-She did not think Resident #1 had constipation.
-Resident #1 could not complain about constipation.
-Resident #1 had hard stools and loose stools.

Interview with a medication aide (MA) on 07/09/25 at 2:58pm revealed:
-Resident #1 had an order for polyethylene glycol with water once daily.
-She administered Resident #1 her polyethylene glycol every day.
-She had not had to order Resident #1's polyethylene glycol because it was always some on the medication cart.
-Resident #1 had not had issues with constipation.
-The PCAs would report to her if Resident #1 had hard stools.
-Resident #1 could not complain of constipation but she responded to pain.

Interview with a second MA on 07/11/25 at 10:03am revealed:
-She did not know how long a bottle of polyethylene glycol would last, she thought two to three weeks.
-If a resident had an order for polyethylene glycol they had their own bottle with their name.
-The facility did not have a house stock of

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D 358	Continued From page 112	D 358		

polyethylene glycol.
-The MAs were supposed to use the medications that came in first before opening a new bottle.
-She always administered Resident #1's polyethylene glycol.
-Resident #1 had not complained about constipation.

Interview with the Special Care Coordinator (SCC) on 07/14/25 at 8:31am revealed:
-The eMAR was the only way to see if polyethylene glycol was administered because it was in a bottle and difficult to see how much was used.
-She did not look at the dispense date on the bottle to determine how long a bottle of polyethylene glycol was on the medication cart.
-The opened medications the residents had on the cart were used first before starting a medication that was recently dispensed; the MAs were supposed to use the oldest first.
-Any medications a resident was admitted with were used first until the pharmacy dispensed more medications.
-Polyethylene glycol was not on a cycle fill and a refill request had to be submitted to the pharmacy by a MA.
-The MAs must have borrowed polyethylene glycol from another resident and that was why Resident #1 had so much available.
-The pharmacy put a medication label on each bottle of polyethylene glycol; the label included the resident's name.
-The MAs were not allowed to borrow medication for one resident from another resident.
-She believed the MAs had borrowed seven months' worth of daily doses of polyethylene glycol from other residents to administer to Resident #1 because there were a lot of residents on polyethylene glycol.

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D 358	Continued From page 113 -She was sure Resident #1 was administered her polyethylene as ordered because she had not had problems going to the bathroom. Interview with the Administrator on 07/14/25 at 12:41pm revealed: -He knew polyethylene glycol was ordered for constipation. -If a resident was not administered their polyethylene glycol as ordered they could become constipated and have more issues, get worse and end up in the hospital. -The MAs were not allowed to borrow medications from one resident to another; the labels on the bottle indicated the polyethylene was for a particular resident. -The MAs should not have to borrow from another resident if they ordered the medication from the pharmacy when it was needed. -If Resident #1 had polyethylene glycol available from August 2024, January 2025 and February 2025 and only one other bottle had been dispensed then it would appear she was not administered the polyethylene glycol as it was ordered. Interview with the Special Care Coordinator (SCC) on 07/14/25 at 8:31am revealed: -The MAs on third shift audited the medication carts and eMARs. -She reviewed a report generated by the eMAR every day to make sure medications were administered as ordered. -The eMAR report would show her if a medication was not administered. -There was no other way to tell if a medication was administered or not except look at the medication card because each bubble was dated. Interview with the Administrator on 07/14/25 at	D 358		

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D 358	Continued From page 114 8:04am revealed: -It appeared the medications were not being administered as ordered. -The MAs should administer medications as ordered. -The MAs should pay attention when administering medications -All medications were important and they should be administered as ordered. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. _____ The facility failed to administer medications as ordered for a resident who regularly had problems with constipation and who did not receive the prescribed stool softeners as ordered leading to continued complaints of constipation and abdominal discomfort. The resident also complained of leg pain and her pain medication was changed from PRN to scheduled and was not administered as ordered and complained of being short of breath when ambulating and was not administered an inhaler as ordered. (#5). 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 07/09/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 13, 2025.	D 358		
D 363	10A NCAC 13F .1004 (f) Medication Administration	D 363		

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D 363	Continued From page 115 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure medications	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

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D 363	Continued From page 116	D 363		

prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination and spillage for 5 of 5 residents (#2, #5, #14, #17, and #18).

The findings are:

Observation of the Assisted Living (AL) medication room on 07/09/25 at 8:11am revealed:
-The medication aide (MA) was standing at the medication cart with 11 medication cups sitting on top of the medication cart with residents' medications in them.
-There was a multi-dose pack in each medication cup with the residents name on the multi-dose pack.
-There were 5 of 11 medication cups that contained loose and unsecured pills, in addition to the multi-dose pack.
-The medication cups with the loose pills were not labeled with the names of the medications.
-The loose pills were not sealed; the medication cups did not have a covering.

1. Review of Resident #2's current FL-2 dated 04/02/25 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, and hypertension.

Observation of a medication cup on 07/09/25 at 8:15am revealed:
-There were 5 loose pills and a sealed multi-dose pack dated 07/09/25 in a pill cup.
-The multi-dose pack contained two pills which were identified on the multi-dose pack; Resident #2's name was on the multi-dose pack.
-The 5 loose pills were not sealed and not identified.

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D 363	Continued From page 117 Refer to the interview with the MA on 07/09/25 at 8:11am. Refer to the interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:34pm. Refer to the interview with the Administrator on 07/14/25 at 8:04am. 2. Review of Resident #5's current FL-2 dated 01/28/25 revealed diagnoses included seizures, chronic obstructive pulmonary disease (COPD), hypertension, congested heart failure, and deep vein thrombosis (DVT). Observation of a medication cup on 07/09/25 at 8:15am revealed: -There were 2 loose pills and 2 sealed multi-dose packs dated 07/09/25 in a pill cup. -One multi-dose pack contained one pill and the second multi-dose pack contained 8 pills; each pill was identified on the multi-dose pack; Resident #5's name was on the multi-dose pack. -The 2 loose pills were not sealed and not identified. Refer to the interview with the medication aide (MA) on 07/09/25 at 8:11am. Refer to the interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:34pm. Refer to the interview with the Administrator on 07/14/25 at 8:04am. 3. Review of Resident #14's current FL-2 dated 04/15/25 revealed diagnoses included diabetes, hypertension, hyperlipidemia, and osteoarthritis. Observation of a medication cup on 07/09/25 at	D 363		

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 363	Continued From page 118 8:15am revealed: -There were 3 loose pills and a sealed multi-dose pack dated 07/09/25 in a pill cup. -The multi-dose pack contained 4 pills which were identified on the multi-dose pack; Resident #14's name was on the multi-dose pack. -The 3 loose pills were not sealed and not identified. Refer to the interview with the medication aide (MA) on 07/09/25 at 8:11am. Refer to the interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:34pm. Refer to the interview with the Administrator on 07/14/25 at 8:04am. 4. Review of Resident #17's current FL-2 dated 09/30/24 revealed diagnoses included atrial fibrillation, osteoarthritis, peripheral edema, and hypertension. Observation of a medication cup on 07/09/25 at 8:15am revealed: -There were 2 loose pills and a sealed multi-dose pack dated 07/09/25 in a pill cup. -The multi-dose pack contained 6 pills; each pill was identified on the multi-dose pack; Resident #17's name was on the multi-dose pack. -The 2 loose pills were not sealed and not identified. Refer to the interview with the medication aide (MA) on 07/09/25 at 8:11am. Refer to the interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:34pm. Refer to the interview with the Administrator on	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 363	Continued From page 119 07/14/25 at 8:04am. 5. Review of Resident #18's current FL-2 dated 04/23/25 revealed diagnoses included hypertension, diabetes type II, chronic kidney disease, anemia, Parkinson's disease, depression, and reflux disease. Observation of a medication cup on 07/09/25 at 8:15am revealed: -There were 2 loose pills and 2 sealed multi-dose packs dated 07/09/25 in a pill cup. -One multi-dose pack contained one pill and the second multi-dose pack contained 9 pills; each pill was identified on the multi-dose pack; Resident #18's name was on the multi-dose pack. -The 2 loose pills were not sealed and not identified. Refer to the interview with the medication aide (MA) on 07/09/25 at 8:11am. Refer to the interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:34pm. Refer to the interview with the Administrator on 07/14/25 at 8:04am. _____ Interview with the MA on 07/09/25 at 8:11am revealed: -She prepared residents' medications ahead of time. -She was taught to prepare the medications ahead of time by a previous employee. -The medication pass would go quicker by preparing the medications ahead of time. -She would compare the medications in the medications cups to the electronic medication administration record (eMAR) when she was ready to administer the medications.	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 363	Continued From page 120 -She could compare the medication to the punch card if she needed to. -The resident's name was on the multi-dose pack, so any loose pills in the medication cup would be for the resident whose name was on the multi-dose pack. Interview with the interim RCC on 07/09/25 at 2:34pm revealed: -The MAs should not prepare medications for administration in advance. -The MA should prepare the medication by comparing the medication to the eMAR immediately before administering the medication. -The MA should administer a resident's medications before preparing medications for another resident. -She did not know the MA prepared multiple cups of medications before administering the medications. -She did not observe the MAs during a medication pass; she did not know if the previous RCC observed a medication pass or not. Interview with the Administrator on 07/14/25 at 8:04am revealed: -Medication should not be prepared before administration unless they were property labeled and secured. -The medication cup could get knocked over and the loose pills could spill from the medication cup. -There was an increased risk of a medication error when medications for multiple residents were prepared ahead of time. -The MA should not prepare medications for multiple residents in the medication room and then administer the medications.	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 121	D 366		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed five residents take their medications that were left on the dining room table; and the MA failed to document on the electronic medication administration record (eMAR) immediately after administering medications for 2 of 5 residents (#12 and #22) observed during the 8:00am morning medication pass on 07/09/25. The findings are: 1. Observation of the medication cart on 07/08/25 from 8:05am to 8:40am revealed: -The medication cart was outside of the dining room in the vestibule area. -The MA was preparing medications for administration and taking the cups of medication to the dining room and leaving them next to a resident at a table. -Four residents were able to sit at each table. -There were 36 residents in the dining room. -There were two residents sitting at a dining room	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 122	D 366		

table and each resident had a cup of pills on the dining room table next to them.
-There was a second table that had three residents sitting at it and 1 of the 3 residents had a cup of pills on the dining room table next to them.

Observation of the dining room from 8:10am to 8:40am on 07/08/25 revealed:
-There were 3 residents sitting at a dining room table; each resident had a medication cup of pills on the table in front of them.
-There were 2 residents sitting at a second dining room table and each resident had a medication cup of pills on the table in front of them.
-The MA was in and out of the dining room to the vestibule area continue to prepare medications and bringing the medications to the residents in the dining room.

Interview with a resident on 07/10/25 at 11:26am revealed:
-The MAs placed the medication on the table and walked away; she did not watch her take her medications.
-The MAs always left the medications on the tables during breakfast.

Interview with another resident on 07/10/25 at 11:22am revealed:
-The MAs placed the medication on the table and walked away to give medication to other residents in the dining room.
-The MAs always left the medications on the tables during breakfast.
-She took five pills during breakfast.

Interview with the MA on 07/08/25 at 2:45pm revealed:
-She would leave residents' cups of pills on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 123	D 366		

dining room tables with the residents.
-The residents waited to be served their water at breakfast before they took their medications.
-She did not have cups on her medication cart so the residents would take their morning medications with the water served at breakfast.
-She was in and out of the dining room and she watched residents take their medications when she was giving other residents their medications.
-She tried to administer medications to everyone at one dining room table before moving to another dining room table.
-She was not concerned about a resident taking another residents' medications.

Interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:47pm revealed:
-Medication should not be left on the dining room table or anywhere else.
-The MA who administered the medication should have watched the residents take their medications before the MA moved on to the next resident.
-Four residents could sit at one dining room table; the medications left on the table could be taken by other residents who thought the medication was theirs.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-The MA should watch the residents take their medications before moving on to the next resident.
-It was important to ensure the residents were taking their medications; the residents may not take the medications and their conditions could worsen.
-The residents sitting at the dining room table may be confused and take the wrong

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 124	D 366		

medications.
-He expected the MAs to watch the residents take their medications.

2. Review of the facility's undated medication services policy revealed the MAs should document all administered medications on the eMAR.

a. Review of Resident #22's current FL-2 dated 08/28/24 revealed:
-Diagnoses included depression, vitamin B12 deficiency, and vitamin D3 deficiency.
-There was an order for escitalopram 10mg (used to treat depression) daily.
-There was an order for ferrous sulfate 325mg (used to treat anemia) daily.

Observation of the morning medication pass on 07/09/25 from 8:15am revealed: (move down to a and b)
-At 8:15am, the MA removed a multi-dose pack for Resident #22 that contained a ferrous sulfate 325mg tablet and an escitalopram 10mg tablet and prepared the medication for administration.
-The MA administered the medications and returned to the medication cart and started preparing the next residents medications.

Review of Resident #22's July 2025 eMAR on 07/09/25 revealed:
-There was an entry for escitalopram 10mg daily.
-There was no documentation that escitalopram 10mg was administered on 07/09/25.
-There was an entry for ferrous sulfate 325mg daily.
-There was no documentation that ferrous sulfate 325mg was administered on 07/09/25.

b. Review of Resident #12's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 125 04/03/25 revealed: -Diagnoses included dementia, osteoporosis, hypertension and a history of cerebral vascular accident (CVA). -There was an order for aspirin 81mg (used to reduce the risk of a heart attack or stroke) daily. -There was an order for lisinopril 20mg (used to treat elevated blood pressure) daily. -There was an order for vitamin B12 1000mcg (used as a supplement) daily. -There was an order for Preservision AREDS 2 (used to slow the progression of age-related macular degeneration) take 2 tablets daily. Review of Resident #12's signed physician order dated 06/10/2 revealed there was an order for calcium carbonate-vitamin D3 500mg-10mcg (used as a supplement) daily. Observation of the morning medication pass on 07/09/25 from 8:23am revealed: -At 8:23am, the MA removed a multi-dose pack for Resident #12 that contained an aspirin 81mg tablet, a vitamin B 12 tablet, a Preservision AREDS tablets, and a calcium carbonate-vitamin D3 500mg-10mcg tablet and prepared for administration. -The medication aide (MA) removed a bottle of lisinopril from the medication cart and placed one tablet in the medication cup for administration. -The MA administered 5 pills to Resident #12, returned to the medication cart and started preparing the next residents' medication. Review of Resident #12's July 2025 electronic medication administration record (eMAR) on 07/09/25 revealed: -There was an entry for aspirin 81mg daily. -There was no documentation aspirin 81mg was administered on 07/09/25.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 126	D 366		

-There was an order for lisinopril 20mg daily.
-There was no documentation lisinopril 20mg was administered on 07/09/25.
-There was an order for vitamin B12 1000mcg daily.
-There was no documentation vitamin B12 1000mcg was administered on 07/09/25.
-There was an order for Preservision AREDS 2 take 2 tablets daily.
-There was no documentation Preservision AREDS 2 was administered on 07/09/25.
-There was an order for calcium carbonate-vitamin D3 500mg-10mcg daily.
-There was no documentation calcium carbonate-vitamin D3 500mg-10mcg was administered on 07/09/25.

Interview with the MA on 07/09/25 at 12:15pm revealed:
-She did not know she did not sign the eMARs after the morning medication pass.
-Sometimes the computer would time out before she returned to the computer to document that she had administered the medications.
-When she signed back in, she would go to the next resident and administer their medications.
-She would sign off the medications she had previously administered later in the day.

Interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:47pm revealed:
-The MA should document the administration of medications immediately after the medications were administered.
-There could be confusion if another MA logged in and saw the medications were not signed; they may think the medications were not administered.

Interview with the Administrator on 07/14/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 366	Continued From page 127 8:04am revealed: -The MA should sign the eMAR after the medications were administered. -It only took one second to click the eMAR and document the medications were administered. -He expected the MAs to sign the eMAR after administering each resident their medications.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 128	D 367		

electronic medication administration record (eMAR) was accurate for 1 of 5 residents (#9) related to a medication for memory.

The findings are:

Review of Resident #9's undated FL-2 revealed diagnoses included Alzheimer's disease.

Review of Resident #9's signed physician orders dated 06/01/25 revealed there was an order for donepezil 10mg (used to help improve thinking ability and memory with Alzheimer's disease) take one tablet daily.

Observation of the morning medication pass on 07/09/25 at 7:53am revealed:
-The medication aide (MA) removed a multi-dose pack that contained 5 pills for Resident #9 from the medication cart and scanned the multi-dose pack.
-An error reading appeared on the computer screen in red regarding donepezil 10mg.
-The MA stated the donepezil had been discontinued; she removed the donepezil 10mg and disposed of the pill.
-The MA administered the other 4 pills that remained in the multi-dose pack to Resident #9.

Review of Resident #9's May 2025 eMAR revealed:
-There was an entry for donepezil 10mg daily with a scheduled administration time of 8:00pm.
-There was documentation donepezil was administered at 8:00pm from 05/01/25 to 05/31/25.
-There was no entry for donepezil 10mg to be administered daily at 8:00am.
-There was no documentation donepezil 10mg was administered daily at 8:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 129 Review of Resident #9's June 2025 eMAR revealed: -There was an entry for donepezil 10mg daily with a scheduled administration time of 8:00pm. -There was documentation donepezil was administered at 8:00pm from 06/01/25 to 06/30/25. -There was no entry for donepezil 10mg to be administered daily at 8:00am. -There was no documentation donepezil 10mg was administered daily at 8:00am. Review of Resident #9's July 2025 eMAR from 07/01/25 to 07/09/25 revealed: -There was an entry for donepezil 10mg daily with a scheduled administration time of 8:00pm. -There was documentation donepezil 10mg was administered at 8:00pm 7 of 8 times from 07/01/25 to 0708/25. -There was one exception documented on 07/04/25; the exception was Resident #9 was unavailable. -There was no entry for donepezil 10mg to be administered daily at 8:00am. -There was no documentation donepezil 10mg was administered daily at 8:00am. Observation of Resident #9's medications on hand on 07/09/25 at 2:34pm revealed: -Resident #9 had a weekly multi-dose pack. -The donepezil 10mg tablet was in the 8:00am multi-dose pack. -There was no donepezil 10mg tablet in the 8:00pm multi-dose pack. Interview with a representative from the facility's contracted pharmacy on 07/10/25 at 11:58am revealed: -Resident #9 had an order dated 02/03/25 for	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 130	D 367		

donepezil 10mg daily.
-The donepezil was placed in the morning multi-dose pack and should be administered during the morning medication pass.
-The pharmacy was not aware Resident #9's donepezil was scheduled for 8:00pm on the eMAR; the facility had not notified them.
-The pharmacy would package the donepezil in the evening multi-dose pack if they were made aware of the time change on the eMAR.
-She did not know who changed the time from 8:00am to 8:00pm on the eMAR, but the facility had the ability to change the time of administration.

Interview with a MA on 07/09/25 at 2:34pm revealed:
-She did not administer donepezil 10mg to Resident #9 during the morning medication pass because it was not scheduled for 8:00am; it was scheduled for 8:00pm; she was wrong when she said the donepezil was discontinued.
-She removed donepezil from the 8:00am multi-dose pack because it was scheduled for 8:00pm on the eMAR.
-She had not removed the donepezil from the 8:00am multi-dose pack before today, 07/09/25.
-If the donepezil had always been in the 8:00am multi-dose pack, then she had administered it without knowing it was in the 8:00am multi-dose pack.
-She thought the donepezil 10mg was in the 8:00pm multi-dose pack since it was scheduled for 8:00pm.

Telephone interview with a second MA on 07/14/25 at 9:30am revealed:
-She administered Resident #9's donepezil 10mg to her each evening she worked.
-Her medications came in a punch card and in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 131	D 367		

multi-dose pack.
-She did not know Resident #9's donepezil was not in the 8:00pm multi-dose pack.
-She did not know she had signed the eMAR that she administered donepezil in the evening.

Interview with Resident #5's Primary Care Provider (PCP) on 07/14/25 at 11:23am revealed donepezil should be administered at bedtime because it could cause dizziness and a decrease in the heart rate.

Interview with the Special Care Coordinator (SCC) on 07/09/25 at 4:27pm revealed:
-The pharmacy should be notified when there was a time change on the eMAR.
-The MA should have notified the pharmacy if they noticed there was an issue with the scheduled time and the packing of the medication in the multi-dose pack.
-The management team could change administration times on the eMAR after consulting with the PCP.
-She did not know who changed the administration time of the donepezil from 8:00am to 8:00pm.
-She expected the MAs to report to her and call the pharmacy for any discrepancies with medications and administration times.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-The MA should have notified the SCC and the pharmacy since the time for administration on the eMAR did not match the time of day the medication was packaged for administration.
-The MAs needed to pay more attention when they were administering medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 371	Continued From page 132	D 371		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), picking up pills with her bare hands prior to the administration of the medications. The findings are: Review of the facility's undated medication handling policy revealed: -If a medication was contaminated, the MA should use the next dose and notify the Resident Care Coordinator (RCC) or Special Care Coordinator (SCC). -A dose of any medication prepared for administration and accidentally contaminated should be destroyed at the facility according to the facility's standards. Observation of the morning medication pass on 07/09/25 between 7:50am and 8:00am revealed: -At 7:50am, the MA popped a pill into a medication cup from a punch card. -She proceeded to pop a second pill into the medication cup from a second punch card when the medication cup turned over, causing the first pill in the medication cup to spill onto the top of	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 371	Continued From page 133	D 371		

the medication cart and the second pill to land on the top of the medication cart when popped from the punch card.
-The MA picked up both tablets from the top of the medication cart with her bare hands and returned them to the medication cup for administration.
-She administered these two pills with two other medications to a resident.
-At 8:00am, the MA removed a resident's multi-dose pack from the medication cart.
-She opened the multi-dose pack, and removed one of the 5 tablets from the multi-dose pack with her bare hands and discarded the medication; the MA said the medication was discontinued.
-The MA took a bottle of pills and attempted to pour one pill in the medication cup, but two pills fell into the medication cup.
-She reached into the medication cup with her bare hands and removed one of the two pills and returned the pill to the original bottle.
-She administered these medications to a resident.

Interview with the MA on 07/09/25 at 2:34pm revealed:
-She knew she should not touch pills with her bare hands; she made a mistake.
-She was nervous because the surveyor was watching her pass medications.
-She should put on a pair of gloves when she needed to touch pills.
-She should have discarded the pills that she touched with her hands.

Interview with the interim RCC on 07/09/25 at 2:47pm revealed:
-The MAs should not touch pills with their bare hands.
-The MAs should wear gloves when there was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 371	Continued From page 134 need to touch pills. -Any pills touched by the MAs without wearing gloves should be thrown away. Interview with the SCC on 07/09/25 at 4:27pm revealed: -The MAs should wear gloves when handling pills. -The MAs should not touch pills with their bare hands. -The germs from the MA's hand could get on the pills. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The MAs should not touch pills with their bare hands. -The MAs should wear gloves when they touched pills. -There could be a transfer of bacteria/germs from the MA's hand to the residents' pills. -The bottle of medication was contaminated after the MA touched a pill and placed it back in the original bottle. -The MA should have destroyed the medications that were touched and prepared the medications again for administration.	D 371		
D 388	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident.	D 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 388	Continued From page 135 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure expired and discontinued medications were disposed of or returned to the pharmacy within 90 days for 1 of 1 residents (#1). The findings are: Review of Resident #1's current FL-2 dated 01/29/25 revealed: -Diagnoses included dementia, depression and insomnia. -There was an order for acetaminophen (used to treat pain) 500mg two tablets every eight hours as needed for pain. Review of Resident #1's six month signed physician's orders dated 07/08/25 revealed there was no orders for metoprolol or apixaban for Resident #1. Observation of Resident #1's medication on hand on 07/08/25 at 1:50pm revealed: -There was a bubble package of acetaminophen 500mg two tablets every eight hours as needed for pain. -Sixty tablets of acetaminophen 500mg were dispensed on 04/19/24, with an expiration date of 04/15/25. -There were 10 tablets in the bubble package. -There was a bubble package of metoprolol 25mg (used to treat hypertension) take half a tablet every other day. -Eight doses of metoprolol were dispensed on 08/17/24 with an orange sticker with instructions not to use after 02/17/25. -There was a box of apixaban (used to treat blood clots) 5mg with Resident #1's name written on the	D 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 388	Continued From page 136	D 388		

box but no dispense date or expiration date.
-There was a blister package of apixaban tablets inside the box; there were 11 of 14 tablets.

Interview with a medication aide (MA) on 07/11/25 at 10:03am revealed:
-The MAs destroyed any expired medications by putting them in a special jug that dissolved capsules and tablets.
-Once medications were destroyed, the MA filled out a log with the resident's name, the dosage, the quantity destroyed, and the date it was destroyed.
-Any medications that were discontinued were destroyed in the same jug and documented on a log.
-Discontinued medications were destroyed right away and were not kept.
-She did not know why there were expired and discontinued medications available for Resident #1.

Interview with the Special Care Coordinator (SCC) on 07/14/25 at 8:47am revealed:
-The MAs were responsible for auditing medications on the medication cart and in the medication room.
-The MAs were responsible for disposing of discontinued or expired medications.
-Expired or discontinued medications were disposed of immediately.
-She was responsible for making sure the MAs had disposed of the medications.
-The MAs documented the disposition of medications on a log and gave them to her.
-If medications had never been opened or used, the MAs sent them back to the pharmacy.
-There should never be expired or discontinued medications because they could be administered to the resident by accident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 388	Continued From page 137 Interview with the Administrator on 07/14/25 at 1:24pm revealed: -The staff destroyed medications that were discontinued or expired. -He was not sure of the process. -Medications that expired or were discontinued should be destroyed within 24 hours. -He was concerned the expired and discontinued medications that were not destroyed because they could be administered by mistake because they were available to administer.	D 388		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration and disposition of a controlled medication for 1 of 3 sampled residents (#5) related to a medication used for pain. The findings are: Review of the facility's undated controlled substance policy revealed: -A controlled substance medication count must be completed at the end of each shift, or anytime	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 392	Continued From page 138	D 392		

controlled substance keys were exchanged.
-The oncoming staff should count the controlled substance medication and the off going staff should enter the number counted into the electronic medication administration record (eMAR).
-If the controlled substance count was incorrect, the supervisor and the Administrator must be notified immediately.

Review of Resident #5's current FL-2 dated 01/28/25 revealed diagnoses included seizures, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF), and deep vein thrombosis (DVT).

Review of Resident #5's signed physician orders revealed:
-There was an order dated 06/13/25 for hydrocodone-acetaminophen 5/325mg (used to treat pain) every 8 hours as needed (PRN).
-There was an order to discontinue hydrocodone-acetaminophen 5/325mg every 8 hours PRN.
-There was an order dated 06/20/25 for hydrocodone-acetaminophen 5/325mg at bedtime.

Review of Resident #5's June 2025 eMAR from 06/16/25 to 06/30/25 revealed:
-There was an entry for hydrocodone-acetaminophen 5/325mg every 8 hours PRN.
-There was documentation hydrocodone-acetaminophen was administered 8 times from 06/16/25 to 06/23/25.
-Hydrocodone-acetaminophen 5/325mg every 8 hours PRN was discontinued on 06/27/25.
-There was a second entry for hydrocodone-acetaminophen 5/325mg at bedtime

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 392	Continued From page 139	D 392		

with a scheduled administration time of 8:00pm.
-There was documentation hydrocodone-acetaminophen was administered each night from 06/21/25 to 06/30/25.

Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/07/25 revealed:
-There was an entry for hydrocodone-acetaminophen 5/325mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation hydrocodone-acetaminophen was administered each night from 07/01/25 to 07/07/25.

Observation of Resident #5's medications on hand revealed:
-There was a punch card with 22 of 30 hydrocodone-acetaminophen 5/325mg to be administered every 8 hours PRN dispensed on 06/13/25.
-There was a second punch card with 13 of 30 hydrocodone-acetaminophen 5/325mg to be administered every night dispensed on 06/20/25.

Review of Resident #5's electronic controlled substance count sheets (CSCS) revealed:
-There was an entry for 30 hydrocodone-acetaminophen 5/325mg tablets to be administered every 8 hours PRN received on 06/15/25.
-There was documentation that 8 of 30 PRN hydrocodone-acetaminophen tablets were administered from 06/16/25 to 06/23/25, leaving 22 hydrocodone-acetaminophen tablets.
-There was a second entry for 30 hydrocodone-acetaminophen 5/325mg tablets to be administered every night received on 06/21/25.
-There was documentation that 17 of 30 scheduled hydrocodone-acetaminophen tablets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 392	Continued From page 140	D 392		

were administered nightly from 06/21/25 to 07/07/25, leaving 13 hydrocodone-acetaminophen tablets.
-The 30 hydrocodone-acetaminophen 5/325mg tablets to be administered every night was added to the electronic CSCS with the remaining 22 hydrocodone-acetaminophen 5/325mg tablets to be administered every 8 hours PRN.
-After the scheduled nightly dose of 30 hydrocodone-acetaminophen was added to the electronic CSCS on 06/21/25, the total of hydrocodone-acetaminophen tablets was 30 instead of 52.

Interview with a representative from the facility's contracted pharmacy on 07/08/25 at 4:07pm revealed:
-Resident #5 had an order for hydrocodone-acetaminophen 5/325mg tablets to be administered every 8 hours PRN dated 06/13/25.
-The pharmacy dispensed 30 hydrocodone-acetaminophen 5/325mg for the PRN order on 06/13/25.
-The pharmacy received an order on 06/20/25 to discontinue hydrocodone-acetaminophen 5/325mg tablets every 8 hours PRN and to start a scheduled dose of hydrocodone-acetaminophen 5/325mg tablet every night.
-The pharmacy dispensed 30 hydrocodone-acetaminophen 5/325mg for administration every night on 06/20/25.

Interview with a medication aide (MA) on 07/10/25 at 10:23pm revealed:
-She counted controlled substances with another MA at each shift change.
-The oncoming MA would count the controlled substances and the off going MA would ensure the documentation on the electronic CSCS was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 392	Continued From page 141	D 392		

correct.
-There was 13 hydrocodone-acetaminophen 5/325mg tablets remaining on the electronic CSCS and in the punch card.
-She did not realize the 22 hydrocodone-acetaminophen 5/325mg tablets in the PRN punch card were not being counted on the electronic CSCS.
-The PRN hydrocodone-acetaminophen 5/325mg tablets were being counted until the schedule hydrocodone-acetaminophen 5/325mg tablets for bedtime were added.

Telephone interview with a second MA on 07/14/25 at 9:30am revealed:
-She counted controlled substances with another MA at shift change.
-She knew the PRN punch card for hydrocodone-acetaminophen 5/325mg was still on the medication cart after it was discontinued.
-She knew the PRN punch card was not being counted; she had wondered why it was not being counted but she had not mentioned it to anyone.

Interview with the interim Resident Care Coordinator (RCC) on 07/09/25 at 2:47pm revealed:
-The RCC was responsible for receiving and signing for controlled substances.
-The RCC would document the name of the controlled substance and the number of pills that were dispensed on the electronic CSCS when controlled substances were received.
-The computer would automatically add the number of pills received to the number of pills already available for administration.
-She did not realize the count of the CSCS was 13 and there were an additional 22 pills in the PRN pack of hydrocodone-acetaminophen 5/325mg that were not being counted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 392	Continued From page 142 -She did not know why the computer did not calculate the 30 hydrocodone-acetaminophen 5/325mg at bedtime when they were received and entered on 06/21/25. -The MAs should be counting the controlled substances at each shift change. -The MAs would have noticed the count was not correct if they had been counting the controlled substances as they should. Interview with the Administrator on 07/14/25 at 8:04am revealed: -The MAs should be counting the controlled substances at shift change and comparing the number of pills remaining to the CSCS. -He expected the controlled substances to be counted each shift and compared with the documentation; if the number counted and the number documented did not match, the MA should notify the RCC.	D 392		
D 612	10A NCAC 13F .1801(c) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 612	Continued From page 143	D 612		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during an outbreak of the coronavirus (COVID-19) as related to residents not being confined to their rooms during an outbreak.

The findings are:

Review of the facility's undated Covid-19 policy revealed:
-When there was an outbreak of two or more positive cases of Covid-19 in the community, the facility would follow the local health department's guidance and the CDC guidelines.
-Symptoms of Covid-19 were fever, chills, cough, fatigue, muscle aches, congestion and runny nose.
-Residents with symptoms of Covid-19 should be placed in a singe room pending results of the test.
-Staff should wear recommended personal protective equipment (PPE) when providing care in the room.
-Once the resident's symptoms had improved and they were fever free for 24 hours, the resident could resume normal activities, but wear a face mask for an additional 24 hours.
-The staff was to follow the local health department guidelines given to the facilty in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 612	Continued From page 144	D 612		

event of an outbreak as they may be more complex than the policy above.

Review of Resident # 4's current FL-2 dated 02/11/25 revealed diagnoses included gait instability, lymphedema of lower extremity, diabetes mellitus type 2 with diabetic neuropathy, venous insufficiency, hypertension, and arthritis of both knees.

Review of Resident #4's Primary Care Provider (PCP) after visit summary dated 03/24/25 revealed:
-Resident #4 was seen for an evaluation and management visit as a new resident to the facility.
-Resident #4 had a harsh cough that had lingered for a week.
-She ordered a Covid-19 test for Resident #4.

Review of Resident #4's after-hours PCP triage summary dated 03/24/25 revealed:
-The staff notified the on-call PCP that Resident #4 had a congested cough and a low-grade temperature.
-No new orders; waiting on Covid-19 results.

Review of Resident #4's record revealed there was no Covid test results available for review.

Review of Resident #4's electronic progress notes from 03/14/25 to 03/31/25 revealed:
-There was no documentation of Resident #4's respiratory condition
-There was no documentation of Resident #4 having a Covid-19 test.
-There was no documentation of Resident #4 being diagnosed with Covid-19.

Telephone interview with Resident #4's Power of Attorney (POA) on 07/10/25 at 6:40pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 612	Continued From page 145	D 612		

-Resident #4 had Covid-19 the last week in March 2025.
-He was told by someone, he did not recall who, that precautions were not put in place when the facility had Covid-19.
-Residents were allowed to come out of their rooms.
-He thought Resident #4 needed to be kept away from other residents.

Interview with Resident #4's PCP on 07/14/25 at 11:23am revealed:
-The facility had several Covid-19 cases a few months ago.
-Residents with Covid-19 should be confined to their rooms, but the residents were allowed to come out of their rooms and mingle with other residents.
-She questioned the previous Administrator why the residents with Covid-19 were not placed on isolation precautions and were able to leave their room and join other residents.
-The previous Administrator told her the residents with Covid-19 could not be confined, it was their right to come out of their room if they wanted to.
-She informed the Administrator that other facilities who had residents with Covid-19 were confined to their rooms and she suggested that the residents in this facilty be confined also.
-If the residents with Covid-19 were not confined, they could infect other residents.

Interview with the interim Resident Care Coordinator (RCC) on 07/10/25 at 7:45am revealed:
-There were about 5 residents who had Covid-19 in the Assisted Living (AL) in March 2025.
-Resident #4 was one of the residents who tested positive for Covid-19.
-The staff had placed signs on the doors alerting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 612	Continued From page 146	D 612		

everyone there was Covid-19 in the facility.
-The 5 residents had been confined to their rooms and were to stay confined for 5 days and then be retested for Covid-19.
-The PPE was placed outside of each resident's room, including Resident #4s.
-The previous Administrator said the residents who were positive for Covid-19 could not be confined to their rooms; it was their right to leave their room if they wanted to but they could not go in the dining room with the other residents.
-She did not agree with the previous Administrator's decision; she thought the residents should be confined to their room to decrease the spread of Covid-19.

Interview with the Administrator on 07/14/25 at 8:04am revealed:
-There had not been any Covid-19 cases since he had been the administrator of the facility.
-He would follow the CDC guidelines for a Covid-19 outbreak.
-Residents would be confined in their rooms and PPE equipment would be set up at the door for each resident diagnosed with Covid-19.

Attempted interview with the previous Administrator on 07/14/25 at 9:45am was unsuccessful.