Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065020	A. BUILDING: _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPIONS ASSISTED LIVING	1007 PORTERS NECK ROAD WILMINGTON, NC 28411

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover Department of Social Services conducted an annual survey and complaint investigation on 06/30/25 through 07/03/25. The New Hanover Department of Social Services initiated the complaint investigations on 05/06/25, 05/28/25, 06/02/25, 06/20/25, 06/25/25, and 07/02/25.	D 000	Champions Assisted Living acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of residents. The plan of correction is submitted as a written assertion of compliance. Responses to the stated deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Champions Assisted Living reserves the right to refute and incorporates by reference any rebuttal of deficiencies that it submits through informal dispute resolution, formal appeal and/or other administrative or legal procedures.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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, interviews, and record review, the facility failed to maintain an environment free of hazards including personal care products that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's census report received on 06/30/25 revealed 11 residents resided in the	D 079		

Reviewed and acknowledged on 08/11/2025 Joyce Johnston

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D 079	Continued From page 1 SCU of the facility. Review of the facility's memory care (SCU) disclosure statement revealed: -The facility would provide a safe environment. -Residents in the SCU would not have access to potentially harmful objects. -Resident use of potentially harmful electrical appliances such as razors would be prohibited. Observations on the SCU on 06/30/25 during the initial tour from 8:25am to 9:48am revealed residents ambulated freely in the halls to and from their rooms to the other areas of the SCU. Interview with a resident ambulating in the hallway on 06/30/25 at 8:35am revealed she did not know where her room was located. Observations in room 100 of the SCU on 06/30/25 at 9:16am revealed: -The room door was unlocked. -There was no staff or residents present in the room. -There were bottles of personal care items on the shower ledge including a 28-ounce bottle of hair moisturizing shampoo, a 22-ounce bottle of hair shampoo, and a 35-ounce bottle of body wash. -Ingredients listed on the label of the body wash included benzyl alcohol, sodium salicylate, and plant derived cleanser ingredients. Observations in room 129 of the SCU on 06/30/25 at 9:34am revealed: -The room door was open. -A resident was asleep in the bed. -There was no staff present in the room. -There was a 24-ounce bottle of body wash and a 10.1-ounce bottle of color care shampoo in the bathroom shower area.	D 079	10A NCAC 13F 0306 (a) (5) Housekeeping and Furnishings At time of incident, all rooms were thoroughly searched. Bathrooms received cabinet locks for all ingestible items. Staff received training on policy for locking up all personal care items. Families will be notified of items purchased and the need for them to be in locked cabinets Key locks have been ordered to replace the ones that are currently in place Audits will be conducted daily times 30 day, then weekly x 1 week, then monthly for 3 months Care staff will be re-educated on policy for ingestible's being locked up upon hire and every 6 months	6/30/25 06/30/25 08/03/25 10/01/25 Ongoing Ongoing

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D 079	Continued From page 2 -There was a printed label on the back of the color care shampoo that read "do not ingest, avoid contact with eyes and skin". -There was an electric razor lying on the bathroom sink countertop. Interview with the medication aide (MA) on 06/30/25 at 9:40am revealed: -Resident personal care items were supposed to be kept in the locked cabinet under the sink. -She was not sure why the cabinet doors were not locked. -There were residents in the SCU that were disoriented and confused. Interview with the Memory Care Coordinator (MCC) on 06/30/25 at 9:42am revealed: -The doors to the cabinet sink were supposed to be locked. -She thought the cabinet sink doors were not locking because staff were "yanking" and the locks were "worn out". -The cabinet doors were supposed to "open a little and push down on the lock to release it". -She did not know how long the cabinet door locks had been broken. Interview with the Administrator on 06/30/25 at 10:33am revealed: -Resident personal care items were supposed to be kept in locked cabinets in the resident's bathroom. -The personal care aides (PCAs) and MCC were responsible for performing a visual walkthrough of the SCU rooms to ensure there were no personal care items unsecured. -She was not sure why personal care items were unsecured in the SCU resident rooms on 06/30/25. -Visual walkthrough checks of the SCU resident	D 079		

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D 079	Continued From page 3 rooms should be completed daily. -There was not an audit form to show when the visual walkthroughs of SCU resident rooms were completed. Based on observations, interviews, and record reviews, it was determined the residents residing in rooms 100 and 129 were not interviewable.	D 079		
D 150	10A NCAC 13F .0501 (a & b) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within	D 150	10 A NCAC 13F .0501 (a&b) Staff Personnel files were reviewed for PCA currently on staff PCA's on staff who have not received their 80 PCA training will receive information on course available through Southern Pharmacy All PCA's will complete their training within 6 months of hire date. Documentation of the completion will be maintained in their personnel files HR to assist with compliance and tracking upon hiring PCA Administrator/designee will monitor 80 hour compliance quarterly	07/25/25 8/1/25 Ongoing ongoing

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D 150	Continued From page 4 six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 11 staff sampled (G) who provided personal care services to the residents had completed the state-approved 80-hour personal care training and competency evaluation program. The findings are: Review of Staff G's personnel record revealed: -Staff G was hired as a personal care aide (PCA) on 10/31/24. -Staff G was not found on the North Carolina Nurse Aide 1 registry per an inquiry on 10/31/24. -The was no documentation of Staff G completing the state-approved 80-hour personal care training and competency evaluation program. Interviews with the Administrator on 07/02/25 at 1:55pm and 4:15pm revealed: -Human Resources (HR) was responsible for making sure new staff hires had the required documentation and qualifications for employment as a PCA.	D 150		

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D 150	Continued From page 5 -She was not involved in the hiring process of Staff G. -Staff G was hired as an experienced PCA by the previous Resident Care Director (RCD). -She was unable to locate the 80-hour PCA training certificate for Staff G. -Staff records were audited every 6 months on a staggered basis by the RCD which included making sure staff had the required documentation and training, tuberculosis screening, continuing education hours, in-services, and licensed health professional support (LHPS) check lists among other things. -Staff G was terminated on 05/29/25. -The previous RCD was no longer employed at the facility as of last month. -Staff G's 6-month employee record review was not completed by the former RCD since both were no longer employed by the facility. -It was important for the PCAs to have the required 80-hour training and competency evaluation to ensure they had the skill set to provide personal care to the residents. -Ultimately, it was her responsibility as the Administrator to ensure Staff G had the required documentation of training for employment as a PCA in the facility.	D 150		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 338		

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D 338	Continued From page 6 Based on observations, interviews and record reviews, the facility failed to ensure residents were treated with dignity and respect and protected from abuse for 2 of 7 sampled residents (#10, #11) related to a resident who was antagonized by a staff member and sustained fractures to the arm, nose, and orbital floor (#10) and a resident who fell, complained of severe pain, and change in mobility after a fall that resulted in a hip fracture (#11). The findings are: 1. Review of Resident #11's FL2 dated 05/01/25 revealed: -Diagnoses included delusional disorders, insomnia, depression, hypertension, chronic kidney disorder, generalized anxiety disorder, abnormal weight loss, and amnesia. -The resident was intermittently disoriented. -The resident was ambulatory. -The resident's level of care was documented as domiciliary. -Resident #11 was ambulatory without assistance. -The resident was able to communicate verbally. Review of Resident #11's Resident Register revealed an admission date of 04/02/24. Review of Resident #11's care plan dated 05/02/25 revealed: -Resident #11 had no problems with ambulation/locomotion or upper extremities. -The resident was independent with all activities of daily living. -Resident #11 had a normal speech/communication method.	D 338	10A NCAC 13F .0909 Resident Rights Staff were immediately re-trained on reporting procedures and follow up and through on acute resident needs Unit staff will report immediately any acute changes with a resident. Supervisor on duty will immediately contact PCP, informing them of acute change and wait for further instructions. Supervisor on duty will immediately activate 911 for emergency care as needed and ensure notification of the PCP and family. For non-emergent issues, the supervisor on duty will follow appropriate reporting procedures including but not limited to physician notification, and notification of family members. Front line staff are instructed to notify member of management team immediately if there are concerns with follow up to issues reported to the supervisor. The Administrator/designee will review shift to shift report in morning meeting and follow up to ensure appropriate notifications were complete	7/5/25 7/16/25 and ongoing

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D 338	Continued From page 7 Review of 05/12/25 facility progress notes for Resident #11: - At 7:59am an entry by a medication aide (MA) stated the resident complained of pain in the upper left hip after falling. - The resident reported falling and being unable to walk. - At 1:06pm there was an entry by the Administrator for post fall observation. - Resident #11 reported not losing balance or tripping. -The resident's leg "gave away". - At 9:28pm an entry by a nurse indicated Resident #11's left knee was visibly swollen and the resident was given an ice pack. - Mobile x-ray arrived at approximately 9:30pm. Review of Resident #11's radiology report revealed: -The resident's PCP ordered the x-ray. -The date of service was 05/12/25. -The order was for: left hip unilateral with 2-3 views that did not include the pelvis. Those results were an acute left femoral neck fracture with mild displacement; the joint showed no dislocation; and the pubic rami was intact, with conclusion documented as acute left femoral neck fracture. -The order was also for x-ray of left femur with a minimum of two views. Those results indicated there was an acute fracture of the neck with mild displacement. The remainder of the femur was intact including the hip and knee joints, with conclusion documented as acute left femoral neck fracture. -The report was electronically signed by a physician on 05/12/25 at 11:25pm. -The word "ALERT" as in capital letters and was printed on the report. -At the top of the report, there was a transmittal	D 338	Administrator/designee will provide training to care staff regarding resident rights, reporting procedure.	7/16/25 and ongoing

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D 338	Continued From page 8 date of 05/12/25 at 11:29pm that indicated Final Report. Interview with Resident #11 on 07/03/25 at 9:01am revealed: -She had an unwitnessed fall enroute to the dining room for breakfast. -She reported being on the floor for approximately 10 minutes. -She was assisted from the floor by staff and transferred into a dining room chair with wheels. -She reported to staff the immediate pain after the fall. -The facility "didn't do anything right away" after she fell on 05/12/25. -She was moved into the dining room by staff and remained in the dining room until after breakfast with no pain medication provided. -She was unable to eat breakfast as normal as she "didn't feel like chewing and swallowing" as she was very uncomfortable. -Her pain level was an 8 out of 10 in her left leg and hip during breakfast. -She requested pain medication several times on 05/12/25 and did not receive any. - She was unable to recall which staff she asked for medication. - She was upset about not receiving the requested pain medication. - Prior to the fall on 05/12/25, she was able to transfer, toilet, and ambulate independently. - She was unable to ambulate to the dining room for lunch on 05/12/25 and meals were brought to her apartment. - She felt handicapped because she was not able to independently ambulate. - She would normally engage in daily activities at the facility. - Not being able to attend activities due to her injury caused her to feel embarrassed.	D 338		

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D 338	Continued From page 9 -She was uncomfortable in the recliner on the night of 05/12/25. -She verbalized to staff being uncomfortable and received no assistance with pain management or comfort. - She would not normally sit in the recliner all day and night. - She would normally not sleep in the recliner. - She was in a lot of pain and could not sleep comfortably in the recliner on 05/12/25. - No staff checked on her during the night. - She was assisted with ambulation and transfer to the toilet while awaiting transport to a local hospital. - She felt handicapped due to the need for toileting and transfer assistance. - She reported a pain left of 8 (or 9) of 10 upon arrival at the local area hospital. - She believed the facility failed to take appropriate care of her acute pain and needs. - The former Administrator nor the former Resident Care Director talked to her on 05/12/25. -No facility staff examined her left leg until the mobile x-ray arrived after 9:00pm. Interview with a resident on 07/03/25 at 11:45am revealed: -Resident #11 normally ate breakfast at the same table in the dining room. -She did not witness the incident which caused Resident #11's pain on 05/12/25. Resident #11 reported having a fall before breakfast. -Resident #11 was in a lot of pain at breakfast on 05/12/25. -Resident #11 verbally complained of pain in the left hip and leg during breakfast. -Staff were aware of Resident #11's complaints of pain during breakfast.	D 338		

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D 338	Continued From page 10 - Resident #11 was "getting along very well" before 05/12/25. - Resident #11 had no problems with ambulating and transferring prior to 05/12/25. Review of Resident #11's May 2025 electronic medication administration report (eMAR) revealed: -There was an entry for Acetaminophen 500mg two (1000mg) by mouth as needed. -The start date for this order was 05/12/25. -The diagnosis was left knee pain. -There was documentation Acetaminophen was administered on 05/12/25 at 9:28pm due to pain that was somewhat effective. Telephone interview with Resident #11's family member on 07/03/25 at 10:31pm revealed: - Resident #11 was hospitalized for 10 days and required a blood transfusion after hip surgery. - She was told Resident #11 was not sent out to a local hospital after the fall on 05/12/25 due to increased infection risk of being in the emergency room for hours. - She was told Resident #11's injury was not an emergency. - She did not recall which staff called to advise of Resident #11's fall on 05/12/25. - Resident #11 was taken to the dining room for breakfast and left in the dining room with no measures to limit the resident's pain. - She repeatedly called the facility on 05/12/25 and was advised the mobile x-ray was "running late". - Resident #11 had to remain in a recliner all night on 05/12/25 and was unable to get into bed due to the injury. Interview with a personal care aide (PCA) on 07/03/25 at 11:35am revealed:	D 338		

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D 338	Continued From page 11 -Resident #11 walked without assistance before 05/12/25. -Resident #11 required assistance with ambulating and transferring after the fall on 05/12/15. -Resident #11 was interviewed by the Administrator, the first shift nurse supervisor, and a medication aide (MA) on the morning of 05/12/25. -Resident #11 repeatedly reported leg and hip pain from a fall on the morning of 05/12/25. -It was unusual that Resident #11 was not transported to a local area hospital after repeatedly expressing pain. -Residents in the dining room on the morning of 05/12/25 were very concerned that Resident #11 was in obvious pain. Interview with a MA on 05/28/25 at 2:15pm revealed: -Facility policy regarding falls indicated that a resident would be automatically sent to a local emergency department for evaluation if the resident had problems with range of motion after a fall. -She completed a progress note on the morning of 05/12/25 at 7:59am regarding Resident #11's fall. -Resident #11 reported not being able to walk after she fell on 05/12/25. -Resident #11 was transferred by staff from the dining room chair to a wheelchair, then from the dining room chair to a wheelchair, then from the wheelchair to a recliner after breakfast on 05/12/25. -The resident had to ask for assistance from the MA and PCA with transferring and toileting on the morning of 05/12/25. -Resident #11 required no assistance with activities of daily living prior to 05/12/25.	D 338		

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D 338	Continued From page 12 Telephone interview with the former first shift nurse supervisor on 07/03/25 at 9:50am revealed: -Resident #11 did not immediately complain of pain during her 7:00am - 3:00pm shift on 05/12/25. -She never saw Resident #11 on the floor. -She did not report to the PCP on 05/12/25 that Resident #11 had fallen. -She recalled Resident #11 reported having a fall however the fall was not witnessed by staff and the resident was not found on the floor. -When Resident #11 declined to walk, she assumed the resident did not want to walk back to her apartment. -Resident #11 was transferred to a dining room chair with wheels and taken to the dining room for breakfast. -Resident #11 was transferred to a recliner by staff after breakfast and could not transfer from the recliner independently. -Resident #11 slept in the recliner on the night of 05/12/25 because the resident could not get into bed. -It was unlike Resident #11 to sleep in the recliner. Resident #11 should have been reassessed and sent out to a local hospital. -Resident #11 previously ambulated independently and engaged in daily activities at the facility. Interview with the Administrator on 05/28/25 at 3:55pm revealed mobile x-ray was ordered for Resident #11 with the goal of eliminating an extended say in the emergency department and to keep her in a "familiar and comfortable environment". Interview with the facility's Chief Operating Officer (COO) on 07/03/25 at 12:17pm revealed:	D 338		

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D 338	Continued From page 13 -The facility should have followed up with Resident #11's PCP on 05/12/25 for more guidance. -Resident #11 "clearly had more pain" and was transferred several times on 05/12/25. -They expected that the Resident Care Director or a nurse would be responsible for immediately responding to Resident #11's acute care needs on 05/12/25. Telephone interview with Resident #11's primary care provider (PCP) on 07/02/25 at 11:32am revealed: -Resident #11 was in Assisted Living prior to her hospital admission on 05/12/25. -She had reviewed facility documentation and saw that the resident complained of pain below the hip area at approximately 7:59am after falling. -Resident #11 was unable to walk after falling on 05/12/25. -She expected the facility to send residents to the local hospital for a more thorough evaluation after multiple complaints of pain after a fall. -Mobile x-ray was not always effective. -The fracture would have caused Resident #11 acute pain that was not present prior to the injury. -She was not advised that Resident #11 had fallen on the morning of 05/12/25 when the mobile x-ray was requested by the facility. 2. Review of Resident #10's FL-2 dated 11/24/25 revealed: -Diagnoses included Alzheimer's disease, depression, constipation, rash, cough, scabies, conjunctivitis, and hypokalemia. -She was constantly disoriented. -She was ambulatory. Review of Resident #10's Resident Register revealed she was admitted on 09/10/21.	D 338		

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D 338	Continued From page 14 Review of Resident #10's Care Plan dated 10/16/24 revealed: -She was independent with transfers. -She needed supervision with eating and ambulation. -She needed extensive help with toileting, bathing, dressing, and grooming. Review of an investigation document from the facility's interviews by the former Administrator and Chief Operating Officer (COO) undated revealed: -The first shift supervisor and a medication aide (MA) had reported an incident that allegedly took place on 05/04/25. -A personal care aide (PCA) stated that they witnessed another PCA poke Resident #10's bottom and "mushed" another resident's hair while walking a resident to their room on 05/04/25. -The behaviors from the PCA were perceived to annoy the residents. -The accused PCA said that she was playing with the residents. -The accused PCA was terminated. Review of the 911 communications event report dated 05/29/25 at 5:36pm revealed: -The former Administrator stated she had received an allegation that a personal care aide (PCA) had been antagonizing residents by poking them, playing with their feet and hair, and the employee admitted to doing so. -The incident of antagonizing residents happened on 05/04/25 but was not reported to her until 05/29/25. -Resident #10 was named as a resident who was antagonized by the accused PCA.	D 338	10A NCAC 13 .0909 Staff were immediately re-trained regarding reporting procedures in Abuse/Neglect/Exploitation. Further, more in-depth training will be provided by administrator and/or designee with documentation of training maintained in the community for review by regulatory entity. Allegations of actual or suspected abuse, neglect or misappropriation will be reported to the supervisor on duty. Supervisor on duty will immediately notify Administrator and/or designee for appropriate and timely follow-up The Administrator/designee will immediately notify COO/CEO of allegations and complete the initial 24 hour required report and submit to state regulatory agency within 24 hours as required. All allegations will be thoroughly investigated and findings completed on the 5 day report and provide to the state within the 5 days of the initial submission of the report	7/5/25 ongoing

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D 338	Continued From page 15 Interview with the Memory Care Manager (MCM) on 07/02/25 at 3:11pm revealed: - A MA notified her about the accused PCA poking and tickling residents about two months ago and she did not report this to anyone because she did not think it was something that needed to be reported and she did not talk with the staff member. - Tickling and poking residents was not appropriate behavior when working with dementia residents. Telephone interview with a former activities assistant on 06/02/25 at 5:05pm revealed: -She had reported concerns with the accused PCA's treatment of residents to the former Resident Care Director (RCD). -There was no trust in the Administrator or the first shift nurse supervisor to address concerns with resident care and treatment. -The Administrator "micro-managed" and would not allow the RCD to report incidents. -All concerns about the accused PCA were reported to the RCD in writing. -She assistant failed to maintain a copy of what was reported to the RCD. Telephone interview with the former RCD on 06/07/25 at 11:07am revealed: -She denied any reports from staff alleging that the accused PCA was inappropriate with residents. -It was "hearsay" that the accused PCA escalated negative behaviors with residents and had poked residents on the butt. -Facility policy stated that any allegations of abuse/neglect/exploitation would be reported immediately to the Administrator and the local Department of Social Services (DSS) for investigation.	D 338		

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D 338	Continued From page 16 -She had no knowledge of any allegations about Staff G being inappropriate with residents before 05/29/25. Interview with the Administrator on 06/02/25 at 3:05pm revealed: -Allegations had been reported that the accused PCA had antagonized special care unit (SCU) residents by tickling feet and mussing hair on 05/04/25. -The allegations regarding the accused PCA's inappropriate behavior with residents were not reported to her until 05/29/25 at 3:30pm. Review of Resident #10's emergency department (ED) encounter dated 05/29/25 revealed: -Resident #1's chief complaint on arrival was a fall with a hematoma to the left elbow, left hip pain, and dried blood in the nose. -The resident had left orbital floor and left anterior maxillary sinus wall fractures with layering hemorrhage in the maxillary sinus (fractures to the face). -The resident had a mildly displaced nasal bone fracture. -Resident #10 had an acute displaced fracture to the proximal left ulna (arm bone). Second interview with the Administrator on 06/02/25 at 6:15pm revealed: -Two third shift PCAs found Resident #10 with injuries at approximately 11:15pm on 05/28/25. -Resident #10 was found sitting in a chair with her left arm "guarded" and dried blood around her mouth. -Resident #10 had an unwitnessed fall on 05/28/25. -She then stated it was an "assumption" that Resident #10 fell on 05/28/25. -Resident #10 was unable to communicate how	D 338		

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D 338	Continued From page 17 the injuries were obtained due to a dementia diagnosis. -The accused PCA was interviewed on 05/29/25 regarding the injuries sustained by Resident #10 on 05/28/25 during the PCA's shift. -Resident #10 was last observed by the accused PCA at 9:30pm on 05/28/25. -The accused PCA reported that Resident #10 was "fine" at that time. Interview with the accused PCA on 06/26/25 at 9:00am revealed: -She was hired at the facility in October 2024 as a PCA. -She admitted to inappropriately tickling and poking SCU residents, and some residents were agitated by the tickling and poking behavior. -Resident #10 required hands-on care with all activities of daily living except feeding. -Resident #10 could not stand without assistance. -Resident #10 was not able to independently transfer. -The accused PCA initially reported no knowledge of how Resident #10 was injured during her shift on 05/28/25. -She was assigned to provide care and supervision of Resident #10 in the SCU during the 3:00pm-11:00pm shift on 05/28/25 -Resident #10 was being assisted with toileting before bed at approximately 9:30pm on 05/28/25 when the incident occurred. -Resident #10 attempted to leave the bathroom which caused the accused PCA to pull the resident by the arm to prevent the resident from leaving the room. -By pulling the resident by the arm, she caused Resident #10 to fall onto the floor. -Resident #10 suffered a facial injury because of the fall which resulted in bleeding. -Resident #10 also had a left arm injury.	D 338		

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D 338	Continued From page 18 -She assisted Resident #10 from the floor into a chair after the fall. -She pulled a chair close to the bed to assist Resident #10 into the chair which caused the resident's blood to stain the bedspread. -She removed the blood-stained nightgown from Resident #10 and placed it in the laundry with the blood-stained bedspread. -She failed to document or advise other SCU staff of putting the blood-stained nightgown and bedspread into the laundry after Resident #10 fell on 05/28/25. -She did not report Resident #10's injuries to any facility staff on 05/28/25. -She understood that a MA should have been immediately notified of Resident #10's injuries. -She failed to report the Resident's #10's injury because she was fearful of being fired. -She did not check on Resident #10 was not checked on by Staff G for the remainder of her shift which ended at 11:00pm. -She did not report Resident #10's injuries to staff at the beginning of the 11:00pm shift. Interview with Resident #10's primary care provider (PCP) on 07/02/25 at 4:00pm revealed: -She was not sure what happened to Resident #10 on 05/28/25. -She was notified by the ED that Resident #10 was there for a fall. -Resident #10 was admitted to the hospital for left orbital floor fracture, left ulna fracture, and nasal fracture. -Resident #10 went to a higher level of care after she was discharged from the hospital. -The facility had not reached out to her related to Resident #10. The facility failed to ensure residents were treated with dignity and respect and free from abuse and	D 338		

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D 338	Continued From page 19 neglect for a resident who was observed to be antagonized by a staff member with no interventions put into place resulting in the resident suffering fractures to the arm, nose, and left orbital floor (#10), and a resident that who sustained a hip fracture and remained in the facility, in pain and unable to walk for more than 24 hours (#11). This failure resulted in serious abuse and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with GS. 131D-34 July 3, 2025 for the violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED August 3, 2025.	D 338	10A NCAC 13F .1004 (a) Medication Administration Medication Aides/Techs received an inservice on medication administration policy and procedures	07/01/25
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policy and procedure for medication administration for 2 of 4 residents (#1,	D 358	Policy and procedure for Self Administration of medications was reviewed immediately Resident identified in survey #1 & #2 had self admin assessment reviewed/revised as needed Residents identified as able to self administer medications will be assessed/reassessed All orders for self administration were updated	07/01/25 07/01/25 07/01/25 07/01/25

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D 358	Continued From page 20 #2) observed during the medication pass and for 1 of 7 residents (#1) sampled for record review including errors with a medication used to treat dry eyes, a medication used to relieve urinary tract infection symptoms,an injectable medication used to treat elevated blood glucose (#1), a medication used to treat constipation, and a medication used to treat dry skin (#2). The findings are: Review of an undated medication administration policy provided by the facility revealed: -All medications, including over- the-counter non-prescription medications require a physician's order. -No medications, including over-the counter non-prescription medications, may be kept in the resident's apartment unless the physician has approved self-administration of medications. -Medications will be administered by the facility's medication aides (MAs). -State rules allow medications to be administered within one hour before and one hour after the scheduled time in order to get medications to all residents, unless precluded by emergency situations. -Although the facility recognizes personal habits and previous medication scheduled, medications will be given as close to the scheduled time as possible. -MAs are not permitted to leave medications in the apartment for a resident to take later. -The medication must be taken in the presence of the MA. Review of second medication administration policy dated 07/22/99 and revised 02/26/18 provided by the facility revealed: -No medication shall be administered without a	D 358	Reevaluation of self administration of medications will occur every 3 months or as needed in the event of acute medical changes	ongoing

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D 358	Continued From page 21 physician's order. -The MA will administer medications to the residents following medication administration guidelines posted in the front of each medication administration record (MAR) and following good professional practice including, check, double check and check again. -The MA will chart each medication for every resident on the electronic medication administration record (eMAR) immediately following medication administration. Review of a provided policy for insulin storage recommendations dated 09/28/16 revealed: -Humalog insulin could be stored refrigerated and unopened until the expiration date. -Humalog insulin could be stored unopened at room temperature for 28 days. -Humalog insulin could be stored at room temperature for 28 days after being opened. Review of a second document titled "Medications with shortened expiration dates" provided by the facility from the facility's contracted pharmacy provider dated May 2022 revealed: -Unopened Humalog vials stored at room temperature expire after 28 days, once opened refrigerated or not, product must be used within 28 days. -Humalog Kwikpens, refrigerate until opened, once opened, do not refrigerate, product must be used within 28 days. Review of the facility's provided undated policy labeled "Key Points for Insulin Pen injections" revealed identify when a specific pen will expire and note (pharmacy can give the number of days each insulin is stable at room temperature). Review of the manufacturer's recommendations	D 358	Medication cart audits will be completed weekly beginning 8/4/25 by Resident Care Director/designee to ensure that there are no expired/ discontinued medications on the cart. Audits will be conducted to ensure all prescribed medications are available and reordered in a timely manner. Administrator/designee will monitor weekly for one month then quarterly thereafter.	8/5/25 ongoing

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D 358	Continued From page 22 for storage of Humalog Kwipens revealed open humalog vials, prefilled pens and cartridges must be thrown away 28 days after first use even if they still contain insulin. 1. The medication error rate was 11% as evidenced by 3 errors out of 27 opportunities during the 7:00am/9:00am medication pass on 06/30/25. a. Review of Resident #2's current FL-2 dated 10/30/24 revealed: -Diagnoses included abdominal aortic aneurysm, hypothyroidism, hyperlipidemia, mitral valve prolapsed, and peripheral artery disease. -He was intermittently disoriented. Review of a signed physician's order for Resident #2 dated 04/09/25 revealed an order for Miralax (Miralax is used to treat constipation) powder, take 17 grams once a day. Observation of the 7:00am/9:00am medication pass on 06/30/25 revealed: -The medication aide (MA) prepared 8 tablets in a medication cup and stirred a capful of Miralax into 8 ounces of water in a disposable cup for Resident #2 at 9:12am. -The MA took the medication cup containing the 8 tablets and the 8 oz cup of water containing Miralax to Resident #2's room. -The MA administered the 8 tablets to Resident #2 with the cup that contained Miralax at 9:13am. -Resident #2 drank approximately one half of the cup of water that contained Miralax and set the cup down. -The MA left the cup of water containing Miralax with Resident #2 and left the resident's room without observing him or prompting him to finish the cup of water that contained Miralax.	D 358		

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D 358	Continued From page 23 Review of Resident #2's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax Powder 17-gram dose, once a day, scheduled at 7:00am to 9:00am. -Miralax 17 grams was documented as administered on 06/30/25 at 7:00am to 9:00am. Observation of Resident #2's medications on hand on 06/30/25 at 2:06pm revealed there was an 8.3-ounce bottle of Miralax powder with a dispense date of 06/23/25, labeled with Resident #2's name, to place one capful (17 grams) in 8 ounces of choice and drink once daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/25 at 3:12pm revealed: -An order was received for Resident #2 for Miralax powder 17 grams daily on 04/09/25. -Miralax powder was last dispensed for Resident #2 on 06/23/25 for 238 grams (8.3 ounces) to take 17 grams in 8 ounces of liquid choice daily for a 14-day supply. -There was no self-administer order for Miralax powder. Interview with the MA on 06/30/25 at 2:01pm revealed: -She usually left the cup of water that contained the Miralax in Resident #2's room after he took his tablets. -It had not occurred to her to watch Resident #2 finish the water containing Miralax to make sure he received the full dose. -She thought Resident #2 usually drank all the water containing Miralax.	D 358		

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D 358	Continued From page 24 Interview with Resident #2 on 07/01/25 at 8:42am revealed: -He was not aware that the water he received with his morning medications contained Miralax. -He was not aware that he needed to drink the full cup of water. -He knew Miralax was for constipation. -He currently denied issues with constipation. Interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm revealed: -The MAs should always observe residents taking their medications. -The MAs were not to leave medications in a resident's room unless they had a self-administration order. Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:35pm revealed: -The MAs were never to leave medications in the residents' room. -The MAs were to always observe the residents take their medications. Interview with the Administrator on 06/30/25 at 2:32pm revealed: -The MAs should never leave medications with a resident unless they had a self-administer order. -The MAs were to always observe the residents taking their medications. -Not receiving the entire dose of Miralax could cause Resident #2 to experience constipation. Interview with Resident #2's primary care provider (PCP) on 07/02/25 at 1:36pm revealed: -Miralax powder was ordered for Resident #2 to treat constipation. -Not receiving the entire dose of Miralax could cause Resident #2 to experience constipation. -She expected the facility to follow their policy	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPIONS ASSISTED LIVING	1007 PORTERS NECK ROAD WILMINGTON, NC 28411

(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 25 regarding medication administration. b. Review of Resident #2's signed physicians order sheet dated 01/08/25 revealed an order for Sarna Sensitive lotion (Sarna lotion is used to treat dry, scaly skin) 1%, apply to dry skin on bilateral ears twice a day. Observation of the 7:00am to 9:00am medication pass on 06/30/25 revealed: -The medication aide (MA) prepared 8 tablets in a medication cup and stirred a capful of Miralax into 8 ounces of water in a disposable cup for Resident #2 at 9:12am. -The MA took the medication cup containing the 8 tablets and the 8 oz cup of water containing Miralax to Resident #2's room. -The MA administered the 8 tablets to Resident #2 with the cup that contained Miralax at 9:13am. -The MA did not prepare or apply Sarna Sensitive Lotion 1% to Resident #2. Review of Resident #2's June 2025 eMAR revealed: -There was an entry for Sarna Sensitive lotion 1%, apply to dry skin on bilateral ears twice a day scheduled at 7:00am to 9:00am and 7:00pm to 9:00pm. -Sarna Sensitive lotion 1% was documented as not administered on 06/30/25 at 7:00am to 9:00am with the exception documented as "self". Observations of Resident #2's medications on hand on 06/30/25 at 2:07pm revealed: -There was a 7.5-ounce (222 ml) pump bottle of Sarna Sensitive lotion 1% with a dispense date of 11/28/24. -The 7.5-ounce pump bottle of Sarna Sensitive lotion 1% was labeled with Resident #2's name and instructions to apply one application topically	D 358		

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D 358	Continued From page 26 to bilateral ears twice a day. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/01/25 at 3:08pm revealed: -Sarna Sensitive lotion 1% was dispensed for Resident #2 on 11/27/24 and on 07/01/25 for 222 mls to apply to both ears twice daily. -There was no self-administer order on file for Resident #2's Sarna Sensitive lotion 1%. Interview with the MA on 06/30/25 at 2:06pm revealed: -Resident #2 preferred to administer his own Sarna Sensitive lotion. -She usually pumped some Sarna Sensitive lotion in a medication cup and took to Resident #2, and he would tell her to leave it, and he would apply it himself. -She did not take Sarna to Resident #2 this morning because he probably had Sarna lotion left over from last night. -Resident #2 did not have a self-administer order for Sarna lotion and it had not occurred to her to request a self-administer order for the Sarna lotion. -She always left the Sarna lotion in Resident #2's room because he requested her to do so. Interview with Resident #2 on 07/01/25 at 8:42am revealed: -He had dry skin and used Sarna Sensitive lotion. -He had a bottle of Sarna Sensitive lotion 1% he kept in his room. -He used Sarna lotion on his face and ears a couple times per day. -He always applied his own Sarna lotion. -Staff occasionally brought Sarna lotion to him in a medication cup and left it for him to apply.	D 358		

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D 358	Continued From page 27 Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:23pm revealed: -The residents could self-administer medications only if they had an order from the primary care provider (PCP). -She did not see a self-administer order for Resident #2's Sarna lotion on the eMAR. -If Resident #2 did not have a self-administer order for the Sarna lotion, the Sarna lotion should have been administered by the MA to Resident #2. Interview with Resident #2's primary care provider (PCP) on 07/02/25 at 1:38pm revealed: -Sarna Sensitive lotion was ordered for Resident #2 for dry, scaly skin. -Resident #2 could experience dry itchy skin without the use of the Sarna cream. -She expected the facility to follow their policy regarding medication administration. Refer to interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm. Refer to interview with the Administrator on 06/30/25 at 2:34pm. c. Review of Resident #1's current FL-2 dated 03/11/25 revealed: -Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease, chest pain, repeated falls, chronic obstructive kidney disease (COPD) and metabolic encephalopathy. -She was intermittently disoriented. -There was an order for Refresh Plus Tears (Refresh Plus Tears is a lubricant eye drop used to relieve dry, irritated eyes) 0.5% dropperette, apply 2 drops to both eyes three times per day. Review of Resident #1's signed physician's order	D 358		

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D 358	Continued From page 28 sheet dated 12/31/24 revealed an order for Refresh Plus Tears 0.5% dropperette, apply 2 drops to both eyes three times per day for dry eye syndrome of unspecified lacrimal gland. Observation of the 7:00am to 9:00am medication pass on 06/30/25 revealed: -The MA prepared 9 oral medications that consisted of 10 and a half tablets and an insulin injection for Resident #1 at 8:23am. -The MA entered Resident #1's apartment and administered the insulin injection at 8:27am. -The MA administered Resident #1's oral medications at 8:31am. -The MA did not administer Refresh Plus Tears to Resident #1. Review of Resident #1's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Plus Tears dropperette, 0.5%, apply 2 drops to both eyes three times per day for dry eye syndrome scheduled at 7:00am, 12:00pm and 5:00pm. -Refresh Plus Tears was documented not administered at 7:00am on 06/30/25 with the exception documented as "self". Observation of Resident #1's medications on hand on 06/30/25 at 2:01pm revealed there were no Refresh Plus Tears available on the medication cart for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/25 at 3:08pm revealed: -The original order for Refresh Plus Tears for Resident #1 was received on 04/23/22 to use 2 drops to both eyes three times per day. -50 dropperettes of Refresh Tears Plus were	D 358		

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D 358	Continued From page 29 dispensed on 01/11/23 to use 2 drops in each eye three times per day for about a 16-day supply. -There was previously no self-administer order for Resident #1's Refresh Plus Tears. -A new order was received for Resident #1 for Refresh Plus Tears on 06/30/25 to use 2 drops in each eye three times per day, resident may keep in room and self-administer. -50 dropperettes of Refresh Plus Tears were last dispensed on 07/01/25, to use 2 drops in each eye three times per day, may keep in room and self-administer for a 16-day supply. Interview with the medication aide (MA) on 06/30/25 at 2:01pm revealed: -She did not administer Refresh Tears to Resident #1 because the resident preferred to administer her own Refresh Plus Tears. -There were no Refresh Plus Tears on the medication cart for Resident #1. -Resident #1 kept the Refresh Plus Tears in her apartment. -Resident #1 self-administered her Refresh Plus Tears for as long as she could remember. -She did not witness Resident #1 administer the Refresh Plus Tears. -She thought Resident #1 had a previous self-administer order for the Refresh Plus Tears, but she was not sure why she did not currently have a self-administer order for the Refresh Plus Tears. Interview with Resident #1 on 07/01/25 at 9:09am revealed: -She always administered her own Refresh Plus Tears. -She or her family member purchased the Refresh Plus Tears and she kept them at her bedside. -She used the Refresh Plus Tears as needed two	D 358		

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D 358	Continued From page 30 or three times per day. -She was not sure exactly how many drops she put in each eye, she just put some in. -She had recently purchased Refresh Plus Tears and had a .33-ounce (10 ml) bottle in the original box with an expiration date of January 2027 at her bedside. Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:23pm revealed: -The residents could self-administer medications if they had an order from the primary care provider (PCP). -She did not see a self-administer order for Resident #1's Refresh Plus Tears on the eMAR. -If Resident #1 did not have a self-administer order for the Refresh Plus Tears, the Refresh Plus Tears should have been administered by the MA to Resident #1. Telephone interview with Resident #1's PCP on 07/02/25 at 10:02am revealed: -She ordered Refresh Plus Tears for Resident #1 for dry eyes. -She was not aware of a request for Resident #1 to self-administer Refresh plus Tears prior to 06/30/25. -If Resident #1 did not receive the Refresh Plus Tears as ordered, she could experience dry eyes. Refer to interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm. Refer to interview with the Administrator on 06/30/25 at 2:34pm. Interview with the RCD on 06/30/25 at 2:16pm revealed: -She had just started at the facility in the RCD role about 1 and half weeks ago.	D 358		

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D 358	Continued From page 31 -She thought a resident must have an order from their primary care provider to self-administer medications, but it would depend on the residents' ability to self-administer medications. Interview with the Administrator on 06/30/25 at 2:34pm revealed: -The residents must have an order from their PCP to self-administer any medications including over the counter medications. -She thought if a resident had an order to self-administer a medication, the medication would not show up on the eMAR. -The MAs should always administer medications to the residents if they did not have a self-administer order from the PCP. 2. Review of Resident #1's current FL-2 dated 03/11/25 revealed: -Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease, chest pain, repeated falls, chronic obstructive kidney disease (COPD) and metabolic encephalopathy. -She was intermittently disoriented. -There was an order for Pyridium (Pyridium is used to relieve symptoms of urinary tract infections) 100mg, 1 tablet every 8 hours as needed for urinary pain and burning. -There was an order for Humalog (Humalog is a rapid acting insulin used to treat elevated blood sugar) Kwikpen 100units/ml per sliding scale, if fingerstick blood sugar (FSBS) is 300-399, give 4 units, if FSBS is greater than 399 give 6 units before meals twice a day. a. Review of Resident #1's signed physicians order sheet dated 12/31/24 revealed there was an order for Pyridium 100mg, take one tablet every 8 hours as needed for urinary pain and burning.	D 358		

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D 358	Continued From page 32 Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry Pyridium 100mg, take one tablet every 8 hours as needed for urinary pain and burning. -Pyridium 100mg was not documented as administered in April 2025. Review of Resident #1's May 2025 eMAR revealed: -There was an entry Pyridium 100mg, take one tablet every 8 hours as needed for urinary pain and burning. -Pyridium 100mg was not documented as administered in May 2025. Review of Resident #1's June 2025 eMAR revealed: -There was an entry Pyridium 100mg, take one tablet every 8 hours as needed for urinary pain and burning. -Pyridium 100mg was not documented as administered in June 2025. Observation of Resident #1's medications on hand on 07/01/25 at 10:43am revealed there was no supply of Pyridium 100mg tablets for Resident #1 available on the medication cart. Telephone interview with a representative with the facility's contracted pharmacy on 07/02/25 at 9:40am revealed: -An order for Resident #1's Pyridium 100mg, take 1 every 8 hours as needed for urinary pain and burning was received on 08/12/24. -Pyridium 100mg was dispensed for Resident #1 on 12/07/24 for a quantity of 30 tablets to take 1 tablets every 8 hours as needed for urinary pain	D 358		

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D 358	Continued From page 33 and burning. -Pyridium 100mg was requested by the facility for Resident #1 on 07/01/25 and was dispensed the same day for 30 tablets to take 1 tablet every 8 hours as needed for urinary pain and burning. Interview with Resident #1 on 07/01/25 at 2:56pm revealed: -Pyridium was ordered by her urologist for urinary tract infections. -She used to have frequent urinary tract infections, but her urologist added a daily antibiotic several months ago and it has helped. -She could not remember the last time she needed Pyridium. Interview with a MA on 06/30/25 at 10:23am revealed: -Scheduled medications were on cycle refill from the pharmacy. -As needed or PRN medications had to be requested. -The MAs were responsible for requesting medication refills when a resident's medication ran low. -She was not sure why there was no Pyridium on the medication cart for Resident #1. -The MAs did not perform medication cart audits. -The previous Resident Care Director (RCD) used to do monthly medication cart audits. -A pharmacist from the facility's contracted pharmacy, came to the facility periodically and performed medication cart audits. -Since the previous RCD left, she was not sure who was responsible for performing medication cart audits. Interview with a second MA on 07/01/25 at 11:02am revealed: -The facility received batch filled medications	D 358		

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D 358	Continued From page 34 from the pharmacy every 28 days. -The MAs could request refills for as needed medications electronically by hitting the "re-supply" option on the eMAR or they called the pharmacy to request refills. -MAs did not perform medication cart audits. -Medication cart audits were performed by the supervisors. Interview with the Resident Care Director (RCD) on 07/01/25 at 11:17am revealed: -She had been employed at the facility in the RCD role for just over a week. -Medications were batch filled monthly by the pharmacy and the MAs could request medications by selecting the re-supply option on the eMAR. -She was not sure when medication cart audits were done. -She was not sure who was responsible for performing medication cart audits. -It was her understanding the MAs were to make sure all medications were on the medication cart and available when the batch refills were received from the pharmacy. Interview with the Clinic Nurse (CN) on 07/02/25 at 9:32am: -Scheduled medications were cycle-filled by the facility's pharmacy every 28 days. -The MAs were responsible for re-ordering as needed medications for the residents. -The former RCD performed medication cart audits, looking for expired and discontinued medications and to make sure all the medications were available for administration. -Since the former RCD left, there was no process in place for performing medication cart audits. -She was not sure when medication cart audits had last been performed.	D 358		

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D 358	Continued From page 35 -She expected medications to be available on the medication cart for the residents. Interview with the Administrator on 07/02/25 at 10:12am revealed: -The MAs were responsible for re-ordering the residents' medications. -The MAs were responsible to make sure all medications were available on the medication cart for the residents. -Medication cart audits were performed on the sixth day of every month. -The former RCD was responsible for the monthly medication cart audits. -The former RCD was no longer employed at the facility as of last month, and she was not sure if medication carts audits were done in June 2025. -She was in the process of getting the monthly medication cart audits re-established. Telephone interview with Resident #1's primary care provider on 07/02/25 at 10:02am revealed: -Resident #1 had a history of chronic cystitis (frequent urinary tract infections). -Pyridium was used to help relieve urinary tract symptoms. -Pyridium was prescribed for Resident #1 by her urologist. -Not having Pyridium available for Resident #1 could cause her to experience urinary burning and discomfort if she had a urinary tract infection. -Pyridium should be available on the medication cart for Resident #1. Attempted telephone interview with Resident #1's urologist on 07/02/25 at 10:12am was unsuccessful. b. Review of Resident #1's signed physicians order sheet dated 12/31/24 revealed an order for	D 358		

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D 358	Continued From page 36 Humalog Kwikpen 100units/ml per sliding scale, if fingerstick blood sugar (FSBS) is 300-399, give 4 units, if FSBS is greater than 399 give 6 units before meals twice a day. Observation of Resident #1's medications on hand on 07/01/25 at 10:32am revealed: -There was one Humalog Kwikpen 100units/ml labeled with Resident #1's name and an opened date handwritten of 04/21/25, there was space for date expired but it was blank. -The one Humalog Kwikpen 100units/ml was stored on the medication cart in a blue plastic bag that contained a pharmacy label with the resident's name, and instructions to check blood sugar twice a day, sliding scale insulin (SSI) 300-399= 4 units, greater than 399= 6 units (prime pen with 2 units prior to each use-pen expires 28 days after opening) with a dispensed date of 01/25/25 and a label attached with "date opened" hand written as 04/21/25, the "date expired" was blank. -The 28th day after 4/21/25 was 5/18/25. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100units/ml, administer per sliding scale, if FSBS is 300-399, give 4 units, if FSBS is greater than 399, give 6 units, scheduled before meals at 5:00am to 7:00am and 5:00pm to 6:00pm. -Humalog Kwikpen was documented as administered on 5 occasions in April 2025. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for Humalog Kwikpen 100units/ml, administer per sliding scale, if FSBS is 300-399, give 4 units, if FSBS is greater than	D 358		

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D 358	Continued From page 37 399, give 6 units, scheduled before meals at 5:00am to 7:00am and 5:00pm to 6:00pm. -Humalog Kwikpen was documented as administered on 5 occasions in May 2025, including 05/31/25 at 5:00pm to 6:00pm, after the 28-day opened date. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Humalog Kwikpen 100units/ml, administer per sliding scale, if FSBS is 300-399, give 4 units, if FSBS is greater than 399, give 6 units, scheduled before meals at 5:00am to 7:00am and 5:00pm to 6:00pm. -Humalog Kwikpen was documented as administered on 4 occasions in June 2025, on 06/01/25 at 5:00pm to 6:00pm, 06/07/25 at 5:00pm to 6:00pm, 06/25/25 at 5:00pm to 6:00pm, and on 06/28/25 at 5:00pm to 6:00pm, after the 28-day opened date. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/25 at 3:12pm revealed: -An order was received for Humalog Kwikpen 100units/ml, administer per sliding scale, if FSBS is 300-399, inject 4 units, if FSBS is greater than 399, inject 6 units twice daily on 05/14/24 for Resident #1. -Humalog Kwikpen 300 units/3ml to administer per sliding scale, if FSBS is 300-399, inject 4 units, if FSBS is greater than 399 inject 6 units, twice daily was dispensed on 01/25/25 for Resident #1. -A request was received from the facility on 07/01/25 for a Humalog Kwikpen refill. -Humalog Kwikpens were to be disposed of 28 days after opening per the manufacturer's recommendations. -Humalog can lose efficacy after 28-days at room	D 358		

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D 358	Continued From page 38 temperature and not be as effective at controlling blood sugar. Interview with Resident #1 on 07/01/25 at 9:04am revealed: -Staff checked her FSBS twice daily. -Staff administered one insulin injection every morning and occasionally administered additional sliding scale insulin depending on what she ate. -She thought her FSBSs had been pretty good lately. Interview with a medication aide (MA) on 07/01/25 at 10:23am revealed: -She thought Humalog Kwikpens were to be disposed of either 30 or 60 days after being opened. -She was not sure why Resident #1's Humalog Kwikpen did not have an expiration date written on the label. -She had not noticed Resident #1's Humalog Kwikpen was out of date because she never had to administer sliding scale insulin to her. -The MAs did not perform medication cart audits. -The former Resident Care Director (RCD) did medication cart audits monthly, but she was no longer employed at the facility and did not know who was currently responsible for medication cart audits. Interview with a second MA on 07/01/25 at 11:07am revealed: -Some insulin pens had to be discarded 14 days after opening and some had to be discarded 30 days after opening. -It was important to read the insulin packaging for the discard date. -It was the responsibility of the MAs to document the opened date and discard date on insulin pens.	D 358		

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D 358	Continued From page 39 -The MAs did not perform medication cart audits. -The former RCD did medication cart audits monthly and a pharmacist did medication cart audits every 90 days. Interview with a third MA on 07/01/25 at 3:59pm revealed: -Insulin pens were to be discarded after 30 days. -The MAs were to document on the insulin pen the date opened and the expiration date. -She had not noticed Resident #1's Humalog Kwikpen was expired. -She thought the former RCD performed medication cart audits on a weekly basis. -The MAs did not do medication cart audits, and she was not sure who was responsible for medication carts currently. Interview with the current RCD on 07/01/25 at 11:17am: -She had been employed at the facility in the RCD role for just over a week. -Insulin pens were to be discarded 30 days after being opened. -Medication cart audits included making sure medications were on the cart and available for the residents and looking for expired medications. -She was not sure when medication cart audits were done. -She was not sure who was responsible for performing medication cart audits Interview with the Clinic Nurse (CN) on 07/02/25 at 9:32am revealed: -Resident #1's Humalog Kwikpen should have been discarded after 28 days. -The MAs were responsible to document the date opened and the expiration date on insulin. -The former RCD performed medication cart audits, looking for expired and discontinued	D 358		

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D 358	Continued From page 40 medications and to make sure all the medications were available for administration to the residents. -Since the former RCD left, there was no process in place for performing medication cart audits. -She was not sure when medication cart audits had last been performed. Interview with the Administrator on 07/02/25 at 10:12am revealed: -Insulin pens were to be disposed of depending on the type of insulin. -The MAs had a medication communication book on each medication cart that lists type of insulins and the dispose of date. -The MAs were to record the opened date and dispose of date on each insulin pen. -Resident #1's Humalog should have been disposed of after the manufacturer's recommended date. -Medication cart audits were performed on the sixth day of every month. -The former RCD was responsible for the monthly medication cart audits. -The former RCD was no longer employed at the facility as of last month, and she was not sure if medication carts audits were done in June 2025. -Resident #1's expired Humalog pen would have been caught on a medication cart audit. -She was in the process of getting the monthly medication cart audits re-established. Telephone interview with Resident #1's primary care provider (PCP) on 07/02/25 at 10:02am revealed: -Humalog was prescribed for Resident #1 for diabetes. -She was not familiar with the dispose of date for Humalog. -If Humalog was administered past the dispose of date, it was possible the insulin could have	D 358		

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D 358	Continued From page 41 decreased effectiveness leading to poorer control of Resident #1's blood sugar.	D 358		
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, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides (Staff C), observed during the 7:00am to 9:00am medication pass on 06/30/25, who did not sanitize her hands between the preparation and administration of medications to each resident to prevent the transmission of disease, infection, prevent cross-contamination, to provide a safe and sanitary environment for residents. The findings are: Review of the facility's Hand Washing/Hand Hygiene policy date 07/22/99 and reviewed 05/28/21 revealed: -Policy, these recommendations are designed to improve hand-hygiene practices and to reduce transmission of pathogenic microorganisms to residents and personnel at the community. -Procedure, employees should wash their hands	D 371	10A NCAC 13 F.1004 (n) medication administration Staff were inserviced on proper Handwashing/Hand Hygiene immediately	06/30/25 Ongoing

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D 371	Continued From page 42 based on the following guidelines. -When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with an anti-microbial soap and water, if hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical settings. -Decontaminate hands before having direct contact with patients. -Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure and lifting a patient). Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of of the resident. -Wash hands after removing gloves. Review of the facility's provided undated policy labeled "Key points for Insulin Pen injections" revealed when preparing injection, wash or sanitize hands. Observation of the medication aide (MA), Staff A, during the medication pass on 06/30/25 between 8:20am and 8:44am revealed: -There was hand sanitizer on the medication cart located on the North 1 B hall of the assisted living side. -The MA returned to the medication cart from a resident's room at 8:20am. -She did not sanitize her hands. -She reviewed a resident's electronic medication administration record (eMAR) using the computer keyboard on the medication cart. -She donned gloves. -She removed medication cards from the medication cart and prepared nine oral medications that consisted of 10 and a half tablets for a resident.	D 371		

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D 371	Continued From page 43 -She prepared an insulin pen by dialing a two-unit air shot and dialed up the prescribed units of insulin for the same resident. -She locked the medication cart. -She entered the resident's room with the medication cup and insulin pen, cleaned an area of the resident's abdominal skin with an alcohol pad and administered the insulin into the resident's abdomen, held the insulin in place for 10 seconds and removed the pen. -She removed her gloves and administered the resident's oral medications. -She returned to the medication cart and documented the resident's medications on the eMAR using the computer keypad. -She unlocked the medication cart and returned the insulin pen. -She locked the medication cart. -She did not wash or sanitize her hands. -She proceeded to the Special Care Unit (SCU). -She used the keypad by the SCU entrance to open the door to the SCU. -She unlocked the medication cart on the SCU. -There was hand sanitizer on the medication cart located in the SCU. -She placed a can liner in the small waste receptacle attached to the side of the medication cart in SCU. -She reviewed the eMAR for the next resident using the computer keyboard on the medication cart. -She retrieved a pitcher of water from the refrigerator in the common kitchen area and some paper towels and placed the water pitcher on the paper towels on the medication cart. -She unlocked the medication cart. -She prepared two oral medications for a SCU resident. -She locked the medication cart. -She took the two oral medications and a blood	D 371		

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D 371	Continued From page 44 pressure cuff to the resident in the SCU common area. -She administered the two oral medications to the resident in the SCU common area. -She then helped the same resident remove her arm from her sweater and checked the resident's blood pressure. -She returned to the medication cart with the blood pressure cuff and documented on the resident's eMAR using the computer keyboard. -She unlocked the medication cart to prepare medication for the next resident. -She did not sanitize or wash her hands. Interview with Staff C on 06/30/25 at 2:01pm revealed: -She washed her hands before starting the medication pass. -She was supposed to use hand sanitizer between each resident. -She was supposed to wash her hands after administering insulin and removing gloves. -She should have washed her hands after entering the SCU. -She usually used hand sanitizer between each resident but was nervous during the medication pass. Interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm revealed: -She had been at the facility in the RCD role for just over a week. -The MAs were to wash their hand at the start of the medication pass. -The MAs were to use hand sanitizer between each resident. Interview with the Clinic Nurse (CN) on 06/30/25 at 3:45pm revealed: -The MAs were to wash their hands at the start of	D 371		

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D 371	Continued From page 45 the medication pass and before and after using gloves. -The MAs were to use hand sanitizer between each resident contact. -She expected the MAs to wash and sanitize their hands frequently because you can never be too clean, Interview with the Administrator on 06/30/25 at 2:34pm revealed: -The MAs were expected to wash their hands at the beginning of the medication pass and between every 3rd resident or if visibly soiled and before and after using gloves. -The MAs were to use hand sanitizer between each resident. -It was important for the MAs to follow hand hygiene guidelines to prevent the spread of pathogens and germs.	D 371		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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D 375	Continued From page 46 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 7 sampled residents (#1, #2) had physicians' orders to self-administer a prescription cream used to treat vaginal dryness and itching, medications to treat dry eyes (#1) and a lotion to treat dry skin (#2). The findings are: Review of an undated medication administration policy provided by the facility revealed: -All medications, including over- the-counter non-prescription medications require a physician's order. -No medications, including over-the counter non-prescription medications, may be kept in the resident's apartment unless the physician has approved self-administration of medications. -Self-administration of medications must be approved by the facility, the responsible party, and the resident's primary physician. -Certain specific medications, such as eye drops and inhalers may be approved for self-administration even when self-administration of other medications is not approved, self-administration of these medications must be approved by the facility, the responsible party and the resident's primary physician. -Approval for self-administration may be rescinded at any time by the facility when after evaluation, the resident is deemed unable or unreliable to accurately manage his won medications or is non-compliant with physician's orders or facility medication policy and procedures. -Medications brought into the facility for which there is no physician's order will be removed from	D 375		

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D 375	Continued From page 47 the resident's apartment and given to the responsible party. Review of second medication administration policy dated 07/22/99 and revised 02/26/18 provided by the facility revealed no medication shall be administered without a physician's order. Review of the facility's Self Administration of Medication policy dated 02/10/00 revealed: -Residents who are competent and physically able to administer their own medications may do so if self-administration is authorized by the physician, approved by the Resident Care Coordinator and if specific instructions for administration are printed on the label. -When there is a change in in the resident's physical or mental ability to self-administer or the resident exhibits non-compliance with the physician's orders or the facilities policies and procedure, the facility shall notify the physician to discontinue self-administration. -Obtain order from physician. -Instruct the resident on proper use. -Medications will be kept in a locked drawer of the resident's room, both the resident and the medication nurse will possess keys to the drawer. -The medication nurse will check with the resident each shift to ensure compliance. -Document self-administration of medications on the medication administration record. -Note and document specifically any indication that the resident is not complying with prescription directions or is in any other way not appropriate for self-administration, report concerns to the Resident Care Coordinator. -A resident's right to refuse medications does not imply the inability of the resident to self-administer medications, refusals will be documented in the resident's record and the physician notified.	D 375		

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D 375	Continued From page 48 1. Review of Resident #1's current FL-2 dated 03/11/25 revealed: -Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease, chest pain, repeated falls, chronic obstructive kidney disease (COPD) and metabolic encephalopathy. -She was intermittently disoriented. -There was an order for estradiol cream (estradiol cream is used to treat vaginal dryness and itching) 0.01%, apply 1 gram vaginally once per day on Monday, Wednesday and Friday. -There was an order for Refresh Plus Tears (Refresh Plus Tears is a lubricant eye drop used to relieve dry, irritated eyes) 0.5% dropperette, apply 2 drops to both eyes three times per day. a. Review of Resident #1's signed physician's order sheet dated 12/31/24 revealed an order for estradiol cream 0.01% vaginally on Monday, Wednesday and Friday. -There was no order for self-administration of estradiol cream. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for estradiol cream 0.01%, administer 1 gram vaginally once a day on Monday, Wednesday and Friday, scheduled at 7:00pm to 9:00pm. -There was documentation that estradiol cream 0.01% was not administered on 10 of 13 occasions with the exception documented as self-administered. -There was no documentation on the eMAR of a self-administer order for Resident #1's estradiol cream. Review of Resident #1's May 2025 eMAR	D 375		

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D 375	Continued From page 49 revealed: -There was an entry for estradiol cream 0.01%, administer 1 gram vaginally once a day on Monday, Wednesday and Friday, scheduled at 7:00pm to 9:00pm. -There was documentation that estradiol cream 0.01% was not administered on 13 of 13 occasions with the exception documented as self-administered. -There was no documentation on the eMAR of a self-administer order for Resident #1's estradiol cream. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for estradiol cream 0.01%, administer 1 gram vaginally once a day on Monday, Wednesday and Friday, scheduled at 7:00pm to 9:00pm. -There was documentation that estradiol cream 0.01% was not administered on 12 of 12 occasions with the exception documented as self-administered. -There was no documentation on the eMAR of a self-administer order for Resident #1's estradiol cream. A request was made for a self-administration order for Resident #1's estradiol cream prior to 06/30/25 on 07/01/25 at 8:25am and was not provided. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/01/25 at 3:08pm revealed: -The original order date for Resident #1's estradiol cream 0.01% was 10/05/22 to use 1 gram once a day on Monday, Wednesday and Friday. -Estradiol 0.01% cream was dispensed on	D 375		

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D 375	Continued From page 50 03/24/25 to use 1 gram once a day on Monday, Wednesday and Friday, for a quantity of 42.5 grams, for about a 3 and half months supply. -A new order was received today for estradiol cream 0.01% to use 1 gram once day on Monday, Wednesday and Friday, may self-administer and keep in room. -Resident #1 did not have a self-administer order for Estradiol cream prior to 07/01/25. Observation of Resident #1's medications on hand on 07/01/25 at 10:43am revealed there was no estradiol cream on the medication cart for Resident #1. Interview with the medication aide (MA) on 07/01/25 at 10:23am revealed: -Resident #1 kept the estradiol cream in her room. -Resident #1 had always self-administered her estradiol cream. -She was not sure if Resident #1 had a self-administer order for estradiol cream. -If Resident #1 did not have a self-administer order for estradiol cream, then it should not be kept in the resident's room. Interview with a second MA on 07/01/25 at 3:59pm revealed: -Resident #1 had always self-administered her estradiol cream. -She was not sure if Resident #1 had a self-administration order for her estradiol cream. Interview with Resident #1 on 07/02/25 at 10:35am revealed: -Her urologist prescribed estradiol cream for her frequent urinary tract infections. -She was supposed to use the estradiol cream on Mondays, Wednesdays and Fridays but she used	D 375		

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D 375	Continued From page 51 it when she remembered. -She has always self-administered her estradiol cream. -When the estradiol cream ran low, she notified the medication aide to order more for her. -She kept her estradiol cream in her bathroom. Observation of Resident #1's room on 07/01/25 at 10:35am revealed: -There was tube of estradiol cream 0.01% in a clear plastic zip closure bag with a pharmacy label that contained Resident #1's name for estradiol cream 1% insert one gram into vagina once a day on Monday, Wednesday and Friday with a dispense date of 03/24/25. -The clear plastic zip closure bag that contained Resident #1's estradiol cream also had an applicator. -Resident #1's tube of estradiol cream appeared to have about 20% of product remaining in the tube. Review of a Self-Administration Assessment for Resident #1 provided on 07/01/25 revealed: -The date recorded was 06/30/25 at 7:30pm. -The creator was the facility's Clinic Nurse. -Under description, the resident may self-administer estradiol cream. -Based on answers to the assessment, it was determined that Resident #1 was appropriate to self-administer estradiol cream. -The observation date was 06/30/25 at 6:30pm. Telephone interview with Resident #1's primary care provider on 07/02/25 at 10:02am revealed: -Resident #1 had a history of chronic cystitis (frequent urinary tract infections). -Estradiol cream was prescribed for Resident #1 to help prevent urinary tract infections. -Estradiol cream was prescribed initially for	D 375		

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D 375	Continued From page 52 Resident #1 by her urologist. -The facility requested a self-administration order for Resident #1's estradiol cream on 06/30/25. -She had not given a self-administration order for Resident #1's estradiol cream prior to the facility's request on 06/30/25. -If Resident #1 did not receive the estradiol cream as ordered, she could experience vaginal dryness, irritation and be more susceptible to urinary tract infections. Refer to interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm. Refer to interview with the Administrator on 06/30/25 at 2:34pm. Refer to the second interview with the Administrator on 07/02/25 at 10:59am. b. Review of Resident #1's signed physician's order sheet dated 12/31/24 revealed an order for Refresh Plus Tears 0.5% dropperette, apply 2 drops to both eyes three times per day for dry eye syndrome of unspecified lacrimal gland. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Plus Tears dropperette, 0.5%, apply 2 drops to both eyes three times per day for dry eye syndrome scheduled at 7:00am to 9:00am, 12:00pm to 2:00pm and 5:00pm to 7:00pm. -Refresh Plus Tears was documented not administered on 80 occasion out of 90 opportunities in April 2025 with the exception documented as "self". -There was no documentation on the eMAR of a self-administer order for Resident #1's Refresh	D 375		

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D 375	Continued From page 53 Plus Tears. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for Refresh Plus Tears dropperette, 0.5%, apply 2 drops to both eyes three times per day for dry eye syndrome scheduled at 7:00am to 9:00am, 12:00pm to 2:00pm and 5:00pm to 7:00pm. -Refresh Plus Tears was documented not administered on 93 occasions with 93 opportunities in May 2025 with the exception documented as "self". -There was no documentation on the eMAR of a self-administer order for Resident #1's Refresh Plus Tears. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Refresh Plus Tears dropperette, 0.5%, apply 2 drops to both eyes three times per day for dry eye syndrome scheduled at 7:00am to 9:00am, 12:00pm to 2:00pm and 5:00pm to 7:00pm. -Refresh Plus Tears was documented not administered on 89 occasions with 89 opportunities in June 2025 from 06/01/25 to 06/30/25 at 12:00pm to 2:00pm with the exception documented as "self". -There was no documentation on the eMAR of a self-administer order for Resident #1's Refresh Plus Tears. Observation of Resident #1's medications on hand on 06/30/25 at 2:01pm revealed there were no Refresh Plus Tears available on the medication cart for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/25 at	D 375		

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D 375	Continued From page 54 3:08pm revealed: -The original order for Refresh Plus Tears for Resident #1 was received on 04/23/22 to use 2 drops to both eyes three times per day. -50 dropperettes of Refresh Tears Plus were dispensed on 01/11/23 to use 2 drops in each eye three times per day for about a 16-day supply. -There was previously no self-administer order for Resident #1's Refresh Plus Tears. -A new order was received for Resident #1 for Refresh Plus Tears on 06/30/25 to use 2 drops in each eye three times per day, resident may keep in room and self-administer. -50 dropperettes of Refresh Plus Tears were last dispensed on 07/01/25, to use 2 drops in each eye three times per day, may keep in room and self-administer for a 16-day supply. Interview with the medication aide (MA) on 06/30/25 at 2:01pm revealed: -She did not administer Refresh Tears to Resident #1 because the resident preferred to administer her own Refresh Plus Tears. -There were no Refresh Plus Tears on the medication cart for Resident #1. -Resident #1 kept the Refresh Plus Tears in her apartment. -Resident #1 self-administered her Refresh Plus Tears for as long as she could remember. -She did not witness Resident #1 administer the Refresh Plus Tears. -She thought Resident #1 had a previous self-administer order for the Refresh Plus Tears, but she was not sure why she did not currently have a self-administer order for the Refresh Plus Tears. Interview with Resident #1 on 07/01/25 at 9:09am revealed: -She always administered her own Refresh Plus	D 375		

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D 375	Continued From page 55 Tears. -She or her family member purchased the Refresh Plus Tears and she kept them at her bedside. -She used the Refresh Plus Tears as needed two or three times per day. -She was not sure exactly how many drops she put in each eye, she just put some in. -She had recently purchased Refresh Plus Tears and had a .33-ounce (10 ml) bottle in the original box with an expiration date of January 2027 at her bedside. Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:23pm revealed: -The residents could self-administer medications if they had an order from the primary care provider (PCP). -She did not see a self-administer order for Resident #1's Refresh Plus Tears on the eMAR. -If Resident #1 did not have a self-administer order for the Refresh Plus Tears, the Refresh Plus Tears should have been administered by the MA to Resident #1. Telephone interview with Resident #1's PCP on 07/02/25 at 10:02am revealed: -She ordered Refresh Plus Tears for Resident #1 for dry eyes. -She was not aware of a request for Resident #1 to self-administer Refresh plus Tears prior to 06/30/25. Refer to interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm. Refer to interview with the Administrator on 06/30/25 at 2:34pm. Refer to the second interview with the	D 375		

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D 375	Continued From page 56 Administrator on 07/02/25 at 10:59am. c. Observations of Resident #1's room on 07/01/25 at 9:59am revealed there was a manufacturer labeled box of Ivizia lubricant eye drops, inside the box was a .33-ounce bottle of Ivizia lubricant eye drops on the bedside table. Interview with Resident #1 on 07/01/25 at 10:02am revealed: -She had dry eyes and used Refresh Plus Tears and had recently purchased Ivizia eye drops and preferred the Ivizia to the Refresh Pus Tears. -She used the Ivizia drops two or three times per day for dry eyes. -She was not sure if she had mentioned to staff that she had purchased the Ivizia eye drops. Review of Resident #1's FL2 dated 03/11/25 revealed there was no order for Ivizia lubricant eye drops. Review of Resident #1's signed physician's order sheet dated 12/31/24 revealed there was no order for Ivizia lubricant eye drops. Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed there was no entry for Ivizia lubricant eye drops. Review of Resident #1's May 2025 eMAR revealed there was no entry for Ivizia lubricant eye drops. Review of Resident #1's June 2025 eMAR revealed there was no entry for Ivizia lubricant eye drops. An order for Ivizia lubricant eye drops and a	D 375		

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D 375	Continued From page 57 self-administration order for Ivizia eye drops were requested on 07/01/25 at 10:11am and not provided. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/01/25 at 3:08pm revealed: -There was no order on file for Ivizia lubricant drops for Resident #1. -Ivizia lubricant drops had not been dispensed for Resident #1. Interview with the Clinic Nurse (CN) on 07/02/25 at 9:32am revealed: -She did not see an order for Ivizia lubricant eye drops for Resident #1 on the eMAR. -If a resident or family members brought in a medication, they were to notify either her or one of the medication aides (MAs). -She was not aware Resident #1 had Ivizia eye drops and was self-administering them. Interview with the Administrator on 07/02/25 at 10:59am revealed: -All medications, even over the counter medications required a physician's order. -The residents could not self-administer medications without a self-administer order. -If the resident or their family members brought in any type of medications, prescription and over the counter, they were supposed to be given to the MAs or any of the nursing staff. -Resident #1 should not have Ivizia eye drops without a physician's order. Telephone interview with Resident #1's primary care provider (PCP) on 10:14am revealed: -She was not familiar with Ivizia lubricant eye drops. -She had not ordered Ivizia lubricant eye drops	D 375		

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D 375	Continued From page 58 for Resident #1. -She ordered Refresh Plus Tears for Resident #1 for dry eyes. -She had not been contacted by the facility for an order or self-administer order for Ivizia eye drops for Resident #1. -She had no concerns with Resident #1 using both Refresh and Ivizia eye drops. 2. Review of Resident #2's current FL-2 dated 10/30/24 revealed: -Diagnoses included abdominal aortic aneurysm, hypothyroidism, hyperlipidemia, mitral valve prolapsed, and peripheral artery disease. -He was intermittently disoriented. Review of Resident #2's signed physicians order sheet dated 01/08/25 revealed an order for Sarna Sensitive lotion (Sarna lotion is used to treat dry, scaly skin) 1%, apply to dry skin on bilateral ears twice a day. Review of Resident #2's June 2025 eMAR (electronic medication administration record) revealed: -There was an entry for Sarna Sensitive lotion 1%, apply to dry skin on bilateral ears twice a day scheduled at 7:00am to 9:00am and 7:00pm to 9:00pm. -Sarna Sensitive lotion 1% was documented as administered on 06/01/25 through 06/29/25 at 7:00am to 9:00am and at 7:00pm to 9:00pm. -Sarna Sensitive lotion 1% was documented as not administered on 06/30/25 at 7:00am to 9:00am with the exception documented as "self". -There was no documentation of a self-administer order on the eMAR for Resident #2's Sarna Sensitive lotion 1%. Observations of Resident #2's medications on	D 375		

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D 375	Continued From page 59 hand on 06/30/25 at 2:07pm revealed: -There was a 7.5-ounce (222 ml) pump bottle of Sarna Sensitive lotion 1% with a dispense date of 11/28/24. -The 7.5-ounce pump bottle of Sarna Sensitive lotion 1% was labeled with Resident #2's name and instructions to apply one application topically to bilateral ears twice a day. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/01/25 at 3:08pm revealed: -Sarna Sensitive lotion 1% was dispensed for Resident #2 on 11/27/24 and on 07/01/25 for 222 mls to apply to both ears twice daily. -There was no self-administer order on file for Resident #2's Sarna Sensitive lotion 1%. Interview with the MA on 06/30/25 at 2:06pm revealed: -Resident #2 preferred to administer his own Sarna Sensitive lotion. -She usually pumped some Sarna Sensitive lotion in a medication cup and took to Resident #2, and he would tell her to leave it, and he would apply it himself. -She did not take Sarna to Resident #2 this morning because he probably had Sarna lotion left over from last night. -Resident #2 did not have a self-administer order for Sarna lotion and it had not occurred to her to request a self-administer order for the Sarna lotion. -She always left the Sarna lotion in Resident #2's room because he requested her to do so. Interview with Resident #2 on 07/01/25 at 8:42am revealed: -He had dry skin and used Sarna Sensitive lotion. -He had a bottle of Sarna Sensitive lotion 1% he	D 375		

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D 375	Continued From page 60 kept in his room. -He used Sarna lotion on his face and ears a couple times per day. -He always applied his own Sarna lotion. -Staff occasionally brought Sarna lotion to him in a medication cup and left it for him to apply. Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:23pm revealed: -The residents could self-administer medications only if they had an order from the primary care provider (PCP). -She did not see a self-administer order for Resident #2's Sarna lotion on the eMAR. -If Resident #2 did not have a self-administer order for the Sarna lotion, the Sarna lotion should have been administered by the MA to Resident #2. Interview with Resident #2's primary care provider (PCP) on 07/02/25 at 1:38pm revealed: -Sarna Sensitive lotion was ordered for Resident #2 for dry, scaly skin. -She expected the facility to follow their policy regarding medication administration. Refer to interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm. Refer to interview with the Administrator on 06/30/25 at 2:34pm. Refer to the second interview with the Administrator on 07/02/25 at 10:59am. Interview with the Resident Care Director (RCD) on 06/30/25 at 2:16pm revealed: -She had just started at the facility in the RCD role about 1 and half weeks ago. -She thought a resident must have an order from	D 375		

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D 375	Continued From page 61 their primary care provider to self-administer medications, but it would depend on the residents' ability to self-administer medications. Interview with the facility's Clinic Nurse (CN) on 06/30/25 at 3:23pm revealed: -The residents could self-administer medications if they had an order from the primary care provider (PCP). -A self-administer assessment was performed with the resident first to see if they met the criteria for medication self-administration. -If the resident passed the self-administer assessment, then a self-administer order was requested from the resident's PCP. Interview with the Administrator on 06/30/25 at 2:34pm revealed: -The residents must have an order from their PCP to self-administer any medications including over the counter medications. -She thought if a resident had an order to self-administer a medication, the medication would not show up on the eMAR. -The MAs should always administer medications to the residents if they did not have a self-administer order from the PCP. Second interview with the Administrator on 07/02/25 at 10:59am revealed: -If a resident requested to self-administer medications, a self-administer assessment was done by the CN. -If the resident met the self-administration criteria, then a self-administration order was requested from the resident's PCP.	D 375		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 62 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of an accident/incident that required emergency medical evaluation for 1 of 11 sampled residents (#10) who sustained a fall that required transport to the local hospital by emergency medical services (EMS). The findings are: Review of the facility's Accident/Falls/Disaster and Fire Safety Policy and Procedures dated September 2021 revealed: -An accident is an unexpected, unplanned event which may or may not cause injury. An emergency is any situation which arises suddenly and calls for prompt action. -When an accident or an emergency occurs, staff should: remain calm and do not panic; remove resident from immediate danger, if possible; send for or call for help; evaluate the situation; call 911 or have some call 911 if necessary; assess the resident; if injury is apparent or possible, do not move resident; determine if resident is breathing, conscious and check for pulse; administer CPR	D 451		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 63 as appropriate (first check for DNR status); administer first aide as appropriate; continue emergency intervention until emergency medical services (EMS) arrives; staff member must remain with the resident until EMS arrives; send appropriate information with resident; call/notify the resident's physician and responsible party; and if injury, complete the Report of Accident and Incident Form. -If the accident or incident requires intervention greater than first aide, the Accident and Incident (A/I) Report Form should be sent to the local county Department of Social Services (DSS) with 48 hours. Review of Resident #10's current FL-2 dated 11/13/24 revealed: -Diagnoses included Alzheimer's disease, constipation, rash and other nonspecific skin eruptions, cough, scabies, conjunctivitis, depression, and hyperkalemia. -The resident was constantly disoriented and wandered. -The resident required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident was ambulatory. -The resident's level of care was documented as memory care. Review of Resident #10's electronic progress note dated 05/29/25 at 12:41am revealed, a personal care aide (PCA) was doing their shift change round and observed resident sitting in her chair holding her left arm/elbow crying in pain; resident was assessed by staff, range of motion (ROM) was performed; EMS also performed ROM; resident had swelling and redness on left arm/elbow; resident also had redness in her face	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065020	A. BUILDING: _____ B. WING _____	C 07/03/2025

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D 451	Continued From page 64 and dried blood on her lip and teeth; resident's power of attorney (POA) and primary care provider (PCP) were notified of the incident; and resident was sent out to hospital due to incident. Review of an electronic non fall incident report dated 05/29/25 for Resident #10, which was printed on 06/02/25 by the former Administrator revealed: -On 05/28/25 at 11:30pm, a Personal Care Aide (PCA) observed the resident sitting in a chair in her room holding her left arm and crying. -The incident was not witnessed by staff. -The resident had swelling, exhibited/complained of pain for left arm, due to left elbow injury. -There was not first aide administered to the resident. -The resident was sent out to the hospital, the power of attorney (POA), and the primary care provider (PCP) were notified. -The section for Regulatory Agency was not checked to indicate the report was faxed to DSS if treatment required more than first aide. -There was no closed date to indicate this report/event was closed. Review of Resident #10's emergency department (ED) encounter dated 05/29/25 revealed: -The chief complaint was a fall and trauma. -The resident arrived at the ED via EMS after a fall with left hematoma to left elbow, left hip pain, dried blood to nose, and potential closed head injury. -The final impression was left elbow fracture, left orbital floor fracture, closed heady injury, and mechanical fall. -The resident was discharged on 06/02/25 to a Skilled Nursing Facility (SNF). Review of the electronic non fall incident report	D 451		

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D 451	Continued From page 65 dated 05/29/25 for Resident #10, which was printed on 07/03/25 by the Resident Care Coordinator (RCC) revealed: -On 05/28/25 at 11:30pm, a PCA observed the resident sitting in a chair in her room holding her left arm and crying. -The incident was not witnessed by staff. -The resident had swelling, exhibited/complained of pain for left arm, due to left elbow injury. -There was not first aide administered to the resident. -The resident was sent out to the hospital, the POA, and the PCP were notified. -The section for Regulatory Agency was checked to indicate the report was faxed to DSS if treatment required more than first aide. -The report/event was closed by the former Administrator on 06/10/25. Interview with a Medication Aide (MA) on 07/03/25 at 8:46am revealed: -The MA's were responsible for completing the A/I Report in computer system as well as notifying the PCP, responsible party (RP), nurse supervisor, and documenting interventions. -Once the A/I Report was completed in the computer system, she assumed the nurse supervisor reviewed them. -She was not sure if A/I Reports were sent to an outside agency such as DSS, as she had sent one. -If an A/I Report had to be sent to an outside agency such as DSS she would assume the nurse supervisor would be responsible for sending the report. Interview with the Memory Care Manager (MCM) on 07/03/25 at 9:15am revealed: -The MA's were responsible for completing incident reports and notifying a supervisor (nurse)	D 451		

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D 451	Continued From page 66 of the incident. -She could review incident reports once that are completed, as well as a supervisor, the RCD, or Administrator. -Typically, the supervisor notified of the incident would be responsible for faxing the A/I Report to DSS if the resident required treatment greater than first aide and was sent out to the hospital, but could also be faxed by the RCD, MCM, or Administrator. -Incident reports were faxed to DSS via electronic fax (eFax), which provided a confirmation the fax was sent. -Anytime she faxed an incident report to DSS she would print the confirmation sheet, staple it to the A/I Report, and give it to the Administrator personally or put under the Administrator's office door. Interview with the interim Administrator on 07/03/25 at 9:23am revealed: -She started at the facility on 06/24/25 as the RCD. -The MA's were responsible for completing A/I Reports electronically, calling the family, and the PCP. -The Administrator would be responsible for faxing the A/I Report to DSS if the resident was sent out to the hospital for further evaluation. -Incident reports were faxed to DSS via eFax, which would provide a confirmation. Second interview with the interim Administrator on 07/03/25 at 11:34am revealed: -She had no explanation why the 05/29/25 A/I Report printed on 06/02/25 for Resident #10 indicated the report was not faxed to DSS, but the same 05/29/25 A/I report printed on 07/03/25 indicated the A/I Report was documented as faxed to DSS.	D 451		

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D 451	Continued From page 67 -The facility could not provide a confirmation that the 05/29/25 A/I Report for Resident #10 was faxed to DSS. -She would expect the facility to be able to provide confirmation a fax was sent successfully. Interview with the Clinic Nurse (CN) on 07/03/25 at 10:42am revealed: -The MA's usually completed A/I Reports, but they could also be completed by the CN, Supervisors, MCM, RCD, or Administrator. -Any treatment that required more than first aide and required the resident to be sent out to the hospital for evaluation should be faxed to DSS by CN, Supervisors, MCM, RCC, or Administrator. -She had no explanation why the 05/29/25 A/I Report printed on 06/02/25 for Resident #10 indicated the report was not faxed to DSS, but the same 05/29/25 A/I report printed on 07/03/25 indicated the A/I Report was documented as faxed to DSS. -The facility should be able to provide documentation of a confirmation a fax was sent. Interview with the Chief Operating Officer (COO) on 07/03/25 at 12:17pm revealed: -The MA's were responsible for notifying the supervisor of an A/I, as well as notifying the PCP and family. -She was not sure who was responsible for completing the A/I Report and sending the report to DSS. -If a resident is sent out to the hospital for evaluation, an A/I Report would need to be sent to DSS as required by policy. -She did not know who the fax system worked and was not sure about confirmations, but the facility would need to have some documentation at fax was sent successfully. -She had no explanation why the 05/29/25 A/I	D 451		

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D 451	Continued From page 68 Report printed on 06/02/25 for Resident #10 indicated the report was not faxed to DSS, but the same 05/29/25 A/I report printed on 07/03/25 indicated the A/I Report was documented as faxed to DSS, as she did not know why it was changed and who changed it. Interview with the local Department of Social Services Adult Home Specialist (AHS) on 07/03/25 at 12:40pm revealed: -The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aid. -She had not received an A/I Report related to Resident #10 being sent to hospital on 05/29/25 for further evaluation.	D 451		