STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036015	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ROBINWOOD	1750 ROBINWOOD ROAD GASTONIA, NC 28054

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D 000	Initial Comments The Adult Care Licensure Section and Gaston County Department of Social Services conducted an annual survey and complaint survey on 07/07/25-07/08/25. The complaint investigation was initiated by Gaston County Department of Social Services on 06/16/25.	D 000	The Following is the Plan of Correction for Brookdale Robinwood Assisted Living regarding the Satement of Deficiencies dated July 8th, 2025. The Plan of Correction is not to be construesd as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies,or any related sanction or fine. Rather it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirments. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality healths care services and will continue to make changes and improvement to satisfy that objective.	
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the exit	D 067	10A NCAC 13F .0305(h)(4) Physical Environment- TypeA2 The lock on the main door to the kitchen was replaced on June 8th Kitchen staff have been instructed by the Executive Director (ED) that when they leaveat night after dinner, they need to verify the backdoor leading to the outside islocked and alarm is turned on. The ED instructed kitchen staff to verify main door is locked and closed to the kitchen. Medication Technicians have a master key to main kitchen door if they need to enter kitchen. All staff was retrained on door alarms and key pads Retraining will be conducted by the Maintenance Manager and Executive Director to Med- techs and Care Partners on the procedures for checking the back door leading to the outside and make sure the alarm is in working order, the door is closed and locked securely. To assist with ongoing compliance, the Maintenance Manager(MM) or designee will conduct daily door alarm checks for (3) weeks and weekly for (3) additional weeks on all doors with alarm and key pad to verify all devices are working properly and alarmes sound when activated. These result of the MM checks will be added to the community's TELs system and reviewd by the Executive Director or designee daily for 3 weeks and weekly for an additional 3 weeks Completed on or June 8th, 2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Nina Clyburn TITLE Executive Director (X5) DATE 8/18/2025

Reviewed and Acknowledged by Salem Smeltzer RN 8/25/25

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D 067	Continued From page 1 doors of the facility had a continuous sounding device that was activated when Resident #1 who was disoriented and exit seeking exited the facility without staff being alerted. The findings are: Review of Resident #1's current FL-2 dated 11/21/24 revealed: -Diagnoses included diabetes type 2, malformation of cerebral vessels and anxiety -His level of care was assisted living -There was no documentation of Resident #1's orientation. Review of Resident #1's care plan dated 05/29/25 revealed he ambulated independently. Review of Resident # 1's Accident/Incident Report dated 06/11/25 revealed: -The report was completed by the facility Administrator, and sent to Department of Social Services on 06/11/25, and revised on 06/12/25 with additional information. -Resident #1 was observed by the 3rd shift medication aide (MA) sitting on his bed on 06/11/25 at 2.00am. -On 06/11/25 around 2:30am the MA received a call from Emergency Medical Services (EMS) informing her Resident #1 was found alongside of the road and was taken to the Emergency Room (ER) for evaluation -At 2:40am, the MA called the facility Administrator and informed the Administrator what happened -The facility staff conducted a head count of all residents and checked all exit doors and alarms were working. -At 3:50am, the Administrator arrived at the facility to start paperwork.	D 067	10A NCAC 13F .0901(b) Personal Care and Supervision- Type A2 The MM or designee will conduct Elopement /Missing person drills monthly alternating between all three(3) shifts. Direct Care staff were retrained by the Health and Wellness Director or designee to add residents to the hot rack that are showing signs of confusions and to inform Health and Wellness Director (HWD) or designee. Direct Care Staff have been instructed by the Health and Wellness Director or designee to complete documentation if a resident is added to the hot rack. To assist with ongoing compliance, HWD or designee will check 24 hour report daily to verify follow-up steps for any new documentation on the 24hour report Completed as June 8th 2025 10A NCAC 13F .0902(b) Health Care All discharge paperwork, new orders, and FL2's will be reviewed by the HWD, Resident Care Coordinator or designee to verify orders. Requests for clarifications or changes will be faxed to the prescribing provider. New Orders will be put in the "Hot Box" and reviewed by HWD or designee daily. Any new orders will be entered in the new order tracking form by the HWD or designee. Orders from other doctors, discharging hospital or nursing homes are to be forwarded to the Primary Care Provider (PCP) for coordination of care. All staff will be re-trained by the HWD or designee on Medication Carts. Medication Pass Observation pass were completed by HWD on all Med Techs and HWD. All direct care staff were retrained by the HWD or designee on Vitals and Parameters for Blood pressures medication and insulin dependence resident. To assist with ongoing compliance, residents with parameters will be audited weekly by the HWD or designee for three(3) months. Completed as of July 30th 2025	

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D 067	Continued From page 2 -The Administrator and the staff again checked the doors and alarms and found all alarms working except in the kitchen. -The Administrator and staff figured Resident #1 got out through the kitchen door without the door alarm sounding. Review of the local weather report revealed the temperature in the area on 06/11/25 at 2:00am was 72 degrees, mostly cloudy, and the wind was light and variable. Review of Resident #1's facility notes revealed: -On 05/24/25 at 9:22pm, Resident #1 had increased confusion and believed he was in a hotel and called the facility from his cell phone asking what activities was going on at this time. -Resident #1 was told by staff it was 3:00am and there would be activities later in the day. -Resident #1 walked to the lobby to see who was up and what activities they were doing. -MA redirected Resident #1 back to his room. -On 05/25/25 at 3:06pm, Resident #1 continued to be confused. -Resident #1 asked continuously if he would be returning to this facility. -Resident #1 could not be redirected. -Resident #1 continued to believe he was in a motel. -Resident #1 was not able to navigate around in the facility without staff assistance. -On 05/25/25 at 9:19pm, Resident #1 was increasingly agitated. -Resident #1 was unaware of his whereabouts and unsure about being in an assisted living facility. -On 05/28/25 at 3:40am, Resident #1 was confused about the time of day. -Resident #1 stayed up for two hours waiting on breakfast.	D 067	10A NCAC 13F. 1004 Medication Administration HWD or designee is completing Medication Pass observations with all Medication Technicians, which will be conducted on an annual bases. Medication Technicians were retrained by HWD or designee on how to check Vitals Systolic, diastolic, and pulse against parameters to verify Medications are administered and on following physician orders on parameters and physician notifications of readings that are outside of the parameters. The HWD or designee will review residents orders with parameters daily for three (3) weeks and weekly for an additional three(3) weeks.	Completed as of July 16th 2025

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D 067	Continued From page 3 -On 05/28/25 at 9:33pm, the MA observed Resident #1 going outside through the bistro door and he was just outside of the door. -Resident #1 stated he was going to look for his car to return his books. -The Health Wellness Director (HWD) was notified. -Resident #1 was administered Ativan for agitation. -The MA sat with Resident #1 until he went to his room. -On 05/31/25 at 9:03pm, Resident #1 was confused and observed going in and out of other resident's rooms. -On 06/02/25 at 2:20pm, Resident #1 was confused. -On 06/03/25 at 2:05pm, Resident was very anxious and continued to remain confused. -On 06/07/25 at 9:26pm, Resident #1 was confused and was redirected by staff several times. -Resident #1 started walking towards his room but went into another resident's room. -Resident #1 was administered Ativan for agitation. -Resident #1 went to his room and went to sleep. Observation on 07/08/25 at 4:30pm revealed the alarm on the door in the dining room that led to outside sounded when the door was opened. Observation on 07/08/25 at 4:35pm revealed the alarm on the door in the kitchen that led to outside sounded when the door was opened. Observation on 07/08/25 at 4:45pm revealed the computer system indicated the front door alarm was set to lock automatically at 7:00pm and unlocked automatically at 5:30am.	D 067		

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D 067	Continued From page 4 Interview with a personal care aide (PCA) on 06/23/25 at 10:35am revealed: -A few nights prior to the elopement incident she had Resident #1 sitting in the bistro area near her because he was trying to find an exit door. -This was an ongoing process for a few weeks with Resident #1 being confused/ wandering around in the facility -She did not know some of the doors were not locked. -Some of the doors were on an automatic locking time but they would not lock if the doors were on by-pass. -She would check the doors when she came on duty and found many time the doors were on by-pass and would not alarm if they were opened. -She would enter the code to lock and alarm the door. -She was not aware the kitchen door would not lock but had noticed it was on by-pass. Interview with a MA on 06/23/25 at 11:10am revealed: -She and the PCA usually tried to check all the doors when they came on duty to ensure the doors were alarmed. -If a door was found to be unlocked or on by-pass the Health and Wellness Director (HWD) would be notified by text. -On 06/11/25 after becoming aware of the elopement, she and the PCA checked all the doors, except the kitchen door and the doors were locked/set to alarm. -She thinks Resident #1 possibly eloped through the kitchen door. If the kitchen door was on by-pass the alarm would not have sounded to alert the door was opened. -She had no reason to think the kitchen door would be unlocked or on by-pass. -There was an issue a few months ago with the	D 067		

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D 067	Continued From page 5 kitchen door being on by-pass and, staff were unable to set to alarm. -She informed the Maintenance Director of the door not being able to set to alarm and the Maintenance Director said it was being worked on. -The door between the dining room and the kitchen was kept closed at night after she and the PCA set up the tables for breakfast, they did this to prevent anyone from going into the kitchen. -She could not recall if the kitchen door was shut on 06/11/25. -The door in the bistro was kept on by-pass during the day because residents like to sit outside in the garden area. -She or the PCA set the alarm at 10:00pm when they came on duty on 06/10/25-06/11/25. Interview with a MA on 07/07/25 at 3:30pm revealed: -Resident #1 was anxious often. -Resident #1 did not like loud noises. -Resident #1 started wandering about 2 weeks prior to eloping. -Resident #1 would say "Don't lock me in here". -Resident #1 would ask if the "bus" gone yet. -She was aware of the doors being unlocked. -The bistro door was on by-pass daily but locked once 3rd shift came on duty. -The kitchen staff used the kitchen door to take out kitchen trash. -Other staff members used the door in the dining room to take out facility trash. -She was unaware if there was a problem with any door alarms. Interview with the MA on 07/07/25 at 3:40pm revealed: -Resident #1 ambulated slowly. -Resident #1 started exhibiting wandering	D 067		

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D 067	Continued From page 6 behaviors a few days prior to the elopement. -After Resident #1 eloped, staff were to make sure all the doors were locked. Interview with MA on 07/08/25 at 10:15am revealed: -Resident #1 was very confused several weeks before he eloped from the facility. -Resident #1 thought he was in another state and asked often during a shift how could he get back to the facility. -She thought Resident #1 probably eloped through the front door. -The front door was always on by-pass. -When 2nd shift left at 10:00pm the staff would just press in the lock on the doorknob to ensure 3rd shift was locked in the facility but the alarm was not set and if the door was opened the alarm would not sound. Interview with a dietary aide on 06/25/25 at 10:30am revealed: -When the kitchen staff left the facility at the end of their shift they left through the front door. -The alarm for the kitchen door was set but if the door was not closed completely the alarm would go to by-pass. -He realized he had to make sure the door was completely closed, enter the code and the alarm would set. -He did not know if all the staff were aware of this issue. Interview with the Resident Care Director (RCD) on 6/25/25 at 10:05am revealed: -The door in the bistro was set on by-pass daily so residents could go outside. -The bistro door was locked, and alarm set by 3rd shift staff each night. -The front door was set to automatically lock at	D 067		

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D 067	Continued From page 7 6:00pm and unlock at 6:00am. -When the alarm on the front door was set, the handicap button could be pressed and the door would unlock. - For over six months the kitchen door was stuck on by-pass and could not be alarmed. -She and other staff had made the Maintenance Director and the Administrator aware of their concerns regarding the kitchen door and it was eventually fixed approximately six months prior to Resident #1's elopement. -She was unaware there was another issue with the kitchen door. Interview with the Health and Wellness Director (HWD) on 06/25/25 at 10:15am revealed: -She was unaware the kitchen door alarm could not be set. -All the facility doors had alarms. -She was unaware of any issues with other doors in the facility not locking or not being able to set to be alarm if the doors were opened. -The facility front door was set to an automatic locking system. -The front door was locked at 8:00pm and unlocked at 8:00am. -The bistro door was set on by-pass daily so residents could go outside. Interview with the Maintenance Director on 06/25/25 at 9:50am revealed: -On 06/11/25 at 4:00am he received a call from facility staff asking him to change the keypad for the kitchen door due to a resident eloping from the facility. -He had not been told prior to the elopement the keypad numbers were sticking, the keypad was stuck on by-pass, and the alarm code could not be punched in to set the door to alarm.	D 067		

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D 067	Continued From page 8 Interview on 06/30/25 at 11:50am with the Maintenance Director revealed: -A new keypad lock was installed on the kitchen door on 06/11/25 due to the keypad numbers sticking and would not go off by-pass code. -No staff mentioned to him there was a problem with the door staying on by-pass. -He made minor adjustments to two other doors because when those two doors were pulled or opened the alarm did not sound. Interview on 07/01/25 at 1:10pm with the Administrator revealed: -On 06/11/25 when she received the call from staff that Resident #1 had eloped from the facility, she told staff to check all the doors. - Staff checked the doors and reported all the doors were locked. -When she arrived at the facility, she and the staff checked the doors again and found the kitchen door was on by-pass. -When the doors were on by-pass they would not alarm when the door was opened. -She did not know if the staff checked the kitchen door. -Since the kitchen door was on by-pass, she thought it was the door Resident #1 was able to walk out of the facility without causing the alarm to sound. -On 06/11/25, new keypad locks were installed due to the numbers on the keypad being frozen. -The kitchen door was equipped with an automatic lock, and the alarm did not sound on 06/11/25 when Resident #1 eloped from the facility because the keypad numbers were frozen. -A new keypad lock was installed on the C-hall because the keypad numbers were frozen. -She did not know the keypad numbers were frozen until Resident #1 walked out of the facility without the alarm sounding.	D 067		

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D 067	Continued From page 9 -The Maintenance Director was to check the doors monthly for any issues. -The Maintenance Director had not reported any problems with the doors to her. Attempted telephone interview with Resident #1 on 06/24/25 at 12:15pm revealed Resident #1 was not interviewable. The facility failed to ensure a sounding device was continuously activated to alert staff when an exit door was opened, allowing Resident #1 to elope from the facility without staff knowledge. Resident #1 was determined to be disoriented and exhibited wandering behaviors and was able to exit the facility through a door that was not equipped with an operational sounding device and was found by EMS along side of the road approximately 0.2 miles from the facility. This failure resulted in substantial risk for physical harm to the resident and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/03/25 with revisions on 07/08/25. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 7, 2025.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	D 270		

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D 270	Continued From page 10 care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#1) resulting in the resident leaving the facility without staff knowledge. The findings are: Review of Resident #1's current FL-2 dated 11/21/24 revealed: -Diagnoses included diabetes type 2, malformation of cerebral vessels and anxiety. -His level of care was assisted living. Review of Resident #1's Resident Register revealed: -He was admitted to the facility on 05/08/2019. -A family member was his responsible party. Review of Resident #1's care plan dated 05/29/25 revealed he ambulated independently. Review of Resident # 1's Accident/Incident Report dated 06/11/25 revealed: -The report was completed by the facility Administrator, and sent to Department of Social Services on 06/11/25, and revised on 06/12/25 with additional information. -Resident #1 was observed by a 3rd shift	D 270		

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D 270	Continued From page 11 medication aide (MA) on 06/11/25 at 2:00am sitting on his bed in his room. -On 06/11/25 around 2:30am the MA received a call from Emergency Medical Services (EMS) informing her Resident #1 was found along side of the road and was taken to the Emergency Room (ER) for evaluation. -On 06/11/25 at 2:40am, the MA called the Administrator and stated Resident #1 was last seen sitting on his bed at 2:00am. -The facility staff conducted a head count of all residents and checked all exit doors and alarms were working. -At 3:50am, the Administrator arrived at the facility to start paperwork. -The Administrator and the staff again checked the doors and alarms and found all alarms working except in the kitchen. -The Administrator and staff figured Resident #1 got out through the kitchen door without the door alarm sounding. -The hospital called the facility around 5.00am and stated the resident (Resident #1) fell in the road when EMS found him. -Resident #1 called 911 himself, gave his name and that he lived at the facility -Resident #1 had an abrasion to his left elbow. -Resident #1 was returned to the facility by EMS. -Upon returning to the facility Resident #1 was assessed by a medical professional, a wander guard was placed on him, and 24-hour sitters were brought in until a Memory Care (MC) bed was found. Review of the local weather report the temperature in the area on 06/11/25 at 2.00am was 72 degrees, mostly cloudy and wind was light and variable. Observation on 06/16/25 at 12:35pm of the	D 270		

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	HAL036015	A. BUILDING _____ B. WING _____	07/08/2025

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D 270	Continued From page 12 location EMS found Resident #1 revealed: -Resident #1 was located in an apartment complex. -The apartment complex had sidewalks and paved driveways. -The apartment complex was approximately 0.2 miles from the facility. -The street had five lanes which included a turning lane. Review of Resident #1's facility notes revealed: -On 05/24/25 at 9:22pm, Resident #1 exhibited increased confusion. -Resident #1 believed he was in a hotel and called the facility from his cell phone asking what activities were going on at this time. -Resident #1 was told by staff it was 3:00am and there would be activities later in the day. -Resident #1 walked to the lobby to see who was up and what activities they were doing, and a medication aide (MA) redirected the resident back to his room. -On 05/25/25 at 3:06pm, Resident #1 continued to be confused. -Resident #1 asked continuously if he would be returning to this facility. -Resident #1 could not be redirected. -Resident #1 continued to believe he was in a motel. -Resident #1 was not able to navigate around in the facility without staff assistance. -On 05/25/25 at 9:19pm, Resident #1 was increasingly agitated. -Resident #1 was unaware of his whereabouts and unsure about being in an assisted living facility. -On 05/28/25 at 3:40am, Resident #1 was confused about the time of day. -Resident #1 stayed up for two hours waiting on breakfast.	D 270		

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D 270	Continued From page 13 -On 05/28/25 at 9:33pm, the MA observed Resident #1 going out the bistro door to outside and he was found just outside of the door. -Resident #1 stated he was going to look for his car to return his books. -The Health and Wellness Director (HWD) was notified. -Resident #1 was administered Ativan for agitation. -The MA sat with Resident #1 until he went to his room. -On 05/31/25 at 9:03pm, Resident #1 was confused, and observed going in and out of other resident's rooms. -On 06/02/25 at 2:20pm, Resident #1 was confused. -On 06/03/25 at 2:05pm, Resident was very anxious and continued to remain confused. -On 06/07/25 at 3:42am Resident #1 stated he was going to the dining room for lunch. -The MA redirected Resident #1 by saying it was not time for lunch, it was bedtime. -Resident #1 would not go to bed. -Resident #1 sat at a table in the bistro and laid his head on the table. -Resident #1 got up from the table and started repeatedly moving the table in different directions. -The MA asked Resident #1 if he was okay. -Resident #1 stated yes and that he just needed to rest. -The MA encouraged Resident #1 to lie down but the resident became agitated and started to cry. -Resident #1 started pulling chairs out from the tables in the bistro. -Resident #1 began walking towards his room but went into another resident's room. -The MA walked Resident #1 to his room and administered PRN Ativan. -On 06/07/25 at 9:26pm, Resident #1 was confused and was redirected by staff several	D 270		

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D 270	Continued From page 14 times. -Resident #1 believed he was at a hotel and not at his place of residence. -On 06/07/25 at 11:00pm, Resident #1 stated he was going to the dining room for lunch. -The MA redirected the resident and told him it wasn't time for lunch it was bedtime. -Resident #1 laid his head on a table in the bistro for a few minutes, then moved to a different table and laid his head down. -Resident #1 stated he just wanted to rest. -Resident #1 was asked by the MA if he wanted to lay down. -Resident #1 became agitated and started pulling all the chairs from the tables in the bistro area. -Resident #1 started walking towards his room but went into another resident's room. -Resident #1 was administered Ativan for agitation. -Resident #1 went to his room and went to sleep. Review of Resident #1's hospice Registered Nurse (RN) notes on 07/08/25 at 2:15pm revealed: -On 05/14/25 Resident #1 was ambulatory and held onto rails to walk, -On 06/11/25, upon arrival to the facility the Administrator informed the hospice RN that Resident #1 had eloped from the facility last night, 06/11/25. -Resident #1 walked a short distance down the road and fell. -Resident #1 called 911 himself and was assisted back to the facility by EMS. -Resident #1 stated he was going to "the other" facility because this facility was being remodeled. -Resident #1 also stated he was going somewhere to look for his family members. -Resident # 1 was having more confusion per facility staff.	D 270		

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D 270	Continued From page 15 -The confusion seemed to come and go. -Resident #1 informed the hospice RN he did not know he tried to leave last night. -Resident #1 had a small abrasion on the left elbow. -The Administrator requested a sitter who should start today, 06/11/25. -The Administrator revealed Resident #1 needed to be transferred to a locked unit or memory care due to wandering. Interview with a personal care aide (PCA) on 06/23/25 at 10:35am revealed: -A few nights prior to the elopement incident she had Resident #1 sitting in the bistro area near her because he was trying to find an exit door. -This was an ongoing process to keep Resident #1 from exit doors for a few weeks with Resident #1 being confused/ wandering around in the facility. -She talked with MA C and was informed Resident #1 had tried many times to leave the facility the weekend prior to 06/11/25. -On 06/11/25 at 10:00pm, Resident #1 was in bed asleep. -On 06/11/25 at 1:45am she observed Resident #1 sitting in the lobby by the dining room. -She told Resident #1 to go back to his room. -Resident #1 walked back towards his room. -She went to the laundry room and told the MA to check on Resident #1. -The MA checked on Resident #1 and told her he was sitting on his bed. -She went on her break at 2:00am. -When she returned from her break at 2:30am, the MA said she received a call from EMS stating they had picked up Resident #1 from the side of the road. -A few nights prior to the elopement incident she had Resident #1 sitting in the bistro area because	D 270		

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D 270	Continued From page 16 he was trying to find an exit door. -It was an ongoing process for a few weeks with Resident #1 being confused/ wandering around in the facility. -The MA told her Resident #1 had tried many times to leave the facility the weekend prior to 06/11/25. -She asked other staff members if Resident #1 had a wander guard and was told he did not have one. -She was told wander guards were activated only when the resident was near the front door. -She did not know some of the doors were not locked. -She was unaware of any extra supervision or intervention put in place when Resident #1 was noticed to being confused. Interview with a MA on 06/23/25 at 11:10am revealed: -On 06/11/25 around 1:30am Resident #1 was sitting by the front living room area. -She and the PCA told Resident #1 to go to bed. -Around 2:00am she went to check on Resident #1 he was sitting in his recliner. -At 2:30am she received a call from EMS stating they had one of the residents from the facility and they had picked him up where they found him sitting alongside of the road. -Resident #1 became more confused about two weeks prior to the elopement. -Resident #1 would ask how he could "get out" of the facility. -Resident #1 would be redirected back to his room. -She was unaware of any extra supervision or interventions put in place when Resident #1 was observed to be confused. Interview with a second MA on 07/07/25 at	D 270		

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D 270	Continued From page 17 2:50pm revealed: -Resident #1 began exhibiting wandering behaviors 2-3 weeks prior to his elopement on 06/11/25. -Resident #1 did not like loud noise and was anxious often. -She was unaware of any extra supervision or interventions put in place when Resident #1 was observed confused/wandering. Interview with a PCA on 07/07/25 at 4:40pm revealed: -Resident #1 was confused. -Resident #1 had a history of wandering but she had not seen him try to leave the facility. -He observed Resident#1 in April 2025 or May 2025 confused and wandering in the facility parking lot -He brought Resident #1 back into the facility. -He informed the HWD of the incident. -No additional interventions or instructions were given after Resident #1 was wandering in the facility parking lot. Interview with a MA on 07/08/25 at 10:15am revealed: -Resident #1's health had declined. -Resident #1 was very confused before he eloped from the facility. -Resident #1 ambulated slowly and had to hold on to the hallway rails to prevent falling. -Resident #1 thought he was in another city and state and asked often how he could get back to the facility. -Staff had not been given any instruction regarding Resident #1's wandering as he had not left the facility prior to his elopement on 06/11/25. Interview with the Resident Care Director (RCD) on 06/25/25 at 10:05am revealed:	D 270		

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D 270	Continued From page 18 -Resident #1 had a decline in health and was confused. -In May 2025, Resident #1 was observed by a staff member going through the bistro door. -He was found just outside the door. -Resident #1 was brought back into the facility. -Resident #1 stated he was going to look for his car to return his books. Interview with the Administrator on 06/16/25 at 12:30pm revealed: -Resident #1 eloped from the facility on 06/11/25. -Resident #1 had a diagnosis of liver cancer. -She was told by the Hospice RN the enzymes from the cancer had moved to the brain, causing Resident #1 to have confusion. -She did not know Resident #1 had tried to leave the facility prior to 06/11/25. Attempted telephone interview with Resident #1 on 06/24/25 at 12:15pm revealed Resident #1 was not interviewable. Attempted telephone interview with Resident #1's hospice RN on 07/08/25 at 2:15pm was unsuccessful. _____ The facility failed to ensure 1 of 1 resident (Resident #1) who had confusion due to medical diagnoses causing exit seeking behaviors and was not properly supervised resulting in Resident #1 leaving the facility alone, walking up the road, falling, and calling 911 himself for medical assistance. These failures resulted in substantial risk for physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/03/25 with revisions on 07/08/25.	D 270		

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D 270	Continued From page 19 CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 7, 2025.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 2 of 5 sampled residents (#4 and #5) related to notifying the Primary Care Provider (PCP) for systolic blood pressure readings of 100 or less, heart rates less than 60 (#4) and finger stick blood sugar (FSBS) of less than 80 (#5). The findings are: 1. Review of Resident #4's current FL2 dated 02/24/25 revealed diagnoses included hypertension. Review of Resident #4's current FL2 dated 02/24/25 revealed: -There was an order for hydrochlorothiazide (HCTZ) (a medication to lower blood pressure and decrease fluid retention) 12.5mg one tablet daily. -The order indicated there were parameters for the medication. -There was an order for lisinopril (a medication to lower blood pressure) 40mg one tablet daily.	D 273		

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D 273	Continued From page 20 -The order indicated there were parameters for the medication. Review of Resident #4's signed physician's orders dated 06/30/25 revealed: -There was an order for HCTZ 12.5mg one tablet daily. -There was an order for lisinopril 40mg one tablet daily. -HCTZ 12.5mg one tablet daily and lisinopril 40mg one tablet daily were to be held for systolic blood pressure of 100 or less and/or for heart rate less than 60 and staff were to contact the PCP for further orders. Review of Resident #4 May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There was an entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 14 of 31 opportunities when Resident #4's heart rate was less than 60. -There were 4 of 31 opportunities when Resident #4's systolic blood pressure was less than 100. -For example, on 05/13/25 at 7:00am Resident #4's blood pressure was 99/64 and her heart rate was 58. -There was no documentation Resident #4's PCP was notified. Review of Resident #4 June 2025 eMAR revealed: -There was an entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less	D 273		

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D 273	Continued From page 21 and/or heart rate less than 60 and contact the PCP for further orders. -There were 16 of 30 opportunities documented on the HCTZ 12.5mg entry when Resident #4's heart rate was less than 60. -There were 8 of 30 opportunities documented on the HCTZ 12.5mg entry when Resident #4's systolic blood pressure was less than 100. -For example, on 06/15/25 at 7:00am Resident #5's blood pressure was 85/58 and her heart rate was 53. -There was an entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 15 of 30 opportunities documented on the lisinopril 40mg entry when Resident #4's heart rate was less than 60. -There were 8 of 30 opportunities documented on the lisinopril 40mg entry when Resident #4's systolic blood pressure was less than 100. -For example, on 06/15/25 at 7:00am Resident #5's blood pressure was 85/58 and her heart rate was 53. Review of Resident #4 July 2025 eMAR revealed: -There was entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There was entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 4 of 7 opportunities when Resident #4's heart rate was less than 60. -There were 3 of 7 opportunities when Resident #4's systolic blood pressure was less than 100. -For example, on 07/03/25 at 7:00am Resident #5's blood pressure was 94/66 and her heart rate	D 273		

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D 273	Continued From page 22 was 51. -There was no documentation Resident #4's PCP was notified. Review of Resident #4's record revealed there was no documentation her PCP was notified when her heart rate was less than 60 or her systolic blood pressure was 100 or less. Interview with Resident #4 on 07/08/25 at 3:32pm revealed: -She took blood pressure medications and her blood pressures were "good". -She did not remember any instances she felt dizzy or lightheaded. -Staff brought her medications to her and she was not sure of the names of the medications she took. Interview with a medication aide (MA) on 07/08/25 at 2:03pm revealed: -The MAs were responsible for checking Resident #4' blood pressure and heart rate and notifying her PCP if her heart rate or blood pressure was outside of parameters. -The MAs were responsible to document all PCP notifications in the resident's progress notes. -She did not always notify Resident #4's PCP of her systolic blood pressures less than 100 or heart rates less than 60 because she was often too busy. Refer to the interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:02pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm. Refer to the interview with the Administrator on 07/08/25 at 4:57pm.	D 273		

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D 273	Continued From page 23 Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 07/08/25 at 11:15am was unsuccessful. 2. Review of Resident #5's current hospital FL2 dated 05/28/25 revealed diagnoses included diabetes type II. Review of Resident #5's signed physician's order dated 05/15/25 revealed: -Resident #5 was to have his finger stick blood sugar (FSBS) four times daily before meals and at bedtime. -The PCP was to be notified if Resident #5's FSBS was below 80 or greater than 400. Review of Resident #5's May 2025 eMAR revealed: -There was an entry to monitor Resident #5's FSBS before meals and at bedtime and notify PCP if FSBS is less than 80 or greater than 400. -On 05/29/25 at 5:00pm Resident #5's FSBS was 71. -There was 1 of 22 opportunities when Resident #5's FSBS was less than 80. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's June 2025 eMAR revealed: -There was an entry to monitor Resident #5's FSBS before meals and at bedtime and notify PCP if FSBS is less than 80 or greater than 400. -There were 13 of 120 opportunities when Resident #5's FSBS was less than 80. -For example, at 8:00am on 06/03/25, 06/11/25 and 06/16/25 Resident #5's FSBS was 72. -There was no documentation Resident #5's PCP was notified.	D 273		

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D 273	Continued From page 24 Review of Resident #5's record revealed there was no documentation his PCP was notified when his FSBS was less than 80. Interview with a MA on 07/08/25 at 2:03pm revealed: -The MAs were responsible for checking Resident #5's FSBS and notify his PCP if his FSBS was outside of parameters. -The MAs were responsible to document all PCP notifications in the resident's progress notes. -She did not always notify Resident #5's PCP of FSBS less than 80 because she was often too busy. Refer to the interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:02pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm. Refer to the interview with the Administrator on 07/08/25 at 4:57pm. Attempted telephone interview with Resident #5's PCP on 07/08/25 at 11:15am was unsuccessful. Interview with the RCC on 07/08/25 at 4:02pm revealed: -The MAs were responsible to contact the PCP when vital signs or FSBS were outside of parameters or according to the order. -The MAs usually notified the PCP by fax and put the fax confirmation in the PCPs box for them to see when they came to the facility. -The MAs were responsible for documenting all contact with the PCP in the residents' progress notes.	D 273		

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D 273	Continued From page 25 Interview with the HWD on 07/08/25 at 4:27pm revealed: -The MAs were responsible for notifying the residents' PCPs according to the orders. -The MAs were responsible for putting a note in the eMAR system any time they contacted a provider. Interview with the Administrator on 07/08/25 at 4:57pm revealed: -The MAs were responsible to notify residents' PCP as indicated in the orders. -The MAs were responsible for documenting all PCP notifications in the residents' progress notes. -If the MAs faxed the PCP, the fax confirmation should be kept but a note should still be in the eMAR system.	D 273		
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: The facility failed to administer medications as ordered for 3 of 5 sampled resident related to medications for blood pressure, fluid retention (#4) and elevated blood sugar levels (#5). The findings are:	D 358		

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D 358	Continued From page 26 1. Review of Resident #4's current FL2 dated 02/24/25 revealed diagnoses included hypertension. a. Review of Resident #4's current FL2 dated 02/24/25 revealed: -There was an order for hydrochlorothiazide (HCTZ) (a medication to lower blood pressure and decrease fluid retention) 12.5mg one tablet daily. -The order indicated there were parameters for the medication. Review of Resident #4's signed physician's orders dated 06/30/25 revealed: -There was an order for HCTZ 12.5mg one tablet daily. -HCTZ 12.5mg one tablet daily was to be held for systolic blood pressure of 100 or less and/or for heart rate less than 60 and staff were to contact the primary care provider (PCP) for further orders. Review of Resident #4 May 2025 electronic medication administration record (eMAR) revealed: -There was entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 7 of 31 opportunities HCTZ 12.5mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60. -For example, on 05/05/25 at 7:00am Resident #4's heart rate was 50 and HCTZ 12.5mg one tablet was administered to the resident. -There was 1 of 31 opportunities HCTZ 12.5mg one tablet was not administered to the resident	D 358		

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D 358	Continued From page 27 when her systolic blood pressure was greater than 100 and her heart rate was greater than 60. -On 05/17/25 at 7:00am Resident #4's blood pressure was 101/68, her heart rate was 65 and HCTZ 12.5mg one tablet was documented held due to vital signs outside of parameter. Review of Resident #4 June 2025 eMAR revealed: -There was entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 5 of 30 opportunities HCTZ 12.5mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60. -For example, on 06/20/25 at 7:00am Resident #4's heart rate was 53 and HCTZ 12.5mg one tablet was administered to the resident. Review of Resident #4 July 2025 eMAR revealed. -There was entry for HCTZ 12.5mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There was 1 of 7 opportunities HCTZ 12.5mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60. -On 07/07/25 at 7:00am Resident #4's heart rate was 48 and HCTZ 12.5mg one tablet was administered to the resident. Observation of Resident #4's medications on hand on 07/08/25 at 1:38pm revealed there were 11 tablets of HCTZ 12.5mg available for administration. Interview with Resident #4 on 07/08/25 at 3:32pm	D 358		

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D 358	Continued From page 28 revealed: -She took blood pressure medications and her blood pressures were "good". -She did not remember any instances she felt dizzy or lightheaded. -Staff brought her medications to her and she was not sure of the names of the medications she took. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/08/25 at 10:06am revealed: -HCTZ 12.5mg 30 tablets were dispensed for Resident #4 on 04/05/25 and 05/22/25. -Resident #4's HCTZ 12.5mg should have run out depending on how often it was held or if she received the medication from another pharmacy. -HCTZ was a medication to control blood pressure and reduce water retention. -If Resident did not receive HCTZ 12.5mg as prescribed she could have unstable blood pressures resulting in a hypertensive crisis or low blood pressures increasing the risk of falls. Interview with a medication aide (MA) on 07/08/25 at 2:03pm revealed: -The MAs were responsible for checking Resident #4's blood pressure and pulse prior to administering her HCTZ 12.5mg. -She had administered Resident #4's HCTZ 12.5mg one tablet to Resident #4 when her heart rate was less than 60. -She focused on Resident #4's blood pressure parameters and because she was going "too fast" she missed Resident #4's heart rate was outside of parameters. -She was unsure if any eMAR audits were completed. Refer to the interview with the Resident Care	D 358		

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D 358	Continued From page 29 Coordinator (RCC) on 07/08/25 at 4:02pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm. Refer to the interview with the Administrator on 07/08/25 at 4:57pm. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 07/08/25 at 11:15am was unsuccessful. b. Review of Resident #4's current FL2 dated 02/24/25 revealed: -There was an order for lisinopril (a medication to lower blood pressure) 40mg one tablet daily. -The order indicated there were parameters for the medication. Review of Resident #4's signed physician's orders dated 06/30/25 revealed: -There was an order for lisinopril 40mg one tablet daily. -Lisinopril 40mg one tablet daily was to be held for systolic blood pressure of 100 or less and/or for heart rate less than 60 and staff were to contact the primary care provider (PCP) for further orders. Review of Resident #4 May 2025 electronic medication administration record (eMAR) revealed: -There was entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 7 of 31 opportunities lisinopril 40mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60.	D 358		

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D 358	Continued From page 30 -For example, on 05/05/25 at 7:00am Resident #4's heart rate was 50 and lisinopril 40mg one tablet was administered to the resident. -There was 1 of 31 opportunities lisinopril 40mg one tablet was not administered to the resident when her systolic blood pressure was greater than 100 and her heart rate was greater than 60. -On 05/17/25 at 7:00am Resident #4's blood pressure was 101/68 and her heart rate was 65 and lisinopril 40mg one tablet was documented held due to vital signs outside of parameter. Review of Resident #4 June 2025 eMAR revealed: -There was entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 5 of 31 opportunities lisinopril 40mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60. -For example, on 06/20/25 at 7:00am Resident #4's heart rate was 53 and lisinopril 40mg one tablet was administered to the resident. Review of Resident #4 July 2025 eMAR revealed. -There was entry for lisinopril 40mg one tablet daily, hold for systolic blood pressure 100 or less and/or heart rate less than 60 and contact the PCP for further orders. -There were 2 of 7 opportunities lisinopril 40mg one tablet was documented as administered to Resident #4 when her heart rate was less than 60. -For example, on 07/07/25 at 7:00am Resident #4's heart rate was 48 and lisinopril 40mg one tablet was administered to the resident. Observation of Resident #4's medications on	D 358		

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D 358	Continued From page 31 hand on 07/08/25 at 1:38pm revealed there were two tablets of lisinopril 40mg available for administration. Interview with Resident #4 on 07/08/25 at 3:32pm revealed: -She took blood pressure medications and her blood pressures were "good". -She did not remember any instances she felt dizzy or lightheaded. -Staff brought her medications to her and she was not sure of the names of the medications she took. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/08/25 at 10:06am revealed: -Lisinopril 40mg 30 tablets were dispensed for Resident #4 on 03/17/25 and 05/12/25. -Resident #4's lisinopril 40mg should have run out depending on how often it was held or if she received the medication from another pharmacy. -Lisinopril was a medication to lower blood pressure. -If Resident did not receive lisinopril 40mg as prescribed she could have unstable blood pressures resulting in hypertensive crisis or low blood pressures increasing the risk of falls. Interview with a medication aide (MA) on 07/08/25 at 2:03pm revealed: -The MAs were responsible for checking Resident #4's blood pressure and pulse prior to administering her lisinopril 40mg. -She had administered Resident #4's lisinopril 40mg one tablet to Resident #4 when her heart rate was less than 60. -She focused on Resident #4's blood pressure parameters and because she was going "too fast" she missed Resident #4's heart rate was outside	D 358		

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D 358	Continued From page 32 of parameters. -She was unsure if any eMAR audits were completed. Refer to the interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:02pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm. Refer to the interview with the Administrator on 07/08/25 at 4:57pm. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 07/08/25 at 11:15am was unsuccessful. 2. Review of Resident #5's current hospital FL2 dated 05/28/25 revealed diagnoses included diabetes type II. a. Review of Resident #5's signed physician's order dated 05/15/25 revealed: -Resident #5 was to have his finger stick blood sugar (FSBS) four times daily before meals and at bedtime. -There was an order for Humalog (a medication to lower blood sugar levels) 3 units with meals to be given along with sliding scale insulin: 70-100 = 0, 101-149 = 1 unit, 150-199 = 2 units, 200-249 = 3 units, 250-299 = 4 units, 300-349 - 6 units. -The Primary Care Provider (PCP) was to be notified if Resident #5's FSBS was below 80 or greater than 400. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog inject 3 units with meals, give with sliding scale and notify PCP	D 358		

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D 358	Continued From page 33 if FSBS is less than 80 or greater than 400. -There was documentation Resident #5' FSBS on 05/20/25 at 8:00am was 96 and the resident did not receive Humalog 3 units with code "19" documented indicating "outside of parameter". -There was 1 of 22 opportunities Humalog 3 units was documented not administered. Review of Resident #5's June 2025 eMAR revealed: -There was an entry for Humalog inject 3 units with meals, give with sliding scale and notify PCP if FSBS is less than 80 or greater than 400. -There were 18 of 90 opportunities Humalog 3 units was documented not administered with code "19" documented indicating "outside of parameter". -For example, at 8:00am on 06/03/25, 06/11/25 and 06/16/25 Resident #5's FSBS was 72 and Humalog 3 units was documented not administered. Review of Resident #5's July 2025 eMAR revealed: -There was an entry for Humalog inject 3 units with meals, give with sliding scale and notify PCP if FSBS is less than 80 or greater than 400. -There was documentation Resident #5' FSBS on 07/03/25 at 12:00pm was 100 and the resident did not receive Humalog 3 units with code "19" documented indicating "outside of parameter". -There was documentation Resident #5' FSBS on 07/04/25 at 12:00pm was 90 and the resident did not receive Humalog 3 units with code "19" documented indicating "outside of parameter". -There were 2 of 19 opportunities Humalog 3 units was documented not administered. Observation on 07/08/25 at 1:38pm of medications on hand for Resident #5 revealed	D 358		

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D 358	Continued From page 34 there was one Humalog 100units/ml 3ml pen available for administration. Interview with Resident #5 on 07/08/25 at 3:55pm revealed: -The MAs gave him his medication. -He did not know how much insulin the MAs administered to him. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/08/25 at 10:06am revealed: -One Humalog insulin pen containing 3mls was dispensed for Resident #5 on 05/09/25 and 06/02/25. -One Humalog insulin pen containing 3mls should last 28 days. -There was no parameter on the order indicating when to hold Resident #5' Humalog 3 units with meals. -If he did not receive his Humalog insulin as ordered he could have elevated blood sugar levels. Interview with a medication aide (MA) on 07/08/25 at 2:03pm revealed: -The MAs were responsible for checking Resident #5's FSBS prior to administering his Humalog. -Resident #5 had orders for Humalog 3 units before meals and depending on his FSBS he could additionally receive sliding scale Humalog -She held Resident #5's Humalog 3 units when his FSBS were in the 70s because she did not want his blood sugar to drop too low. -She did not realize Resident #5 did not have a parameter for when to hold his Humalog 3 units before meals. -She was unsure if any eMAR audits were completed.	D 358		

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D 358	Continued From page 35 Refer to the interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:02pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm. Refer to the interview with the Administrator on 07/08/25 at 4:57pm. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 07/08/25 at 11:15am was unsuccessful. c. Review of Resident #2's current FL2 dated 07/24/24 reveled: -There was an order for Cardizem 120mg one tablet daily. -There was an order for Valsartan 80mg one tablet twice daily. -The order indicated there were parameters for the medications. Review of Resident #2's Resident Register revealed he was admitted on 08/11/24. Review of Resident #2's signed physician orders dated 06/30/25 revealed: -There was an order for Cardizam 120mg one tablet daily. -The order indicated to hold for systolic blood pressure less than 110 and/or a diastolic blood pressure less than 70 and heart rate less than 60. -There was an order for Valsartan 80 mg one tablet two times daily. -The order indicated to hold for systolic blood pressure less than 120 and/or diastolic blood pressure less than 80 and heart rate less than 60. Review of Resident #2's May 2025 eMAR	D 358		

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D 358	Continued From page 36 revealed: -There was an order for Cardizem 120mg one tablet daily. -Cardizem 120mg one tablet daily was to be held for systolic blood pressure less than 110 and/or a diastolic blood pressure less than 70 and heart rate less than 60. There were 3 of 31 opportunities Cardizem 120mg one tablet was administered when her systolic blood pressure was less than 110 and diastolic blood pressure was less than 70. -For example, on 05/02/25 at 7:00am Resident #2's blood pressure was 98/60 and one tablet was documented as given. -There was an order for Valsartan 80mg one tablet twice daily. -Valsartan 80mg one tablet twice daily was to be held for systolic blood pressure less than 120 and/or diastolic blood pressure less than 80 and heart rate less than 60. -There were 27 of 62 opportunities Valsartan 80mg one tablet twice a day was administered when her systolic blood pressure was less than 120 and diastolic blood pressure was less than 80. -For example, on 05/04/25 at 7:00am Resident #2's blood pressure was 133/71 and 7:00pm his blood pressure was 138/78 and Valsartan 80mg was documented as given at 7:00am and 7:00pm. Review of Resident #2's June 2025 eMAR revealed: -There was an order for Cardizem 120mg one tablet daily. -Cardizem 120mg one tablet daily was to be held for systolic blood pressure less than 110 and/or diastolic blood pressure less than 70 and heart rate less than 60. -There was 1 of 31 opportunities Cardizem	D 358		

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D 358	Continued From page 37 120mg one tablet was administered when Resident #2's systolic blood pressure was less than 110 and diastolic blood pressure was less than 70. -For example, on 06/03/25 Resident #2's blood pressure was 138/63 and one tablet was documented as given. -There was an order for Valsartan 80mg one tablet twice daily. -Valsartan 80mg one tablet twice daily was to be held for systolic blood pressure less than 120 and/or diastolic blood pressure less than 80 and heart rate less than 60. -There were 28 of 60 opportunities Valsartan 80mg one tablet twice a day was administered when Resident #2's systolic blood pressure was less than 120 and diastolic blood pressure was less than 80. -For example on 06/03/25 Resident #2 s blood pressure at 7:00am was 138/63 and at 7:00pm was 138/77 and Valsartan 80mg one tablet was given at 7 00am and 7 00pm Review of Resident #2's July 2025 eMAR revealed -There was an order for Cardizem 120mg one tablet daily -Cardizem 120mg one tablet daily was to be held for systolic blood pressure less than 110 and/or diastolic blood pressure less than 70 and heart rate less than 60 -There were 2 of 7 opportunities Cardizem 120mg one tablet was administered when Resident #2's systolic blood pressure was less than 110 and diastolic blood pressure was less than 70. -For example, on 07/05/25 Resident #2's blood pressure was 159/64 and one tablet was documented as given -There was an order for Valsartan 80mg one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036015	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ROBINWOOD	1750 ROBINWOOD ROAD GASTONIA, NC 28054

(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 38 tablet twice daily. -Valsartan 80mg one tablet twice daily was to be held for systolic blood pressure less than 120 and/or diastolic blood pressure less than 80 and heart rate less than 60. -There were 6 of 13 opportunities Valsartan 80mg one tablet twice daily was administered when Resident #2's systolic blood pressure was less than 120 and diastolic blood pressure was less than 80. -For example, on 07/05/25 Resident #2's blood pressure at 7:00am was 159/64 and at 7:00pm was 113/82 and Valsartan 80mg one tablet was given at 7:00am and 7:00pm. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/08/25 at 12:00pm revealed: -Cardizem 120mg and Valsartan 80mg were on cycle fill monthly. -Cardizem 120mg was dispensed 30 tablets on 04/20/25, 05/10/25, and 06/10/25. -Valsartan 80mg was dispensed 60 tablets on 05/12/25 and 06/16/25. -Resident #2 could have an increased risk of dizziness, falling and low blood pressure if Cardizem 120mg and Valsartan 80mg was given when blood pressure was low. Interview with a medication aide (MA) on 07/08/25 at 1:38pm revealed: -She knew about the parameters on Resident #2's blood pressure medication. -She went too fast when she passed medications and needed to slow do. -She missed the parameters because she was so busy. -The MAs did not audit the charts and was not sure if anyone did.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL038015	A. BUILDING: _____ B. WING _____	07/08/2025

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D 358	Continued From page 39 Interview with the Resident Care Coordinator (RCC) on 07/08/25 at 4:02pm revealed: -The MAs were responsible to administer medications according to ordered parameters. -In January 2025, there were issues with MAs administering resident medications when the medication should have been held due to being outside of parameters. -All MAs were retrained in January 2025 regarding medication parameters and vital signs. -When the March 2025 Pharmacist's Medication Regimen Review revealed issues again with parameters, there was mainly one MA making the errors and she was retrained by the facility nurse. Interview with the Health and Wellness Director (HWD) on 07/08/25 at 4:27pm revealed: -The MAs were responsible to administer medications according to ordered parameters. -All MAs were retrained on parameters in January 2025. -When the March 2025 Pharmacist's Medication Regimen Review revealed issues again with parameters, there was mainly one MA making the errors. -The MA who made most of the errors was taken off the medication cart and retrained on medication administration and checked off on medication administration again by the corporate RN. -Audits of the eMARs are done quarterly by the pharmacy. Interview with the Administrator on 07/08/25 at 4:57pm revealed: -The MAs were responsible for following parameters and to follow ordered parameters. -The eMAR audits were completed quarterly by the pharmacy. -The HWD was responsible to follow up on the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 40 quarterly pharmacy reviews.	D 358		