Received via electronic mail on 09/25/25. Spoike to Administrator on 09/25/25 and Owner would not provide all correction dates certain tags on the plan of correction.

PRINTED: 09/04/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 CORF ECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Rowan County Department of Social Services (DSS) conducted an annual and a follow up survey and complaint investigation on 08/08/25 and from 08/11/25 through 08/13/25.	D 000	All exit doors will be equipped with audible alarms. Alarms will be tested daily at shift change and documented. Malfunctions will be reported immediately and corrected within 2 hours.	
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, interviews, and record reviews, the facility failed to ensure 10 of 10 exit doors had engaged audible alarms allowing residents, who were disoriented, to exit the facility without staff's knowledge, including two residents	D 067	Residents at risk for wandering or with intermittent forgetfulness will identified on admission and reassessed quarterly. Care plans specify alarm monitorin and interventions. Staff respond immediately when an alarm sounds. Resident is safely redirected and incident documented. Repeated attempts trigger care pla review. An Alarm Event Log records all activations, including date, time, resident, staff responder, and follov up. Staff are trained on alarm use, response protocol, and respectful resident redirection at hire and during annual in-service.	10.30.2025

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-25-25

Reviewed and Acknowledge by S.A. on 09/29/2025.

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D 067	Continued From page 1 who were intermittently or constantly disoriented (#2, #5). The findings are: Review of Resident #2's current FL2 dated 01/12/25 revealed: -Diagnoses included type 2 diabetes, hypertension morbid obesity, and septic shock. -She was intermittently disoriented. Review of Resident #2's progress notes dated 06/23/25 revealed: -At 2:58am, the resident was found outside after curfew. -She fell asleep and fell out of her wheelchair. -Staff had to call the local fire department to assist with getting the resident off the ground. Observation of Resident #2 on 08/13/25 at 10:12am revealed: -She was sitting in her wheelchair outside of the facility. -The door she exited out of was not locked. -There was no staff supervising her. -She was dozing off while talking. Interview with Resident #2 on 08/13/25 at 10:12am revealed: -She did not recall any alarms ever being on the doors. -She never had to unlock a door to go outside. Review of Resident #5's FL2 dated 11/13/24 revealed: -Diagnoses included chronic pain, alcohol dependence, schizoaffective disorder, major depressive disorder, reflux, tremors, anxiety disorder, and hypertension. -She was constantly disoriented.	D 067	Daily: Alarm testing log completed Monthly: Administrator reviews alarm logs for patterns. Quarterly: Care plans updated.	

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D 067	Continued From page 2 Interview with Resident #5 on 08/13/25 at 10:37am revealed: -She did not recall any alarms ever being on the door over the last 5 years that she had lived at the facility. -She never had to unlock a door to go outside but she remained in her room most of the time. Observation of the exit door in the living room on the North Hall on 08/11/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to the front parking lot, which was next to the highway. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door in the living room on the North Hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The 3-inch by 1-inch white alarm box that would activate the alarm was in the off position. -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door in the living room on the North Hall on 08/13/25 at various times between 10:00am and 4:00pm revealed: -The 3-inch by 1-inch white alarm box that would activate the alarm was in the off position.	D 067		

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D 067	Continued From page 3 -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. -At 5:04pm, the audible alarm was turned on by the surveyor. -The exit door was opened and the alarm sounded for 20 seconds; the door was closed and no staff came to check to see if anyone left the facility. At 5:39pm, a resident exited the door, the door alarmed about 30 seconds and no staff came to check to see if anyone left the facility. Observation of the exit door at the front of the North Hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to the front parking lot, which was next to the highway. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door at the back of the longest North Hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to a stoop that had 8 steps leading to the backyard. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. -At 10:16am, the surveyor placed the slide switch in the on position, the door was opened, and	D 067		

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D 067	Continued From page 4 there was an audible sound. -The door was closed, and the audible sound stopped. -At 10:22am, no staff checked the exit door to see why the alarm sounded. Interview with a resident on 08/12/25 at 10:23am revealed: -He went outside to smoke during the day and night. -He would go out the exit door at the back of the longest North Hall; this door was the closest to his room. -There was no audible alarm when he went outside. -He did not remember a time the exit door alarmed. Observation of the exit door at the back of the North Hall's shortest hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to a stoop that had 6 steps leading to the backyard. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the door was opened. -There were no staff supervising the exit door. -No residents were observed exiting this door. Observation of the exit door at the front of the hallway that separated the North Hall from the South Hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to the front parking lot, which was next to the highway.	D 067		

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D 067	Continued From page 5 -There was no alarm attached to the exit door. -There were visitors, staff, and residents observed entering and exiting the door during the day. -There were no staff supervising the exit door. Observation of the exit door at the back of the hallway that separated the North Hall from the South Hall on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to the backyard. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door beside the South dining room on 08/12/25 at various times between 10:00am and 4:00pm revealed: -The exit door led to a covered porch with chairs; the area was the designated smoking area. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Interview with a second resident on 08/12/25 at 10:52am revealed:	D 067		

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D 067	Continued From page 6 -Most residents would come to the smoking area several times a day. -He went to the smoking area 6 to 8 times daily. -He never heard an alarm on the door when he went outside to smoke. Observation of the exit door on the front of the South Hall, on 08/12/25 at various times between 9:30am and 4:00 revealed: -The exit door led to the front parking lot, which was next to the highway. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. -At 9:32am, a resident entered the exit door and there was no audible sound. Observation of the exit door on the side of the South Hall, on 08/12/25 at various times between 9:30am and 4:00 revealed: -The exit door led to the side yard, which led to the highway. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. -There was a sign posted on the exit door that read, "no one out this door." -There was a second sign posted on the exit door that read, "no smoking after 10:00pm." Observation of the exit door on the back of the South Hall, on 08/12/25 at various times between 9:30am and 4:00pm revealed: -The exit door led to the back yard. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door at the back of the South Hall on 08/13/25 at 10:25am revealed	D 067		

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D 067	Continued From page 7 there were 3 residents outside smoking. Interview with a third resident on 08/13/25 at 10:26am revealed: -He came outside to smoke several times a day; other times he would come outside just to sit and talk with others. -He would go out of other exit doors sometimes to smoke and visit with other residents. -He did not hear door alarms when he opened and closed the exit doors. -He did not know if the doors were alarmed or not. Interview with a fourth resident on 08/13/25 at 10:30am revealed: -He knew some of the exit doors had alarms. -Sometimes the doors would be alarmed; he would cut the alarm off by sliding the black button on the alarm box to off. -No one had told him he could not turn the alarms off. -If the alarm was turned on it would go off when the door was opened but would stop when the door was closed. Interview with a personal care aide (PCA) on 08/13/25 at 2:34pm revealed: -The doors were not alarmed during the day. -The residents would go in and out of the facility during the day as they wanted. -Some residents would go outside to smoke, and others would go outside to sit and visit with other residents. -She had not heard of any residents wandering away from the facility. -There were a few residents who were confused at times, but they did not try to leave the facility. Telephone interview with another PCA on	D 067		

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D 067	Continued From page 8 08/13/25 at 6:45pm revealed: -She worked third shift. -Most of the exit doors had an alarm attached to them; she thought there were three exit doors that did not have alarms. -The alarms should be turned on each night before she came to work. -She did not remember hearing an alarm sound when she entered the building for third shift. -She knew some residents would turn the alarms off and go outside. -Some residents knew how to turn the exit door alarms off. -She had found some residents who had gone outside during the night to smoke. -The residents were not allowed outside to smoke after 10:00pm. Telephone interview with a medication aide (MA) on 08/13/25 at 10:40am revealed: -When she entered the facility in the mornings, the doors were unlocked and unalarmed. -She did not know if the exit doors had an alarm on them; she had not heard a door alarm. -When she worked at the facility about 2 years ago, the doors had alarms and they worked. -There were no residents who wandered in the facility and there were no intermittently or constantly confused residents in the facility. -There were a few residents with dementia, but they did not try to leave the facility. Interview with a second MA on 08/13/25 at 11:15am revealed: -The exit door alarms were turned on during second shift; she did not know what time. -The exit door alarms were turned off during the day shift. -She knew some exit doors did not have an audible alarming device.	D 067		

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D 067	Continued From page 9 -The facility did not have any residents who wandered. -There was only one resident who was confused and she never left the facility. Interview with a third MA on 08/13/25 at 7:39am revealed: -The exit door alarms were turned on around 10:00pm. -There were a few doors that the alarm was broken and a few doors that did not have alarms. -The 3rd shift staff tried to keep a close eye on the doors during the night. -She was not aware of anyone going outside after 10:00pm. -There was one resident who would get confused at times but she had never left the facility. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -The doors should be alarmed from 10:00pm to 6:00am. -She thought there were two doors that did not have alarms on them. -The alarms were turned on and off at each door with a slide switch. -Some residents would turn the alarms off; the residents had been told not to turn the alarms off. -The exit doors that were not alarmed should be locked and monitored by the staff to ensure residents did not exit those doors. -The facility had about 5 residents who were intermittently or constantly disoriented on their FL-2. -The staff would have to follow the sound of the alarming exit door to know which exit door was alarming. -Once the door was closed the alarm would stop and the staff would not know which exit door alarmed.	D 067		

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D 067	Continued From page 10 -There was only one door in the facility that did not have a working audible alarm. -She did not know there were 5 doors that did not have an alarm or a working alarm. -All doors should be locked, and the doors with alarms should be turned on between 9:30pm and 10:00pm and turned off between 6:00am and 6:30am. -She did not realize since she had residents who were disoriented that the alarms should be on at all times. -The staff should check all the exit doors when an alarm sounded to see if a resident had exited the facility. _____ The facility failed to ensure 10 of 10 exit doors were alarmed with an audible sounding device when the door was opened allowing residents who were intermittently or constantly disoriented to go outside the facility without staff's knowledge. One resident (#2), who was intermittently disoriented, went outside after midnight without staff's knowledge, fell out of her wheelchair, and was not discovered until 2:58am. The facility's failure resulted in a substantial risk for serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2025.	D 067		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And	D 074		

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D 074	Continued From page 11 Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the floors were kept in good repair related to slipping floor tiles, tiles with duct-tape, and a gap in the floor in the hallways. The findings are: Review of the environmental inspection report from the local county health department dated 06/10/25 revealed: -The facility received 10 demerits. -There was cracked tile or laminate floor damaged in the hallways. Observation of the North Hall on 08/11/25 at	D 074	All affected areas with cracked tile c damaged laminate flooring were inspected and temporarily marked with visible caution signage to prevent resident, staff, and visitor injury. Housekeeping and care staff have been instructed to provide addition supervision in the hallways until the repairs are completed. Residents with mobility impairment will be assisted and redirected away from affected areas whenever possible. Bethamy Retirement Center has contracted Mr. Maintenance & Remodeling to complete all necessary floor repairs and replacements in the hallways. Work is scheduled to begin immediately. After the repairs, the Administrator and Maintenance Supervisor will inspect the flooring to confirm it is safe, free of cracks, and meets regulatory requirements.	

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D 074	Continued From page 12 9:00am revealed: -The floor that transitioned the hallway and the activity room adjacent to the North Hall dining room had a missing tile with a gap in the floor. -The floor outside the kitchen and dining room had several loose tiles and some tiles were held down with duct-tape that was peeling. Observation of South Hall on 08/11/25 at 9:15am revealed the hallway floor outside the dining room had several loose tiles and a some of those tiles were held down with duct-tape that was peeling. Observation of the North Hall of the facility on 08/11/25 at 11:45am revealed: -Residents stumbled (without falling) by catching their feet in the gap from the missing tile hallway floor that transitioned the activity room to the North Hall dining room. -Residents' rollators tilted and caused residents difficulty transitioning between the hallway and the activity room of the North Hall. -Residents stumbled (without falling) by catching their feet on the loose tiles and duct tape from the hallway floor outside the kitchen and resident dining room. Observation of the South Hall on 08/11/25 at 12:45pm revealed residents stumbled (without falling) by catching their feet on the loose tiles and duct tape from the hallway floor outside the dining room. Interview with a resident who resided on the North Hall on 08/12/25 10:10am at revealed: -The duct tape on the floor tiles outside of the North Hall dining room had been there for as long as he could remember. -He had stumbled on the duct tape and the loose tiles numerous times.	D 074	The Maintenance Supervisor will conduct monthly facility walk-throughs to identify and documen any flooring or structural concerns Any reported flooring issues will b logged in the maintenance work order system and addressed withir 48 hours. Staff will be re-educated to promp report flooring or environmental safety hazards to administration. Mr. Maintenance & Remodeling wi continue to provide annual preventative maintenance checks and repairs as needed to ensure long-term compliance. Executive Director/Administrator – oversight and compliance Maintenance Supervisor – monitoring, documentation, and follow-up Mr. Maintenance & Remodeling – contracted floor repair and replacement	10.30.2025

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D 074	Continued From page 13 -He had not noticed any maintenance staff in the facility to fix the floors. -He was aware of the gap in the floor from a missing tile on the North Hall because his rollator fell into the gap on occasion and he had difficulty maneuvering his rollator out. Interview with a resident who resided on the South Hall on 08/12/25 4:20pm at revealed: -The duct tape on the floor tiles outside of the South Hall dining room had been there for months. -She and the other residents had stumbled on the duct tape and the loose tiles several times. -She had not noticed any maintenance staff in the facility to fix the floors. Interview with a housekeeper on 08/11/25 at 10:00am revealed: -She was a housekeeper for both the North and the South Hall. -She was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room. -Both residents and staff had stumbled on the duct tape, the gap from the missing tile, and the loose tiles. -She had reported the issues to the Administrator within the last couple of weeks because she stumbled on the duct tape from the floors. -She was not aware of any plans to fix the repairs for the floors on the North and South Hall. -The floor issues had continued for the last couple of months. -She and the housekeeping staff were previously responsible for conducting weekly room and facility audits for maintenance concerns but she was not sure who was responsible now. -The Administrator was responsible for providing	D 074		

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D 074	Continued From page 14 the results of the weekly room and facility audit logs to the Owner for maintenance repairs. Interview with another housekeeper on 08/12/25 at 9:45am revealed: -He was a housekeeper for the whole building. -He was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room. -Both residents and staff had tripped on the duct tape, the hole from the missing tile, and the loose tiles. -He had reported the issues to the Administrator over the last month. -The housekeeper thought the issue had been addressed and the floor would be fixed soon. -He, the housekeeping staff, personal care aides (PCA), and the medication aides (MA) were responsible for monitoring maintenance issues and reported any concerns to the Administrator. -The housekeeping staff used to complete weekly audits on the building and the residents' rooms to report maintenance needs to the previous Administrator. -He was not sure who was responsible now because the procedures had changed since the new Administrator started in April. Request for the Facility Maintenance Room Audit Log for June 2025 through August 2025 was made on 08/12/25 at 5:00pm and on 08/13/25 at 11:45am and was not provided for review. Interview with a PCA on 06/26/24 at 10:05am revealed: -She was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room.	D 074		

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D 074	Continued From page 15 -She was aware that both residents and staff had stumbled on the duct tape, the gap from the missing tile, and the loose tiles. -She had not noticed any maintenance staff in the building working on the floors. -The issues had continued for the last couple of months and she was not aware of any plans for the floors to be fixed. Interview with a MA on 06/26/24 at 10:05am revealed: -She was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room. -She was aware that both residents and staff had stumbled on the duct tape, the hole from the missing tile, and the loose tiles. -The floors were repaired several months ago but residents with wheelchairs and powered scooters caused the tiles and duct tape to tear by rolling across the floor quickly. -She and the PCAs had reported the hallway floor issues to the Administrator within the last month but had heard nothing about the progress of any repairs. Interview with the Administrator on 06/26/24 at 11:15am revealed: -She was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room. -She was not aware that both residents and staff had tripped on the duct tape, the hole from the missing tile, and the loose tiles. -She was unaware if any repair projects were completed before her start date of April 2025 and she had no documentation for estimates or completed maintenance work.	D 074		

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D 074	Continued From page 16 -The Administrator recognized maintenance repair issues upon her start date of April 2025 and sent daily emails to the Owner about maintenance concerns. -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs and the Owner contacted the Administrator the day the contracted maintenance staff was scheduled to arrive at the facility. -She had notified the Owner when repair projects were not completed by the contracted maintenance staff after the contracted maintenance staff told the Owner the repair projects were finished. -Completing maintenance projects were difficult due to the history of unpaid repair projects by the Owner. -She expected the maintenance repair projects to be completed in a prompt manner when maintenance issues were addressed from her communication with the Owner. -She expected a chain of communication from both the Owner and the contracted maintenance staff on the progress of maintenance repair projects. Telephone interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware of the duct tape on the South and North hallway floors due to loose tiles and was aware of the missing tile on the North Hall near the activity room. -He was not aware that both residents and staff had tripped on the duct tape, the hole from the missing tile, and the loose tiles. -The floors were repaired several months ago but residents with wheelchairs and powered scooters caused the tiles and duct tape to tear by rolling across the floor quickly. -The floor tile had "outlived its use" and he	D 074		

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D 074	Continued From page 17 planned to replace with new flooring. -Previous maintenance projects were not completed satisfactorily due to the former contracted maintenance staff being unreliable. -The Owner and the contracted maintenance staff had communicated on a constant basis and the Owner had provided updates to the Administrator. -When asked about concerns about funding available for needed repairs and supplies the Owner responded, there were no issues that should have delayed the completion of the maintenance repair projects. -He expected the Administrator to report maintenance concerns in a timely manner and for the contracted maintenance staff to complete repair projects in a timely manner. Attempted telephone with the facility's previous contracted maintenance worker on 08/12/25 at 1:30pm and on 08/13/25 at 10:40am were unsuccessful. The facility failed to ensure the floors were kept in good repair related to the floors on the South Hall which had loose tiles and duct tape on the floor. The hallway floor on the North Hall outside the dining hall also had loose tiles and duct tape on the floor and there was a missing tile from the hallway floor outside the activity room of the North Hall with a gap. This failure resulted in residents stumbling and being exposed to trip hazards, which resulted in substantial risk for harm and injury, which constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 08/13/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER	D 074		

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D 074	Continued From page 18 12, 2025.	D 074	Bethamy Retirement Center contracted At Ease Pest Control to conduct professional bed bug treatment on August 27, 2025, and August 28, 2025. All identified rooms and common areas received thorough inspection and treatment according to industry standards for bed bug eradication. Affected resident belongings (mattresses, box springs, and upholstered furniture) were inspected, encased, or treated as recommended by the pest control company. Monitoring & Inspections Weekly bed bug checks will be performed by housekeeping and nursing staff during room cleaning. Any suspected sightings will be immediately reported to the Administrator and At Ease Pest for follow-up treatment if needed.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to maintain an environment that was clean and free from hazards, as evidenced by an active infestation of bedbugs. The findings are: Review of the environmental inspection report from the local county health department dated 06/10//25 revealed the facility received 10 demerits. Review of information about bed bugs from the Centers for Disease Control (CDC) dated	D 079		

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D 079	Continued From page 19 04/26/24 revealed: -Bed bug infestations usually happened around where people slept. -Bed bugs hid during the day in the seams of mattresses, box springs, bed frames, headboards, dressers, in cracks, in crevices, and behind wallpaper. -Bed bugs could travel over 100 feet at night but tended to live within eight feet of where people slept. -Signs of infestations included bites on the face, neck, arms, and other parts of the body, exoskeletons and live bed bugs in the folds of mattresses and sheets, rusty colored blood spots on mattresses, sheets, and nearby furniture, and a sweet musty odor. -Professional pest control companies should be contacted to treat bed bug infestations. Review of the Facility's Pest Control and Bedbug Policy and Procedures revealed the facility's purpose was to maintain a safe, clean, and comfortable living environment for residents, staff, and visitors by effectively managing pest control and preventing, identifying, and addressing bedbug infestations in a timely and humane manner. Observations of resident room #4 on the South Hall on 08/08/25 at 9:25am revealed: -There were several live bed bugs in between the resident's bed mattress and box spring at the head of the bed. -There were live bed bugs on the curtains. -There was bed bug waste on the floors, walls, and windows. Observation of resident room #4 on 08/11/25 at 1:20pm revealed: -There were live bed bugs on the curtains and	D 079	Residents in treated rooms were temporarily relocated during treatment for safety. Staff assisted with laundering all be linens, clothing, and curtains on hig heat cycles to eliminate pests and eggs. In-service training provided to staff on August 26, 2025, on recognizing signs of bed bugs, proper reporting procedures, and containment steps. Training will be reinforced quarterly to ensure ongoing awareness. Treatment reports from At Ease Pes dated 08/27/2025 and 08/28/2025 will be maintained on file for DHSR review. A log of inspections, treatments, an staff reports will be kept in the facility's maintenance binder. Mattress and box spring encasements have been purchased and will be installed to reduce the risk of recurrence. Facility will maintain a standing service agreement with At Ease Pes for ongoing prevention and emergency response. Initial corrective actions completed by August 28, 2025.	

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D 079	Continued From page 20 between the resident's bed mattress and box spring at the head of the bed. -There was bed bug waste on the floors, walls, and windows. Interview with the resident who resided in resident room #4 on 08/08/25 at 9:30am revealed: -She noticed the bed bugs in her room and the bed bugs were an ongoing issue. -She felt the bed bugs crawling on her in the middle of the night while she attempted to sleep. -She had reported the bed bugs to the personal care aides (PCAs) and the medication aides (MAs) but nothing had been done about the bed bugs in her room. Observation of resident room #3 on the South Hall on 08/08/25 at 9:45am revealed: -There were a couple live bed bugs crawling on a resident's bed sheet on the left at the head of the bed. -There was bed bug waste on the floor by the resident's bed. -The wall and floor behind the resident's headboard were covered in bed bug waste. Interview with the resident who resided in resident room #3 on 08/08/25 at 9:50am revealed: -He knew there were bed bugs in his bed and he had smashed one this morning that was crawling across his shirt sleeve. -He felt the bed bugs crawling on him in the middle of the night. Observation of resident room #7 on the North Hall on 08/08/25 at 10:05am revealed: -There were live bed bugs under the resident's bed sheet at the head of the bed. -There were multiple small blood stains on the sheet of the bed.	D 079	Administrator and Housekeeping Supervisor will ensure compliance with this plan.	

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D 079	Continued From page 21 -There was bed bug waste on the walls, floors, and windows. Interview with the resident who resided in resident room #7 on 08/08/25 at 10:10am revealed: -He had not seen any bed bugs in his room for "a while". -He did not know what the black spots were on his wall or on his floor. -He did not know when his sheets were washed. Observation of resident room #5 on the North Hall on 08/08/25 at 10:15am revealed: -There were live bed bugs under the resident's bed. -There was bed bug waste on the floors. Interview with the resident who resided in resident room #5 on 08/08/25 at 10:20am revealed: -He had seen bed bugs "off-and-on" in his room but thought the issue had been resolved. -He felt the bed bugs crawling on him in the middle of the night while he tried to sleep. -He was not aware of the bed bug waste on floors because he had not looked under his bed. Telephone interview with the pest control technician from the facility's previous contracted pest control company on 08/08/25 at 1:45pm revealed: -The pest control company had treated the facility for bed bugs on 06/09/25. -She was not aware of what pest control company treated the facility previously. -She had given tasks to do at the facility between treatments and advised the Owner the liquid spray treatment would only be effective if the suggested steps were followed by the staff. -She told the facility staff to wash and dry the residents' clothes and bedsheets on high heat	D 079		

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D 079	Continued From page 22 between treatments but felt this was not followed due to an inoperative dryer. -She had seen bed bugs all over the facility, but they were the worst in the residents' rooms on the North Hall. -If the facility was not doing the preventative steps needed between treatments, the bed bug infestation would never be resolved. -She had received no communication from the facility staff or Owner about live bed bugs since the bed bug treatment on 06/16/25 or from a general pest treatment on 07/26/25. Observation of the facility on 08/11/25 at 9:00am revealed a visit by a pest control technician from the facility's current contracted pest control company. Interview with the pest control technician from the facility's current contracted pest control company on 08/11/25 at 9:55am revealed: -The Owner had contacted the pest control company on 08/08/25 in the evening to come out for a bed bug analysis on 08/11/25. -The last time he treated the facility for bed bugs was a year ago when he sprayed the North Hall and did not return to treat the South Hall due to non-payment from the Owner. -He had given the facility a list of things to do at the facility between treatments and advised the Owner the liquid spray treatment would only be effective if the suggested steps were followed by the staff. -He told the facility staff to wash and dry the residents' clothes and bedsheets on high heat between treatments at a laundromat outside of the facility. -If the facility was not doing the preventative steps needed between treatments, the bed bug infestation would never be resolved.	D 079		

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D 079	Continued From page 23 -He had analyzed resident room #7 on the North Hall from his visit today (08/11/25) and found a bed bug infestation. -The Owner and facility staff were required to follow the instructions to wash and dry the residents' clothes and bedsheets on high heat between treatments at a laundromat outside of the facility for the bed bug infestation to be resolved. -The Owner requested the pest control technician analyze bed bug activity for resident room #7 on the North Hall but he observed further bed bug infestation across the entire building during his visit. Telephone interview with the primary care provider (PCP) for the residents at the facility on 08/13/25 at 1:30pm revealed: -Bed bugs in the facility put the residents at risk for skin irritation and bed bug bites that were left untreated could become infected. -She was aware there were bed bugs at the facility and she had told the staff to treat the residents' beds/rooms for bed bugs. -She had noticed bed bug bites on residents within the last several weeks but the PCP had not noticed any bites recently. Interview with a housekeeper on 08/11/25 at 10:00am revealed: -She was aware of bed bugs in resident rooms throughout the facility and there had been an ongoing issue with bed bugs for the past year. -The pest control company had treated the facility previously for bed bugs but the spray the pest control technician used seemed ineffective to kill the bed bugs. -She brought her own 'homemade" spray that was alcohol based and the facility staff also used a bed bug spray from the local store.	D 079		

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D 079	Continued From page 24 -She and the facility staff made the Business Office Manager (BOM) and the Administrator aware of the bed bug activity across the facility within the last month. -She was not aware that any residents were having issues with bed bug bites or with bed bugs crawling on them at night. Interview with another housekeeper on 08/12/25 at 9:45am revealed: -The pest control company sprayed at the facility one day within the last two months, but he could not recall the date. -The facility was treated for bed bugs by staff with a bed bug spray every day. -He sprayed some days but not every day and the bed bug spray was kept in the housekeeping closet. -Staff dried the residents' clothes with the dryer at the facility several times to treat the bed bugs. -He and the facility staff made the BOM aware of the bed bug activity across the facility within the last couple weeks. Observation of a bed bug spray used by the housekeeping staff on 08/13/25 at 2:25pm revealed: -It was a home pest control bed bug killer that killed bed bugs for up to 16 weeks on ceramic non-porous surfaces. -The bed bug spray label indicated success of the product depended on proper application and the severity of the infestation (professional treatment may be necessary). Interview with a personal care aide (PCA) on 08/08/25 at 11:30am revealed she had not seen the BOM or the Administrator address the residents' concerns related to the bed bugs in their rooms.	D 079		

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D 079	Continued From page 25 Interview with the MA on 08/08/25 at 4:20pm revealed: -She knew there were bed bugs in the residents beds and rooms, because she had seen them. -She saw the blood stains on the residents' sheets when she helped wash them. -She did not know that was a sign the bed bugs had bitten the residents. -She had told the BOM and the Administrator about the bed bugs but was not aware of the any plans to treat the residents rooms. Interview with the BOM on 08/08/25 at 12:10pm revealed: -Several pest control companies treated the facility throughout the last year for bed bug infestation but the spray treatments seemed ineffective. -She was aware of the bed bug issue over the last year since she started but was not aware of current active bed bugs in residents' rooms. -No staff had made her aware of bed bug activity in residents' rooms or on residents within the last two weeks. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -She was aware of the current bed bug situation. -She had persistently communicated with the Owner about the ongoing bed bug issue not being resolved since her arrival in April 2025. -She attempted to contact pest control companies the facility had previously used but they would not come because of the Owner's past due invoices. -She contacted a pest control company in June 2025 and had the North Hall treated for a bed bug infestation with the treatment seeming ineffective. -She was not aware of the pest control technicians' instructions for staff to wash and dry	D 079		

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D 079	Continued From page 26 the residents' clothes and bed sheets on high heat between treatments at a laundromat outside of the facility for the bed bug infestation to be resolved. -She was not aware if the pest control technicians' suggestions were sent to the Owner; she had never seen the instructions. Telephone interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware of the bed bug situation at the facility and contacted a pest control company last Friday (08/08/25). -He had used a previous pest control company to treat the bed bug infestation but was not sure if the spray treatment was effective to eliminate the bed bugs. -The current pest control company committed to send him the preparation instructions by email communication and the Owner sent any communication to the Administrator. -The previous pest control company provided the Owner with preparation instructions and suggestions which his previous Administrator felt she carried out to resolve the bed bug issue. -He was not sure if previous pest control companies had provided honest and effective bed bug treatment services since the issue was ongoing. -He was not aware of a bed bug infestation until the current pest control company technician communicated with him but this was a work-in-progress. -He was not aware residents were concerned about bed bugs crawling on them in the middle of the night. -He expected the facility staff to communicate any bed bug issues with the Administrator and expected the Administrator to follow-up with him so he could provide timely treatment of pest	D 079		

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D 079	Continued From page 27 control issues. The facility failed to ensure that 4 resident rooms were clean and safe, as evidenced by an active, ongoing infestation of bedbugs. The facility staff were not following recommendations provided by the pest control technician to eliminate the bedbugs. This failure resulted in resulted in serious neglect, which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/25. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2025.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the air conditioning units in six resident rooms on the North and South Hall were maintained in an operating condition.	D 105	On August 12, 2025, the facility contracted with McManus Refrigeration, a licensed HVAC company, to repair and service the air conditioning units. Repairs were initiated on this date to restore proper cooling throughout resident care areas.	

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D 105	Continued From page 28 The findings are: Review of the environmental inspection report from the local county health department dated 06/10/25 revealed: -The facility received 10 demerits. -There was several p-tech (air conditioning units) with the fronts missing off them and some were broken and in poor repair. Observation of resident room #4 on the South Hall on 08/08/25 at 9:25am revealed: -The air conditioner was running and was blowing hot air. -The temperature in resident room #4 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in resident room #4 on 08/08/25 at 9:30am revealed: -It got too hot in her room and she could not get cold air when she turned on the air conditioning unit. -She opened her bedroom door and opened her window so that she could get cool air. Observation of resident room #8 on the South Hall on 08/08/25 at 9:45am revealed: -The air conditioner was running and was blowing hot air. -The temperature in resident room #8 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in resident room #8 on 08/08/25 at 9:50am revealed: -It got too hot in his room and the unit had not worked correctly since he first moved into the facility which was close to a year ago.	D 105	Residents were closely monitored for signs of heat stress or discomfort during the time the AC units were not fully operational. Staff provided additional hydration and ensured fans were in place to maintain a safe indoor environment. Common areas were kept cool using temporary portable units until full repairs could be completed. McManus Refrigeration began repairs on August 12, 2025, and is actively working to restore all air conditioning units to proper working order. The facility will obtain documentation from McManus Refrigeration confirming completion of all necessary repairs. Any additional service recommendations from McManus Refrigeration will be implemented immediately.	

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D 105	Continued From page 29 -He had walked around his room drenched in sweat to the point "he looked like he took a shower in his sweat" and would have to change his clothes. -He opened his bedroom door and opened his window so that he could get cool air. -He could not get cold air when he turned on the air conditioning unit. -He had reported the issues with his air conditioning unit to the personal care aides (PCA) and medication aides (MA) but he had not seen a maintenance staff fixing anyone's air conditioning units in the facility. Observation of resident room #3 on the South Hall on 08/08/25 at 10:00am revealed: -The air conditioner was running and was blowing hot air. -The temperature in resident room #3 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in room #3 on 08/08/25 at 10:05am revealed: -It got hot in his room and the air conditioning unit seemed to always blow hot air even when he turned the unit to low. -He opened his window so that he could get cool air. -He had difficulty sleeping at night due to the humidity in his room. -He had reported the issues with his air conditioning unit to the PCAs within the last couple weeks but he had not seen a maintenance staff come to fix his unit. Observation of resident room #7 on the North Hall on 08/08/25 at 10:10am revealed: -The air conditioner was running and was blowing hot air.	D 105	The facility will establish a preventive maintenance contract with McManus Refrigeration to provide quarterly inspections and servicing of all HVAC systems. The Administrator and Maintenance Supervisor will review HVAC maintenance logs monthly. Any concerns will be reported during leadership meetings and corrective actions documented.	

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D 105	Continued From page 30 -The temperature in resident room #7 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in resident room #7 on 08/08/25 at 10:15am revealed: -It got too hot in his room and he could not get cold air when he turned on his air conditioning unit. -He slept most of the time in his bed with less clothes and no blanket to avoid getting hot. -He opened his bedroom door and opened his window so that he could get cool air. -He had reported the issues with his air conditioning unit to the Administrator within the last month but he had not seen a maintenance staff come to fix his unit. Observation of resident room #5 on the North Hall on 08/08/25 at 10:20am revealed: -The air conditioner was running and was blowing hot air. -The front cover was missing from the unit. -The temperature in resident room #5 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in resident room #5 on 08/11/25 at 10:25am revealed: -The air conditioning unit in his room never worked to cool the room down but he knew the unit would blow hot air if he was cold. -The previous Administrator replaced the air conditioning units with the hallway units but the replacements only blew cold for the first couple of months. -He had reported the issues of his room's air conditioning unit to the PCAs numerous times within the last month but he stopped reporting the issues with his air conditioning unit because no	D 105		

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D 105	Continued From page 31 one had completed any repairs. Observation of resident room #3 on the North Hall on 08/08/25 at 10:30am revealed: -The air conditioner was running and was blowing hot air. -The temperature in resident room #3 felt hot and the temperature setting on the air conditioner was set to cold. Interview with a resident who resided in resident room #3 on 08/08/25 at 10:35am revealed: -It got too hot in his room and he constantly had issues with hot air blowing from his air conditioning unit. -He had reported the air conditioning issue to the PCAs and the Administrator but no repairs had been completed to the unit in his room. Interview with a PCA on 08/08/25 at 11:30am revealed: -She was aware the air conditioning units in the residents' rooms were blowing hot air because some of the residents had complained to her within the last month. -She had told the Business Office Manager (BOM) and the Administrator about the air conditioning units not working in the residents' rooms within the last month but had seen no maintenance worker fixing the units recently. Interview with a MA on 08/11/25 at 8:47am revealed: -Residents had complained about it being hot in their rooms and about their air conditioning units blowing hot air. -The housekeeping staff were responsible for completing room audits and for reporting maintenance issues to the Administrator so she had not reported the residents' complaints about	D 105		

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D 105	Continued From page 32 the air conditioning units to the Administrator. -"Management knows the units in the rooms don't work." Interview with a housekeeper on 08/11/25 at 10:00am revealed: -She was a housekeeper for both the North and South Halls. -She was not aware of the air conditioning units in the residents' rooms blowing hot air. -Neither residents nor staff had reported any information about the air conditioning units not working correctly. -She and the housekeeping staff were previously responsible for conducting weekly audits for maintenance concerns. -She was not aware if anyone was responsible for conducting weekly audits now since the new Administrator started in April 2025. -The Administrator was responsible for providing updates to the Owner for maintenance repairs. Request for the Facility Maintenance Room Audit Log for June 2025 through August 2025 was made on 08/12/25 at 5:00pm and on 08/13/25 at 11:45am and was not provided for review. Interview with the BOM on 08/08/25 at 12:10pm revealed: -Several contracted maintenance workers had repaired the hallway air conditioning units and some of the air conditioning units in the residents' rooms over the last several months. -She was not aware of current air conditioning units blowing hot air in the residents' rooms because no issues had been reported by staff recently. -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs and she was not aware if any repair projects were	D 105		

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D 105	Continued From page 33 scheduled for the air conditioning units in the residents' rooms. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -Some of the air conditioning/heating units in the resident rooms were older. -She was not aware of current air conditioning units blowing hot air in the residents' rooms because no issues had been reported by staff recently. -She was not aware residents were complaining about the hot air blowing from the air conditioning units or that residents had lost sleep or walked around in sweaty clothes due to the heat in their rooms. -She would have reported any maintenance concerns to the Owner who was responsible for arranging for the contracted maintenance staff to complete repairs. -She expected staff to report any concerns related to air conditioning units in resident rooms in a timely manner to resolve any issues with residents experiencing room unit concerns. Interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware some of the air conditioning units in the residents' rooms were not working correctly and had arranged for a maintenance contractor to repair the units over the last several months. -Previous maintenance projects were not completed satisfactorily due to the former contracted maintenance staff being unreliable. -He was not aware residents were complaining about the hot air blowing from the air conditioning units in their rooms and would not have expected the residents to endure those conditions. -He expected the facility staff and the Administrator to report maintenance issues in a	D 105		

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D 105	Continued From page 34 timely manner so he could have arranged repairs to the residents' air conditioning units. Attempted telephone interviews with the facility's previous contracted maintenance staff on 08/12/25 at 1:30pm and on 08/13/25 at 10:40am were unsuccessful. Review of the National Weather Service report for June 2025 revealed North Carolina had experienced its warmest June on record, with an average temperature of 88.5°F and the highest temperature reaching 99°F. Review of the National Weather Service report for July 2025 revealed the average temperature was 92°F, with the highest temperature reaching 100°F. Review of the National Weather Service report for August 2025 revealed: -Average daily high temperatures were 88°F and average daily low temperatures were 71°F. -High heat and humidity were expected, which was typical for August in North Carolina. The facility failed to ensure six air conditioning units in resident rooms were operating correctly as evidenced by the units blowing hot air despite the control being on the cool setting. Residents were complaining about their rooms being hot and having trouble sleeping. The facility's failure was detrimental to the health, safey and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/25. THE CORRECTION DATE FOR THE TYPE B	D 105		

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D 105	Continued From page 35 VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2025.	D 105	Service Contract Initiated: The facility contacted McManus Refrigeration, a licensed HVAC anc plumbing service company, to inspect, repair, and certify the hot water heater for proper operation. Immediate Repairs: McManus Refrigeration began wor on the hot water heater system on August 12, 2025, addressing deficiencies and performing necessary maintenance to ensure consistent delivery of hot water within the safe temperature range. While repairs were pending, staff monitored water temperature befc use in resident care areas to prevent risks of scalding or inadequate sanitation. Post signag regarding temperature of water.	
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 3 of 5 fixtures sampled that were less than 100 degrees and were readily accessible and used by residents. The findings are: Review of the environmental inspection report from the local county health department dated 06/10/25 revealed: -The facility received 10 demerits. -Hot water temperatures ranged from 88-105 degrees F. -Residents consistently mentioned water being extremely hot water first thing and then cold water throughout the day.	D 113		

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D 113	Continued From page 36 Observation of the bathroom in resident room #10 on the North Hall on 08/11/25 at 9:55am revealed the water temperature in the bathroom shower was 95.0 degrees Fahrenheit (F). Second observation of the bathroom in resident room #10 on the North Hall on 08/21/25 at 1:45pm revealed the water temperature in the bathroom sink was 95.0 degrees F. Interview with a resident who resided in resident room #10 on the North Hall on 08/11/25 at 10:05am revealed: -Her shower water temperature had been cold for the last several months. -She had let the personal care aides (PCA), the medication aides (MA), the housekeeping staff, and the Administrator know her shower water temperatures were cold and they told her to use the shower in the common bathroom shower on the North Hall. -She had not seen any maintenance worker in her room to address or fix the cold water temperatures in her bathroom. -She preferred to use her own shower in her bathroom instead of being told to use the common bathroom shower on the North Hall. Observation of the bathroom in resident room #9 on the North Hall on 08/11/25 at 10:10am revealed the water temperature in the bathroom shower was 95.0 degrees F. Second observation of the bathroom in resident room #9 on the North Hall on 08/12/25 at 1:50pm revealed the water temperature in the bathroom sink was 95.0 degrees F. Interview with a resident who resided in resident	D 113	McManus Refrigeration will perforr quarterly inspections and routine maintenance of the hot water heat system, documenting all services and corrective actions taken. Facility staff will record and log wat temperatures at multiple resident-use points daily to verify complianc with state regulations. Any deviations outside of regulato standards will be immediately reported to McManus Refrigeratior for prompt resolution. Direct care and housekeeping staff have been trained on safe hot wate practices, monitoring protocols, an the importance of promptly reporting any irregularities. McManus Refrigeration – Inspectio repair, and ongoing maintenance. Maintenance Director – Daily temperature monitoring and oversight. Executive Director – Ensuring compliance and reporting to regulatory authorities.	

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D 113	Continued From page 37 room #9 on the North Hall on 08/11/25 at 10:05am revealed: -His shower water temperature was either cold or lukewarm for the last several months. -He had not seen any of the facility staff ever take water temperatures while the staff were in his room. -He showered in cold water because he preferred not to use the common bathroom shower on the North Hall. Observation of the bathroom in resident room #8 on the North Hall on 08/11/25 at 10:15am revealed the water temperature in the bathroom shower was 95.0 degrees F. Second observation of the bathroom in resident room #8 on the North Hall on 08/12/25 at 1:55pm revealed the water temperature in the bathroom sink was 95.0 degrees F. Interview with a resident who resided in resident room #8 on the North Hall on 08/11/25 at 10:05am revealed: -His shower temperature had been cold for the last couple months. -He had let the MAs, the housekeeping staff, and the Administrator know his shower water temperatures were cold and they told him to use the shower in the common bathroom shower on the North Hall. -He had not seen any of the facility staff ever take water temperatures while the staff were in his room. -He showered in cold water because he preferred not to use the common bathroom shower on the North Hall. Calibration of the surveyors' thermometers using an ice-water slurry on 08/12/25 at 2:00pm	D 113		

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D 113	Continued From page 38 revealed: -The thermometers read 32 degrees F indicating no adjustment to hot water temperatures were required due to calibration. -The facility thermometer could not be calibrated due to being an infrared thermometer. Request for the Facility Maintenance Room Audit Log for June 2025 through August 2025 was made on 08/12/25 at 5:00pm and on 08/13/25 at 11:45am and was not provided for review with the month of March 2025 being the most recent record. Interview with a housekeeper on 08/11/25 at 10:00am revealed: -She was a housekeeper for both the North and the South Hall. -She was aware of the cold shower temperatures in residents' rooms on the North Hall due to the residents complaining about their concerns to her. -She had reported the issues to the Administrator within the last several weeks but she was not aware of any plans to fix the shower water temperatures on the North Hall. -She and the housekeeping staff were previously responsible for conducting weekly audits for maintenance concerns but she was not aware of that task being assigned to anyone presently. -The Administrator was responsible for providing the results of the weekly audit logs to the Owner for maintenance repairs. Interview with a PCA on 08/13/25 at 11:00am revealed: -She was aware of the cold shower temperatures in residents' rooms on the North Hall due to the residents complaining about their concerns to her.	D 113		

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D 113	Continued From page 39 -She had reported the issues to the Administrator but she was not aware of any plans to fix the shower water temperatures on the North Hall. -She was told to have the North Hall residents use the shower in the common bathroom on the North Hall if they experienced cold water in their showers but she was unable to remember who told her that information. -The housekeeping staff were responsible for taking water temperatures in residents' bathrooms. Interview with a MA on 08/13/25 at 12:30pm revealed: -She was aware of the cold shower temperatures in residents' rooms on the North Hall due to the residents complaining about their concerns to her. -She had reported the issues to the Administrator but she had not seen any maintenance workers in the facility fixing the shower water temperatures on the North Hall. -She told residents to use the shower in the common bathroom on the North Hall if they experienced cold water in their showers. -The housekeeping staff were responsible for taking water temperatures in residents' bathrooms. Interview with the Administrator on 08/13/25 at 12:15pm revealed: -She was aware of some water temperatures in the showers on the North Hall were at 95 degrees F and she thought 95 degrees F was too hot for the residents. -She was not aware the water temperatures for the shower should be between 100 degrees F to 116 degrees F. -The housekeeping staff were responsible for checking the water temperatures every day.	D 113		

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D 113	Continued From page 40 -She was not aware some residents from the North Hall were complaining about the water temperatures being too cold for their showers. Interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware of some of the hot water temperatures being inconsistent in the facility. -He had ordered a hot water pump within the last week from a vendor to potentially fix any cold water issues but was informed the hot water pump was out of stock. -He was not aware some residents from the North Hall were complaining the shower water temperatures were too cold for their showers. -He expected water temperatures to be at the required levels and for facility staff to report timely issues and complaints for residents not to bathe or shower in cold water temperatures. Attempted telephone interviews with the facility's previous contracted maintenance worker on 08/12/25 at 1:30pm and on 08/13/25 at 10:40am were unsuccessful.	D 113		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 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.	D 234	Effective immediately, all new residents will be required to present documented proof of a negative TB test prior to or on the day of admission. Residents without documented proof will be referred to an approved healthcare provider to receive TB testing before finalizing admission. Any resident admitted under emergency circumstances will be isolated until proof of TB clearance is received.	

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D 234	Continued From page 41 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#3 and #5) had completed the two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: 1. Review of Resident #3's current FL2 dated 01/21/25 revealed diagnoses included syncope and collapse, hypertension and mood disorder. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 09/10/24. Review of Resident #3's TB skin tests revealed: -A TB skin test was administered on 09/03/24 and read as negative on 09/05/24. -There was no documentation the resident had received another TB skin test since admission to the facility. Interview with Resident #3 on 08/13/25 at 11:25am revealed: -She had a TB skin test prior to admission while in the hospital. -She had not had a TB skin test since being at the facility. Refer to the interview with the Administrator on 08/13/25 at 3:25pm. 2. Review of Resident #5's current FL2 dated	D 234	A written TB admission policy has been developed and incorporated into the facility's admission procedures. The policy specifies that no residen may be admitted without current T testing results. Resident Admission Checklist: The admission packet has been updated to include a "TB Clearance Verification" form, which must be completed by administrative staff prior to move-in. All administrative and staff have been in-serviced on TB admission requirements, documentation standards, and procedures for emergency admissions. Training will be repeated annually and documented in the staff trainir log. TB test documentation will be filed each resident's health record. A monthly audit of new admissions will be conducted by the Resident Care Coordinator to verify compliance.	

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D 234	Continued From page 42 11/13/24 revealed diagnoses included chronic pain, tremors, hypertension, schizoaffective disorder and anxiety disorder. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 03/29/21. Review of Resident #5's TB skin tests revealed: -A TB skin test was administered on 08/11/20 and read as negative on 08/13/20. -There was no documentation the resident had received another TB skin test since admission to the facility. Interview with Resident #5 on 08/13/25 at 10:37am revealed she did not remember the last time she had a TB skin test. Refer to the interview with the Administrator on 08/13/25 at 3:25pm. Interview with the Administrator on 08/13/25 at 3:25pm revealed: -She had only been working at the facility for 4 months. -She was responsible for ensuring resident TB tests were completed prior to admission. -She was responsible for record audits. -She completed record audits when she needed to look for documents. -She had no set schedule for auditing resident records. -Her expectation was that all residents had both steps of the TB skin test completed and that documentation would reflect that.	D 234	The Executive Director and RCC will oversee compliance with TB admission requirements. Results of the monthly admission audits will be reviewed during quality assurance meetings. Any noncompliance will be addressed immediately with retraining and corrective action. This plan of protection was implemented effective September 24, 2025 and will remain in place on an ongoing basis to ensure compliance with 10A NCAC 13F .0703(a). Responsible Parties: Executive Director Resident Care Coordinator Admission Staff	
D 240	10A NCAC 13F .0703 (h) Tuberculosis Test, Medical Exam & Immunizatio	D 240		

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D 240	Continued From page 43 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunization (h) Upon a resident's return to the facility from a hospitalization, the facility shall obtain and review the hospital discharge summary or discharge instructions, including any discharge medication orders. If the facility identifies discrepancies between the discharge orders and current orders at the facility, the facility shall clarify the discrepancies with the resident's physician or physician extender. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#) who did not have orders to continue an eye drop, a medicated lotion, or the application of Thrombo-Embolic Deterrent (TED) hose after a hospitalization. The findings are: 1. Review of Resident #1's current FL2 dated 06/20/25 revealed: -Diagnoses included diabetes mellitus, hypertension, depression, and anxiety. -Resident #1 was hospitalized from 06/15/25 to 06/20/25. a. Review of Resident #1's signed physician order dated 02/04/25 revealed there was no order for redness relief eye drops 0.25-0.012% (used to treat redness due to irritation and dryness) instill two drops in both eyes every morning.	D 240	All residents who have recently returned from hospitalization will have their discharge instructions re-audited by the Resident Care Coordinator (RCC) and/or Medicatic Technician Supervisor to ensure accuracy of orders. Staff will immediately compare discharge orders against the facility Medication Administration Record (MAR). Any discrepancies will be escalated directly to the resident's physician/physician extender before administering medications. A physician's order verification process has been established. No new or changed medications will be administered until clarification is documented. The facility has developed a written policy for obtaining and reviewing discharge summaries within two (2) hours of a resident's return. All med techs, and RCC staff will be re-trained on: How to obtain discharge instructior from the hospital. Proper medication reconciliation steps. Procedures for contacting physician or physician extenders for clarificati	10.30.2025

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D 240	Continued From page 44 Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was no order for redness relief eye drops 0.25-0.012% instill two drops in both eyes every morning. Review of Resident #1's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for redness relief eye drops instill 2 drops in both eyes every morning with a scheduled time of 8:00am. -There was documentation the eye drops were administered daily from 06/01/25 to 06/14/25 and from 06/21/25 to 06/30/25. -There were dashes (---) entered on the eMAR from 06/15/25 to 06/20/25. -There was one exception documented; the exception was the resident refused. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for redness relief eye drops instill 2 drops in both eyes every morning with a scheduled time of 8:00am. -There was documentation the eye drops were administered 30 of 31 opportunities each morning from 07/01/25 to 07/31/25. -There was one exception documented; the exception was the resident refused. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for redness relief eye drops instill 2 drops in both eyes every morning with a scheduled time of 8:00am. -There was documentation the eye drops were administered each morning from 08/01/25 to 08/11/25. Telephone interview with a representative from	D 240	The Resident Care Coordinator will conduct weekly audits of all hospital returns for the next 90 days to ensur compliance with obtaining, reviewin and reconciling discharge instructior The Executive Director will review audit findings monthly to ensure compliance and to identify trends. After the 90-day period, random monthly audits will continue to verify adherence. Responsible Staff Resident Care Coordinator (RCC): Ensure discharge instructions are obtained and reconciled. Medication Technician Supervisor: Review MARs against hospital discharge orders. Executive Director: Provide oversight and ensure accountability.	

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D 240	Continued From page 45 the facility's contracted pharmacy on 08/12/25 at 11:41am revealed the pharmacy had an active order for redness relief eye drops 0.25-0.012% instill two drops in both eyes every morning dated 02/04/25. b. Review of Resident #1's signed physician order dated 02/18/25 revealed there was an order for minerin therapeutic lotion (used for dry, itchy skin) apply to feet bilaterally twice daily. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was no order for minerin therapeutic lotion apply to feet bilaterally twice daily. Review of Resident #1's June 2025 electronic medication administration record revealed: -There was an entry for minerin therapeutic lotion apply to feet bilaterally daily with a scheduled administration time of 8:00am. -There was documentation the lotion was applied to both feet daily from 06/01/25 to 06/14/25 and from 06/21/25 to 06/30/25. -There were dashes (---) entered on the eMAR from 06/15/25 to 06/20/25. -There was one exception documented; the exception was the resident refused. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for minerin therapeutic lotion apply to feet bilaterally daily with a scheduled administration time of 8:00am. -There was documentation the lotion was applied to both feet daily for 27 of 31 opportunities. -There were four exceptions documented; the exception was the resident refused. Review of Resident #1's August 2025 eMAR from	D 240		

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D 240	Continued From page 46 08/01/25 to 08/11/25 revealed: -There was an entry for minerin therapeutic lotion apply to feet bilaterally daily with a scheduled administration time of 8:00am. -There was documentation the lotion was applied to both feet daily for 6 of 11 opportunities from 08/01/25 to 08/11/25. -There were five exceptions documented; the exception was the resident refused. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed the pharmacy had an active order for mineral therapeutic lotion apply to feet bilaterally dated 02/18/25. c. Review of Resident #1's signed physician order dated 02/26/25 revealed there was an order for TED hose (an anti-embolism stocking used to prevent blood clots and swelling in the legs) on in the morning and off at night. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was no order for TED hose, on in the morning and off at night. Observation of Resident #1 on 08/11/25 at various times between 9:00am and 3:00pm revealed he was not wearing TED hose. Interview with Resident #1 on 08/11/25 at 9:00am revealed: -He was supposed to wear TED hose every day for swelling in his legs. -The PCA said she washed my TED hose and he had not gotten them back. Observation of Resident #1 on 08/12/25 at various times between 8:10am and 4:00pm	D 240		

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D 240	Continued From page 47 revealed he was not wearing TED hose. Observation of Resident #1 on 08/13/25 at various times between 9:30am and 1:30pm revealed he was not wearing TED hose. Interview with Resident #1 on 08/13/25 at 3:00pm revealed; -He had not gotten his TED hose back from being washed. -Sometimes they lose the TED hose when they wash them. Review of Resident #1's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose apply every morning and remove at bedtime with a scheduled time of 8:00am and 8:00pm. -There was documentation TED hose were applied each morning and removed each evening from 06/01/25 to 06/14/25 and from 06/21/25 to 06/30/25. -There were dashes (---) entered on the eMAR from 06/15/25 to 06/20/25. -There were three exceptions documented; the exception was the resident refused. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for TED hose apply every morning and remove at bedtime with a scheduled time of 8:00am and 8:00pm. -There was documentation TED hose were applied each morning and removed each evening 29 of 31 opportunities. -There were two exceptions documented; the exception was the resident refused. Review of Resident #1's August 2025 eMAR from	D 240		

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D 240	Continued From page 48 08/01/25 to 08/10/25 revealed: -There was an entry for TED hose apply every morning and remove at bedtime with a scheduled time of 8:00am and 8:00pm. -There was documentation TED hose were applied each morning and removed each evening from 08/01/25 to 08/10/25. Interview with a medication aide (MA) on 08/12/25 at 3:30pm revealed: -She did not know Resident #1 did not have a current order for TED hose. -The orders would have been clarified if the hospital discharge summary had been sent to the pharmacy. Interview with a second MA on 08/13/25 at 7:39am revealed:-Resident #1 wore his TED hose during the day and they were taken off when he went to bed. -She did not know he did not have a current order for TED Hose. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed the pharmacy had an active order for TED hose on in the morning and off in the evening dated 02/26/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -The pharmacy did not receive an FL2 or hospital discharge orders from Resident #1's hospitalization dated 06/15/25 to 06/20/25. -If the pharmacy received the hospital discharge orders when Resident #1 returned from the hospital, the pharmacy would have reviewed the orders and would have notified the Primary Care Provider (PCP) for clarification orders for any	D 240		

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D 240	Continued From page 49 discrepancies noted on the hospital discharge summary. Interview with a medication aide (MA) on 08/12/25 at 3:30pm revealed: -Hospital discharge orders should be faxed to the pharmacy and the PCP by the MA who received a resident who returned from the hospital. -The pharmacy would review and make changes as needed on the eMAR. -She did not know the pharmacy did not receive the hospital discharge summary for Resident #1 dated 06/20/25. -She did not know that medications were being administered that the facility did not have an order. Interview with a second MA on 08/13/25 at 7:39am revealed: -When a resident returned from the hospital the hospital discharge summary and orders were given to the oncoming 1st shift. -If there were medication changes she would fax the orders to the pharmacy and notify the PCP. -First shift staff would be responsible for following up with the pharmacy regarding the hospital discharge orders. Interview with the Resident #1's PCP on 08/13/25 at 1:02pm revealed: -She could not remember if she reviewed the hospital discharge summary for Resident #1 or not. -She did not recall a notification about medications or treatments not being on the hospital discharge summary and requesting clarification. -She wanted Resident #1's orders to be accurate when she reviewed the eMARS.	D 240		

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D 240	Continued From page 50 Interview with the Administrator on 08/13/25 at 3:02pm revealed: -The MA who received the discharge summary should review the summary for new orders, fax the hospital discharge summary to the pharmacy, and file it in Resident #1's record. -Resident #1 should not be administered medication that he did not have a current order for -She was concerned the medications were not clarified by the PCP and that Resident #1 was being administered medications that he did not have an order for. -She expected the hospital discharge summary to be faxed to the pharmacy so they could ensure all medications and orders were accurate.	D 240		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment	D 253	The Resident Care Coordinator has reviewed all resident records to identify any residents admitted within the last 30 days who do not have a completed and implemented care plan. Care plans for these residents were completed immediately to ensure compliance with state requirements. Families and physicians were contacted as needed to obtain additional information for individualized care planning.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 253	Continued From page 51 shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253	A new admission checklist has been created requiring that a care plan be initiated within 72 hours of admissic and finalized no later than 30 days. The Resident Care Coordinator will hold a weekly review meeting with the Executive Director to confirm ca plan status for all newly admitted residents. All direct care staff will receive in-service training on the regulatory requirement for timely care plan development and the importance o individualized resident assessments. The Executive Director will maintain Care Plan Tracking Log to monitor the date of admission and the date the care plan is completed for each resident. A monthly audit will be conducted f six months to verify that all new residents have completed care plan within 30 days of admission. Audit results will be shared with the Quali Assurance Committee. Any identified lapses will be correct immediately and retraining will be provided to staff as needed.	

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	HAL080032	A. BUILDING: _____ B. WING _____	08/13/2025

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D 253	Continued From page 52 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement a care plan within 30 days following admission for 1 of 5 sampled residents (#4) and annually for 2 of 5 sampled residents (#1 and #2). The findings are: 1. Review of Resident #2's current FL2 dated 01/12/25 revealed: -Diagnoses included type 2 diabetes, hypertension, lymphedema, morbid obesity, and septic shock. -She was semi-ambulatory and required a wheelchair. -She was incontinent with her bladder and bowel. -She was intermittently disoriented. Review of Resident #2's care plan dated 07/22/24 revealed: -She required supervision from staff with eating, toileting, dressing, and personal hygiene. -She required limited assistance from staff with ambulating, bathing, and transferring. -The care plan was signed by Resident #4's primary care provider on 07/22/24. -There was no updated care plan for review.	D 253	Resident Care Coordinator: Responsible for developing and implementing resident care plans within the required timeframe. Executive Director: Responsible for oversight, monitoring, and ensuring staff accountability. All corrections were completed as o September 24, 2025 and the new monitoring system is effective immediately.	

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D 253	Continued From page 53 Refer to the telephone interview with a medication aide (MA) on 08/13/25 at 10:40am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 2. Review of Resident #4's current FL2 dated 10/29/24 revealed: -Diagnosis included atrial fibrillation, heart failure, hypertension, chronic kidney disorder, diabetes mellitus, and hyperlipidemia. -He was semi-ambulatory and required a walker. -He was intermittently disoriented. -He was incontinent with his bladder. Review of Resident #4's record revealed there were no care plans available for review. Refer to the telephone interview with s MA on 08/13/25 at 10:40am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 3. Review of Resident #1's current FL2 dated 06/20/25 revealed: -Diagnoses included diabetes mellitus type 2 with chronic kidney disease, hypertension, and a history of a cerebral vascular accident with residual deficit. -He was semi-ambulatory and required moderate assistance. -He had impaired vision. -He required assistance with bathing and dressing. -He was incontinent of his bladder. Review of Resident #1's care plan dated 07/24/24 revealed: -He used a wheelchair for ambulating.	D 253		

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D 253	Continued From page 54 -He had limited strength in his upper extremities. -He was disoriented sometimes. -He was forgetful and needed reminders. -He required supervision from staff with eating and dressing. -He required limited assistance from staff with toileting, ambulation, bathing, grooming, and transferring. -The care plan was signed by the Primary Care Provider (PCP) on 07/22/24. -There was no updated care plan for review. Refer to the telephone interview with a MA on 08/13/25 at 10:40am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. Telephone interview with a MA on 08/13/25 at 10:40am revealed: -She did not do anything with the care plans. -It was not her responsibility to do the care plans. -She did not know who was responsible for the care plans since the Resident Care Coordinator (RCC) was no longer there. -She knew how to do care plans, but no one had asked her to do them. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -She did know there were care plans that had not been completed, updated, or had expired. -She did not have anyone to do the care plans at this time since the facility did not have a RCC. -She would have to start doing the care plans until a RCC was hired.	D 253		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service	D 283		

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D 283	Continued From page 55 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the kitchen was clean and free of contamination related to the reach-in ice machine being clean and held together with duct tape, a dishwasher that was not maintained in an operating condition, and meals that were not served under sanitary conditions. The findings are: Review of the environmental inspection report from the local county health department dated 11/19/24 revealed: -The facility received eight demerits.	D 283	The reach-in ice machine was thoroughly cleaned, and sanitized. A service technician has been scheduled to properly repair or replace the unit to ensure structural integrity and sanitary use. The dishwasher was inspected by a licensed service company. Repairs have been scheduled, and in the meantime, all dishwashing has been transitioned to a 3-compartment sink with appropriate wash, rinse, and sanitize procedures in compliance with state sanitation rules. All staff were re-educated on proper food handling, storage, and serving techniques to ensure meals are served under sanitary conditions.	10.30.2025

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D 283	Continued From page 56 -The exterior of the ice machine near the lid and hinges was worn and need to be sealed and repaired. -The hold in the ice machine component was coming away from the machine. -The dish washing machine was broken and not used. 1. Observation of the reach-in ice machine located in the kitchen on 08/11/25 at 10:59am revealed: -There was duct tape applied to several areas from the top to the bottom left side of the ice machine. -There was duct tape applied to the door opening of the ice machine. -The air filters were covered in heavy dust and build-up. Interview with the cook on 08/12/25 at 8:30am revealed: -The ice machine had not been serviced for maintenance since she had started within the last year. -The duct tape on the sides of the ice machine and around the door opening had been there for several months. -She and the Dietary Manager (DM) had reported the condition of the ice machine to the Administrator over the past couple of months. -She was not aware if there were any plans to fix the ice machine and the ice machine filters had not been cleaned for a while. Interview with the DM on 08/12/25 at 9:15am revealed: -She could not recall the last time the ice machine was serviced for maintenance. -The duct tape on the sides of the ice machine and around the door opening had been there for	D 283	A written preventive maintenance schedule has been established for all kitchen equipment, including the ice machine and dishwasher. Maintenance staff will conduct mont inspections and document repairs ar service needs. The Dietary Manager or designee wi conduct daily kitchen inspections to ensure all equipment is clean, operational, and in sanitary conditio Any findings will be documented an corrected immediately. Dietary staff received refresher training on infection control, sanitati and food safety protocols. Ongoing in-service training will be conducted quarterly, with attendanc documented in staff training logs. The Administrator and Dietary Manager will review kitchen sanitatic checklists weekly.	

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D 283	Continued From page 57 several months. -She and the cook had reported the condition of the ice machine to the Administrator several times over the last year. -She was not aware if there were any plans to fix the ice machine due to lack of funding and the ice machine filters had not been changed for a while. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -She was aware the ice machine had duct tape all around the sides and around the door opening along with dirty air filters. -She was aware the condition of the ice machine was a sanitation issue for the residents. -She was unaware if any repair projects were completed before her start date of April 2025 and she had no documentation for estimates or completed maintenance work. -The Administrator recognized maintenance repair issues upon her start date of April 2025 and sent daily emails to the Owner about maintenance concerns. -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs. -The Owner contacted the Administrator the day the contracted maintenance staff was scheduled to arrive at the facility. -She had notified the Owner repair projects were not completed by the contracted maintenance staff after the contracted maintenance staff told the Owner the repair projects were finished. -She was not aware the Owner had not paid the current contracted maintenance staff for completed repair projects until contacted by several maintenance contractors about unpaid projects. -Completing maintenance projects were difficult due to the history of unpaid repair projects by the Owner.	D 283	Any issues will be addressed in monthly Quality Assurance and Performance Improvement (QAPI) meetings. Daily: Kitchen sanitation inspectior by the Dietary Manager/designee. Weekly: Administrator review of inspection logs and corrective actions. Quarterly: Staff training and QAPI committee review of sanitation compliance. Service contracts with professional maintenance and sanitation vendo to ensure equipment remains operational and safe. All immediate corrective actions were completed as of August 12, 2025. Preventive measures and monitoring processes are ongoing ensure sustained compliance. Responsible: Administrator and Dietary Manager, Bethamy Retirement Center	

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D 283	Continued From page 58 -She expected the maintenance repair projects to be completed in a prompt manner when maintenance issues were addressed from her communication. -She expected a chain of communication from both the Owner and the contracted maintenance staff on the progress of maintenance repair projects. Interview with the Owner on 08/13/25 at 3:55pm revealed: -He was not aware the ice machine had duct tape all around the sides and around the door opening along with dirty air filters. -He was aware the condition of the ice machine was a sanitation issue for the residents. -There were no issues with funding that should have delayed the completion of the maintenance repair projects. -He expected the Administrator to report maintenance concerns in a timely manner and for the contracted maintenance staff to complete repair projects in a timely manner. Attempted telephone interviews with the facility's previous contracted maintenance staff on 08/12/25 at 1:30pm and on 08/13/25 at 10:40am were unsuccessful. 2. Observation of dishwasher in the kitchen on 08/11/25 at 10:59am revealed: -The dishwasher was not running and had an "out-of-order" sign on it. -The kitchen staff used disposable silverware and Styrofoam cups. -The kitchen staff washed the limited amount of non-disposable plates and cups in the kitchen sink with a common dishwashing detergent. Request for the Facility Maintenance Room Audit	D 283		

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D 283	Continued From page 59 Log for June 2025 through August 2025 was made on 08/12/25 at 5:00pm and on 08/13/25 at 11:45am and was not provided for review. Interview with the cook on 08/12/25 at 8:30am revealed: -The dishwasher had not been serviced for maintenance since she had started within the last year. -The kitchen staff washed dishes and silverware in the sink. -She and the Dietary Manager (DM) had reported the condition of the dishwasher to the Administrator within the last several months. -She was not aware if there were any plans to fix the dishwasher. Interview with the DM 08/12/25 at 9:15am revealed: -She could not recall the last time the dishwasher was serviced by a contracted maintenance worker. -The kitchen staff washed dishes and silverware in the sink. -She and the cook had reported the condition of the dishwasher to the Administrator several times over the last year. -She thought there were no plans to fix the dishwasher due to lack of funding. -She had switched to disposable silverware due to the amount of time needed to wash the dishes by hand. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -She was aware the dishwasher was not working in the kitchen. -The Administrator recognized maintenance repair issues upon her start date in April 2025 with the dishwasher as one of those issues and	D 283		

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D 283	Continued From page 60 sent daily emails to the Owner about maintenance concerns. -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs and the Owner contacted the Administrator the day the contracted maintenance staff was scheduled to arrive at the facility. -The Owner arranged for a contracted maintenance staff to repair the dishwasher but the contracted maintenance staff advised the Administrator the dishwasher needed to be replaced due to being obsolete. -The contracted maintenance staff communicated the details of his findings with the Owner. -The Owner had not communicated any further plans with the Administrator. Interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware the dishwasher unit in the kitchen was not working since some time last year. -Previous maintenance projects were not completed satisfactorily due to the former contracted maintenance staff being unreliable. -The contracted maintenance staff had communicated with him within the last couple months about replacing the dishwasher unit because parts for the dishwasher unit would be expensive. -He knew the dishwasher unit "was on its last leg" but he had not completed the process to replace the dishwasher unit. -He had not received communication back from a vendor. -He could not recall who he had contacted to replace the dishwater unit. Attempted telephone interviews with the facility's previous contracted maintenance staff on 08/12/25 at 1:30pm and on 08/13/25 at 10:40am	D 283		

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D 283	Continued From page 61 were unsuccessful. 3. Observation of the lunch meal service in the South Hall dining room on 08/11/25 from 12:00pm to 12:15pm revealed: -The Dietary Manager (DM) delivered the food cart to the South Hall dining room by pushing the food cart with gloved hands. -There was one large bowl of chicken tenders, one large bowl of biscuits, one large container of baked potatoes, and a container of melted cheese with bits of broccoli; the food was covered with foil. -There was a ladle in the melted cheese with bits of broccoli and a knife on the food cart; there were no serving utensils on the food cart. -There were four dining room tables with four residents at each table in the South Hall dining room. -There was a place setting on the table for each resident. -The DM placed the food cart next to a dining table and picked up a resident's plate from the table. -The DM picked up a baked potato and used the knife on the food cart to cut the baked potato open and poured the cheese and bits of broccoli onto the baked potato using the ladle. -The DM picked up two chicken strips and a biscuit with her gloved hand, placed them on the resident's plate and served the resident. -After serving the four residents at one table, the DM pushed the food cart to the next table and served the four residents in the same manner. -The DM did not change gloves after pushing the food cart from the kitchen to the South Hall dining room or pushing the food cart from table to table. Interview with the DM on 08/13/25 at 11:15am revealed:	D 283		

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D 283	Continued From page 62 -She had a box of gloves on the food cart and usually changed gloves before she started serving the lunch meal. -She thought she changed gloves before she started serving the lunch meal. -She did not change gloves when she pushed the food cart from table to table in the South Hall dining room. -She thought she could pick up food with a gloved hand and place the food on the residents' plates. -She should have changed gloves each time she moved the food cart. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -The DM should have changed gloves after pushing the food cart into the dining room. -She expected the DM to use utensils to serve the food and not her gloved hand. The facility failed to ensure the kitchen and food preparation areas were maintained under sanitary conditions. Food was served with contaminated gloved hands and the ice machine was held together with duct tape and the filters had not been cleaned or serviced. The dishwasher was not being used as it had not been serviced or replaced, resulting in dietary staff using disposable silverware and beverage cups to reduce the amount of dishes to be washed. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER	D 283		

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D 283	Continued From page 63 27, 2025.	D 283	Effective immediately, all disposable place settings were removed from use during regular meal services. Non-disposable plates, cups, and utensils were ordered on Septembe 1, 2025 and sanitized according to facility infection control standards. Residents were served their meals c non-disposable place settings starting with the next scheduled me service after the deficiency was identified. A complete inventory of non-disposable place settings (plates, bowls, cups, forks, knives, and spoons) has been completed to ensure there are adequate supplies for all residents and staff support during meals. Any damaged or insufficient items were replaced through immediate orders placed with the facility's vendor. A par-level system has been established to maintain an adequat supply of non-disposable place settings at all times.	
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that residents were provided with non-disposable place settings, including plates, forks, knives, spoons, and cups, during meal service. The findings are: Observation of the kitchen on 08/11/25 at 11:45am revealed: -Only plastic forks and spoons were available in the kitchen for meal service. -There was a limited supply of non-disposable silverware that would have not been enough for all the residents for the meal services. Observation of the North Hall dining room during the lunch meal service on 08/11/25 at 12:00pm	D 286		

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D 286	Continued From page 64 revealed: -There were 17 residents in the dining room. -The place setting consisted of a plastic fork and a plastic spoon. -Residents were served water in a Styrofoam cup. Observation of the South Hall dining room during the lunch meal service on 08/11/25 at 11:47am revealed: -There were 16 residents in the dining room and the place setting consisted of a plastic fork and a plastic spoon for every resident. -Residents were served water in a Styrofoam cup. Observation of the North Hall dining room during the breakfast meal service on 08/12/25 at 8:00am revealed: -There were 15 residents in the dining room and the place setting consisted of a plastic fork and a plastic spoon for every resident. -Residents were served milk in paper cups. Observation of the South Hall during the breakfast meal service on 08/12/25 between 8:10am and 8:35am revealed: -There were 16 residents in the dining room and the place setting consisted of a plastic fork and a plastic spoon for every resident. -Residents were served water and milk in a Styrofoam cup. -Resident were served individual sized cereal in the original plastic container. -A resident left the dining room before eating and returned with a bowl and a non-disposable spoon. -He poured his cereal from the plastic container into his bowl, prior to adding the milk, and ate his cereal with his non-disposable spoon.	D 286	A dining services policy was updat to clearly state that disposable utensils or place settings are only t be used during emergency situatio (e.g., outbreaks requiring isolation, kitchen equipment failure, or speci outings). The Dietary Manager or designee will perform daily meal service aud for the next 60 days to ensure all residents are served meals with no disposable place settings. Weekly audits will then continue fo 6 months, and results will be reported to the Administrator. Findings will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) committee meetings for ongoing monitoring and corrective action if necessary. All dietary staff and direct care staf have received in-service training or Regulatory requirement 10A NCAC 13F .0904(b)(1). The facility's updated Dining Services Policy. Proper handling, cleaning, and storage of non-disposable place settings.	

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D 286	Continued From page 65 Interview with a resident on 08/12/25 at 8:10am revealed: -The kitchen staff provided a plastic fork and spoon at every meal and they only used non-disposable silverware for special occasions. -His family brought him non-disposable silverware from home upon his request but he usually kept the non-disposable silverware in his room. -Staff members said they were short on utensils. Interview with a second resident on 08/12/25 at 8:10am revealed: -The dining tables were set before he walked in for every meal. -Every table usually was set with a plastic fork, spoon, napkin, and a paper cup. -He was not sure why the residents were not served with non-disposable silverware and cups. Interview with a third resident on 08/12/25 at 8:25am revealed: -She was provided with a plastic fork and spoon at every meal and usually was provided with a paper cup for one of her beverages. -She could not recall the last time the kitchen staff provided her with a knife for the meal service but she had stopped asking. -Staff members said they were short on utensils. Interview with a fourth on 08/12/25 at 3:11pm revealed: -The staff served his cereal in the plastic container it came in. -He could not eat his cereal in the plastic container. -When the milk was added it would overflow. -He had a bowl in his room, that he eats his cereal out of. -I have a complete place setting in my room; a plate, a bowl, a cup, and silverware.	D 286	Staff competency will be assessed by the Dietary Manager through direct observation during meal services.	

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D 286	Continued From page 66 -He did not like eating with plastic utensils. -When he finished eating, he would wash his place setting and return it to his room.. Interview with a fifth resident on 08/13/25 at 11:25am revealed: -The kitchen staff provided a plastic fork and spoon at every meal and they only used non-disposable silverware for special occasions. -The residents were never provided with a knife by the kitchen staff. -She was not sure why the residents were not served with non-disposable silverware and cups but she preferred non-disposable silverware and cups. Interview with a personal care aide (PCA) on 08/12/25 at 3:19pm revealed: -Residents usually had plastic spoons and forks with paper cups for one of their drinks at every meal. -She was not aware if residents ever used non-disposable silverware. -The dietary staff set the table before the meal services and no knives were usually set at the table for residents. Interview with a medication aide (MA) on 08/13/25 at 11:00am revealed: -Residents usually had plastic spoons and forks with paper cups for one of their drinks at every meal. -Residents used non-disposable silverware only on special occasions such as holidays and parties. -The dietary staff set the table before the meal service. Interview with the cook on 08/12/25 at 8:30am revealed:	D 286		

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D 286	Continued From page 67 -She was aware the residents were using plastic forks and spoons while drinking from paper cups. -The dietary staff had switched to plastic silverware and paper cups due to long shifts and less staff for washing dishes. -She was not aware residents were supposed to be provided with non-disposable silverware and cups. -She was not aware residents were supposed to be provided with a knife. Interview with the Dietary Manager (DM) 08/12/25 at 9:15am revealed: -She was aware the residents were using plastic forks and spoons while drinking from paper cups. -She was not aware residents were supposed to be provided with non-disposable silverware, which included a knife and non-disposable cups. -There had been an issue with the residents taking the silverware with them to their rooms. -She had requested new non-disposable silverware and there had been a funding issue for replacing them. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -She was not aware residents were using plastic forks and spoons due to she had not monitored the dining rooms during meal times. -She was not aware residents were not provided with a knife and were drinking from paper cups. -She expected every resident to be provided with a non-disposable fork, knife, spoon, and cups during meals.	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 296		

Division of Health Service Regulation

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D 296	Continued From page 68 (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to have a matching therapeutic diet menu for the guidance of food service staff for 1 of 1 sampled residents (#4), who was ordered a no concentrated sweets diet. The findings are: Review of Resident #4's current FL2 dated 10/29/24 revealed: -Diagnosis included diabetes mellitus, atrial fibrillation, chronic kidney disease, heart failure, hyperlipidemia, and hypertension. -There was a check beside the diet but no specified diet written. Review of Resident #4's signed physician orders dated 08/26/24 revealed an order for a no concentrated sweets (NCS) diet. Review of the therapeutic diet menus on 08/11/25 at 11:15am revealed there was no current therapeutic diet menu available for a NCS diet. Observation of the lunch meal on 08/11/25 from 12:08pm to 12:26pm revealed Resident #4 was served fried chicken tenders, a baked potato with melted cheese and broccoli, a biscuit, and vanilla	D 296	Effective immediately, the facility obtained therapeutic diet menus that correspond with the physiciar ordered diets of all residents. The menus were reviewed by a licensed dietitian to ensure they align with therapeutic needs (e.g., diabetic, low sodium, cardiac, mechanical soft). Food service staff were instructed to follow the updated therapeutic menus beginning with the next scheduled meal service. A complete audit of all current physician-ordered diets was performed to verify accuracy and match them to the appropriate therapeutic diet menus. Menus were posted in the kitchen and dining service areas to ensure dietary staff have consistent acces to the correct information. A new procedure was established requiring the Dietary Manager or designee to review physician diet orders against the posted menus weekly to prevent discrepancies. Policies were updated to include a requirement that therapeutic men must be kept current and available at all times for dietary staff guidance.	

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D 296	Continued From page 69 pudding. Observation of the breakfast meal on 08/12/25 between 8:00am revealed Resident #4 was served a piece of toast, scrambled eggs and a sausage patty. Interview with Resident #4 on 08/13/25 at 11:49am revealed: -He was not aware that he was on a special diet. -He had the same meal as every other resident in the facility. -He wished the facility had more healthier options. -He did not remember the last time the facility offered a salad option. Interview with Resident #4's primary care provider (PCP) on 08/13/25 at 1:12pm revealed she expected the facility to implement Resident #4's therapeutic diet. Interview with the Dietary Manager (DM) on 08/13/25 at 4:15pm revealed: -She was not aware Resident #4 was on a therapeutic diet. -She served Resident #4 the same meal she served every other resident in the facility. Interview with the Administrator on 08/13/25 at 3:25pm revealed: -She was not aware of the NCS therapeutic diet requirements. -She was not aware there was no therapeutic diet menu available in the facility's kitchen for a NCS diet. -She expected the DM to have a menu for each therapeutic diet. -She would get a therapeutic diet menu for a NCS diet or ask Resident #4's PCP to change the diet to low concentrated sweets.	D 296	The Dietary Manager or designee w conduct daily meal audits for 30 da to confirm that residents receive meals aligned with their therapeutic diets. After the initial 30 days, audits will continue weekly for 3 months, and then monthly thereafter as part of routine QA monitoring. Audit results will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings, with corrective actions taken promptly for any variances. All food service staff received in-service training on: The requirement of 10A NCAC 13F .0904(c)(7). How to read and follow therapeutic diet menus. The process for verifying that meals served match both the therapeutic menu and physician's orders. Competency was validated by direct observation during meal prep and service by the Dietary Manager.	10.30.2025

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D 296	Continued From page 70 Based on observations, interviews, and record reviews, it could not be determined if Resident #4 was served the appropriate diet because there was not a NCS therapeutic diet menu available for staff guidance.	D 296	The Dietary Manager is responsible for ensuring therapeutic menus are accurate, posted, and followed by food service staff. The Administrator will oversee compliance and ensure this is reported and discussed in QAPI for ongoing accountability.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 1 sampled resident (#6) who had an order for a mechanical soft diet. The findings are: Review of Resident #6's current FL2 dated 01/14/25 revealed there was a typed entry that read, see attached. Review of the signed physicians' orders dated 01/14/25 revealed: -Diagnoses included bipolar disorder, hyperlipidemia, atrial fibrillation, heart disease with heart failure, diabetes mellitus type 2, and insomnia. -There was an order for a mechanical soft diet.	D 310		

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D 310	Continued From page 71 Review of the diet order list posted on the refrigerator in the kitchen revealed Resident #6 was to receive a mechanical soft diet. Review of the mechanical soft menu for the lunch meal service on 08/11/25 revealed Resident #6 was to be served ground herbed pork loin with gravy, garlic mashed potatoes, sauteed green cabbage, cornbread, and a lemon cheesecake bar. Observation of the lunch meal on 08/11/25 from 12:08pm to 12:26pm revealed: -Resident #6 was served two fried chicken tenders, a baked potato with melted cheese and broccoli, a biscuit, and pre-packaged pudding; the chicken tenders were broken into smaller pieces before serving. -Resident #6 ate one-half of the baked potato, 1 and ½ chicken tenders, and a biscuit. Review of the mechanical soft menu for the breakfast meal service on 08/12/25 revealed Resident #6 was to be served scrambled eggs, wheat toast, and a ground sausage patty. Observation of the breakfast meal on 08/12/25 between 8:10am and 8:35am revealed: -Resident #6 was served a piece of toast, scrambled eggs and a whole sausage patty. -Resident #6 ate 100% of her eggs, asked for a second helping, and consumed 100% of the second helping. -Resident #6 ate 100% of her toast except the edges. -Resident #6 did not not eat the sausage. Interview with Resident #6 on 08/12/25 at 3:02pm revealed:	D 310		

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D 310	Continued From page 72 -She did not know she was on a special diet. -She did not have problems chewing. -She ate what she wanted. -She did not get choked or have coughing spells when she was eating. Interview with a personal care aide (PCA) on 08/13/25 at 2:37pm revealed: -Resident #6 ate regular food. -She had not observed her coughing or choking when eating. -She would cut Resident #6's meats up when Resident #6 asked. -She did not know Resident #6 had an order for a mechanical soft diet. Interview with a medication aide (MA) on 08/13/25 at 10:40am revealed: -Resident #6 was on a mechanical soft diet. -She was not aware that Resident #6 was not being served a mechanical soft diet. -She did not go into the dining room unless a PCA needed her. -The PCAs had not reported that Resident #6 was coughing or choking during meals. Interview with the cook on 08/13/25 at 9:16am revealed: -Resident #6 was on chopped meats. -She knew it was listed mechanical soft on the dietary list, but she was told by the Dietary Manager (DM) to chop Resident #6's meats. -The DM said Resident #6 would not eat her food if her meats were mechanical soft. -She did not know if the DM received an order for chopped meats. Interview with the DM on 08/13/25 at 11:15am revealed: -Resident #6 had an order for a mechanical soft	D 310		

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D 310	Continued From page 73 diet. -She had requested a blender from the previous Resident Care Coordinator (RCC) to serve a mechanical soft diet to Resident #6. -The RCC was going to ask the Owner, but she never heard anything back about approval to purchase a blender. -Since she did not have a blender, she started mashing Resident #6's food the best she could with her gloved hands. -Resident #6 refused to eat the mashed food. -She started serving Resident #6 chopped meats and Resident #6 ate well. -She served Resident #6 her lunch meal on 08/11/25; she broke up the chicken tenders into smaller pieces and served them to Resident #6. -She had not mentioned to the Primary Care Provider (PCP) that Resident #6 was not receiving a mechanical soft diet; she did not know if the previous RCC had notified the PCP. Telephone interview with the PCP on 08/13/25 at 1:02pm revealed: -Resident #6 had an order for a mechanical soft diet due to dental issues and difficulty chewing. -She was not aware that Resident #6 was not receiving a mechanical soft diet. -She was not notified that the facility was unable to provide a mechanical soft diet. -She knew the facility had trouble providing certain therapeutic diets but did not realize a modified texture was a problem. -She would have wanted to be notified so she could order a diet suitable for Resident #6. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -She was not aware Resident #6 was ordered a mechanical soft diet. -She did not know the DM did not have a blender	D 310		

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D 310	Continued From page 74 to prepare a mechanical soft diet. -She expected the DM to notify her of any kitchen needs. -She expected the DM to ensure Resident #6 was provided with a mechanical soft diet if that was the PCP's order. _____ The facility failed to serve a mechanical soft diet as ordered to a resident (#6), who had dental issues and difficulty chewing. The resident was not served ground meats and soft, textured food. This failure was detrimental to the health, safety, and welfare of the resident, and constitutes a Type B Violation. _____ A plan of protection was requested on 09/04/25 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2025.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to provide at least 14 hours per week of planned group activities for the residents residing	D 317	The facility has developed and implemented a weekly Activity Calendar ensuring a minimum o 14 hours per week of planned group activities. Staff currently on duty are facilitating group activities until the newly hired Activities Direct begins on September 30, 2025. Residents have been informed o the activity schedule and are encouraged to participate.	

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D 317	Continued From page 75 at the facility. The findings are: Observations during the facility tour on 08/11/25 at 9:00am revealed there was no August 2025 activity calendar posted in the facility. Observation of the facility from 08/08/25 to 08/13/25 at various times revealed: -There was one activity offered for residents on 08/13/25 and the residents were notified by an announcement over the facility's intercom system. -A personal care aide (PCA) offered the residents a printed cross word puzzle and only 3 residents attended the activity. Interview with a resident on 08/13/25 at 10:12am revealed: -She wished the facility had activities for them to participate in. -She could not remember the last time the facility had an activity. Interview with a second resident on 08/13/25 at 10:12am revealed: -The only field trip the staff took the residents on was a weekly trip to the grocery store and a tobacco store. -She could not remember the last time an activities calendar was posted. Interview with a third resident on 08/12/25 at 8:25am revealed: -She could not recall the last time an activity calendar was posted on the facility bulletin board or on the televisions in the facility. -She was never informed activities were available until one of the staff announced the activity for the	D 317	Residents are now provided with structured daily activities, includir social, physical, cognitive, and recreational opportunities to enhance quality of life. Activities are designed to be inclusive of all residents, with adaptations for those with mobili cognitive, or health limitations. Activity attendance is documente to ensure consistent engagement and accountability.	

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D 317	Continued From page 76 day over the facility's intercom system. Interview with a fourth resident on 08/13/25 at 11:25am revealed: -She was not sure where or if an activity calendar was posted anywhere throughout the facility. -She was not aware the television in the hallway was designated for residents to view the activity calendar. -She was never informed activities were available until one of the staff announced the activity for the day over the facility's intercom system and it was usually bingo. Interview with a PCA on 08/13/25 at 11:10am revealed: -She helped with activities on occasion but there was not a designated Activity Director at the facility for the residents. -The activity calendar was posted previously on the facility's bulletin board and had not been posted since the new Administrator arrived in April 2025. -The new Administrator was responsible for posting the monthly activity calendar on the televisions in the facility. -She had not seen the monthly calendar posted on the televisions in the last 2 months but she was aware of why the calendar had not been posted. Interview with a medication aide (MA) on 08/13/25 at 11:00am revealed: -She had helped previously with resident activities but was told to stop when the new Administrator arrived in April 2025. -The activity calendar had not been posted for a couple months on the televisions or on the facility's bulletin board. -The Administrator was responsible for posting	D 317	The Executive Director will review the activities calendar weekly to verify that it meets the 14-hour requirement. Attendance records will be reviewed monthly to confirm that scheduled activities are conducted as planned. The Activities Director will submit a monthly activities report to administration, documenting total hours offered and resident participation. Any gaps in activity hours will be immediately corrected through staff reassignment or supplemental programs. Responsible Staff and Completion Date Activities Director (effective September 30, 2025): Responsible for planning, implementing, and documenting activities. Executive Director: Responsible for oversight and ensuring compliance with state regulations. Full correction was initiated as of September 16, 2025 and will be fully transitioned to the Activities Director by September 30, 2025.	

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D 317	Continued From page 77 the monthly activity calendar on the televisions in the facility. Interview with the Administrator on 08/13/25 at 4:00pm revealed: -The facility did not have a current Activity Director. -A MA had been the previous Activity Director. -She was currently in charge of scheduling activities. -When she made an activities calendar, it was posted on the televisions within the facility but she had not posted the calendar for the month of August 2025. The facility failed to implement an activities program with at least 14 hours of group activities each week. There were no activities offered to promote socialization and interaction among the residents. This failure was detrimental to the health and welfare of the residents, and constitutes a Type B Violation. A plan of protection was requested on 09/04/25 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2025.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 78 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to ensure residents were treated with respect and dignity as evidenced by residents who were bitten by bed bugs and and were yelled at by staff when residents asked about medications. The findings are: 1. Review of the Facility's Pest Control and Bedbug Policy and Procedures revealed the facility's purpose was to maintain a safe, clean, and comfortable living environment for residents, staff, and visitors by effectively managing pest control and preventing, identifying, and addressing bedbug infestations in a timely and humane manner. Observations of resident room #4 on the South Hall on 08/08/25 at 9:25am revealed: -There were several live nymphs (young bed bugs) in between the resident's bed mattress and box spring at the head of the bed. -There were live bed bugs on the curtains. Observation of resident room #4 on 08/11/25 at 1:20pm revealed there were live bed bugs on the curtains and between the resident's bed mattress and box spring at the head of the bed. Interview with the resident who resided in resident room #4 on 08/08/25 at 9:30am revealed: -She noticed the bed bugs in her room and the bed bugs were an ongoing issue. -She felt the bed bugs crawling on her in the middle of the night while she attempted to sleep. -She had been bitten by bed bugs previously on	D 338	All residents who reported bed bug bites were evaluated by nursing staff. Treatment and follow-up care were provided per physician instructions. Resident rooms were thoroughly cleaned, laundered, and monitored. The facility has initiated a pest control service agreement and is awaiting a finalized contract with Sage Pest Control to ensure comprehensive and ongoing eradication of bed bugs. Interim pest management measures are being carried out until services begin. Staff members who were identified as yelling at residents were immediately counseled and removed from resident care until retraining on resident rights and communication was completed. The Administrator and Resident Care Coordinator met with affected residents to apologize and assure them of corrective actions and their continued right to be treated with dignity and respect.	

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D 338	Continued From page 79 her neck but that was several weeks ago. Observation of resident room #3 on the South Hall on 08/08/25 at 9:45am revealed there were live bed bugs crawling on a resident's bed sheet on the left at the head of the bed. Interview with the resident who resided in resident room #3 on 08/08/25 at 9:50am revealed: -Bed bugs had bitten him on the arms previously. -He had not slept at night related to concerns of bed bugs crawling on him while he slept. -Sometimes he left the overhead light on at night because he felt like the bed bugs did not bite him as much with the light on. Observation of resident room #7 on the North Hall on 08/08/25 at 10:05am revealed: -There were live bed bugs under the resident's bed sheet at the head of the bed. -There were multiple small blood stains on the sheet of the bed. -There was bed bug waste on the walls, floors, and windows. Interview with the resident who resided in resident room #7 on 08/08/25 at 10:10am revealed: -He had not seen any bed bugs in his room for "a while" but bed bugs were an ongoing issue. -He did not know what the black spots were on his wall or on his floor. -He had killed numerous bed bugs and squished them in his hands after he removed them from his shirt sleeve. -Bed bugs had bitten him on the arms previously. -He did not know when his sheets were last washed. Observation of resident room #5 on the North Hall on 08/08/25 at 10:15am revealed there were live	D 338	Once the contract is finalized, Sage Pest Control will provide scheduled and emergency pest management services, with ongoing monitoring and treatment as needed. Weekly inspections by housekeepir and maintenance will be conductec for all resident rooms and common areas to identify and report any sig of pests. All staff will undergo mandatory training on: Resident Rights under 10A NCAC 1. .0909. Professional communication and respect in resident interactions. Medication administration communication — ensuring staff respond respectfully and clearly to residents' medication-related questions. A zero-tolerance policy for yelling, intimidation, or disrespectful communication toward residents ha been reinforced.	

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D 338	Continued From page 80 bed bugs under the resident's bed. Interview with the resident who resided in resident room #5 on 08/08/25 at 10:20am revealed: -He had seen bed bugs "off-and-on" in his room but thought the issue had been resolved. -He felt the bed bugs crawling on him in the middle of the night while he tried to sleep and a couple bed bugs previously bit him on the foot which made it hard for him to sleep. Telephone interview with the primary care provider (PCP) for the residents at the facility on 08/13/25 at 1:30pm revealed: -Bed bugs in the facility put the residents at risk for skin irritation and bed bug bites that were left untreated could become infected. -She was aware there were bed bugs at the facility and she had told the staff to treat the residents' beds/rooms for bed bugs. -She had noticed bed bug bites on residents within the last several weeks but she had not noticed any bites recently. Interview with a personal care aide (PCA) on 08/08/25 at 11:30am revealed: -She was aware that residents were having issues with bed bug bites and with bed bugs crawling on the residents at night that caused them to lose sleep. -She had reported that residents were having issues with bed bug bites and with bed bugs crawling on them at night to the Business Office Manager (BOM) and the Administrator. -She had not seen the BOM or the Administrator address the residents' concerns. Interview with the medication aide (MA) on 08/08/25 at 4:20pm revealed: -The residents had not complained about bed	D 338	The Administrator or designee will conduct weekly walk-throughs to monitor resident rooms and common areas for cleanliness and signs of pests. The Resident Care Coordinator will conduct weekly resident interviews (minimum of 5 residents) to ensure residents feel safe, respected, and free from intimidation. The Director of Nursing or Medication Supervisor will conduct weekly medication pass observations to ensure respectful communication with residents during medication administration. Documentation of pest control services, staff training, audits, and resident interviews will be reviewed monthly in Quality Assurance meetings.	

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D 338	Continued From page 81 bugs biting them. -She knew there were bed bugs in their beds; she had seen them. -She saw the blood stains on the residents' sheets when she helped wash them. -She did not know that was a sign the bed bugs had bitten the residents. -She had told the BOM and the Administrator about the bed bugs. Interview with the BOM on 08/08/25 at 12:10pm revealed: -Several pest control companies had treated the facility throughout the last year for bed bug infestation but the spray treatments seemed ineffective. -She was aware of the bed bug issue over the last year since she started but was not aware of current active bed bugs in residents' rooms. -No staff had made her aware of bed bugs crawling and biting residents and residents were scared to sleep at night. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -She was aware of the current bed bug infestation since her arrival in April 2025 and had persistently communicated with the Owner about the ongoing bed bug issue not being resolved. -She was not aware residents were concerned about bed bugs crawling on them in the middle of the night. -She was not aware residents were losing sleep due to fear of bed bugs bites in the middle of the night. Telephone interview with the Owner on 08/13/25 at 3:55pm revealed: -He was aware of the bed bug infestation at the facility and contacted a pest control company last	D 338	Administrator – oversees compliance and pest control contracting. Resident Care Coordinator – conduct resident interviews and monitors dignity concerns. Medication Supervisor – ensures medication administration is carried out respectfully and audits staff performance. Housekeeping/Maintenance Supervisor – monitors rooms for pes and coordinates with Sage Pest Control. Immediate corrective actions were implemented as of August 27, 2025. Contract with Sage Pest Control is pending finalization, with anticipatec start date of October 15, 2025. Staff retraining will be completed by October 30, 2025. Ongoing monitoring will continue monthly through the Quality Assurance process.	

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D 338	Continued From page 82 Friday (08/08/25). -He had used a previous pest control company to treat the bed bug infestation but was not sure if the spray treatment was effective to eliminate the bed bugs. -He was not aware of a bed bug infestation until the current pest control company technician communicated with him but this is a work-in-progress. -He was not aware residents were concerned about bed bugs crawling on them in the middle of the night. -He was not aware residents were losing sleep due to fear of bed bugs bites in the middle of the night. 2. Review of the Facility's Resident Agreement revealed: -Each resident had the right to express complaints or suggestions without fear of reprisal, interference, coercion or discrimination. -Each resident had the right to suggest, recommend and be heard per the facility's grievance policy. -Every resident had the following rights: to be treated with respect, consideration, dignity, and full recognition and to be free of mental and physical abuse, neglect, and exploitation. Review of Staff A's personnel record revealed: -Staff A was hired on 07/29/22. -There was no documentation of Resident Rights training. -There was documentation of a Criminal Background check dated 08/10/22. -There was documentation of a Health Care Personnel Registry (HCPR) check dated 08/04/22. Interview with a resident on 08/08/25 at 9:25am	D 338		

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D 338	Continued From page 83 revealed: -The medication aides (MA) on the morning shift treated the residents "like they were less than them" and ordered them around. -Staff A (a MA) used the [expletive] word a lot when Staff A was mad or upset with the residents. -She had not reported Staff A to the Administrator because she was scared when one of the MAs commented "anyone who told on her would get it." Interview with a second resident on 08/08/25 at 9:35am revealed: -The morning shift MAs had horrible attitudes towards the residents and would call him a "dog" for no reason. -Staff A used the [expletive] word a lot when Staff A was mad or upset with the residents. -He had witnessed Staff A withhold another resident's medication when Staff A was upset with the resident. -He used to report Staff A's behavior to the Business Office Manager (BOM) and the Administrator but stopped due to nothing had been done. Interview with a third resident on 08/11/25 at 10:00am revealed: -Staff A ignored her when she asked questions about her medications and Staff A walked away from her numerous times. -Staff A screamed at her once when she asked about her medications and Staff A said "Do you really need something or do you love to bother me?" several times. Interview with a fourth resident on 08/11/25 at 11:06am revealed: -When she asked two specific MAs, Staff A and another MA, questions about her medications,	D 338		

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D 338	Continued From page 84 they would become angry and refuse the resident her medication. -She was uncomfortable asking the staff in the facility for assistance with daily tasks because the staff were mean and would "bite her head off". Interview with a fifth resident on 08/11/25 at 4:20pm revealed: -Staff A would make her the last to receive her medications on the medication pass when she upset Staff A and asked questions about her medications. -Staff A was very "tough, rude, and nasty" toward residents and made demeaning remarks that were not fair toward the residents' age. -She preferred not to report Staff A's rude comments and behavior to the Administrator because she was afraid "to lose her home" if she spoke out. Interview with a personal care aide (PCA) on 08/08/25 at 10:25am revealed: -She had witnessed Staff A yell at the residents because the residents had asked questions related to their medications. -She had not reported Staff A to the BOM or Administrator because of fear Staff A would retaliate against her. -Staff A had commented "anyone who told on her would get it." Interview with another PCA on 08/08/25 11:30am at revealed: -She had witnessed Staff A yelling and cussing at the residents because the residents had asked questions related to their medications. -She had reported Staff A to the Administrator but nothing had been done to Staff A because Staff A had continued their rude behavior.	D 338		

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D 338	Continued From page 85 Interview with Staff A on 08/08/25 at 11:55am revealed: -She had not witnessed any rude behavior to the residents from the MAs. -She administered the resident's medications on the morning shift. -Residents had become upset with her when she held their medications until the specified time on the electronic Medication Administration Record (eMAR). -She administered residents medications at the "exact" specified time on the eMAR. -She refused to answer residents' questions after she told the residents constantly she would not administer their medications until the specified time on the eMAR. -She did not recall an instance when she or any MA had become upset when a resident asked about their medications but she was aware residents had accused her of yelling at them. Interview with a MA on 08/13/25 at 11:00am revealed: -She had witnessed Staff A yelling and cussing at the residents because the residents had asked questions related to their medications. -She had reported Staff A to the Administrator but nothing had been done to Staff A because Staff A had continued their rude behavior. Interview with the Business Office Manager (BOM) on 08/08/25 at 12:10pm revealed: -She was not aware of Staff A yelling at the residents because the residents had asked questions related to their medications. -No staff had reported any instances of Staff A's rude behavior, withholding medications. or issuing threats of retaliation. Interview with the Administrator on 08/12/25 at	D 338		

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D 338	Continued From page 86 3:38pm revealed: -She was not aware of Staff A yelling or cussing at the residents because the residents had asked Staff A questions related to their medications. -There was not an HCPR report completed because she was not aware of the verbal abuse by Staff A. -The staff had not been provided Resident Rights training since her start in April 2025 and she was not aware training was available for staff on Resident Rights. -She expected staff or residents to report any instance of verbal abuse to her and for residents to be unafraid to ask staff questions. -She expected staff to treat all the residents with dignity and respect and residents to express their concerns without retaliation. _____ The facility failed to ensure the residents were treated with dignity and respect related to residents who were bitten by bed bugs and were unable to sleep at night due to bed bed bugs crawling on them. Multiple residents were being yelled and cursed at by Staff A causing the residents to be frightened and afraid to report Staff A's behavior because Staff A told them she would retaliate if the residents reported them. This failure resulted in verbal abuse and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/25. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2025.	D 338		

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D 344	Continued From page 87	D 344	All current medication orders were reviewed by the Resident Care Coordinator (RCC) and Medication Supervisor. Any unclear, incomplet or conflicting medication orders were immediately clarified with the prescribing physician or physician extender. Residents impacted by unclear medication orders were assessed t ensure no harm occurred, and adjustments were made promptly i accordance with the clarified physician's instructions. Documentation of all clarifications was entered into residents' medica records and Medication Administration Records (MARs). Staff will not administer medicatio with incomplete, unclear, or conflicting orders. Instead, the nur or RCC will immediately contact th prescribing physician for clarificati before medication is administered. All medication orders will be required to include the resident's name, drug name, dose, route, frequency, and physician's signatur	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#2) related to a medication used to treat nerve pain. The findings are: Review of Resident #2's current FL2 dated 01/12/25 revealed diagnoses included type 2 diabetes, hypertension, lymphedema, morbid obesity, and septic shock. Review of Resident #2's signed physicians orders dated 01/12/25 revealed there was an order for gabapentin 100mg capsule every evening (a medication used to treat nerve pain). Review of Resident #2's June electronic medication administration record (eMAR) from 06/01/25 through 06/30/25 revealed there was no entry or documentation for gabapentin 100mg capsule every evening.	D 344		

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D 344	Continued From page 88 Review of Resident #2's July eMAR revealed there was no entry or documentation for gabapentin 100mg capsule every evening. Review of Resident #2's August eMAR from 08/01/25 through 08/11/25 revealed there was no entry or documentation for gabapentin 100mg capsule every evening. Observation of Resident #2's medication on hand on 08/12/25 at 9:50am revealed there was no gabapentin 100mg capsules available for administration. Interview with Resident #2 on 08/13/25 at 10:12am revealed: -She did not like taking gabapentin because it made her sleepy. -She stopped taking gabapentin a while ago. Interview with the facility's contracted pharmacy on 08/13/25 at 1:30pm revealed: -There was no active order for gabapentin. -There was an order on 10/18/24 to discontinue gabapentin 100mg capsule every evening. Interview with Resident #2's primary care provider (PCP) on 08/13/25 at 1:12pm revealed: -She was not aware that Resident #2's current signed physicians order included gabapentin 100mg capsule every evening. -She did not intend for Resident #2 to be on gabapentin 100mg capsule every evening. -She was not the PCP who signed the physicians' orders on 01/12/25. Interview with the Administrator on 08/13/25 at 3:25pm revealed: -She was in charge of auditing records.	D 344	Ongoing staff training will be conducted on the importance of medication order accuracy, includi Identifying incomplete or unclear orders. Proper chain of communication foi clarification. Documentation of clarifications in the resident record and MAR. Medication audits will be conducte to ensure all orders are current, clear, and complete. The Medication Supervisor will conduct weekly MAR audits to ensure all active medication orders are complete and properly documented. The Resident Care Coordinator will review new medication orders with 24 hours of receipt to ensure completeness and clarity. The Administrator will review audit findings during monthly Quality Assurance meetings, addressing any trends or re-education needs.	

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D 344	Continued From page 89 -She completed record audits if she needed to look for something specific for any residents. -She would call the facility's PCP if she found discrepancies with any medications. -She was not aware Resident #2's current signed physicians orders included gabapentin 100mg capsule every evening.	D 344	Resident Care Coordinator – reviews new and existing orders for accurac and completeness. Medication Supervisor/Charge Nurs – performs weekly audits and provides clarification with physician as needed.	
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 5 sampled residents (#1, #2, #3, and #5) including four medications to manage fingerstick blood sugars (FSBS) (#1); a medication used to treat vitamin B12 deficiency (#2); two discontinued medications for a resident used to treat constipation and a supplement that can be used to treat elevated cholesterol levels and errors with an anti-anxiety medication (#5); and one discontinued medication for anxiety (#3). The findings are:	D 358	Administrator – oversees compliance, reviews QA reports, an ensures corrective actions are sustained. Immediate corrective actions were completed as of August 27, 2025. Staff retraining will be completed b October 30, 2025. Weekly audits and QA reviews will continue on an ongoing basis to ensure sustained compliance. 8 10A NCAC 13F .1004 (a) Medication Administration All residents identified in the deficiency were immediately assessed by nursing staff to determine if any harm occurred due to medication errors. Physicians were notified of the errors, and follow-up orders were obtained and implemented.	

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D 358	Continued From page 90 Review of the facility's medication administration policy revealed: -The facility would ensure medications were administered in a safe, consistent, and compliant manner. -The facility would complete monthly audits of medication records. 1. Review of Resident #1's current FL2 dated 06/20/25 revealed diagnoses included diabetes mellitus type 2 with chronic kidney disease and hypertension. Review of Resident #1's laboratory values dated 03/26/25 revealed a hemoglobin A1C (HBA1c) value of 7.7. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%). a. Review of Resident #1's signed physician order dated 12/08/23 revealed: -There was an order for FSBS checks three times daily before meals. -There was an order for lispro 100units/ml inject 30 units (a fast-acting insulin used to lower blood sugar) three times daily before meals; hold for FSBS readings less than 70 and notify the physician for FSBS readings greater than 400. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed: -There was an order for lispro 100 units/ml inject 30 units 15 minutes before meals. -There was no order to check FSBS readings before meals. Observation of Resident #1's FSBS check and medication administration on 08/11/25 at 11:45am revealed: -Resident #1's FSBS reading was 165.	D 358	Discontinued medications were removed from the medication cart, destroyed per facility policy, and documented on the medication destruction record. The affected MARs were corrected to reflect only current, active medicatior orders. Staff directly involved in the errors were counseled and removed from medication administration until retraining was completed. Double-check system: Two staff members (a Med Tech and a Supervisor/Nurse) will review all new and discontinued orders before they are entered into the MAR. Medication reconciliation: On admission, re-admission, physician order change, or hospital discharge, the Resident Care Coordinator (RCC) will review the medication list to ensu accuracy and discontinue outdated orders. Staff retraining: All Med Techs and licensed staff will receive in-service training on:	

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D 358	Continued From page 91 -Resident #1 was administered 30 units of lispro. Review of Resident #1's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times daily with meals with a scheduled time of 7:30am, 11:30am, and 5:30pm. -There was documentation FSBS was checked 72 of 90 opportunities ranging from 92 to 400 from 06/01/25 to 06/30/25. -There were exceptions documented from 06/15/25 at 7:30am to 06/20/25 at 11:30am; the exception was the resident was in the hospital and on 06/03/25 at 5:30pm and the eMAR was blank on 06/03/25 at 5:30pm. -There was an entry for lispro 100units/ml inject 30 units subcutaneously (SQ) three times a day with meals; hold for blood sugar less than 70 and notify the physician if the FSBS was greater than 400 with a scheduled administration time of 7:30am, 11:30am, and 5:30pm. -There was documentation lispro was administered 71 of 90 opportunities from 06/01/25 to 06/30/25. -There were exceptions documented from 06/15/25 at 7:30am to 06/20/25 at 11:30am; the exception was the resident was in the hospital and on 06/03/25 at 5:30pm and on 06/24/25 at 7:30am the eMAR was blank. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for FSBS checks three times daily with meals with a scheduled time of 7:30am, 11:30am, and 5:30pm. -There was documentation FSBS was checked 91 of 93 opportunities ranging from 86 to 541 from 07/01/25 to 07/31/25. -There were exceptions documented on 07/08/25	D 358	Staff retraining: All Med Techs and licensed staff will receive in-service training on: Proper medication administration procedures. Correct documentation on the MAR Timely removal of discontinued medications. Importance of clarifying orders immediately if questions arise. Medication cart checks: Supervisory staff will perform daily medication c audits to ensure discontinued medications are removed and that only active medications are availabl The Medication Supervisor or designee will conduct weekly MAR audits to ensure orders match curre physician directives. The Resident Care Coordinator will review all new medication orders within 24 hours to confirm accuracy The Administrator will review audit findings monthly during Quality Assurance meetings and address an ongoing trends with retraining or disciplinary action as needed. Random medication pass observations will be conducted weekly to monitor compliance with correct administration procedures.	

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D 358	Continued From page 92 at 7:30am and 07/16/25 at 11:30am; the exception was the resident was out of the facility. -There was an entry for lispro 100units/ml inject 30 units SQ three times a day with meals; hold for blood sugar less than 70 and notify the physician if the FSBS was greater than 400. -There was documentation lispro was administered 90 out of 93 opportunities from 07/01/25 to 07/31/25. -There were exceptions documented on 07/08/25 at 7:30am, 07/16/25 at 11:30am, and 07/25/25 at 11:30am; the exceptions were the resident was out of the facility and withheld per the physician's orders. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for FSBS checks three times daily with meals with a scheduled time of 7:30am, 11:30am, and 5:30pm. -There was documentation FSBS was checked 29 of 31 opportunities ranging from 74 to 265 from 08/01/25 to 08/11/25. -There were exceptions documented on 08/03/25 at 11:30am and 08/06/25 at 5:30pm; the exceptions were the resident was out of the facility and the resident refused. -There was an entry for lispro 100units/ml inject 30 units SQ three times a day with meals; hold for blood sugar less than 70 and notify the physician if the FSBS was greater than 400. -There was documentation lispro was administered 25 of 31 opportunities. -There were exceptions documented on 08/01/25 at 5:30pm, 08/03/25 at 11:30am, 08/05/25 at 7:30am and 11:30am, 08/06/25 at 5:30pm, and 08/08/25 at 5:30pm; the exceptions were the resident refused, the resident was out of the facility, the resident was physically unable to take and held per the physician's orders.	D 358	Resident Care Coordinator (RCC): Order reconciliation and oversight c MAR accuracy. Medication Supervisor/Charge Nurse: Weekly MAR audits and medication pass observations. Administrator: QA oversight, monitoring compliance, and ensurir corrective actions remain in place. Immediate corrective actions were completed as of August 27, 2025. Staff retraining will be completed by October 30, 2025. Ongoing audits and QA monitoring will continue monthly to ensure sustained compliance.	

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D 358	Continued From page 93 Observation of Resident #3's medication on hand on 08/11/25 at 12:46pm -There was a lispro 100 units/ml 3ml pen on the medication cart that contained 180 of 300 units of medication dispensed on 07/11/25. -There were two lispro 100 units/ml 3ml pens in the medication room refrigerator that were dispensed on 07/11/25, unopened. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -Resident #1 had an order for FSBS checks three times daily with meals dated 12/28/23. -Resident #1 had an order for lispro 30 units three times daily with meals and to hold lispro for FSBS readings less than 70 and call the Primary Care Provider (PCP) for FSBS readings greater than 400 dated 12/28/23. -The pharmacy dispensed 10 lispro 100 units/ml 3ml pens on 04/07/25, 05/10/25, and 07/11/25. -The facility should be using the last lispro pen of the 10 lispro pens dispensed on 07/11/25. -There were no lispro pens dispensed in June 2025. -The facility had not requested a refill for lispro pens. -Lispro was not a cycle filled medication; the facility would have to reorder the medication by pulling the sticker and faxing the information to the pharmacy, by calling the pharmacy or by re-ordering on the computer. Interview with a medication aide (MA) on 08/12/25 at 3:30pm revealed: -She administered Resident #1's lispro if the FSBS was greater than 70 in the morning. -She would hold Resident #1's lispro at lunch unless it was "really high" because he would get	D 358		

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D 358	Continued From page 94 more insulin at 2:00pm. -Today, 08/12/25, at lunch she held Resident #1's lispro because his blood sugar was 120; she did not want his blood sugar to drop too low. Telephone interview with a second MA on 08/13/25 at 10:40am revealed: -Resident #1 received lispro three times daily before meals. -She had never held Resident #1's lispro for a blood sugar less than 70. b. Review of Resident #1's signed physician order dated 10/02/24 revealed there was an order for Tresiba 200 units/ml inject 42 units (a long-acting insulin used to lower blood sugar) every day. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was an order for Tresiba 200 units/ml inject 42 units every day. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Tresiba 200 units/ml inject 42 units SQ daily with a scheduled administration time of 8:00am. -There was documentation Tresiba was administered 24 of 30 opportunities. -There were exceptions from 06/15/25 to 06/20/25; the exception was the resident was in the hospital. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for Tresiba 200 units/ml inject 42 units SQ daily with a scheduled administration time of 8:00am. -There was documentation Tresiba was	D 358		

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D 358	Continued From page 95 administered 28 of 31 opportunities. -There were exceptions documented; the exceptions were the resident was out of the facility and physically unable to take. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for Tresiba 200 units/ml inject 42 units SQ daily with a scheduled administration time of 8:00am. -There was documentation Tresiba 200 units/ml was administered 11 of 12 opportunities from 08/01/25 to 0/11/25. -There was an exception documented on 08/05/25; the exception was the resident was physically unable to take. Observation of Resident #1's medication on hand on 08/11/25 at 12:45pm revealed: -There was a Tresiba 200 unit/ml 3ml pen on the medication cart that contained 450 of 600 units of medication dispensed on 07/24/25. -There was a Tresiba 200 unit/ml 3ml pen in the medication room refrigerator that was unopened. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -Resident #1 had an order for Tresiba 200 units/ml inject 42 units SQ every day dated 10/02/24. -The pharmacy dispensed 3 Tresiba 200 units/ml 3ml pens on 02/21/25, 04/07/25, and 07/24/25. -Three Tresiba pens would last 42 days if administered as ordered. -The facility would have completed one pen of the 3 pens dispensed on 07/24/25 and started on the second pen if Tresiba was administered as ordered. -There should be about 130 units used out of the	D 358		

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D 358	Continued From page 96 second pen. -The facility did not request any re-fills for Tresiba in May 2025 or June 2025. Interview with a MA on 08/12/25 at 3:30pm revealed: -She would hold Resident #1's lispro at lunch unless it was "really high" because he would get "autoshield" at 2:00pm; "autoshield" was the same thing as Tresiba. -The previous MA who trained her on the medication cart told her autoshield and Tresiba were the same thing. -Today, 08/12/25, at lunch she held Resident #1's 2:00pm "autoshield" because his blood sugar was 120; she did not want his blood sugar to drop. -She was told by the previous MA who trained her not to administer the Tresiba if Resident #1's FSBS was below 100. -She administered Tresiba at 8:00am, 2:00pm, and 8:00pm if Resident #1's blood sugar was "really high". Telephone interview with a second MA on 08/13/25 at 10:40am revealed: -She administered Resident #1's Tresiba every morning. -Tresiba had always been available for administration . c. Review of Resident #1's signed physician order dated 04/04/25 revealed there was an order for Trulicity 0.75mg/0.5ml (used to control high blood sugar) inject 0.5ml weekly. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was an order for Trulicity 0.75mg/0.5ml inject 0.5ml weekly.	D 358		

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D 358	Continued From page 97 Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Trulicity 0.75mg/0.5ml weekly on Thursday scheduled at 8:00am. -There was documentation Trulicity was administered 2 of 4 opportunities from 06/01/25 to 06/30/25. -There was an exception documented on 06/26/25; the exception was the resident was physically unable to take; the eMAR for 06/19/25 was blank. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for Trulicity 0.75mg/0.5ml weekly on Thursday scheduled at 8:00am. -There was documentation Trulicity was administered 2 of 5 opportunities from 07/01/25 to 07/31/25. -There were exceptions documented; the exception was the resident was physically unable to take. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for Trulicity 0.75mg/0.5ml weekly on Thursday scheduled at 8:00am. -There was documentation Trulicity was administered 1 of 1 opportunity on 08/07/25. Observation of Resident #1's medication on hand on 08/12/25 at 3:11pm revealed there were 2 of 4 Trulicity 0.75mg/0.5ml pens in the medication room refrigerator that were dispensed on 07/24/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -Resident #1 had an order for Trulicity	D 358		

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D 358	Continued From page 98 0.75mg/0.5ml administer 0.5ml every week on Thursday. -The pharmacy dispensed 4 single dose Trulicity 0.75mg/0.5ml pens on 04/11/25 and 07/24/25. -The pharmacy did not dispense Trulicity 0.75mg/0.5ml pens in May 2025 or June 2025. -There would have been no Trulicity available for administration for May 2025, June 2025 or the first 3 weeks in July 2025. -The facility had not requested a refill for Trulicity the months of May 2025 and June 2025. -Trulicity was not a cycle filled medication; the facility would have to reorder the medication by pulling the sticker and faxing the information to the pharmacy, by calling the pharmacy or by re-ordering on the computer. Interview with a MA on 08/12/25 at 3:30pm revealed: -Resident #1 received Trulicity once a week. -She administered Trulicity if it was in the facility, but if it was not in the facility she would document physically unable to administer since the medication was not in the facility. -There had been several weeks Trulicity was not in the facility and she would notify the pharmacy to send it. Telephone interview with a second MA on 08/13/25 at 10:40am revealed: -Resident #1 received Trulicity every week. -It had always been available for administration Interview with Resident #1 on 08/13/25 at 10:34am revealed: -His FSBS was checked three times a day and he received insulin three time a day. -He only received one injection of insulin at each meal.	D 358		

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D 358	Continued From page 99 Telephone interview with Resident #1's PCP on 08/13/25 at 1:02pm revealed: -Resident #1 required all 3 injections of insulin to manage his blood sugar. -She was not notified that medication was not available to administer as ordered. -She was concerned that Resident #1's FSBS readings could be elevated if he did not receive the insulin injections as ordered. -She expected the MAs to administer the medications as ordered. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -Resident #1's blood sugar could go up and he could get very sick if he did not receive his medication for diabetes as ordered. -She expected the MAs to administer medications as ordered. d. Review of Resident #1's hospital discharge summary dated 06/20/25 revealed there was an order for Jardiance 25mg (used to improve blood sugar control) daily. Review of Resident #1's June 2025 eMAR revealed: -There was an entry for Jardiance 25mg daily with a scheduled administration time of 8:00am. -There was documentation Jardiance was administered 24 of 30 opportunities from 06/01/25 to 06/30/25. -There was no exceptions documented from 06/15/25 to 06/20/25; the eMAR was blank. Review of Resident #1's July 2025 eMAR revealed: -There was an entry for Jardiance 25mg daily with a scheduled administration time of 8:00am. -There was documentation Jardiance was	D 358		

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D 358	Continued From page 100 administered 28 of 31 opportunities 07/01/25 to 07/31/25. -There were exceptions documented; the exceptions was the resident was physically unable to take. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for Jardiance 25mg daily with a scheduled administration time of 8:00am. -There was documentation Jardiance was administered 8 of 11 opportunities from 08/01/25 to 0/11/25. -There were exceptions documented; the exception was the resident was physically unable to take. Observation of Resident #1's medication on hand on 08/11/25 at 12:46pm revealed there were no Jardiance available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -Resident #1 had an order for Jardiance 25mg daily dated 01/30/25. -The pharmacy dispensed 28 Jardiance 25mg tablets on cycle fill each month. -The pharmacy dispensed 16 Jardiance 25mg tablets on 07/07/25 and requested a new prescription from the PCP on 07/05/25. -The pharmacy had not received a new prescription after serveral attempts of communication with the PCP's office. -There was no documentation that the facility had notified the pharmacy regarding Jardiance and why it had not been dispensed since 07/07/25. Interview with a MA on 08/12/25 at 3:30pm revealed:	D 358		

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D 358	Continued From page 101 -She did not administer Jardiance to Resident #1 this morning, 08/11/25. -There was no Jardiance on the medication cart; she did not know how long the Jardiance had not been on the medication cart. -She called the pharmacy yesterday to see why Resident #1 did not have any Jardiance in the facility to administer. -Jardiance was a cycle filled medication and should have arrived and been available for administration starting on 07/23/25. -She did not document that she contacted the pharmacy about Resident #1's Jardiance. -When the medication was not in the facility for administration she would document physically unable to take. -The PCP had access to the eMAR to review; she would think Resident #1 was receiving Jardiance if it was not documented correctly on the eMAR. Telephone interview with a second MA on 08/13/25 at 10:40am revealed: -Resident #1 had been administered Jardiance as ordered. -Resident #1's Jardiance had been on the medication cart. -She was sure she had administered Jardiance over the past week. -She did not know the pharmacy did not send Jardiance with the cycle filled medications to start 07/23/25. Telephone interview with the PCP on 08/13/25 at 1:02pm revealed: -Jardiance was used to control Resident #1's blood sugar. -Resident #1's blood sugar could increase, which could effective his kidneys, blood pressure, and affect his heart if his blood sugar was not controlled with the medications he was ordered.	D 358		

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D 358	Continued From page 102 Interview with the Administrator on 08/13/25 at 3:02pm revealed when the MA was administering medications and the medication was not on the medication cart, the MA should notify the pharmacy and her. Refer to the interview with a third MA on 08/13/25 at 7:39am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 2. Review of Resident #5's FL2 dated 11/13/24 revealed diagnoses included chronic pain, alcohol dependence, schizoaffective disorder, major depressive disorder, reflux, tremors, anxiety disorder, and hypertension. a. Review of Resident #5's FL2 dated 11/13/24 revealed an order for docusate/senna (a medication used to treat constipation) 50mg/8.6mg take 1 tablet twice a day. Review of Resident #5's signed physician order dated 06/05/25 revealed an order for docusate/senna 50mg/8.6mg take 1 tablet once a day. Review of Resident #5's signed physician order dated 07/31/25 revealed an order to discontinue docusate/senna 50mg/8.6mg take 1 tablet once a day. Review of Resident #5's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/12/25 revealed: -There was an entry for docusate/senna 50mg/8.6mg 1 tablet once daily. -Docusate/senna was documented as	D 358		

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D 358	Continued From page 103 administered for 12 of 12 opportunities from 08/01/25 to 08/12/25. Observation of Resident #5's medications on hand for administration on 08/13/25 at 12:30pm revealed there were 239 tablets remaining of 300 tablets dispensed on 06/10/25 in a cartridge box labeled as docusate/senna one tablet once a day. Interview with Resident #5 on 08/13/25 at 10:37am revealed: -She relied on the medication aides (MA) to give her medications because she was not aware of what medication she was administered every day. -She was not aware of any medication changes by her physician but she was having "terrible diarrhea" issues. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/13/25 at 9:40am revealed: -There was a current order for docusate/senna 50mg/8.6mg take 1 tablet once a day for Resident #5. -Docusate/senna was dispensed on 06/10/25 for a quantity of 300 tablets. -There was no order on file to discontinue docusate/senna for Resident #5. -The pharmacy was responsible for updating the eMAR for the facility. -The pharmacy expected the facility staff to provide new orders for the pharmacy to have current orders on file. Telephone interview with Resident #5's primary care provider (PCP) on 08/13/25 at 1:00pm revealed: -She had discontinued Resident #5's docusate/senna due to Resident #5's issues with diarrhea.	D 358		

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D 358	Continued From page 104 -She was not aware the facility staff had continued to administer Resident #5's docusate/senna and the potential outcome would be increased diarrhea. -She expected staff to administer or discontinue Resident #5's medications as ordered. Interview with a MA on 08/13/25 at 12:45pm revealed: -She administered Resident #5's medications during the morning shift and had administered Resident #5's docusate/senna. -First shift MAs were responsible to administer Resident #5's docusate/senna since it was ordered as a morning medication. -She was not aware of the physicians' order from 07/31/25 to discontinue docusate/senna. -All MAs were responsible for reviewing physician orders and ensuring discontinued medications were sent to the pharmacy to be removed from the eMAR. -The second shift MA was designated primarily to review physician orders even though all MAs were also responsible for the same task. Interview with a second MA on 08/13/25 at 11:00am revealed: -All MAs were responsible for reviewing physician orders and ensuring discontinued medications were sent to the pharmacy to be removed from the eMAR. -She was not aware of the Resident #5's physicians' order from 07/31/25 to discontinue docusate/senna. Interview with the Administrator on 08/13/25 at 4:55pm revealed she was not aware of Resident #5's physician's order from 07/31/25 to discontinue docusate/senna.	D 358		

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D 358	Continued From page 105 b. Review of Resident #5's FL2 dated 11/13/24 revealed there was an order for niacin (a supplement that can be used to treat elevated cholesterol levels) 500mg capsule take 1 capsule one time a day. Review of Resident #5's signed physician order dated 07/31/25 revealed an order to discontinue niacin 500mg take 1 tablet once a day. Review of Resident #5's August 2025 eMAR from 08/01/25 to 08/12/25 revealed: -There was an entry for niacin 500mg 1 tablet once daily. -Niacin was documented as administered 12 of 12 opportunities from 08/01/25 to 08/12/25. -Niacin should not have been administered and there were no additional notes for the niacin administered to Resident #5. Observation of Resident #5's medications on hand for administration on 08/13/25 at 12:30pm revealed there were 7 tablets remaining of 28 tablets dispensed on 07/16/25 in a bubble pack labeled for niacin 500mg one tablet once a day. Interview with Resident #5 on 08/13/25 at 10:37am revealed: -She relied on the MAs to give her medications because she was not aware of what medication she was administered every day. -She was not aware of any medication changes by her physician but she was having "terrible diarrhea" issues. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/13/25 at 9:40am revealed: -There was a current order for niacin 500mg take 1 tablet once a day for Resident #5.	D 358		

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D 358	Continued From page 106 -Niacin was dispensed on 07/16/25 for a quantity of 28 tablets. -There was no order on file to discontinue niacin for Resident #5. -The pharmacy was responsible for updating the eMAR for the facility. -The pharmacy expected the facility staff to provide new orders for the pharmacy to have current orders on file. Telephone interview with Resident #5's PCP on 08/13/25 at 1:00pm revealed: -She had discontinued Resident #5's niacin due to possible minimal interactions between niacin and Resident #5's colestipol. -Colestipol would bind to niacin and would reduce its absorption into the bloodstream, potentially making the niacin less effective. -She was not aware the facility staff had continued to administer Resident #5's niacin. -She expected staff to administer or discontinue Resident #5's medications as ordered. Interview with a MA on 08/13/25 at 12:45pm revealed: -She administered Resident #5's medications during the morning shift and had administered Resident #5's niacin. -First shift MAs were responsible to administer Resident #5's niacin since it was ordered as a morning medication. -She was not aware of the physician's order from 07/31/25 to discontinue niacin. -All MAs were responsible for reviewing physician orders and ensuring discontinued medications were sent to the pharmacy to be removed from the eMAR. -The second shift MA was designated primarily to review physician orders even though all MAs were also responsible for the same task.	D 358		

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D 358	Continued From page 107 Interview with a second MA on on 08/13/25 at 11:00am revealed: -All MAs were responsible for reviewing physician orders and ensuring discontinued medications were sent to the pharmacy to be removed from the eMAR. -She was not aware of Resident #5's physician's order from 07/31/25 to discontinue niacin. Interview with the Administrator on 08/13/25 at 4:55pm revealed she was not aware of Resident #5's physicians' order from 07/31/25 to discontinue niacin. c. Review of Resident #5's signed physician order dated 06/05/25 revealed an order for buspirone (a medication used to treat symptoms of anxiety) 15mg take 1 tablet three times a day. Review of Resident #5's signed physician order dated 06/23/25 revealed an order for buspirone 7.5mg take 1 tablet three times a day. Review of Resident #5's signed physician order dated 07/07/25 revealed an order for buspirone 5mg take 1 tablet three times a day. Review of Resident #5's signed physician order dated 08/08/25 revealed an order for buspirone 10mg take 1 tablet two times a day. Review of Resident #5's June 2025 eMAR revealed: -There was an entry for buspirone 15mg 1 tablet three times a day. -Buspirone 15mg was documented as administered for 50 of 50 opportunities from 06/09/25 to 06/25/25. -There was a second entry for buspirone 7.5mg 1	D 358		

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D 358	Continued From page 108 tablet three times a day. -Buspirone 7.5mg was documented as administered for 15 of 15 opportunities from 06/26/25 to 06/30/25. Review of Resident #5's July 2025 eMAR revealed: -There was an entry for buspirone 7.5mg 1 tablet three times a day. -Buspirone 7.5mg was documented as administered for 38 of 38 opportunities from 07/01/25 to 07/13/25. -There was a second entry for buspirone 5mg 1 tablet three times a day. -Buspirone 5mg was documented as administered for 72 of 72 opportunities from 07/08/25 to 07/31/25. -Buspirone 7.5mg should not have been administered from 07/08/25 to 07/13/25 and there were no additional notes for the buspirone administered to Resident #5. Review of Resident #5's August eMAR from 08/01/25 to 08/12/25 revealed: -There was an entry for buspirone 5mg 1 tablet three times a day. -Buspirone 5mg was documented as administered for 24 of 24 opportunities from 08/01/25 to 08/08/25. -There was a second entry for buspirone 10mg 1 twice a day. -Buspirone 10mg was documented as administered for 7 of 7 opportunities from 08/09/25 to 08/12/25. Observation of Resident #5's medications on hand on 08/13/25 at 12:30pm revealed: -There were 17 tablets remaining of 24 tablets dispensed on 08/08/25 in a bubble pack labeled for buspirone 10mg one tablet twice a day.	D 358		

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D 358	Continued From page 109 -Buspirone 7.5mg and 5mg were not available for administration. Interview with Resident #5 on 08/13/25 at 10:37am revealed: -She relied on the MAs to give her medications because she was not aware of what medication she was administered every day. -She was not aware of any medication changes by her physician. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/13/25 at 9:40am revealed: -There was a current order for buspirone 10mg take 1 tablet twice a day for Resident #5. -Buspirone was dispensed on 08/08/25 for a quantity of 24 tablets. -There was an order dated 07/07/25 for buspirone 5mg and the order was discontinued on 08/08/25. -There was an order dated 07/07/25 for buspirone 7.5mg and the order was discontinued on 07/07/25. -Buspirone 7.5mg should not have been on the eMAR for Resident #5 from 07/08/25 to 07/13/25. -The pharmacy was responsible for updating the eMAR for the facility but facility staff were able to also update the eMAR. -There was no documentation the pharmacy staff had entered the order for Resident #5's buspirone 5mg. -There was a potential outcome of increased disorientation and confusion if Resident #5 was administered 12.5mg from 07/08/25 to 07/13/25. Telephone interview with Resident #5's PCP on 08/13/25 at 1:00pm revealed: -She had not wrote the order for Resident #5's buspirone and that was managed by Resident #5's mental health provider.	D 358		

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D 358	Continued From page 110 -She was not aware Resident #5 was administered buspirone 7.5mg and buspirone 5mg for a total of 12.5mg at the same time for 1 tablet three times a day from 07/08/25 to 07/13/25 because she had not reviewed his eMAR. -There was a potential outcome of increased confusion and disorientation if Resident #5 was administered more buspirone than ordered. Interview with a MA on 08/13/25 at 12:45pm revealed: -She administered Resident #5's medications during the morning shift and she had administered Resident #5's buspirone. -First shift and second shift MAs were responsible to administer Resident #5's buspirone since it was ordered as a morning and an evening medication. -She was not aware of the physician's order from 07/07/25 to discontinue buspirone 7.5mg 1 tablet three times a day and start buspirone 5mg 1 tablet three times a day. -She was aware there were two different entries on the eMAR for buspirone 7.5mg 1 tablet three times a day and for buspirone 5mg three times a day from 07/08/25 to 07/13/25; she thought either the pharmacy or the second shift MA had entered the orders for Resident #5 that way on to the eMAR -She was aware Resident #5 was administered buspirone 7.5mg and buspirone 5mg for a total of 12.5mg at the same time for 1 tablet three times a day from 07/08/25 to 07/13/25. -All MAs were responsible for reviewing physician orders and ensuring medications were discontinued by the pharmacy on the eMAR. -The second shift MA was designated primarily to review physician orders even though all MAs were also responsible for the same task.	D 358		

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D 358	Continued From page 111 -All MAs were responsible for comparing the eMAR to the medications on hand for accuracy. Interview with a second MA on 08/13/25 at 11:00am revealed: -She administered Resident #5's medications during the evening shift and she had administered Resident #5's buspirone. -First shift and second shift MAs were responsible to administer Resident #5's buspirone since it was ordered as a morning and an evening medication. -She was not aware of the physician's order from 07/07/25 to discontinue buspirone 7.5mg 1 tablet three times a day and start buspirone 5mg 1 tablet three times a day. -She was aware there were two different entries on the eMAR for buspirone 7.5mg 1 tablet three times a day and for buspirone 5mg 1 tablet three times a day from 07/08/25 to 07/13/25; she thought the pharmacy had entered the orders that way on to the eMAR, -She was aware Resident #5 was administered buspirone 7.5mg and buspirone 5mg for a total of 12.5mg at the same time three times a day from 07/08/25 to 07/13/25. -All MAs were responsible for reviewing physician orders and ensuring medications were discontinued by the pharmacy on the eMAR. Interview with the Administrator on 08/13/25 at 4:55pm revealed: -She was not aware of the physician's order from 07/07/25 for Resident #5's buspirone 7.5mg. -She was not aware Resident #5 was administered buspirone 7.5mg and buspirone 5mg for a total of 12.5mg at the same time three times a day from 07/08/25 to 07/13/25. Attempted telephone interview with Resident #5's	D 358		

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D 358	Continued From page 112 mental health provider on 08/13/25 at 9:30am was unsuccessful. Refer to the interview with a third MA on 08/13/25 at 7:39am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 3. Review of Resident #3's FL2 dated 01/01/25 revealed: -Diagnoses included syncope and collapse, hypertension, hyperlipidemia, mood disorder, irritable bowel syndrome, Raynaud's phenomenon, constipation, stenosis of right subclavian artery, and chronic intractable pain. -There was an order for escitalopram (a medication used to treat major depressive disorder) 20mg take 1 tablet in the morning. Review of Resident #3's signed physician order dated 07/25/25 revealed an order to discontinue escitalopram 20mg 1 tablet in the morning. Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was anentry for escitalopram 20mg 1 tablet every morning. -Escitalopram was documented as administered for 31 of 31 opportunities from 07/01/25 to 07/31/25. Review of Resident #3's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for escitalopram 20mg 1 tablet every morning. -Escitalopram was documented as administered for 11 of 11 opportunities from 08/01/25 to 08/11/25	D 358		

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D 358	Continued From page 113 Observation of Resident #3's medications on hand for administration on 08/13/25 at 12:30pm revealed there were 6 tablets remaining of 28 tablets dispensed on 07/16/25 in a bubble pack labeled escitalopram 20mg one tablet every morning. Interview with Resident #3 on 08/13/25 at 10:37am revealed: -She was aware of her medications ordered by her physician and the medication aides (MA) administered most of her medications to her every day. -She was not aware of any medication changes by her physician and had not experienced any health issues other than her chronic pain. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/13/25 at 9:40am revealed: -There was a current order on file for escitalopram 20mg 1 tablet every morning for Resident #3. -Escitalopram was dispensed on 07/16/25 for a quantity of 28 tablets. -There was no order on file to discontinue escitalopram for Resident #3. -The pharmacy was responsible for updating the eMAR for the facility. -The pharmacy expected the facility staff to provide new orders for the pharmacy to have current orders on file. Interview with a MA on 08/13/25 at 12:45pm revealed: -She administered Resident #3's medications during the morning shift and had administered Resident #5's escitalopram. -First shift MAs were responsible to administer	D 358		

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D 358	Continued From page 114 Resident #3's escitalopram since it was ordered as a morning medication. -She was not aware of the physician's order from 07/25/25 to discontinue escitalopram. -All MAs were responsible for reviewing physician orders and ensuring orders for discontinued medications were sent to the pharmacy to be removed from the eMAR. -The second shift MA was designated primarily to review physician orders even though all MAs were also responsible for the same task. Interview with a second MA on 08/13/25 at 11:00am revealed: -All MAs were responsible for reviewing physician orders and ensuring orders for discontinued medications were sent to the pharmacy to be removed from the eMAR. -She was not aware of the physician's order from 07/25/25 to discontinue escitalopram. Interview with the Administrator on 08/13/25 at 4:55pm revealed she was not aware of Resident #3's physicians' order from 07/25/25 to discontinue escitalopram. Attempted telephone interview with the mental health provider on 08/13/25 at 9:30am who discontinued the orders for Resident #3's escitalopram was unsuccessful. Refer to the interview with a third MA on 08/13/25 at 7:39am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 4. Review of Resident #2's current FL2 dated 01/12/25 revealed:	D 358		

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D 358	Continued From page 115 -Diagnoses included type 2 diabetes, hypertension, lymphedema, morbid obesity, and septic shock. -There was an order for vitamin B12 1000mcg/1ml injection (used to treat vitamin B12 deficiency) to be administered once a month. Review of Resident #2's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin B12 1000mcg/1ml injection to be administered once a month. -There was no documentation that vitamin B12 1000mcg/mL intramuscular injection was administered. Review of Resident #2's July 2025 eMAR revealed: -There was an entry for vitamin B12 1000mcg/1ml injection to be administered once a month. -There was no documentation that vitamin B12 1000mcg/mL intramuscular injection was administered. Review of Resident #2's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for vitamin B12 1000mcg/1ml injection to be administered once a month. -There was no documentation that vitamin B12 1000mcg/mL intramuscular injection was administered. Observation of Resident #2's medications on hand on 08/12/25 at 9:50am revealed: -Vitamin B12 1000mcg/mL injection was not on the medication cart. -Vitamin B12 1000mcg/mL injection was not in	D 358		

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D 358	Continued From page 116 the facility's medication storage room. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 3:04pm revealed: -There was a current order on file for Resident #2 for vitamin B12 1000mcg/mL injection to be administered once every month. -One dose of vitamin B12 1000mcg/mL injection was last dispensed on 12/31/24. -Vitamin B12 1000mcg/mL injection was not dispensed in 2025. -The facility was responsible for contacting the pharmacy to refill vitamin B12 1000mcg/mL injection. Interview with Resident #2 on 8/13/25 at 10:12am revealed: -She had not received any injections since she was admitted to the facility. -She was not aware she was supposed to receive a monthly B12 injection. Telephone interview with Resident #2's primary care provider (PCP) on 08/13/25 at 1:12pm revealed: -She expected the facility to implement the vitamin B12 injection as ordered. -If the vitamin B12 injection was not administered, she expected documentation to reflect that. Interview with a medication aide (MA) on 08/13/25 at 4:15pm revealed: -She never administered the vitamin B12 injection to Resident #2 because on the days she worked, it was not in the facility when it was due to be administered. -If she did not administer a medication, her documentation would reflect that.	D 358		

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D 358	Continued From page 117 Telephone interview with a second MA on 08/13/25 at 11:05am revealed: -She was under the impression a licensed nurse had to administer the vitamin B12 injection. -No licensed nurses worked in the facility. -She was not scheduled to work on the days when Resident #2's vitamin B12's injection was due. Interview with the Administrator on 08/13/25 at 4:00pm revealed: -A home health agency was supposed to come into the facility to administer injections. -She was not sure why a home health agency was not scheduled to come in to the facility to give Resident #2 her monthly vitamin B12 injection. -She did not acknowledge who was responsible for scheduling the home health agency. -If a medication was not available, the MAs were to call the facility's contracted pharmacy to find out where the medication was, and if it could be dispensed to the facility. Refer to the interview with a third MA on 08/13/25 at 7:39am. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. _____ Interview with a third MA on 08/13/25 at 7:39am revealed: -She did not do medication cart audits. -She did not have time during the night to do the medication cart audits. -The Administrator had not asked her to do medication audits. Interview with the Administrator on 08/13/25 at 3:02pm revealed:	D 358		

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D 358	Continued From page 118 -The third shift MA completed the medication cart audits. -Medication cart audits were not scheduled; the MA would do them when she had time. -No MAs had voiced any concerns about medications that were not on the medication cart. -She expected staff to administer medications as ordered by the provider. The facility failed to administer medications as ordered including a resident (#1) who was a diabetic and was ordered four medications to manage her blood sugar. There were multiple doses not administered with blood sugar readings as high as 541. The resident could have kidney and eye damage and further damage to his heart if his blood sugars were not controlled. Another resident was administered a discontinued medication to treat constipation which caused the resident further diarrhea (#5). This failure resulted in substantial risk for serious harm which constitutes a Type A2 Violation. This facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2025.	D 358	The eMAR was reviewed and corrected for the identified residents ensure accuracy of current physician orders. Physicians were contacted to verify medication orders, and any discrepancies were clarified immediately.	
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;	D 367	Staff responsible for documentation errors were counseled and temporari removed from medication administration until retraining was completed. The affected residents were assessed by nursing staff to ensure no adverse outcomes occurred due to documentation errors.	

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D 367	Continued From page 119 (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 3 of 7 sampled residents (#1, #4, #7) including an anti-anxiety medication (#1); documentation for a medication used to treat and prevent heart rhythm disorders (#4); and a medication for anxiety (#7). The findings are: Review of the facility's medication administration policy revealed the medication administration record should be accurate for each resident. 1.Review of Resident #4's FL2 dated 10/29/24 revealed diagnoses included atrial fibrillation, heart failure, hypertension, chronic kidney disorder, diabetes mellitus, and hyperlipidemia.	D 367	Order reconciliation: All new, change or discontinued medication orders w be verified by the Resident Care Coordinator (RCC) or Medication Supervisor within 24 hours to ensure eMAR accuracy. Double-entry verification: Two staff members will review all orders entere into the eMAR before approval. Staff retraining: All Med Techs and licensed staff will undergo in-service training on: Accurate documentation in the eMA Importance of timely updates to refle new, changed, or discontinued order Procedures for reporting and correcting documentation errors. Daily documentation checks: Supervisors will review the eMAR eac shift to ensure accuracy and completion of medication documentation.	

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D 367	Continued From page 120 Review of Resident #4's signed physician orders dated 01/07/25 revealed there was an order for amiodarone 200mg tablet to be administered every day. Review of Resident #4's June 2025 eMAR revealed: -There was 2 separate entries for amiodarone 200mg tablet to be administered every day at 8:00am . -There was documentation on both entries that amiodarone was administered daily from 06/01/25 through 06/30/25. Review of Resident #4's July 2025 eMAR revealed: -There was 2 separate entries for amiodarone 200mg tablet to be administered every day at 8:00am. -There was documentation on the first entry that amiodarone was administered from 07/01/25 through 07/26/25. -There was documentation on the second entry that amiodarone was administered from 07/01/25 through 07/31/25. Observation of Resident #4's medication on hand on 08/13/25 at 10:39am revealed: -There was a bubble pack with 6 tablets of amiodarone available for administration and was last dispensed on 07/23/25. -The order on the label was for amiodarone 200mg take 1 tablet once daily. Interview with Resident 4's primary care provider (PCP) on 08/13/25 at 1:12pm revealed: -She intended for the facility to administer Resident #4's amiodarone as ordered. -She did not know why the facility had the	D 367	The Medication Supervisor/Charge Nurse will perform weekly eMAR audits to verify that all medications administered match current physicia orders. The RCC will review all physician orders and compare them against th eMAR within 24 hours of receipt. Random medication pass observations will be conducted wee to ensure staff are documenting correctly in real time. Audit findings will be reviewed by th Administrator at monthly Quality Assurance meetings, and corrective actions will be implemented as needed. Resident Care Coordinator (RCC): Reviews orders and verifies eMAR accuracy. Medication Supervisor/Charge Nurs Conducts weekly audits and medication pass observations. Administrator: Oversees compliance and monitors QA findings.	

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D 367	Continued From page 121 amiodarone order listed twice on the eMAR. Interview with a medication aide (MA) on 08/13/25 at 4:15pm revealed: -She was aware Resident #4's eMAR had 2 separate entries for amiodarone 200mg tablet to be administered every day. -She was not in charge of eMAR audits. -If a medication had two separate entries with the same orders on the eMAR, she would administer the medication one time and document the administration one time. Refer to the interview with the Administrator on 08/13/25 at 3:04pm. 2. Review of Resident #7's current FL2 dated 01/20/25 revealed diagnoses included traumatic brain injury, bipolar disorder, and behavioral concerns. Review of Resident #7's signed physician's order dated 01/28/25 revealed there was an order for alprazolam 0.5mg (used to treat anxiety) three times daily. Review of Resident #7's July 2025 electronic medication administration record (eMAR) from 07/23/25 to 07/31/25 revealed: -There was an entry for alprazolam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation alprazolam 0.5mg was administered 27 of 27 times from 07/23/25 to 07/31/25. Review of Resident #7's August 2025 eMAR from 08/01/25 to 08/12/25 revealed: -There was an entry for alprazolam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.	D 367	Immediate corrective actions were completed as of August 27, 2025. Staff retraining will be completed b October 30, 2025. Weekly audits and QA reviews will continue on an ongoing basis to sustain compliance.	

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D 367	Continued From page 122 -There was documentation alprazolam 0.5mg was administered 24 of 34 times from 08/01/25 to 08/12/25. -There were 10 exceptions documented; the exceptions were the medication was not given, waiting for the medication to be delivered, and waiting for the Primary Care Provider (PCP) to write a new order. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41pm revealed: -Resident #7 had an order for alprazolam 0.5mg three times daily. -The alprazolam was on cycle fill and the pharmacy dispensed 28 alprazolam 0.5mg tablets on 04/30/25, 05/28/25, and 06/25/25. -Each cycle fill lasted 28 days and the next cycle fill was to start on 07/23/25 but the alprazolam was not filled. -The pharmacy notified the Mental Health Provider (MHP) on several occasions in June 2025 and July 2025, but never received a new order to refill the alprazolam. -The facilty had attempted to re-order the alprazolam for Resident #7 by clicking on the re-order button on the eMAR. -She had spoken to someone at the facility in the past couple of weeks to see if the staff could assist in getting an order from the MHP for the alprazolam. -The alprazolam would not have been in the facility to administer starting 07/23/25 if the medication was being administered as ordered. Interview with a medication aide (MA) on 08/12/25 at 3:30pm revealed: -Resident #7 did not have alprazolam 0.5mg on the medication cart to administer today, 08/12/25. -Resident #7 was not administered alprazolam in	D 367		

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D 367	Continued From page 123 several weeks because it was not on the medication cart. -The MA documenting that the medication was administered was wrong; she did not administer the alprazolam because it was not in the facility to administer. -Resident #7 had not complained of any headaches or problems sleeping. Interview with a second MA on 08/13/25 at 7:39am revealed: -Resident #7 has not had alprazolam on the medication cart to administer in a week or more. -She thought she documented the medication was not in the facility. -If she documented the medication was administered, it was a mistake. Telephone interview with a third MA on 08/13/25 at 10:40am revealed: -Resident #7 had an order for alprazolam. -It had not been available to administered for a while. -She had notified the MHP that Resident #7 was not getting her alprazolam. -She should not have documented on the eMAR the medication was administered. -She made a mistake. Refer to the interview with the Administrator on 08/13/25 at 3:04pm. 3. Review of Resident #1's current FL2 dated 06/20/25 revealed diagnoses included diabetes mellitus, depression disorder, hypertension, cerebral vascular disease (CVA), and anxiety. Review of Resident #1's signed physician order dated 07/29/25 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) twice	D 367		

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D 367	Continued From page 124 daily as needed (PRN) for anxiety. Review of Resident #1's July 2025 eMAR from 07/29/25 to 07/31/25 revealed: -There was an entry for lorazepam 0.5mg one tablet twice daily PRN for anxiety. -There was documentation lorazepam was administered on 07/30/25. Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/11/25 revealed: -There was an entry for lorazepam 0.5mg one tablet twice daily PRN for anxiety. -There was no documentation lorazepam was administered from 08/01/25 to 08/11/25. Review of Resident #1's controlled substance count sheet (CSCS) for lorazepam 0.5mg tablets revealed: -The prescription label read, "take one tablet twice daily PRN for anxiety". -There were 28 lorazepam 0.5mg tablets dispensed on 07/29/25. -There was documentation that a lorazepam tablet was signed out on 07/30/25, 07/31/25, 08/03/25, 08/04/25, 08/06/25, and 08/08/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/12/25 at 11:41am revealed: -Resident #1 had an order for lorazepam 0.5mg twice daily PRN for anxiety dated 07/29/25. -The pharmacy dispensed 28 lorazepam 0.5mg tablets on 07/29/25. Observation of Resident #1's medications on hand on 08/11/25 at 12:44pm revealed there was a punch card with 22 of 28 lorazepam 0.5mg tablets available for administration.	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 125 Interview with a MA on 08/13/25 at 7:39am revealed: -She had not administered lorazepam 0.5mg to Resident #1. -She had offered the lorazepam to Resident #1, but he did not want to take it. -She signed the CSCS when the medication was delivered to verify the pill count, but she had not administered the medication. Interview with a second MA on 08/13/25 at 11:15am revealed: -She administered Resident #1's lorazepam when he needed the medication. -She signed the CSCS but failed to sign the eMAR. -She did not know she needed to sign the eMAR since she signed the CSCS. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -The MA should sign the eMAR each time a medication was given. -The Primary Care Provider (PCP) reviewed the eMARS to see what medications were being taken. -The PCP would think Resident #1 was not taking the lorazepam if it was not documented on the eMAR. Refer to the interview with the Administrator on 08/13/25 at 3:04pm. Interview with the Administrator on 08/13/25 at 3:04pm revealed: -She was not aware that eMAR audits were a process. -If eMAR audits were completed, this error would have been caught or prevented. -She expected the MAs to document medication	D 367		

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D 367	Continued From page 126 administration correctly on the eMAR.	D 367	The MA observed in the deficiency was immediately counseled and removed from medication administration duties until retraining was completed. The affected residents were assessed for any potential harm or risk of infection; no negative outcomes were identified. The Administrator immediately re-educated all staff on proper infection control and safe medication administration practices, emphasizing hand hygiene and the use of medication cups/pour packets instead of touching medications. Staff will be required to sanitize hands before and after every resident encounter, as well as before and after glove use. Hand sanitizer stations have been reinforced at medication administration areas. Staff are prohibited from touching medications directly with their hands. Medications will only be handled using medication cups, gloves, or proper dispensing devices.	
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA) who removed pills with her hands prior to the administration of medications and did not sanitize her hands before and after donning and doffing gloves when obtaining a fingerstick blood sugar (FSBS). The findings are: Review of the facility's undated medication infection control policy revealed the MAs should wash their hands and follow infection control procedures. Observation of the morning medication pass on 08/12/25 between 7:36am and 8:10am revealed: -At 7:36am, the MA removed 9 punch cards from the medication cart for a resident. -The MA picked up one punch card and punched a pill into her ungloved hand and placed the pill in the medication cup; the MA continued the same	D 371		

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D 371	Continued From page 127 technique for the other 8 punch cards. -The MA administered the medications to a resident and sanitized her hands after the administration of medications. -The MA pushed the medication cart down the hall to administer medications to residents in their rooms. -At 7:43am, the MA removed three punch cards from the medication cart for a second resident without sanitizing her hands. - The MA picked up one punch card and punched a pill into her hand and placed the pill in the medication cup; the MA continued the same technique for the other 2 punch cards. -The MA administered the medications to the second resident and did not sanitize her hands. -At 7:45am, the MA donned gloves and removed a glucometer from the top drawer of the medication cart. -The MA checked a resident's FSBS, replaced the glucometer in the medication cart, removed her gloves and did not sanitize her hands. -At 7:49am, the MA removed 11 punch cards from the medication cart. -The MA picked up one punch card and punched a pill into her hand and placed the pill in the medication cup; the MA continued the same technique for the other 10 punch cards. -The MA administered the medications to a third resident and did not sanitize her hands. -At 7:59am, the MA pushed the medication cart to the dining room on the South Hall. -The MA donned gloves and removed a glucometer from the top drawer of the medication cart. -The MA checked a resident's FSBS, replaced the glucometer in the medication cart, removed her gloves and did not sanitize her hands. Interview with the MA on 08/12/25 at 3:16pm	D 371	Staff Training: All Med Techs, MAs, and licensed staff will undergo mandatory retraining on: Infection prevention and control during medication administration. Proper technique for donning/doffing gloves. Safe handling of oral medications and supplies. Zero-Tolerance Policy: Any staff observed bypassing infection control practices will be subject to disciplinary action, up to and including termination.	

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D 371	Continued From page 128 revealed: -She knew she should not have popped medications into her hands. -She knew she should have washed her hands before and after donning and doffing gloves. -She was nervous because she was being watched during the medication pass. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -The MA should not touch medications with their bare hands. -The residents' pills should be popped into a medication cup. -The MA should wear gloves if she needed to touch a pill. -The MA should wash her hands when donning and doffing gloves. -She expected the MA to follow infection prevention guidelines to prevent any spread of infection.	D 371	Audit results will be reviewed during monthly Quality Assurance (QA) meetings, with retraining assigned i deficiencies are noted. Documentation of observations, retraining, and compliance checks will be maintained in the QA binder Resident Care Coordinator (RCC): Oversees infection control retraining and direct observation of practices. Medication Supervisor conducts weekly audits and medication pass observations. Administrator: Provides oversight, enforces disciplinary action if neede and ensures QA monitoring is sustained. Immediate corrective actions were completed as of [insert date]. Staff retraining will be completed by [insert date within 30 days]. Ongoing audits and QA reviews will continue indefinitely to maintain compliance.	
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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D 375	Continued From page 129 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure an assessment and physician's order for 1 of 5 sampled residents (#4) who self-administered medications to control and prevent symptoms of asthma. The findings are: 1. Review of Resident #4's current FL2 dated 10/29/24 revealed: -Diagnosis included atrial fibrillation, heart failure, hypertension, chronic kidney disorder, diabetes mellitus, and hyperlipidemia. -There was an order for budesonide 160/formoterol 4.5 inhaler, 2 puffs to be inhaled 2 times a day (used to prevent symptoms of asthma). -There was an order for albuterol sulfate 108mcg inhaler, 2 puffs to be inhaled every 4 hours as needed, used to control symptoms of asthma. -There was no order to self administer any medications on the FL2. Review of Resident #4's record revealed no care plan was available for review. Review of Resident #4's record revealed there was no assessment for self administration of any medications. Observation of Resident #4's room on 10/13/25 at 11:44am revealed: -There was a budesonide 160 /formoterol 4.5 inhaler on Resident #4's bedside table. -There was an albuterol sulfate 108mcg inhaler	D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications The resident identified as self-administering asthma medication was immediately evaluated by the Resident Care Coordinator (RCC) ai physician was contacted to obtain an order authorizing self-administration. A self-administration assessment was completed by nursing staff to ensure the resident demonstrated the cognitive ability, physical coordination, and safety awarenes required to self-administer. Documentation of the assessment and physician order was placed in the resident's medical record. No negative outcomes were identified during the resident's review. Admission/Quarterly Reviews: All residents will be assessed for self-administration of medications upo admission, quarterly, and with any change in condition. Physician Orders: Self-administrati will only be permitted with a valid physician's order and completed assessment on file.	

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D 375	Continued From page 130 on Resident #4's bedside table. Interview with Resident #4 on 10/13/25 at 11:49am revealed: -He kept his inhalers in his room so there was no delay in being able to use his inhalers when and if he needed them. -The staff at the facility was aware he kept his inhalers in his room. Telephone interview with Resident #4's primary care provider (PCP) revealed: -She did not have an order, in her records, for Resident #4 to self administer any medications. -She was not aware Resident #4 kept his inhalers in his room. Interview with a medication aide (MA) on 10/13/25 at 4:15pm revealed: -She was aware residents needed to have self administration orders and assessments to self administer any medication. -She was told by the previous PCP that residents could keep creams, sprays, and inhalers in their rooms. -She was aware Resident #4 kept his inhalers in his room so that he could use his inhalers when he needed without delay. Interview with the Administrator on 10/13/25 at 3:04pm revealed: -She expected all resident medications to be kept on the medication cart. -She was not aware Resident #4 kept his inhalers in his room. -She was concerned that Resident #4 could possibly under medicate or over medicate. -She expected the MAs to administer as needed medications, promptly, when requested by residents.	D 375	Staff Training: Nursing staff, Med T and the RCC will be re-educated o policy and procedures for self-administration, including the requirement for assessment, documentation, and physician authorization. Resident Education: Residents approved for self-administration w educated on safe handling, proper storage, and reporting requiremen their medications. The RCC will audit all resident char monthly to ensure any resident sel administering medications has bot current physician's order and documented assessment. The Medication Supervisor will cro check medication orders weekly ac the self-administration log to confi compliance. The Administrator will review audit results during monthly Quality Assurance (QA) meetings to track compliance and implement additic training if necessary.	

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D 375	Continued From page 131 -She was aware residents needed to have self administration orders and assessments to self administer any medication.	D 375	Resident Care Coordinator (RCC): Conducts self-administration assessments and ensures orders are documented. Medication Supervisor/Charge Nurse: Performs weekly reviews to confirm documentation is complete. Administrator: Provides oversight and ensures compliance through QA monitoring. Immediate corrective actions were completed as of August 27, 2025. Staff retraining will be completed by October 30, 2025. Monthly audits and QA reviews will continue indefinitely to ensure sustained compliance.	
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure all medications stored by the facility, were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. The findings are: Observation of the medication cart on 08/13/25 at 1:30pm revealed: -There was one medication packet with resident identifying information sitting on the top of the medication cart with 5 tablets left in the packet. -There were no medication aides (MAs) supervising the medication cart. -Two residents passed by the medication cart while the medication packets were left unsupervised. Interview with a MA on 08/13/25 at 1:40pm revealed: -She took the medication packets out of the	D 378		

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D 378	Continued From page 132 medication cart, placed them on top of the cart, got distracted, and forgot to discard the medications appropriately before walking away from the medication cart. -She was aware that medications should not be left unsupervised as residents could easily access them. -There was a few disoriented or confused residents in the facility. Interview with the Administrator on 08/13/25 at 4:00pm revealed: -Medications were not to be left on top of the medication cart unsupervised. -She expected staff to discard and store medications appropriately when taking them out of the cart.	D 378		
D 420	10A NCAC 13F .1104 (b) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (b) No employee of a facility shall handle the personal funds for a resident, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's authorized representative. The facility administrator or their designee shall maintain an accurate account balance and accounting of all funds received, disbursements, and the balance on hand which shall be available upon request to the resident or their authorized representative during the facility's regular business office hours.	D 420	An immediate audit of all resident personal fund accounts was conducted to confirm balances and reconcile any discrepancies. The designated resident fund account was verified to ensure a minimum balance of $2,000 is maintained at all times for resident access. Residents and/or responsible parties were notified of their current account balances in writing.	

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D 420	Continued From page 133 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to maintain an accurate accounting of residents' personal funds, including deposits, withdrawals and balances and have residents' funds available upon request. The findings are: Review of the Facility's Resident Agreement revealed "All or any portion of the funds will be available to the resident ... ...anytime during business office hours" per the Resident's Personal Funds Policy. 1. Review of Resident #3's current FL2 dated 01/21/25 revealed diagnoses included syncope and collapse, hypertension and mood disorder. Review of Resident #3's account balance statement from August 2025 revealed: -There were no deposits or withdrawals reflected in the account balance. -There was a current balance of $20.00 on 08/12/25. Review of Resident #3's receipts from June 2025 to August 2025 revealed: -There was a receipt of a withdrawal of $20.00 on 06/20/25 and the documentation for the reason of the withdrawal was cash to resident. -There was a receipt of a withdrawal of $20.00 on 07/30/25 and the documentation for the reason of	D 420	The facility has established and will maintain a separate, secure account strictly for resident personal funds. A minimum balance of $2,000 will always be available in the account to ensure residents have immediate access to their funds when requested. Each deposit, withdrawal, and expenditure will be documented in detail, with a receipt signed by the staff member and resident (or responsible party). Residents will be provided with monthly account statements for transparency and accountability. A written Resident Funds Management Policy has been implemented requiring: Dual verification of all transactions (staff and administrator signatures). Daily updating of the resident funds ledger, matched against bank records. Documentation of all balances and reconciliations kept in a bound ledger or electronic accounting system that prevents unauthorized alteration.	

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D 420	Continued From page 134 the withdrawal was cash to resident. -In August 2025, there were no receipts of withdrawals. Requests for the Resident #3's personal funds ledger for June 2025 through August 2025 was made on 08/08/25 at 10:00am, 08/08/25 at 12:10pm, and on 08/11/25 at 1:15pm and was not provided for review. Interview with Resident #3 on 08/11/25 at 9:45am revealed: -She used to receive all her funds around the 5th of every month. -For the past few months, residents received their funds every Wednesday but were told they could only request $25.00 or less every week by the Business Office Manager (BOM) and Administrator. -The facility allowed other residents to receive only $25 every Wednesday. -She requested $25.00 in July for a physician's copay and was told by the BOM she was allowed to receive $20.00. Refer to the interview with the BOM on 08/08/25 at 12:10pm. Refer to the interview with the Administrator on 08/12/25 at 3:28pm. Refer to the interview with the Owner on 08/13/25 at 3:55pm. 2. Review of Resident #5's current FL2 dated 11/13/24 revealed diagnoses included chronic pain, tremors, hypertension, schizoaffective disorder and anxiety disorder. Review of Resident #5's account balance	D 420	Residents are assured access to funds during normal business hours and upon reasonable request. The $2,000 balance requirement is no part of the monthly administrative audit checklist. Administrative staff have received in-service training on NCAC 13F .1104(b requirements regarding accounting fo residents' personal funds. Training emphasized: Maintaining the $2,000 minimum balance. Proper documentation of deposits/withdrawals. Prohibition against co-mingling resident funds with facility funds. Refresher training will occur quarterly to ensure compliance is sustained.	

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D 420	Continued From page 135 statement from August 2025 revealed: -There were no deposits or withdrawals reflected in the account balance. -There was a current balance of $139.00 on 08/12/25. Review of Resident #5's receipts from June 2025 to August 2025 revealed: -There were receipts of withdrawals of $25.00 on 06/11/25 and 6/20/25 and they documentation for the reason of the withdrawals was cash to resident. -There were receipts of withdrawals of $25.00 on 07/02/25, 07/11/25, 07/16/25, 07/23/25, and 07/30/25 and the documentation for the reason of the withdrawals was cash to resident. -There was a receipt of a withdrawal of $25.00 on 08/06/25 and the documentation for the reason of the withdrawal was cash to resident. Requests for the Resident #5's personal funds ledger for June 2025 through August 2025 was made on 08/08/25 at 10:00am, 08/08/25 at 12:10pm, and on 08/11/25 at 1:15pm and was not provided for review. Interview with Resident #5 on 08/20/24 at 9:45am revealed: -All of her money had always been available around the 5th of every month previously. -The previous Business Office Manager (BOM) was always in the office during weekday hours and she could get her resident funds any weekday before 3:00pm. -Now she only received $25.00 every Wednesday when they called her name over the loudspeaker to come to the business office. -She had requested more than $25.00 before for snacks in her room but was told she could only receive $25.00 or less by the Administrator and	D 420	The Administrator (or designee) will perform monthly audits of the resident fund account to ensure the $2,000 minimum balance is available and documented. Quarterly oversight will be conducted by a financial officer or outside consultant to provide an additional layer of accountability. Corrective action will be taken immediately for any discrepancy, and findings will be documented for DHSR review. All corrective measures were initiated immediately and will remain in effect on an ongoing basis as of October 30, 2025. Administrator/Executive Director is responsible for ensuring compliance with this Plan of Protection and maintaining adherence to 10A NCAC 13F .1104(b).	

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D 420	Continued From page 136 the BOM. Refer to the interview with the BOM on 08/08/25 at 12:10pm. Refer to the interview with the Administrator on 08/12/25 at 3:28pm. Refer to the interview with the Owner on 08/13/25 at 3:55pm. 3. Review of Resident #6's current FL-2 dated 01/14/25 revealed diagnoses included bipolar disorder, hyperlipidemia, atrial fibrillation, hypertensive heart disease with heart failure, and type 2 diabetes. Review of Resident #6's account balance statement from August 2025 revealed: -There were no deposits or withdrawals reflected in the account balance. -There was a current balance of $7065.89 on 08/12/25. Review of Resident #6's receipts from June 2025 to August 2025 revealed: -There were receipts of withdrawals of $25.00 on 6/04/25, 06/11/25, and 6/20/25 and the documentation for the reason of the withdrawals was cash to resident. -There were receipts of withdrawals of $25.00 on 07/02/25, 07/11/25, 07/16/25, 07/23/25, and 07/30/25 and the documentation for the reason of the withdrawals was cash to resident. -There was a receipt of a withdrawal of $25.00 on 08/06/25 and the documentation for the reason of the withdrawal was cash to resident. Requests for the Resident #6's personal funds ledger for June 2025 through August 2025 was	D 420		

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D 420	Continued From page 137 made on 08/08/25 at 10:00am, 08/08/25 at 12:10pm, and on 08/11/25 at 1:15pm and was not provided for review. Interview with Resident #6 on 08/23/24 at 9:00am revealed: -Recently the facility changed from residents receiving $90.00 a month at one time to being allowed only $25.00 a week. -The previous Business Office Manager (BOM) always had her funds available by the 10th of each month in the office during weekday hours. -The Administrator and the BOM gave residents their money by making an announcement and having residents line up in the hall at the business office. -She had requested more than $25.00 on occasion and was told she was only allowed $25.00 or less by the BOM so she stopped asking for more when she needed it. Refer to the interview with the BOM on 08/08/25 at 12:10pm. Refer to the interview with the Administrator on 08/12/25 at 3:28pm. Refer to the interview with the Owner on 08/13/25 at 3:55pm. Interview with the Business Office Manager (BOM) on 08/08/25 at 12:10pm. -She and the Administrator were responsible for the resident funds. -Resident funds were accessible to residents every Wednesday in the afternoon. -Residents could request more than $25.00 if the funds were available. -She and the Administrator developed the system to fund residents $25.00 every week and	D 420		

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D 420	Continued From page 138 requested residents adjust the money they received due to not having enough for all the residents at once with being allotted only $1500.00 in the Resident Trust fund box. -She was aware of residents' concerns related to accessing more than $25.00 of their funds each week. -She was aware residents were allowed $90.00 a month. -She was not aware all funds should be accessible to residents upon request. Interview with the Administrator on 08/12/25 at 3:28pm revealed: -The Administrator and the BOM were responsible for the resident funds. -Resident funds were accessible to residents every Wednesday in the afternoon. -She received concerns from the BOM related to not having enough funds for all the residents every month with being allotted only $1500.00 in the Resident Trust fund box. -She contacted the Owner and was instructed for the BOM and her to come up with a system to manage the resident funds by the Owner. -She and the BOM developed the system to give residents $25.00 every week from their personal funds, but she expected residents to receive more than $25.00 when they requested more. -She was not aware residents had concerns related to receiving more funds when the residents requested more than $25.00 each week. Interview with the Owner on 08/13/25 at 3:55pm revealed: -The Administrator and the BOM were responsible for the accounting and administration of residents' funds. -Resident Funds and the Resident Trust Fund	D 420		

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D 420	Continued From page 139 Ledger were kept in the BOM's office and only the Administrator and the BOM had access to the office. -Residents had access to funds usually on Wednesdays at any time and residents were able to access more than $25.00 of their funds anytime upon request. -He was not aware residents had concerns about accessing all of their funds upon request and would ensure the BOM and Administrator made the funds available to residents. -He expected residents to be able to access their funds upon request. Based upon the number of residents receiving Speical Assistance (SA) money (22 residents) there should be $1,980.00 available in the Resident Trust fund box instead of $1,500.00; there would not have been enough funds available to cover the montly allowance of $90.00 for the 22 residents receiving SA monies. The facility failed to ensure a record of residents' personal funds allowances were accounted for by recording deposits, withdrawals and balances for three sampled residents (#3, #5 and #6), resulting in residents not having access to their funds and being able to purchase snacks and other items upon request. This failure was detrimental to the welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2025.	D 420		

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D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.	D 610	Immediately upon identification of t deficiency, all shared use of glucometers was stopped. New individual glucometers were ordered and assigned to each resident requiring blood sugar monitoring. Each glucometer has been labeled with the resident's name and stored a separate, designated, and sanitizec container to prevent cross-contamination. Blood sugar monitoring continued without interruption using appropriately assigned equipment tc ensure resident safety. Facility staff were instructed that glucometers are never to be shared between residents under any circumstances. Disposable lancets and testing supplies are provided individually ar stored separately for each resident. Additional glucometers were purchased to ensure sufficient backu equipment is available if a resident's assigned device malfunctions.	

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D 610	Continued From page 141 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 6 of 6 sampled residents (#1, #4 #8, #9, #10, and #11) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the CDC guidelines for infection control revealed: -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. -If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. -If the manufacturer did not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of infectious diseases during the delivery of healthcare services have	D 610	A written Infection Control Policy ha been developed and implemented consistent with CDC guidelines specifically addressing: Cleaning and disinfection of blood glucose meters. Prohibition of shared use of glucometers. Proper labeling, storage, and assignment of glucometers. The policy has been added to the facility's Infection Control Manual ar distributed to all direct care staff. A log system has been implementec to document cleaning, disinfection, and assignment of glucometers. All Medication Aides and Nurses received immediate in-service traini on: The new Infection Control Policy. CDC guidelines for point-of-care blood glucose testing and device us Proper cleaning, labeling, and storag procedures.	

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D 610	Continued From page 142 been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose meters. -The FDA Public Health notification: Use of a fingerstick device on more than one person posed a risk for transmitting blood-borne pathogens. Review of the facility's undated infection prevention policy revealed: -It was the policy of the facility to adhere to the CDC infection prevention guidelines during blood glucose monitoring to reduce the risk of transmitting infectious diseases during blood sugar monitoring. -Glucometers should be assigned to an individual resident and should not be shared with other residents. -Glucometers should be clearly labeled with the resident's name and stored in a manner that prevents contamination (contact with other glucometers or equipment) Observation of the South Hall's medication cart on 08/13/25 at 8:10am revealed: -There were two glucometers in the top drawer of the medication cart. -One glucometer was labeled with a resident's name who resided on the South Hall. -The second glucometer was labeled with a resident's name who resided on the North Hall. Observation of the North Hall's medication cart on 08/13/25 at 11:47am revealed: -There were three glucometers in the top drawer of the medication cart. -One glucometer was labeled with a resident's name who resided on the North Hall. -One glucometer was labeled with a resident's name who resided on the South Hall.	D 610	Training emphasized zero tolerance f sharing glucometers. New hires will receive training during orientation, and refresher training wi occur annually and as needed. The Resident Care Coordinator/Administrator will conduct weekly audits for 90 days to verify that each resident has their ow glucometer and that documentation of cleaning/disinfection is accurate. After 90 days, audits will continue monthly and results will be reviewed the facility's Quality Assurance Committee meetings. Any noncompliance identified will result in immediate retraining and disciplinary action if warranted.	

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D 610	Continued From page 143 -One glucometer was not labeled with a resident's name and did not have any fingerstick blood sugar (FSBS) readings. 1. Review of Resident #1's current FL2 dated 06/20/25 revealed: -Diagnosis included diabetes mellitus. -There was no order for FSBS checks. Telephone interview with a representative from the facility's contracted pharmacy on 08/13/25 at 4:45pm revealed Resident #1 had an order for FSBS checks three times daily before meals dated 07/02/24. Observation of Resident #1's Brand A glucometer on 08/13/25 at 8:43am revealed: -The glucometer in the top drawer of the South Hall's medication cart was labeled with Resident #1's name. -The current date on the glucometer was 08/12/25 at 8:00pm. Review of Resident #1's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/12/25 FSBS readings and glucometer history revealed: -There was an entry for FSBS checks three times a day with meal with a scheduled time of 7:30am, 11:30am, and 5:30pm. -On 08/01/25, there was a documented FSBS reading of 162 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/01/25, there was a documented FSBS reading of 131 at 5:30pm; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/01/25, there were three FSBS readings of 161 at 7:09pm, 120 at 7:23pm, and 74 at 11:14pm on Resident #1's glucometer history that	D 610		

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D 610	Continued From page 144 were not documented on Resident #1's eMAR. -On 08/02/25, there was a documented FSBS reading of 161 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/02/25, there was a documented FSBS reading of 74 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/02/25, there were two FSBS readings of 163 at 5:32pm and 124 at 7:51pm on Resident #1's glucometer history that were not documented on Resident #1's eMAR. -On 08/03/25, there was a documented FSBS reading of 137 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/03/25, there was a documented FSBS reading of 121 at 5:30pm; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/03/25, there were five FSBS readings of 126 at 3:03am, 110 at 4:44am, 148 at 5:54am, 92 at 6:59pm, and 144 at 8:21pm on Resident #1's glucometer history that were not documented on Resident #1's eMAR. -On 08/04/25, there were six FSBS readings of 204 at 3:21am, 106 at 6:31pm, 92 at 7:04pm, 143 at 7:41pm, 139 at 8:16pm, and 214 at 11:42pm on Resident #1's glucometer history that were not documented on Resident #1's eMAR. -On 08/05/25, there was a documented FSBS reading of 233 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/05/25, there was a documented FSBS readings of 127 at 5:30pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 127 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/06/25, there was a documented FSBS reading of 152 at 7:30am; the FSBS reading was	D 610		

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D 610	Continued From page 145 not recorded in Resident #1's glucometer history. -The FSBS reading of 152 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/06/25, there was a documented FSBS reading of 163 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/07/25, there was a documented FSBS reading of 155 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/07/25, there was a documented FSBS reading of 155 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 155 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/08/25, there was a documented FSBS reading of 208 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 208 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/08/25, there was a documented FSBS reading of 176 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/08/25, there was a documented FSBS reading of 200 at 5:30pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The blood sugar reading of 200 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/08/25, there were three FSBS readings of 90 at 7:16pm, 171 at 7:28pm, and 116 at 8:03pm on Resident #1's glucometer history that were not documented on Resident #1's eMAR. -On 08/09/25, there was a documented FSBS reading of 145 at 7:30am; the FSBS reading was	D 610		

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D 610	Continued From page 146 not recorded in Resident #1's glucometer history. -On 08/10/25, there was a documented FSBS reading of 172 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 172 documented on Resident #1's eMAR was in another resident's glucometer history. -On 08/10/25, there was a documented FSBS reading of 152 at 11:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/10/25, there was a documented FSBS readings of 140 at 5:30pm; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/10/25, there were two FSBS readings of 145 at 5:08am and 171 at 5:10am on Resident #1's glucometer history that were not documented on Resident #1's eMAR. -On 08/11/25, there was a documented FSBS reading of 150 at 7:30am; the FSBS reading was not recorded in Resident #1's glucometer history. -On 08/11/25, there were two FSBS readings of 180 at 3:42am and 183 at 3:42am on Resident #1's glucometer history that were not documented on Resident #1's eMAR. Interview with Resident #1 on 08/13/25 at 1:22pm revealed: -The medication aides (MA) checked his FSBS three times a day. -He had a glucometer on the medication cart that the MAs used to check his FSBS. Telephone interview with a MA on 08/13/25 at 10:40am revealed: -Resident #1 had his own glucometer that was labeled with this name. -She checked Resident #1's FSBS before breakfast and before lunch when she worked first	D 610		

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D 610	Continued From page 147 shift. -She did not know why other residents' glucometers were used on Resident #1 when he had his own glucometer. -She did not know why there were multiple readings around the same date and time on Resident #1's glucometer; all residents had their own glucometer. Refer to the telephone interview with a MA on 08/13/25 at 10:40am. Refer to the interview with a second MA on 08/13/25 at 11:15am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm. Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 2. Review of Resident #4's current FL2 dated 10/29/24 revealed diagnosis included diabetes mellitus. Review of Resident #4's signed physician orders dated 01/07/25 revealed there was an order for fingerstick blood sugar (FSBS) checks three times daily. Observation of the South Hall's medication cart on 08/13/25 at 8:10am revealed there was no glucometer labeled with Resident #4's name. Review of Resident #4's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/12/25 FSBS readings and	D 610		

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D 610	Continued From page 148 glucometer history revealed: -There was no entry for FSBS checks three times a day with meals. -There was no documentation FSBS checks were done three times daily. Interview with Resident #4 on 08/13/25 at 1:32pm revealed: -The medication aides (MA) checked his FSBS every morning before breakfast. -He did not know what glucometer the MA used to check his FSBS. Interview with a MA on 08/13/25 at 11:15am revealed: -Resident #4 used to have a glucometer on the South Hall medication cart. -She did not know what happened to Resident #4's glucometer. -She had to use another residents glucometer to check Resident #4's FSBS because she could not find Resident #4's glucometer. Refer to the telephone interview with a MA on 08/13/25 at 10:40am. Refer to the interview with a second MA on 08/13/25 at 11:15am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm. Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 3. Review of Resident #8's current FL-2 dated 07/09/24 revealed:	D 610		

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D 610	Continued From page 149 -There were no diagnoses and no medications listed on the FL-2. -There was a handwritten statement that read, see attached. -There was no attachment to review. Review of Resident #8's signed physician orders dated 01/07/25 revealed: -Diagnoses included epilepsy and recurrent seizures, traumatic brain injury, hypertension, and insomnia. -There was an order for fingerstick blood sugar (FSBS) checks daily. Observation of the North Hall's medication cart on 08/13/25 at 11:47am revealed there was no glucometer with Resident #8's name on it on the medication cart. Review of Resident #8's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/12/25 FSBS readings and glucometer history revealed: -There was an entry for FSBS checks daily with a scheduled time of 8:00am. -On 08/03/25, the FSBS reading of 93 documented on Resident #8's eMAR was in another resident's glucometer history. -On 08/04/25, the FSBS reading of 92 documented on Resident #8's eMAR was in another resident's glucometer history. -On 08/06/25, the FSBS reading of 87 documented on Resident #8's eMAR was in another resident's glucometer history. -On 08/08/25, the FSBS reading of 95 documented on Resident #8's eMAR was in another resident's glucometer history. -On 08/08/25, the FSBS reading of 94 documented on Resident #8's eMAR was in another resident's glucometer history.	D 610		

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D 610	Continued From page 150 -On 08/12/25, the FSBS reading of 96 documented on Resident #8's eMAR was in another resident's glucometer history. Interview with Resident #8 on 08/13/25 at 12:45pm revealed: -The medication aides (MA) checked his FSBS sometimes when he was feeling bad. -He did not think his FSBS was checked everyday. Interview with a MA on 08/13/25 at 11:15am revealed: -Resident #8 used to have a glucometer on the South Hall medication cart. -She did not know what happened to Resident #8's glucometer. -She had to use another resident's glucometer to check Resident #8's FSBS because she could not locate Resident #8's glucometer. Refer to the interview with a MA on 08/13/25 at 11:15am. Refer to the telephone interview with a second MA on 08/13/25 at 10:40am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm. Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 4. Review of Resident #9's current FL-2 dated 01/12/25 revealed: -Diagnosis included diabetes mellitus type 2. -There was no order for fingerstick blood sugar	D 610		

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D 610	Continued From page 151 (FSBS). Review of Resident #9's signed physician orders dated 01/02/25 revealed there was an order for FSBS checks each morning before breakfast. Observation of Resident #9's Brand A glucometer on 08/13/25 at 11:47am revealed: -The named glucometer in the top drawer of the North Hall's medication cart was labeled with Resident #9's name who resided on the North Hall. -The current date on the glucometer was 05/19/25 at 9:58pm. Review of Resident #9's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/13/25 FSBS readings and glucometer history revealed: -There was an entry for FSBS checks every morning before breakfast with as scheduled time of 6:00am. -On 05/01/25, there were seven FSBS readings of 264 at 12:18am, 347 at 3:15am, 165 at 5:31pm, 98 at 5:34pm, 122 at 5:36pm, 149 at 10:14pm, and 235 at 10:19pm on Resident #9's glucometer history that were not documented on Resident #9's eMAR. -On 05/02/25, there were nine FSBS readings of 278 at 3:05am, 157 at 3:07am, 316 at 4:59pm, 88 at 6:18pm, 279 at 6:20pm, 121 at 7:31pm, 249 at 7:55pm, 165 at 10:11pm, and 127 at 10:42pm on Resident #9's glucometer history that were not documented on Resident #9's eMAR. -On 05/02/25, there were nine FSBS readings of 46 at 1:51am, 79 at 2:13am, 291 at 2:18am, 151 at 2:50am, 169 at 5:48pm, 171 at 6:00pm, 129 at 6:09pm, 89 at 6:19pm, and 262 at 10:19pm on Resident #9's glucometer history that were not documented on Resident #9's eMAR.	D 610		

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D 610	Continued From page 152 -On 05/04/25, there were seven FSBS readings of 179 at 2:28am, 97 at 4:14am, 144 at 6:14pm, 269 at 7:01pm, 127 at 7:09pm, 159 at 9:51pm, and 235 at 10:05pm on Resident #9's glucometer history that were not documented on Resident #9's eMAR. -On 05/05/25, there were two FSBS readings of 147 at 4:07am and 110 at 4:16am on Resident #9's glucometer history that were not documented on Resident #9's eMAR. -On 05/09/25, there were two FSBS readings of 123 at 2:47pm and 93 at 6:10pm on another resident's glucometer history that were not documented on that resident's eMAR. -On 05/17/25, there were three FSBS readings of 145 at 5:48pm, 150 at 5:55pm, and 116 at 6:09pm on Resident #9's glucometer history that were not documented on Resident #9's eMAR. -On 08/01/25, there was a documented FSBS reading of 131 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/02/25, the FSBS reading of 118 documented on Resident #9's eMAR was in a second resident's glucometer history. -On 08/04/25, the FSBS reading of 114 documented on Resident #9's eMAR was in a third resident's glucometer history. -On 08/05/25, there was a documented FSBS reading of 136 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/06/25, there was a documented FSBS reading of 118 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/07/25, the FSBS reading of 126 documented on Resident #9's eMAR was in a second resident's glucometer history. -On 08/08/25, the FSBS reading of 95 documented on Resident #9's eMAR was in a third resident's glucometer history. -On 08/09/25, there was a documented FSBS	D 610		

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D 610	Continued From page 153 reading of 101 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/10/25, there was a documented FSBS reading of 129 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/11/25, there was a documented FSBS reading of 137 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/12/25, there was a documented FSBS reading of 128 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. -On 08/13/25, there was a documented FSBS reading of 101 at 6:00am; the FSBS reading was not recorded in Resident #9's glucometer history. Interview with Resident #9 on 08/13/25 at 12:50pm revealed: -The medication aide (MA) checked his FSBS every morning. -He thought he had a glucometer on the medication cart, but he was not sure. Telephone interview with a third MA on 08/13/25 at 6:25pm revealed: -Resident #9 resided on the North Hall and his FSBS was scheduled for 6:00am. -She checked Resident #9's FSBS each morning she worked. -Resident #9 had a glucometer in the North Hall medication cart. -She did not know why other residents' glucometers were used on the second resident when the second residents had his own glucometer. -She did not know why there were multiple readings around the same date and time in Resident #9's glucometer. Refer to the interview with a MA on 08/13/25 at 11:15am.	D 610		

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D 610	Continued From page 154 Refer to the telephone interview with a second MA on 08/13/25 at 10:40am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm. Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 5. Review of Resident #10's current FL-2 dated 01-06-25 revealed: -Diagnoses included asthma, hypertension, hyperlipidemia, traumatic brain injury, and left semi paralysis. -There was no order for fingerstick blood sugar (FSBS) checks. -There was a handwritten statement that read, see attached. -There was no order for FSBS checks on the attachment. Observation of Resident #10's Brand A glucometer on 08/13/25 at 11:58am revealed: -The glucometer in the top drawer of the North Hall's medication cart was labeled with Resident #10's name who resided on the South Hall. -The current date on the glucometer was 02/11/25 at 2:19am. Review of Resident #10's August 2025 electronic medication administration record (eMAR) FSBS readings and glucometer history revealed: -There was an entry for FSBS checks daily with a scheduled time of 8:00am. -On 08/02/25, there was a documented FSBS reading of 120 at 8:00am; the FSBS reading was	D 610		

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D 610	Continued From page 155 not recorded in Resident #10's glucometer history. -The FSBS reading of 120 documented on Resident #10's eMAR was in another resident's glucometer history. -On 08/03/25, there was a documented FSBS reading of 124 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -The FSBS reading of 124 documented on Resident #10's eMAR was in another resident's glucometer history. -On 08/04/25, there was a documented FSBS reading of 144 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -The FSBS reading of 144 documented on Resident #10's eMAR was in another resident's glucometer history. -On 08/05/25, there was a documented FSBS reading of 139 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -On 08/06/25, there was a documented FSBS reading of 103 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -On 08/07/25, there was a documented FSBS reading of 118 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -The FSBS reading of 118 documented on Resident #10's eMAR was in a second resident's glucometer history. -On 08/08/25, there was a documented FSBS reading of 113 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -On 08/09/25, there was a documented FSBS reading of 116 at 8:00am; the FSBS reading was	D 610		

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D 610	Continued From page 156 not recorded in Resident #10's glucometer history. -On 08/10/25, there was a documented FSBS reading of 126 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -The FSBS reading of 126 documented on Resident #10's eMAR was in a second resident's glucometer history. -On 08/12/25, there was a documented FSBS reading of 126 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. -On 08/13/25, there was a documented FSBS reading of 113 at 8:00am; the FSBS reading was not recorded in Resident #10's glucometer history. Interview with a medication aide (MA) on 08/13/25 at 11:15am revealed: -Resident #10 used to have a glucometer on the South Hall medication cart. -She did not know Resident #10's glucometer was on the North Hall medication cart. -She did not check the FSBS on the North Hall; the third shift checked the FSBS on the North Hall. -She did not know why Resident #10's glucometer would be on the North Hall medication cart. -She had to use another residents glucometer to obtain a FSBS reading Resident #10 because she could not find Resident #10's glucometer. Based on observations, interviews, and record reviews it was determined Resident #10 was not interviewable Refer to the interview with a MA on 08/13/25 at 11:15am.	D 610		

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D 610	Continued From page 157 Refer to the telephone interview with a second MA on 08/13/25 at 10:40am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm. Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. 6. Review of Resident #11's current FL-2 dated 02/18/25 revealed: -Diagnoses included end stage renal disease, atrial fibrillation, and dependence on renal dialysis. -There was no order for fingerstick blood sugar (FSBS). Observation of Resident #11's Brand A glucometer on 08/13/25 at 8:43am revealed: -The glucometer in the top drawer of the South Hall's medication cart was labeled with Resident #11's name who resided on the North Hall. -The current date on the glucometer was 08/12/25 at 8:00pm. Review of Resident #11's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/13/25 FSBS readings and glucometer history revealed: -There was an entry for FSBS checks daily. -There were 7 exceptions from 08/01/25 to 08/13/25; the exception was Resident #11 refused. -On 08/05/25, there was documented FSBS reading of 147 at 6:00am; the FSBS reading was not recorded in Resident #11's glucometer	D 610		

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D 610	Continued From page 158 history. -On 08/05/25, there were three FSBS readings of 127 at 5:09pm, 152 at 6:09pm, and 87 at 6:48pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. -On 08/06/25, there was a documented FSBS reading of 122 at 6:00am; the FSBS reading was not recorded in Resident #11's glucometer history. -On 08/06/25, there were three FSBS readings of 132 at 5:31pm, 118 at 7:59pm, and 155 at 11:25pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. -On 08/08/25, there were two FSBS readings of 200 at 5:00am and 265 at 10:57pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. -On 08/09/25, there were four FSBS readings of 172 at 5:55pm, 177 at 6:56pm, 94 at 7:18 pm, and 125 at 8:02pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. -On 08/10/25, there was a documented FSBS reading of 147 at 6:00am; the FSBS reading was not recorded in Resident #11's glucometer history. -On 08/11/25, there was a documented FSBS reading of 133 at 6:00am; the FSBS reading was not recorded in Resident #11's glucometer history. -On 08/11/25, there were four FSBS readings of 141 at 6:09pm, 177 at 7:02pm, 120 at 7:35pm, and 126 at 8:00pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. -On 08/12/25, there was a documented FSBS reading of 109 at 6:00am; the FSBS reading was not recorded in Resident #11's glucometer history.	D 610		

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D 610	Continued From page 159 -On 08/12/25, there were two FSBS readings of 92 at 4:45pm and 139 at 5:27pm on Resident #11's glucometer history that were not documented on Resident #11's eMAR. Interview with Resident #11 on 08/13/25 at 1:02pm revealed: -He went to dialysis three days a week and they checked his FSBS. -He did not have his FSBS checked at the facility; he did not need to have it checked. -He used to have his FSBS checked three times daily and was administered insulin, but that was discontinued a while back. -His FSBS had been between 120 and 150 at dialysis; he was pleased with those readings. Telephone interview with a third medication aide (MA) on 08/13/25 at 6:25pm revealed: -Resident #11 resided on the North Hallway. -Resident #11 did not have a glucometer on the North Hall medication cart. -Resident #11 was scheduled to have a FSBS check at 6:00am. -Resident #11 refused to let her check his FSBS because they checked his FSBS when he went to dialysis. -She did not check FSBS on the South Hall; they were scheduled at 8:00am and the first shift MA would check the resident's FSBS. Refer to the interview with a MA on 08/13/25 at 11:15am. Refer to the telephone interview with a second MA on 08/13/25 at 10:40am. Refer to the telephone interview with a third MA on 08/13/25 at 6:25pm.	D 610		

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D 610	Continued From page 160 Refer to the telephone interview with the Primary Care Provider (PCP) on 08/13/25 at 1:02pm. Refer to the interview with the Administrator on 08/13/25 at 3:02pm. Interview with a MA on 08/13/25 at 11:15am revealed: -There were two glucometers on the South Hall medication cart and 3 glucometers on the North Hall medication cart. -There were 7 residents in the facility who had their FSBS checks at least once a day. -Each resident who had an order to check their FSBS used to have a glucometer a couple of months ago; she did not know where the other glucometers were. -She had to share the glucometers because there were not enough to check each resident's FSBS who had orders for FSBS checks. -She knew glucometers should not be shared due to the possible spread of blood borne pathogens. -She called the pharmacy last week and asked about getting additional glucometers, but she had not heard whether the pharmacy would send new glucometers for everyone. -The residents who received the FSBS checks did not have any diagnoses of blood borne pathogens. Telephone interview with a second MA on 08/13/25 at 10:40am revealed: -Each resident had a glucometer on the medication cart. -Glucometers were not to be shared because of infection and blood disease. -She had not shared glucometers when checking residents' FSBS. -She did not know all residents who received FSBS checks did not have a glucometer on the	D 610		

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D 610	Continued From page 161 medication cart; the glucometers were on the medication cart a few days ago. -She only checked the FSBS on the South Hall. -The third shift MA checked the FSBS checks on the North Hall. Telephone interview with a third MA on 08/13/25 at 6:25pm revealed: -There were not enough glucometers in the facility for every resident who had an order for FSBS checks. -She used a glucometer on several residents. -She had told the previous Resident Care Coordinator (RCC) that each resident who had an order for a FSBS check did not have a glucometer. -She thought the RCC had ordered some glucometers for the facility. -She had not told the Administrator that more glucometers were needed. -Glucometers should not be shared because of the transfer of blood diseases. Telephone interview with the PCP on 08/13/25 at 1:02pm revealed: -Glucometers should not be shared; they were for single use only. -Sharing glucometers could cause transmission of blood borne pathogens. -If the staff were sharing glucometers, they needed to stop and make sure each resident had their own glucometer. -She expected each resident to have their own glucometer. Interview with the Administrator on 08/13/25 at 3:02pm revealed: -Glucometers should not be shared between residents. -Sharing of glucometers could cause	D 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 610	Continued From page 162 cross-contamination and cause residents to become sick. -She did not know each resident did not have their own glucometer. -Each resident should have their own glucometer, which should be in a zippered pouch. -The residents' name should be on the glucometer and the zippered pouch. -She expected each resident to have their own glucometer labeled with their name. _____ The facility failed to implement infection control procedures consistent with the CDC guidelines resulting in staff sharing glucometers for 6 of 6 sampled residents, placing residents at risk for bloodborne pathogen diseases. This failure resulted in substantial risk for harm, and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2025.	D 610		