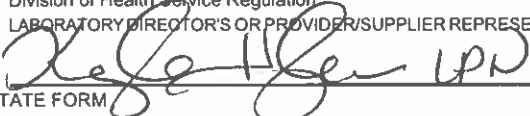


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NAME OF PROVIDER OR SUPPLIER BROOKDALE EDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 314 W KINGS HIGHWAYS EDEN, NC 27288		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 07/08/25 through 07/10/25.	D 000	D234	12/1/2025
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#1, and #3) completed a tuberculosis (TB) skin test prior to admission in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL2 dated 05/23/25 revealed diagnoses included late effects of stroke, urinary retention and nocturnal hypoxia. Review of the Resident # 1's Register an admission date of 05/29/25. Review of Resident #1's immunization records	D 234	The Health & Wellness Director/Nurse/Executive Director or designee will audit current residents for compliance with Tuberculosis Testing. To assist with ongoing compliance the Health & Wellness Director/Nurse/Executive Director or designee will review the new admission medical records weekly for six (6) weeks.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 8/14/2025

STATE FORM 6899 VQ2911 If continuation sheet 1 of 35

" Reviewed and Acknowledged " 08/14/25 *CPP*

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D 234	Continued From page 1 revealed: -There was documentation a chest x-ray for pulmonary TB was completed on 06/06/25 with documentation of no active tuberculosis. -There was no documentation that a one-step TB skin test was completed prior to admission. Interview with the Administrator on 07/10/25 at 3:10pm revealed she was not aware Resident #1 did not have a TB skin test prior to admission. Refer to the interview with the Resident Care Coordinator (RCC) on 07/10/25 at 2:45pm. Refer to the interview with the Administrator on 07/10/25 at 3:10pm. 2. Review of Resident #3's current FL2 dated 03/12/25 revealed diagnoses included failure to thrive, cognitive impairment, chronic obstructive pulmonary disease and Chron's disease. Review of the Resident # 3's Register revealed Resident #3 an admission date of 03/14/25. Review of Resident #3's immunization records revealed: -There was documentation a chest x-ray for pulmonary TB was completed on 12/01/24 with documentation of no active tuberculosis on the FL2 addendum. -There was no documentation for a positive TB test to justify using a chest X-ray instead of a one-step TB test upon admission. Review of Resident #3's record for a tuberculosis (TB) skin test revealed: -There was no documentation for a single interferon-gamma release assay (IGRA) to detect TB had been administered.	D 234			

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D 234	Continued From page 2 -There was no documentation of a first step TB skin test upon admission. -There was no documentation of a second TB skin test. Refer to the interview with the Resident Care Coordinator (RCC) on 07/10/25 at 2:45pm. . Interview with the Administrator on 07/10/25 at 2:40pm revealed Resident #3 had no documentation for a positive TB test to justify the using a chest X-ray instead of a one-step TB test upon admission. Attempted interview with Resident #3 on 07/10/25 at 3:00pm was unsuccessful. Refer to the interview with the Administrator on 07/10/25 at 3:10pm. _____ Interview with the Resident Care Coordinator (RCC) on 07/10/25 at 2:45pm revealed: -She was new to the position of RCC in the facility. -She was a lead medication aide (MA) until she was moved into the RCC position three weeks ago. -The RCC was not responsible for ensuring TB testing requirements were completed for new admissions. -She thought the HWD or Administrator was responsible for TB testing requirements. Interview with the Administrator on 07/10/25 at 3:10pm revealed: -She was the Health and Wellness Director (HWD) and the Administrator for several weeks. -She was aware all residents should have a TB skin test prior to admission and a second TB skin	D 234			

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D 234	Continued From page 3 test within one year of admission. -She was not aware you could not use an x-ray in place of a TB skin test unless the resident had a previous positive TB screening. -It was the responsibility of Sales and Marketing to ensure all residents were screened for TB prior to admission. -It was the responsibility of the HWD and Administer to confirm a resident had a TB skin test 48 hours prior to admission. -She expected all residents to have a TB skin test completed upon their admission.	D 234			
D 272	10A NCAC 13F .0902(a) Health Care 10a NCAC 13F .0902 Health Care (a) An adult care home shall provide care and services in accordance with the resident's care plan. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure health care referral and follow-up was completed for 1 of 5 sampled residents (#2) related to not following up with the primary care provider (PCP) when systolic blood pressure (SBP) elevated. The findings are: Review of Resident #2's current FL2 dated 02/07/25 revealed diagnoses included unspecified dementia, cerebrovascular disease, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, atrial fibrillation,	D 272	D272 The Health & Wellness Director/Nurse/Executive Director or designee will conduct retraining for direct care associates on referral and follow up of physician's orders. The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on current resident records to verify that physician order compliance. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will provide weekly monitoring of physician orders for three (3) months.	12/1/2025	

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D 272	Continued From page 4 depression and gastro-esophageal reflux disease. Review of Resident #2's primary care provider's (PCP) order dated 05/02/25 revealed an order to check blood pressure (BP) every shift every Monday, Wednesday and Friday. Interview with Resident #2 on 07/08/25 at 9:15am revealed: -She was concerned about her elevated blood pressure. -Her systolic numbers had been over 200 for the past month and she was concerned this could cause her to have a stroke. -She spoke with the medication aid (MA) who took her BP yesterday, 07/07/25, about her concern that the systolic number was over 200. -She would like someone to talk to her about what the plan is to address her elevated BP. -She had not felt dizzy or had any headaches. Review of Resident #2's May 2025 electronic medication administration (eMAR) record revealed: - There was an entry to check BP every Monday, Wednesday and Friday. -Resident #2's blood pressure was 182/87 on 05/02/25, 180/84 on 05/07/25, 194/74 on 05/23/25 and 220/76 on 05/28/25. Review of Resident #2's June 2025 (eMAR) record revealed: - There was an entry to check BP every Monday, Wednesday and Friday. -Resident #2's blood pressure was 209/78 on 06/20/25, 209/84 on 06/25/25 and 181/78 on 06/27/25. Review of Resident #2's July 2025 (eMAR) record	D 272			

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D 272	Continued From page 5 revealed: - There was an entry to check BP every Monday, Wednesday and Friday. -Resident #2's blood pressure was 206/92 on 07/02/25 and 204/88 on 07/07/25. Attempted telephone interview with Resident # 2's primary care provider (PCP) on 07/08/25 at 3:40pm was unsuccessful. Interview with a medication aide (MA) on 07/08/25 at 4:00pm revealed: -He took Resident # 2's BP today and it was 172/56. -If a resident's SBP was over 180, he would notify the Health and Wellness Director (HWD) or the Resident Care Coordinator (RCC) and fax a note to the PCP. Interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:30pm revealed: -She was not aware of Resident # 2's elevated BP. -She would expect the MA to notify her or the HWD and call the PCP. -If a resident's SBP was over 180, she would recheck it in 30 minutes and if it was still elevated, she would call emergency medical services (EMS) and send the resident to the hospital. Interview with a second MA on 07/09/25 at 8:30am revealed: -She was aware Resident #2's SBP had been over 200 a few times last month. -She wrote a note in the eMAR and notified the HWD. -She did not know if the HWD every called EMS for the resident when her SBP was over 180.	D 272			

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D 272	Continued From page 6 Review of the facility progress notes for Resident #2 on 07/09/25 at 9:30am revealed there was no documentation that resident's PCP was notified about the elevated SBPs during the month of May, June or July. Interview with the Administrator on 07/09/25 at 11:00am revealed: -She was aware Resident #2 had elevated SBP readings during the past two months. -She had notified Residents # 2's PCP about the elevated BP in March and he ordered her on Metoprolol 12.5mg three times daily. -She had no documentation that she notified the PCP after the month of March. -She called the provider today about Resident #2's elevated BP and requested a return call. -She was aware SBP over 200 required immediate attention. -She had never called EMS for the resident when her SBP was over 200. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/08/25 at 3:40pm and 07/09/25 at 4:00pm was unsuccessful.	D 272			
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358	D358 The Health & Wellness Director/Nurse/Executive Director or designee will re-train medication aids on the 7 Rights of Medication Administration. The HWD or designee will conduct an eMAR to medication cart audit to verify that physician orders and eMAR match. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review the New Order Tracking forms to verify accuracy and transcription of physician orders twice weekly for six (6) weeks.	12/1/2025	

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D 358	Continued From page 7 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 residents (#5, #6, and #7) observed during the medication passes on 07/09/25 at 8:00am and 11:30am including errors with a medication to treat elevated blood pressure (#5), medications for fluid retention and constipation (#6) and insulin to treat elevated blood sugar (#7). The findings are: The medication error rate was 13% as evidenced by 4 errors out of 30 opportunities during the 8:00am and 11:30am medication passes on 07/09/25. 1. Review of Resident #7's current FL2 dated 11/15/24 revealed: -Diagnoses included type 2 diabetes mellitus (DM), and hypertension. -There was an order for Novolog 100units/ml inject 25 units subcutaneously (SQ) before meals. (Novolog is a rapid acting insulin used to treat elevated blood sugar). Review of Resident #7's physician's order dated 05/25/25 revealed: -There was an order to check fingerstick blood sugar (FSBS) before meals and hold insulin if the FSBS value is less than 60. -There was an order for Novolog FlexPen injector 100units/ml inject 20 units SQ with meals for diabetes mellitus. Review of the manufacturer's instructions	D 358	D358 The HWD/ED/RCC or designee will conduct weekly Medication Cart audits to verify all medications are available and in the community. To assist with ongoing compliance, the HWD or designee will conduct audits of the Medication Carts 1 continue weekly for four (4) weeks, then every two (2) weeks for four (4) weeks. The HWD or designee will retrain medication aides on insulin administration.	7/31/2025	

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D 358	Continued From page 8 revealed Novolog FlexPen was a prefilled insulin pen with a calibrated measuring system for dialing the desired number of insulin units to be administered. A needle cap was screwed onto the pen for administering the SQ injection, According to the manufacturer, after the needle cap was attached to the FlexPen, the needle cap is primed by injecting 2 units of Novolog insulin into the newly applied needle and injecting the 2 units of insulin into the air. After the needle cap was primed, the desired amount of insulin to be administered was dialed on the FlexPen and administered SQ to the resident. Observation of the 11:30am medication pass on 07/09/25 revealed: -The medication aide (MA) checked Resident #7's FSBS value. The FSBS was 198. -At 11:35am, the MA removed a Novolog FlexPen 100units/ml from Resident #7's pouch used to store the resident's FSBS supplies, screwed a needle cap onto the FlexPen, dialed 20 units of insulin on the FlexPen's calibrated measuring system and injected SQ into the resident's right lower abdomen. -The MA did not prime the needle cap with 2 units of insulin per the manufacturer's instructions. Review of Resident #7's July 2025 electronic medication administration record (eMAR) from 07/1/25 to 07/09/25 revealed: -There was an entry for Novolog FlexPen SQ pen injector 100units/ml inject 20 units SQ with meals for DM, scheduled for administration at 8:00am, 12:00pm, and 4:00pm daily. (The entry did not include instruction to reload the needle with 2 units of insulin. -There was documentation 20 units of Novolog insulin was administered on 07/09/25 at 12:00pm. -FSBS value ranged from 133 to 369 from	D 358		

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D 358	Continued From page 9 07/01/25 to 07/09/25. Interview with the MA on 07/09/25 at 12:30pm revealed: -She had been a MA for about one year. -She received her MA orientation at a sister facility. -She had not been trained to prime the needle cap prior to administering insulin from the Novolog FlexPen. -She did not routinely prime residents' FlexPen insulin pens prior to administering insulin. -She just applied the needle cap and dialed the indicated amount of insulin on the FlexPen. -She did not know about the manufacturer's instructions to prime the needle cap prior to administering the prescribed dose of insulin. Interview with Resident #7 on 07/09/25 at 4:30pm revealed: -He had been a diabetic for many years. -Staff administered his insulin routinely before meals. -He had not observed if the MAs primed the insulin needle cap each time prior to administering his insulin. -He denied any current issues with high or low blood sugar like sweating, weakness, blurred vision or shakiness. Interview with the Administrator on 07/09/25 at 4:35pm revealed: -She was the facility's Nurse and currently the Administrator. -She did not know the needle caps used on FlexPens were supposed to be primed prior to dialing the ordered insulin dose. -She did not know Resident #7's Novolog FlexPen was administered incorrectly.	D 358			

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D 358	Continued From page 10 Telephone interview with Resident #7's primary care provider (PCP) nurse on 07/10/25 at 10:24am revealed: -The facility should be administering Resident #7's Novolog insulin according to the manufacturer's instructions to ensure the proper amount of insulin ordered for Resident #7 was administered. -It was important the medication aides administered the insulin as ordered for the PCP to monitor FSBS values and adjust insulin doses for controlling blood sugar. -Uncontrolled diabetes could lead to damage to the kidneys, eyes, and circulation problems. 2. Review of Resident #6's current FL2 dated 07/02/24 revealed diagnoses included essential hypertension and acute kidney failure. a. Review of Resident #6's physician's orders revealed: -There was an order dated 05/09/25 for furosemide 20mg one tablet daily for edema. (Furosemide is used to treat excess fluid up.) -There was an order dated 05/28/25 for furosemide 20mg daily. Observation of the 8:00am medication pass on 07/09/25 at 9:00am revealed: -The medication aide (MA) prepared 5 oral medications, one eye drop, and a powder to reconstitute before administration, for Resident #6. -The MA identified Resident #6 had no furosemide 20mg in the medication cart for administration to the resident. -The MA checked the screen for the facility's electronic medication administration record (eMAR) for reorder status of furosemide 20mg. -The MA gathered Resident #6's medications and	D 358		

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D 358	Continued From page 11 proceeded to the MA room used to store overstock medications to look for Resident #6's furosemide. -At 9:08am, the MA administered Resident #6's medications in the resident's room, excluding furosemide 20mg. Review of Resident #6's July 2025 eMAR from 07/01/25 to 07/09/25 revealed: -There was an entry for furosemide 20mg one tablet daily for edema scheduled for administration at 8:00am daily. -Furosemide 20mg was documented as not administered at 8:00am on 07/01/25, 07/03/25, and from 07/05/25 to 07/09/25 with medication not available or see medication note. -There were no additional medication notes available for review for the see medication note documentation. Observation of Resident #6's medication on hand for administration on 07/09/25 at 9:00am revealed there was no furosemide 20mg for Resident #6 available for administration on the medication cart. Interview with the MA on 07/09/25 at 9:00am revealed: -Resident #6's furosemide 20mg was showing reordered from the facility's contracted pharmacy using the facility's eMAR reorder system on 07/01/25. -There was no 20mg furosemide on the medication cart or in the resident's overstock in the MA room. Second interview with the MA on 07/09/25 at 12:30pm revealed: -The MA was responsible for contacting the contracted pharmacy if medication was not	D 358			

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D 358	Continued From page 12 available for administration to see why the medication was not delivered. -The Health and Wellness Director (HWD) was responsible for monitoring the eMARs for medications not administered and assisting MAs with ensuring medications were available for administration. -Medications were reordered when the supply on hand was 7 days remaining for administration. -The eMAR computer reorder system transmitted directly to the contracted pharmacy for ordering. -Medications should be delivered to the facility the next day, in the late evening. -The night shift MA was responsible for stocking the medication carts with medications from the contracted pharmacy on the night the medications arrive. -The pharmacy was supposed to send a list of medications not provided as ordered along with an explanation for why a medication was not delivered as reordered. -She could not locate an explanation why Resident #6's furosemide 20mg was unavailable for administration. -The Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/25 at 3:30pm revealed: -On 05/07/25, the pharmacy dispensed Resident #6's furosemide 20mg for a quantity of 15 tablets labeled one tablet daily. -On 05/28/25, the pharmacy dispensed Resident #6's furosemide 20mg for a quantity of 30 tablets labeled one tablet daily, as needed (PRN). -The pharmacy was using an order dated 05/28/25 received electronically from a hospital provider with directions one tablet daily as needed (PRN). -There were no subsequent refills of furosemide	D 358			

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NAME OF PROVIDER OR SUPPLIER BROOKDALE EDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 314 W KINGS HIGHWAYS EDEN, NC 27288		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 13 20mg for Resident #6 documented at the pharmacy. -The pharmacy received a second order dated 05/28/25 for furosemide 20mg take one daily from the Resident #6's primary care provider (PCP) but added the order to the resident's medication profile and did not fill the order. -The pharmacy staff should have used the more current order for furosemide 20mg daily on 05/28/25 or at least contacted the PCP for directions for administration. -The pharmacy did not cycle fill medications ordered as needed, only medications for scheduled administration. -The pharmacy did not have documentation for the facility's request for a refill of Resident #6's furosemide 20mg through the facility's eMAR system. Observation of Resident #6 on 07/10/25 at 1:00pm revealed: -Resident #6 was wearing loose-fitting slip-on shoes. -Resident #6 had some swelling around her ankles and on the top of her feet (1 plus pitting edema). Interview with Resident #6 on 07/10/25 at 1:00pm revealed: -She took a fluid pill to help with swelling in her feet. -She did not know if she was administered the fluid pill every day. -She elevated her feet when she remembered to do so. -She never had a lot of swelling in her feet, sometimes just a bit puffy. Telephone interview with Resident #6's primary care provider (PCP) on 07/10/25 at 1:15pm	D 358			

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D 358	Continued From page 14 revealed: -Resident #6 was ordered furosemide 20mg daily for swelling in her feet on 01/13/25 originally. -Resident #6 continued to have swelling in her feet and ankles when she saw her on subsequent visits to the facility. -She remembered Resident #6 had a hospital visit and there was a change of furosemide to as needed but she reordered Resident #6 to be on furosemide 20mg daily on 05/28/25. -The facility should be administering her furosemide 20mg daily. -She did not know Resident #6's furosemide 20mg daily was not administered 7 of 9 days in July 2025. -She would see Resident #6 on her next visit scheduled for 07/11/25 to assess her swelling. Interview with the Resident Care Coordinator (RCC) on 07/10/25 at 2:30pm revealed: -She was an MA and recently became the RCC (about 3 to 4 weeks ago). -She was working as an MA most of the time while in the facility because the facility was interviewing to replace her MA position. -She was trying to work one day a week in the RCC duties. -MAs were supposed to order medications before a resident ran out of medications. -Medications were ordered through the facility's eMAR system. -If medications were not available for administration, the MA notified the RCC or the Health and Wellness Director (HWD), which was the facility's nurse, for assistance with the medication reorder. -The RCC was responsible to audit eMARs for missed medication administration daily but she had not been able to do eMAR audits because was she still filling the MA position.	D 358			

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D 358	Continued From page 15 -She was not aware Resident #6 had no furosemide 20mg for administration. Interview with the Administrator on 07/10/25 at 3:00pm revealed: -She was the Administrator in Training until today (07/10/25) when she received her Administrator's approval letter. -She also was the HWD, which was the facility nurse's title, for the facility until her replacement came in August 2025. -MAs should reorder medications before they ran out using the facility's eMAR system or contacting the pharmacy provider for residents not using the contracted pharmacy for medication. -If a resident was out of medications because the resident's pharmacy was not sending the medication, the MA should notify the RCC or the HWD for assistance with ensuring residents had medications as ordered. -She had not been notified there was no furosemide 20mg for administration to Resident #6. b. Review of Resident #6's FL2 dated 07/02/24 revealed there was an order for Senna-Plus 8.6-50mg one time a day (Senna-Plus 8.6-50mg is a combination stool softener and laxative used to treat constipation.) Review of Resident #6's physician's orders dated 04/18/25 revealed an order for Senna-Plus 8.6-50mg take 2 tablets 2 times a day (May hold for loose stools). Review of Resident #6's signed physician's orders dated 05/09/25 revealed an order for Senna-Plus 8.6-50mg take 2 tablets 2 times a day for constipation.	D 358			

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D 358	Continued From page 16 Observation of the 8:00am medication pass on 07/09/25 at 9:00am revealed: -The medication aide (MA) prepared 5 oral medications, one eye drop, and a powder to reconstitute before administration, for Resident #6. -The MA identified Resident #6 had no Senna-Plus 8.6-50mg on the medication cart for administration to the resident. -The MA checked the screen for the facility's electronic medication administration record (eMAR) for reorder status of Senna-Plus 8.6-50mg. -The MA gathered Resident #6's medications and proceeded to the MA room used to store overstock medications to look for Resident #6's furosemide. -At 9:08am, the MA administered Resident #6's medications in the resident's room, excluding Senna-Plus 8.6-50mg. Review of Resident #6's July 2025 eMAR from 07/01/25 to 07/09/25 revealed: -There was an entry for Senna-Plus 8.6-50mg take 2 tablets 2 times a day for constipation scheduled for administration at 8:00am and 8:00pm daily. - Senna-Plus 8.6-50mg was documented as not administered at 8:00am on 07/09/25 with see medication note for reason not administered. -There were no additional medication notes available for review for the see medication note documentation. Observation of Resident #6's medication on hand for administration on 07/09/25 at 9:00am revealed there was no Senna-Plus 8.6-50mg for Resident #6 available for administration on the medication cart.	D 358			

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D 358	Continued From page 17 Interview with the MA on 07/09/25 at 9:00am revealed: -Resident #6's Senna-Plus 8.6-50mg was showing reordered from the facility's contracted pharmacy using the facility's eMAR reorder system on 07/08/25. -There was no Senna-Plus 8.6-50mg on the medication cart or in the resident's overstock in the MA room. -She documented Senna-Plus 8.6-50mg was not administered per the facility's policy. -The Senna-Plus 8.6-50mg should have been in the contracted pharmacy order received last night and put on the medication cart by the night shift MA. -She was not able to reorder Senna-Plus 8.6-50mg via the facility's reorder was through the eMAR computer system and because the system showed the medication was already on order. Interview with Resident #6 on 07/09/25 at 9:05am revealed: -She took a lot of medications and did not know the name of all her medications. -She had a problem with constipation and took medications for regulating her constipation. Second interview with the MA on 07/09/25 at 12:30pm revealed: -The pharmacy was supposed to send a list of medications not provided as ordered along with an explanation for why a medication was not delivered as reordered. -She could not locate an explanation why Resident #6's Senna-Plus 8.6-50mg was not delivered. Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/25 at 3:30pm revealed:	D 358			

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D 358	Continued From page 18 -The pharmacy did not generate residents' eMARs. -The facility used their own order entry system to generate eMARs. -The contracted pharmacy generated a medication profile for each resident and used the pharmacy profile to dispense medications. -The contracted pharmacy staff could not access the residents' eMARs for updating residents' drug orders. -The facility was responsible to notify the pharmacy for discrepancies or changes related to residents' medications. -The pharmacy was using the order dated 05/07/25 with directions one tablet daily to dispense Resident #6's Senna-Plus 8.6-50mg. -On 06/02/25 and 06/24/25, the pharmacy dispensed Resident #6's Senna-Plus 8.6-50mg for a quantity of 28 tablets labeled on tablet daily. -There were no subsequent refills of Senna-Plus 8.6-50mg for Resident #6 documented at the pharmacy. -The pharmacy did not send Senna-Plus 8.6-50mg on 07/08/25 because it was too early to refill the medication based on the order dated 05/07/25 for one tablet daily. -The pharmacy received Resident #6's signed physician's orders dated 05/09/25 for Senna-Plus 8.6-50mg 2 tablets 2 times a day but had the order on file at the pharmacy and she could not explain why the pharmacy did not change the order in the pharmacy computer entry system. Telephone interview with Resident #6's primary care provider (PCP) on 07/10/25 at 1:15pm revealed: -Resident #6 was ordered Senna-Plus 8.6-50mg for her chronic constipation. -Resident #6 was taking a pain medication that added to the constipation due to the pain	D 358		

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D 358	Continued From page 19 medication slowing down lower intestine movement. -Resident #6 would be at risk for impaction if her constipation was not controlled. Interview with the Resident Care Coordinator (RCC) on 07/10/25 at 2:30pm revealed: -She was an MA and recently became the RCC (about 3 to 4 weeks ago). -She was working as an MA most of the time while in the facility because the facility was interviewing to replace her MA position. -She was trying to work one day a week in the RCC duties. -MAs were supposed to order medications before a resident ran out of medications. -Medications were ordered through the facility's eMAR system. -If medications were not available for administration, the MA notified the RCC or the Health and Wellness Director (HWD), which was the nurse, for assistance with the medication reorder. -The RCC was responsible for auditing eMARs for missed medication administration daily, but she had not been able to do eMAR audits because she still filling the MA position. -She was not aware Resident #6 had no Senna-Plus 8.6-50mg for administration. Interview with the Administrator on 07/10/25 at 3:00pm revealed: -She was the Administrator in Training until today (07/10/25) when she received her Administrator's approval letter. -She also was the HWD (the HWD was the facility nurse) for the facility until her replacement came in August 2025. -MAs should reorder medications before they ran out using the facility's eMAR system or contacting	D 358			

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D 358	Continued From page 20 the pharmacy provider for residents not using the contracted pharmacy for medication. -If a resident was out of medications because the resident's pharmacy was not sending the medication, the MA should notify the RCC or the HWD for assistance with ensuring residents had medications as ordered. -She had not been notified there was no Senna-Plus 8.6-50mg for administration to Resident #6. 3. Review of Resident #5's current FL2 dated 3/24/25 revealed: -Diagnoses included muscle weakness, atrial fibrillation, and hypertension. -There was an order for metoprolol tartrate 25mg twice a day. (Metoprolol tartrate is used to lower blood pressure and slow heart rate. Observation of the 8:00am medication pass on 07/09/25 at 7:50am revealed: -The medication aide (MA) consulted the electronic medication administration record (eMAR) as she prepared 4 oral medications in a plastic souffle cup for Resident #5. -The MA pulled the medications packed in bingo cards from the medication cart and held the card up to the eMAR screen. -There was one medication, available for purchase over-the-counter, packaged in the over the counter bottle. -There were 4 tablets corresponding to 4 tablets observed in the soufflé cup. -There was no metoprolol tartrate 25mg in the soufflé administered with Resident #5's medications. -At 7:58am, the MA administered Resident #5's medications in the hallway as the resident was being pushed to the dining room for breakfast.	D 358			

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D 358	Continued From page 21 Review of Resident #5's July 2025 eMAR from 07/01/25 to 07/09/25 revealed: -There was an entry for metoprolol tartrate 25mg two times a day, scheduled for administration at 8:00am and 8:00pm daily. -Metoprolol tartrate 25mg was documented as administered on 07/09/25 at 8:00am. Observation of Resident #5's medication on hand for administration on 07/09/25 at 11:00am revealed there were 26 tablets remaining of 30 tablets dispensed on 07/01/25 in a bingo card labeled one tablet twice a day. Interview with the MA on 07/09/25 at 11:00am revealed: -She routinely compared the medications removed from the medication cart to the eMAR as she pulled the medications. -She punched the tablets from the bingo card or counted from the stock bottle as she prepared medications for administration. -She thought she administered Resident #5's metoprolol 25mg because it was checked off on the eMAR screen as administered. -If she did not administer metoprolol tartrate 25mg to Resident #5 with his other medications at 7:58am, it was an oversight. Interview with Resident #5 on 07/10/25 at 9:00am revealed: -Staff administer his medications routinely. -He did not count his medications but felt like they always gave him all his medications. -He felt no different yesterday than today. Review of Resident #5's blood pressure values revealed the facility documented a blood pressure value of 127/64 and pulse rate 70 beats per minute on 07/10/24 at 9:05am.	D 358			

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D 358	Continued From page 22 Telephone interview with Resident #5's primary care provider (PCP) on 07/10/25 at 12:10pm revealed: -Resident #5 should be receiving metoprolol tartrate 25mg as ordered 2 times a day for his blood pressure control. -Missing medications for blood pressure control could cause residents to experience light-headedness or balance interference. Interview with the Administrator on 07/10/25 at 3:00pm revealed: -She was the Administrator in Training until today (07/10/25) when she received her Administrator's approval letter. -She also was the nurse (Health and Wellness Director) for the facility until her replacement came in August 2025. -MAs should read the residents' eMARs completely and administer all medications as ordered. The facility failed to ensure medications were administered as ordered for 3 of 4 residents observed during medication administration on 07/09/25 related to one diabetic resident with an order for 20 units of Novolog to be administered with meals receiving less than 20 units due to the MA not priming the insulin needle cap prior to measuring the insulin dose causing the resident to receive less insulin than ordered (#7) placing the resident at risk for elevated blood sugars and increased risk for kidney, eyes, or circulatory side effects from unmanaged control of diabetes; another resident with swelling ankle did not receive her furosemide 20mg for more than one week placing the resident at risk for increased swelling (#6) and a resident with hypertension did not receiving metoprolol 25mg placing the	D 358		

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D 358	Continued From page 23 resident at risk for elevated blood pressure which could affect balance and increase fall risk (#5). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 24, 2025.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 1 sampled resident (#8) take his medications related a resident observed ambulating in a hallway with a rolling walker, and had loose medications on the seat of the rolling walker, during medication administration on 07/09/25 at 8:58am.	D 366	D366 The Health & Wellness Director/Nurse/Executive Director or designee will conduct med pass audits with each medication aide to verify compliance. The HWD or designee will retrain medication aides on the correct protocols for medication administration.	12/1/25

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D 366	Continued From page 24 The findings are: Review of the facility's medication services policy revealed the MAs should document all administered medications on the electronic medication administration record (eMAR). Review of Resident #8's current FL2 dated 05/01/25 revealed: -Diagnoses included moderate Alzheimer's dementia, weakness of both lower extremities, physical deconditioning, and chronic kidney disease level 3. -The resident was intermittently disoriented and semi-ambulatory. Observation during the 8:00am medication pass on 07/09/25 revealed: -At 8:50am, the medication aide (MA) being observed for on the front hall of the facility for medication administration. -At 8:55am, the MA proceeded to the medication room, followed by the surveyor, to search for an overstock medication in the medication cart storage room. -At 8:57am, resident #8 was observed ambulating out of a resident room into the back hallway of the facility with a walker. -He was holding a plastic cup in his left hand as he rolled down the hall. -The seat of his rolling walker had loose medications lying in the center. -It could not be determined the exact number or description of the medications on the seat of the rolling walker, but there were at least 4 medications. -Resident #8 was escorted to his room by the MA. -The MA told the resident to "stay right there"	D 366			

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D 366	Continued From page 25 while she got him some water. -She prepared a cup of water from the medication cart located close to the resident's room and returned to Resident #8's room. -The resident reached down to the seat of the walker, scooped all the loose medication into his hand, placed the medication in his mouth followed by a swallow of the water provided by the MA. -The MA assigned to the medication cart on resident #8's hall was not visible prior from 8:55am to 9:00am. Review of Resident #8's current FL2 dated 05/01/25 revealed medication orders included: -Acetaminophen 500mg (used to treat pain and fever) 2 tablets three times a day. -Aspirin (used to help circulation) enteric coated 81mg daily. -Vitamin D 1000 international units (a vitamin supplement) one in the morning and at bedtime. -Vitamin B-12 500mcg (a vitamin supplement) one in the morning and one at bedtime. -Colace 100mg (used to treat constipation) one daily as needed up to 30 doses. -Fish oil-omega 3 fatty acids 1000mg (used to lower cholesterol and triglycerides) twice a day. -Flonase 50mcg/spray (used to treat allergies) one spray into both nostrils twice a day as needed for allergies/rhinitis. -Ifexex 150-150 (used to treat iron deficiency) twice a day. -Pregabalin 100mg (used to treat nerve pain) three times a day. -Atorvastatin 80mg (used to treat high cholesterol) one-half tablet daily. -Donepezil 10mg (used to treat dementia) one at bedtime. -Memantine 10mg (used to treat dementia) twice a day.	D 366		

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D 366	Continued From page 26 -Sertraline 50mg (used to treat depression and anxiety) daily. Review of the primary care provider's (PCP's) medication orders dated 06/20/25 revealed orders including: -Acetaminophen 500mg take 2 tablets three times a day. -Aspirin enteric coated 81mg take daily. -Vitamin D 1000 international units take one in the morning and at bedtime. -Vitamin B-12 500mcg take one in the morning and one at bedtime. -Colace 100mg take one daily as needed up to 30 doses. -Fish oil-omega 3 fatty acids 1000mg take twice a day. -Flonase 50mcg/spray use one spray into both nostrils twice a day as needed for allergies/rhinitis. -Iferex 150-150mg take twice a day. -Pregabalin 100mg take three times a day. -Atorvastatin 80mg take one-half tablet daily. -Donepezil 10mg take one at bedtime. -Memantine 10mg take twice a day. -Sertraline 50mg take daily. Review of Resident #8's July 2025 eMAR from 07/01/25 to 07/09/25 revealed: -There was an entry for acetaminophen 500mg take 2 tablets three times a day, scheduled for administration at 8:00am, 1:00pm and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for aspirin enteric coated 81mg once a day, scheduled for administration at 8:00am daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for Colace 100mg twice a day, scheduled for administration at 8:00am and	D 366		

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D 366	Continued From page 27 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for fish oil-omega 3 fatty acids 1000mg twice a day, scheduled for administration at 8:00am and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for Ifereex 150-150mg twice a day, scheduled for administration at 8:00am and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for memantine 10mg twice a day, scheduled for administration at 8:00am and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for vitamin B-12 500mcg twice a day, scheduled for administration at 8:00am and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for vitamin D 1000 international units twice a day, scheduled for administration at 8:00am and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. -There was an entry for pregabalin 100mg three times a day, scheduled for administration at 8:00am, 1:00pm and 7:00pm daily, and documented as administered at 8:00am on 07/09/25. Interview with the MA on 07/09/25 at 9:00am revealed: -MAs were supposed to watch residents take medications prior to leaving the resident when administering medications. -She did not know why Resident #8 had medications on the seat of his rolling walker. -Resident #8 was fairly new to the facility. Interview a second MA on 07/09/25 at 10:56am	D 366		

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D 366	Continued From page 28 revealed: -She was the MA assigned to administer Resident #8's medications on 07/09/25. -Resident #8 was sitting on his bed when she gave him his morning medications. -She observed Resident #8 place his medications in his mouth. -After she administered morning medications to Resident #8, she heard a gulp sound from Resident #8. -Resident #8 drank all the water given to him with his medications. -She then proceeded to administer medications the next resident. -She did not check Resident #8's mouth before she exited his room. -Resident #8 may have spit out the medications as he had a tendency to hold the medications in his cheek. -Resident #8 was not the type of resident where medication could be left in his room. -Medication had been found on Resident #8's room floor in the past. -She had not alerted Resident #8's primary care provider (PCP) about her concerns but would do so. -She would get an order from his PCP to crush his medication in apple sauce. Interview with Resident #8's PCP on 07/10/25 at 1:15pm revealed: -Resident #8 was a new admission to the facility. -She had seen Resident #8 with routine facility visits at least one time. -She had not been informed Resident #8 was "cheeking" or holding medications in his mouth without swallowing. -If she had been made aware medications not being taken, she would have written an order to check the resident's mouth after each medication	D 366		

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D 366	Continued From page 29 administration. -She had written orders to crush medications that could be crushed and put them in applesauce for residents that were having trouble swallowing medications or "cheeking" medications. -Medications should not be left in residents' room for the resident to take later if that was the case for this resident. Interview with the Administrator on 07/10/25 at 3:00pm revealed: -She had completed her Administrator training and was waiting on the arrival of her full Administrator's license. -In addition, she was the facility nurse, with the title of Health and Wellness Director (HWD), until the replacement HWD came to work in August 2025. -Resident #8 was a fairly newly admission to the facility. -The MAs were responsible for observing residents' medication administration, including ensuring the resident had swallowed medications, before going to the next resident for medication administration. -Resident #8 should not have medications on his walker's seat ambulating around the facility. -If a resident was suspected of "cheeking" medications or had difficulty swallowing medications, the PCP could be contacted for an order to administer medication in applesauce to ensure medications were consumed. -She did not know Resident #8 was suspect for "cheeking" medications. -Resident #8's PCP would be promptly contacted for an order to place his medications in applesauce for administration or to crush medications that could be crushed and administered in applesauce.	D 366		

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D 366	Continued From page 30 Based on observations, interviews, and record review, it was determined Resident #8 was not interviewable.	D 366			
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10ANCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#4) was in compliance with the state and facilities self-administration of medication policy. The findings are: Review of the facilities self-administration of medication policy, last revised August 2023, revealed: -Residents who desire to self-administer medication should be permitted to do so if any applicable requirements are met. -An evaluation should be conducted by the nurse	D 376	D376 The Health & Wellness Director/Nurse/Executive Director or designee will re-train medication aids on the medication self-administration policy. To assist with ongoing compliance the Health & Wellness Director/Nurse/Executive Director or designee will review the self-administration competency evaluation forms to verify accuracy monthly for three (3) months.		12/1/2025

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D 376	Continued From page 31 initially, quarterly, and with a change in residents' condition. -Residents who self-administer their own medications may store their non-controlled medications in their apartment. Review of Resident #4's FL2 dated 04/17/25 revealed: -The diagnosis included type 2 diabetes, chronic heart failure, chronic kidney disease, sleep apnea, hyperlipidemia, and hypothyroidism. -There was an order to keep his ordered medication in his room and self administer his ordered medication. Review of Resident #4's current medication list from the Primary Care Provider (PCP) revealed as follows; rosuvastatin 10mg tablet, finasteride 5mg tablet, glipizide 10mg tablet, levothyroxine 175mcg tablet, and modafinil 100mg tablet to be administered 1 time a day, carvedilol 3.25mg tablet to be administered 2 times a day, citalopram 40mg tablet to be administered at bedtime, lispro sliding scale to be taken with each meal and glargine insulin 61 units to be taken at bedtime. Observation of Resident #4's room on 07/08/25 at 3:15pm revealed: -There was 3 boxes of insulin lispro pens each box dispensed on 06/10/25. -There was 2 insulin glargine pens, with expiration dates of 09/30/26 and 02/28/27. -There was 1 insulin detemir pen, with an expiration date of 11/30/25. -There was 2 bottles of sevelamer carbonate dispensed on 11/21/24 and 05/22/25. -There was 1 bottle of modafinil dispensed on 03/24/25 with 10 of 90 tablets remaining. -There was 2 bottles of flomax dispensed on	D 376		

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D 376	Continued From page 32 05/28/25 and 06/04/25. -There was 1 bottle for diltiazem dispensed on 11/20/23. -There was 6 bottles of lidocaine/prilocaine cream. -There was 1 box of pain-relieving patches. Interview with Resident #4 on 07/08/25 at 3:15pm revealed: -He kept his medications in weekly pill organizers in a locked box in his room. -He did not know how to open the locked box. -His family member helped fill his weekly pill organizers. -All the ordered medication bottles he was ordered was in his room. -He had a continuous blood sugar monitoring device on his arm that transmitted results to his cell phone. -The continuous blood sugar monitoring device alerted him when his blood sugar levels were too high or too low. Interview with Resident #4's family member on 07/09/25 at 3:55pm revealed: -She stored Resident #4's medication bottles at her home. -She filled his weekly pill organizer at her home and brought the pill organizer back to the facility when she was done. -The facility was aware she stored Resident #4's medication bottles at home. Interview with a medication aide (MA) on 07/10/25 at 3:23pm revealed: -He was aware Resident #4 did not know how to open the locked box where his medication were stored and he was not sure how Resident #4 opened the locked box. -He was not aware Resident #4's family member	D 376		

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D 376	Continued From page 33 stored the medication bottles at her home. -There was an incident a few months ago where Resident #4 was unresponsive, his blood sugar level was 53, medication was given and Resident #4's blood sugar levels returned to normal. Interview with the resident care coordinator (RCC) on 07/10/25 at 9:35am revealed: -She reviewed Resident #4's blood sugar levels if she was walking by his room and heard the alarm sound on his phone from his blood sugar levels being too high or too low. -If blood sugar levels were too low, she would give the resident orange juice and document in the facilities electronic system. -She relied on Resident #4's verbal confirmation in relation to compliance with medication orders. -She was not aware that Resident #4's family member stored his medication bottles at her home. -If she witnessed a family member or friend administering medications to a resident, she would alert a nurse. Interview with the Administrator on 7/10/25 at 10:00am revealed: -She was not aware that Resident #4's family member stored his medication bottles at her home. -She was not aware Resident #4's family member filled his weekly pill organizer. -It was the facilities policy that residents must be able to administer ordered medications to themselves in order to qualify for medication self-administration. -She had concerns for the past several months regarding Resident #4's medication self-administration. -She had reached out to Resident #4's power of attorney (POA) regarding her concerns	D 376			

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D 376	Continued From page 34 surrounding medication self-administration. -Resident #4's POA did not agree with the Administrators' concerns regarding Resident #4 not being able to administer his own medication. -Resident #4's POA demanded that the facility continue to let Resident #4 administer his own medication. -She was going to have a registered nurse (RN) come into the facility to complete the self-administration of medication evaluation. Interview with the facilities corporate RN on 07/10/25 at 12:45pm revealed she was unable, that day, to complete the self-administration of medication evaluation on Resident #4 because his ordered medication bottles were not in his room.	D 376			