STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual and follow-up survey from 08/26/25 to 08/28/25..	D 000	Plan of Correction for 10A NCAC 13F .0305 (d) Physical Environment The facility has installed removable pegs in each Special Care Unit window frame so that no window may be opened more than six inches, and screens have been replaced or secured where needed. The Facility Director will monitor the SCU windows on a monthly basis to ensure that the pegs remain in place and that no window opens beyond six inches. Staff working in the unit will be re-educated on the importance of window restrictions for resident safety by the Facility Director. All corrective measures will be completed by October 15, 2025, and ongoing monitoring will continue thereafter.	10/15/25
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305 Physical Environment (d) The requirements for the bedroom are: (1) the number of resident beds set up shall not exceed the licensed capacity of the facility; (2) live-in staff shall be permitted in facilities with a capacity of 7 to 12 residents provided all of the requirements of Section .0600 of these Rules are met; (3) there shall be separate bedrooms for any live-in staff and other persons living in the facility. Residents shall not share bedrooms with live-in staff and other live-in non-residents; (4) live-in staff shall not occupy a licensed bed or live in a licensed bed; (5) residents shall reside in bedrooms with residents of the same sex unless other arrangements are made with each resident's consent; (6) only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms; (7) bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved as a resident's bedroom; (8) private resident bedrooms shall have not less than 100 square feet of occupiable floor area excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "private resident bedroom" is a resident bedroom occupied by one resident;	D 049		

" Reviewed and Acknowledged " 10/06/2025 CPP

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D 049	Continued From page 1 (9) semi-private resident bedrooms shall have not less than 80 square feet of occupiable floor area per bed excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "semi-private resident bedroom" is a resident bedroom occupied by two residents; (10) the total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom; (11) a bedroom may not be occupied by more than two residents; (12) resident bedrooms shall be designed to accommodate all required furnishings; (13) resident bedrooms shall be ventilated with one or more windows which are maintained operable. The window area shall not be less than eight percent of the floor space and be equipped with insect-proof screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and (14) Residents' bedrooms shall have one closet or wardrobe per resident. A closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the window openings in the Special Care Unit (SCU) residents' rooms were restricted to 6 inches to prevent elopement or suicide.	D 049		

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D 049	Continued From page 2 The findings are: Observation of the windows in the SCU on 08/27/25 at 9:30am revealed: -There were 9 resident rooms with one window in each room. -There were 2 windows that were unlocked and opened to 25 inches. -There was one window that was unlocked and opened to 11 ½ inches and had no screen. Observation of the outside area of the SCU on 08/27/25 between 10:00am and 10:15am revealed the area outside of the SCU windows was enclosed with an unsecured gate and was open on each end of the building leading to the parking lot. Interview with the Director of Clinical Services (DCS) on 08/27/25 at 12:00am revealed: -She was not aware that the windows could not be opened mor than 6 inches in the SCU. -She would expect the facility to be compliant with the rule. Interview with the Resident Care Coordinator (RCC) on 08/27/25 at 12:15am revealed: -She was aware that the windows could not be opened more than 6 inches in the SCU. -She was not aware that one window was missing a screen. -She would expect the staff to notify the Special Care Unit Coordinator (SCUC) in the event they saw windows open more than 6 inches or a missing screen. -The staff of the SCU could then notify maintenance to adjust the window and replace the screen.	D 049		

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D 049	Continued From page 3 Interview with the Maintenance Director (MD) on 08/27/25 at 2:00pm revealed: -He was aware that the windows could not be opened more than 6 inches in the SCU. -He was not aware of the three windows that opened more than 6 inches or the missing screen in the SCU. -He placed pins in the windows to prevent them from opening more than 6 inches. -The staff should have notified the SCUC or the RCC about the missing screen and the windows that were missing the pins. -The SCU staff or the RCC could log any maintenance issues in the maintenance logbook. Interview with the SCUC on 08/27/25 at 2:00pm revealed: -She was aware of the rule about window openings in the SCU and thought there were pins placed in the windows to prevent them from opening more than 6 inches. -She did not know about the missing screen in a SCU window. -She would expect the staff to notify her if they saw a window open more than 6 inches or a missing screen so she could notify maintenance. Interview with the Administrator on 08/27/25 at 2:30pm revealed: -He was aware windows could not be opened more than 6 inches to prevent elopement. -Maintenance placed pins in the windows to prevent them from opening more than 6 inches but the residents may have removed them. - He would expect the staff to notify the SCC or MD of windows open more than 6 inches or missing screens.	D 049		

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D 125	Continued From page 4	D 125		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled medication aides (MA) (Staff C) had a Clinical Skills Competency Validation Checklist and passed the written examination prior to administering medications. The findings are: Review of Staff C's, MA, personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 06/02/23. -There was no documentation of a hire date for Staff C as a MA. -There was documentation Staff C completed the 5 hour and 15-hour MA training course on 01/09/25. -There was no documentation Staff C completed the Clinical Skills Competency Validation Checklist. -There was no documentation Staff C passed the written MA examination.	D 125	Plan of Correction for 10A NCAC 13F .0403 Qualifications of Medication Staff The staff member identified as not qualified to administer medications has been removed from medication administration duties until all state-required training, clinical skills validation, and written examination are successfully completed. The Resident Care Coordinator will review all medication staff files to ensure that documentation of competency validation and examination results are on file prior to any staff being scheduled to pass medications. Going forward, the Resident Care Coordinator will monitor medication staff files monthly to ensure compliance. All corrective measures will be completed by October 15, 2025, and ongoing monitoring will continue thereafter.	10/15/25

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D 125	Continued From page 5 Interview with Staff C on 08/28/25 at 11:30am revealed: -She has been an MA for approximately one to two months. -She completed the Clinical Skills Competency Validation Checklist but was unsure of the date but had not taken the written test. -She did not have documentation to show completion of the Clinical Skills Competency Validation Checklist. -The only time she administered medications to residents at the facility was when shadowing another MA. Review of a July 2025 electronic medication administration record (eMAR) on 8/27/25 at 11:50am revealed Staff C administered medication to residents on 07/24/25 and 07/25/25. Review of a August 2025 electronic medication administration record (eMAR) on 8/27/25 11:50am revealed Staff C administered medication to residents on 08/14/25 and 08/18/25. Interview with Special Care Coordinator (SCC) on 08/28/25 at 1:40pm revealed: -Staff C was not a MA but is in training to become a MA. -She had been training and shadowing for approximately one month. -She thought Staff C completed the Clinical Skills Competency Validation Checklist with the former registered nurse. -She was aware Staff C had not taken the test. -Before a MA could administer medication, they must have completed a Clinical Skills Competency Validation Checklist and passed the	D 125		

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D 125	Continued From page 6 MA test. Interview with the Resident Care Coordinator (RCC) on 08/28/25 at 2:00pm revealed: -She was not aware that Staff C had not completed the Clinical Skills Competency Validation Checklist or passed the MA test. -She had seen Staff C on the medication cart administering medication alone. -MAs could be trained on the cart when they completed the Clinical Skills Competency Validation Checklist but must pass the MA test to be able to independently administer medication to residents. -It was her responsibility to ensure MAs completed their training and passed the MA test prior to becoming a MA and passing medication. -Her expectation was that all MAs completed all requirements before administering medications. Interview with the Administrator on 08/28/25 at 2:40pm revealed: -He was not aware a staff had administered medications before completing the requirements to become a MA. -He was aware that staff needed to complete a Clinical Skills Competency Checklist and pass the MA test to become an MA. -His expectation was for MAs to complete all required training and pass the test prior to administering medications independently to residents.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 sampled residents (#4) related to failure to notify the primary care provider (PCP) of a resident not wearing compression socks as ordered. The findings are: Review of Resident #4's FL2 dated 02/19/25 revealed diagnosis included atrial fibrillation, vascular dementia, constipation, and hypertension. Review of Resident #4's current physicians orders dated 08/26/25 revealed there was an order for compression socks to be applied every morning and removed at bedtime. Review of Resident #4's August 2025 eMAR from 08/01/25 to 08/26 revealed: -There was an entry for compression socks apply every morning scheduled for 6:00am. -There was an entry for compression socks remove at bedtime scheduled for 6:00pm. -There was documentation that compression socks had been applied every morning from 08/01/25 to 08/26/25. -There was documentation that compression socks were removed at bedtime from 08/01/25 to 08/25/25. Observation of Resident #4 on 08/26/25 at 10:30am revealed she did not have compression socks on. Observation of Resident #4 on 08/26/25 at	D 273	Plan of Correction for 10A NCAC 13F .0902(b) Health Care All medication technicians were met on September 3, 2025 to review the importance of following physician orders and to ensure that documentation reflects only the care that has actually been provided. Staff were instructed that physician-ordered health supplies, such as compression socks, must be obtained in a timely manner through the pharmacy to avoid missed care. The Resident Care Coordinator will monitor orders and related documentation weekly to ensure supplies are in place and that physician orders are being followed as directed. All corrective measures will be completed by October 15, 2025, and monitoring will continue thereafter.	10/15/25

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D 273	Continued From page 8	D 273		

12:40pm revealed she did not have compression socks on.

Observation of Resident #4 on 08/26/25 at 3:48pm revealed she did not have compression socks on.

Telephone interview with Resident #4's PCP on 08/26/25 at 11:04am revealed:
-She expected the facility to apply Resident #4's compression socks as ordered.
-If Resident #4's compression socks were not being applied as ordered, she expected the facility to inform her.
-She could not remember if anyone from the facility verbally informed her of Resident #4 not wearing her compression socks.
-She had no physical documentation of being informed by the facility that Resident #4 was not wearing her compression socks as ordered.
-If Resident #4's compression socks were not being applied as she ordered, she would expect increased leg and ankle swelling.

Interview with a medication aide (MA) on 08/28/25 at 9:15am revealed:
-Resident #4's compression socks were kept in a drawer in her room.
-She was aware Resident #4 had an order for compression socks to be applied every morning and removed at bedtime.
-On her shift, she was scheduled to remove Resident #4's compression socks.
-She never removed Resident #4's compression socks because they were "never on".
-Sometimes patient care assistants (PCA's) applied and removed Resident #4's compression socks.
-She had no answer as to why documentation reflected that Resident #4's compression socks

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D 273	Continued From page 9	D 273		

were applied on the morning of 08/26/25.
-Resident #4 complained that the compression socks were too tight and that is a possible reason as to why the compression socks were not applied.
-She had not informed Resident #4's PCP that the compression socks were not being worn.

Interview with a PCA on 08/28/25 at 9:45am revealed:
-Resident #4 only had one compression sock available to be applied.
-She was not sure how long the other compression sock had been missing.
-She had informed a MA but was not sure if more compression socks were ordered.
-She could not remember when she informed the MA of the missing compression sock.

Interview with another PCA on 08/28/25 at 9:46am revealed:
-She only applied or removed Resident #4's compression socks if a MA asked her to.
-She used to apply and remove Resident #4's compression socks but had not done so in a few weeks because no one asked her too.

Interview with the Special Care Unit Coordinater (SCUC) on 08/28/25 at 10:00am revealed:
-She was aware Resident #4 had an order for compression socks to be applied every morning and removed at bedtime.
-There was a basket on the medication cart where compression socks were stored, but the basket was no longer there.
-Resident #4 stored her compression socks in her room.
-No one had informed her that Resident #4's compression socks were not being applied and removed as ordered.

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D 273	Continued From page 10	D 273		

-No one had informed her that one of Resident #4's compression socks was missing.
-The MAs had the ability to measure Resident #4's legs and ankles for better fitting compression socks.
-The MAs had the ability to reorder compression socks.
-If there was an issue with Resident #4's compression socks, the MAs were to inform the PCP.

Interview with the Director of Clinical Services (DCS) on 0/28/25 at 10:45am revealed:
-Her expectation for PCA's and the MAs was to apply and remove Resident #4's compression socks as ordered.
-If compression socks were not applied, she expected documentation to reflect it.
-Her expectation for the MAs was to remeasure and reorder compression socks as needed.

Interview with the Resident Care Coordinator (RCC) on 08/28/25 at 10:59am revealed:
-She expected compression sock application and removal to be documented accurately.
-It was the responsibility of PCA's and the MAs to inform her, the SCUC and/or the DCS if compression socks were not being applied and removed correctly.
-No one had informed her Resident #4's compression socks were missing and not being applied as ordered.
-If the MAs did not know how to measure a resident for compression socks, she was available to assist them.

Interview with the Administrator on 08/28/25 at 11:28am revealed his expectation for PCA's and MAs was to apply and remove compression socks as ordered, and reorder supplies as

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D 273	Continued From page 11 needed. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 273	Plan of Correction for 10A NCAC 13F .1004(a) Medication Administration Following the identified errors, all medication technicians were met with on September 3, 2025, to review the importance of following providers' orders exactly as written and to reinforce safe medication administration practices. The Director of Clinical Services will conduct routine cart audits to ensure medications are available, properly labeled, and administered as ordered. The Director will also review medication administration records to verify that medications are both given and signed off accurately. Any discrepancies will be addressed with staff immediately. All corrective measures will be completed by October 15, 2025, and monitoring will continue thereafter.	10/15/25
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 3 of 3 residents observed during the medication administration on 08/27/25 related to a medication used to treat diabetes and an antipsychotic (#1); a medication used to treat iron deficiency and a vitamin (#6); and medication used to treat mental health disorders that was crushed with specific orders to not crush (#7); and 2 of 5 sampled residents for record review related to a resident with a medication used to control heart rate and a laxative (#4); and a medication to treat insomnia (#3). The findings are:	D 358		

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D 358	Continued From page 12 1. The medication pass error rate was 19% as evidenced by 6 errors out of 31 opportunities during the 8:00am medication pass on 08/27/25 from 7:45am to 8:06am. a. Review of Resident #7's FL2 dated 10/03/24 revealed diagnoses included dementia, hypertension, anxiety, mixed hyperlipideora, and carotid bruit. Review of Resident #7's current physician's orders dated 05/21/25 revealed: -There was an order for divalproex sodium (a medication used to treat mental health disorders) 250mg ER (extended release) take 1 tablet every day. -There was an order to not crush divalproex sodium 250mg ER. -Extended release tablets were designed to release medication slowly over a period of time. Observation of the medication pass on 08/27/25 at 8:01am revealed: -The medication aide (MA) prepared 7 oral medications for a total of 8 tablets for Resident #7. -The MA popped one divalproex sodium 250mg ER tablet from a bubble pack. -The MA documented administration on Resident #7's electronic medication administration record (eMAR). -The MA put all 8 tablets in a plastic sleeve and crushed the tablets, which included 1 divalproex sodium 250mg ER tablet. -The MA emptied the contents of the plastic sleeve into a plastic medication cup with applesauce. -At 8:05am, the MA administered the medications to Resident #7.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13	D 358		

Interview with the MA on 08/27/25 at 8:07am revealed:
-She crushed Resident #7's medications because he would spit them out if she did not.
-She was told by the previous primary care provider (PCP) that she could crush all of Resident #7's medications even if the order said to not crush.

Review of Resident #7's August 2025 eMAR revealed:
-There was an entry for divalproex sodium 250mg take 1 tablet every day scheduled for administration at 9:00am.
-There was an entry to not crush divalproex sodium 250mg ER.
-There was documentation divalproex sodium 250mg ER was administered on 08/27/25 at 9:00am.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/25 at 3:20pm revealed:
-Resident #7 had an order for divalproex sodium 250mg extended release.
-It was important to not crush extended-release tablets because crushing them ruined the special coating that made the medicine work slowly over time.

Telephone interview with Resident #7's PCP on 08/27/25 at 11:04am revealed:
-Resident #7 was ordered divalproex sodium 250mg 1 tablet every day, not to be crushed.
-She expected the facility to administer Resident #7's divalproex sodium 250mg as ordered.

Interview with the Resident Care Coordinator (RCC) on 08/27/25 at 5:00 revealed
-She expected MAs to not crush medication if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

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D 358	Continued From page 14	D 358		

order said it could not be crushed.
-If there was a contraindication with an uncrushable medication, MAs could reach out to the resident's PCP to have a different medication ordered.

Interview with the Administrator on 08/27/25 at 5:09pm revealed:
-He expected the MAs to follow the PCP orders in a timely manner.
-If there was a contraindication with uncrushable medications, he expected the MAs to reach out to the RCC.

Attempted telephone interview with Resident #7's previous PCP on 08/27/25 at 9:00am was unsuccessful.

Based on observation, interviews, and record reviews it was determined Resident #7 was not interviewable.

b. Review of Resident #1's current FL2 dated 11/06/24 revealed diagnoses included diabetes, right below the knee amputation, third toe amputation and osteomyelitis.

1. Review of Resident #1's current physician's orders dated 07/23/25 revealed there was an order for metformin (a medication used to treat diabetes) 500mg take 1 tablet twice a day.

Observation of the medication administration pass on 08/27/25 at 7:45am revealed:
-The medication aide (MA) prepared 13 oral medications, an insulin injection, and 5 medications for topical application for Resident #1.
-At 7:53am, the MA administered the medications to Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 15 -The MA documented administration on Resident #1's electronic medication administration record (eMAR). -Metformin 500mg was not included in the medications administered. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for metformin 500mg take 1 tablet twice a day scheduled for administration at 8:00am. -There was documentation metformin 500mg was administered on 08/27/25 at 8:00am. Interview with the MA on 08/27/25 at 4:45pm revealed: -She administered Resident #1's medications according to the eMAR entries. -She was nervous due to being watched by the surveyor during the morning medication pass and that was how she missed Resident #1's metformin 500mg tablet. Observation of Resident #1's medications on hand on 08/27/25 at 2:05pm revealed there was a bubble pack with 5 tablets of metformin 500mg available for administration with a start date of 08/14/25. Telephone interview with Resident #1's primary care provider (PCP) on 08/27/25 at 11:04am revealed: -Resident #1 was ordered metformin 500mg 1 tablet twice a day. -She expected the facility to administer Resident #1's metformin as she ordered. -She expected a possible outcome of increased blood sugar levels if Resident #1 did not receive her metformin as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 16 Interview with the Resident Care Coordinator (RCC) on 08/27/25 at 5:00pm revealed she expected the MA to slow down, be more attentive and make sure all medications that were ordered were administered. Interview with the Administrator on 08/27/25 at 5:09pm revealed: -He expected the MAs to follow the PCP orders in a timely manner. -Medications were to be checked off the eMAR after they were popped into a medication cup. 2. Review of Resident #1's current physician's orders dated 07/23/25 revealed there was an order for quetiapine (a medication used to treat bipolar disorder) 25mg take 1 tablet every morning. Observation of the medication administration pass on 08/27/25 at 7:45am revealed: -The MA prepared 13 oral medications, an insulin injection, and 5 medications for topical application for Resident #1. -At 7:53am, the MA administered the medications. -The MA documented administration on Resident #1's eMAR. -Quetiapine 25mg was not included in the medications administered. Interview with the MA on 08/27/25 at 4:45pm revealed: -She administered Resident #1's medications according to the eMAR entries. -She was nervous due to being watched by the surveyor during the morning medication pass and that was how she missed Resident #1's quetiapine 25mg tablet.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 17 Review of Resident #1's August 2025 eMAR revealed: -There was an entry for quetiapine 25mg take 1 tablet every morning scheduled for administration at 7:00am. -There was documentation quetiapine 25mg was administered on 08/27/25 at 7:00am. Observation of Resident #1's medications on hand on 08/27/25 at 2:05pm revealed there was a bubble pack with 12 tablets of quetiapine 25mg available for administration with a start date of 08/14/25. Telephone interview with Resident #1's PCP on 08/27/25 at 11:04am revealed: -Resident #1 was ordered quetiapine 25mg 1 tablet every morning. -She expected the facility to administer Resident #1's quetiapine as she ordered. -She expected a possible outcome of symptoms of bipolar disorder returning if Resident #1 did not receive her quetiapine as ordered. Interview with the RCC on 08/27/25 at 5:00pm revealed she expected the MA to slow down, be more attentive and make sure all medications that were to be administered were given. Interview with the Administrator on 08/27/25 at 5:09pm revealed: -He expected the MAs to follow the PCP orders in a timely manner. -Medications were to be checked off the eMAR after they were popped into a medication cup. Based on observation, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

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D 358	Continued From page 18 c. Review of Resident #6's current FL2 dated 05/21/25 revealed diagnoses included diabetes mellitus, hypertension, schizophrenia, and sudden blindness. 1. Review of Resident #6's FL2 dated 05/21/25 revealed there was an order for ferrous sulfate (a medication used to treat iron deficiency) 325mg take 1 tablet every morning with breakfast. Observation of the medication administration pass on 08/27/25 at 7:39am revealed: -The medication aide (MA) prepared 7 oral medications for a total of 8 tablets for Resident #6. -At 7:44am, the MA administered the medications. -The MA documented administration on Resident #6's electronic medication administration record (eMAR). - Ferrous sulfate 325mg was not included in the medications administered. Interview with the MA on 08/27/25 at 4:45pm revealed: -She administered Resident #6's medications according to the eMAR entries. -She was positive she gave Resident #6 the last tablet available of the ferrous sulfate 325mg that morning. -If medication was not available to be given, she would reorder the medication from the facility contracted pharmacy. Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg take 1 tablet every morning with breakfast scheduled for administration at 8:00am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

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D 358	Continued From page 19 -There was documentation ferrous sulfate 325mg was administered on 08/27/25 at 8:00am. Observation of Resident #6's medications on hand on 08/27/25 at 2:07pm revealed there was no ferrous sulfate 325mg available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/25 at 3:20pm revealed: -Resident #6's ferrous sulfate 325mg was dispensed by the pharmacy. -Ferrous sulfate 325mg tablets was a medication that could be purchased over-the-counter (OTC). -The pharmacy routinely dispensed medication available OTC in large bulk brown plastic containers for cost saving to residents. -Resident #6 was dispensed ferrous sulfate 325mg for a bulk quantity of 300 tablets on 01/17/25. -No other boxes of ferrous sulfate 325mg were reordered. Telephone interview with Resident #6's primary care provider (PCP) on 08/27/25 at 11:04am revealed: -Resident #6 was ordered ferrous sulfate 325mg 1 tablet every morning with breakfast. -She expected the facility to administer Resident #6's ferrous sulfate as she ordered. -She expected a possible outcome of worsening symptoms of iron deficiency if Resident #6 did not receive his ferrous sulfate as ordered. Interview with the Resident Care Coordinator (RCC) on 08/27/25 at 5:00pm revealed if medication was not available to be administered as ordered, the MAs were expected to reorder the medication from the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 20 Interview with the Administrator on 08/27/25 at 5:09pm revealed: -He expected the MAs to follow the PCP orders in a timely manner. -Medications were to be checked off the eMAR after they were popped into a medication cup. -The MAs had the ability to reorder medication that was missing. -His expectation was that medication would be reordered if it was not on the medication cart or in the medication overstock room. 2. Review of Resident #6's FL2 dated 05/21/25 revealed there was an order for vitamin D3 (a medication used to treat vitamin D3 deficiency) 50mcg to be administered every day. Observation of the medication administration pass on 08/27/25 at 7:39am revealed: -The MA prepared 7 oral medications for a total of 8 tablets for Resident #6. -At 7:44am, the MA administered the medications. -The MA documented administration on Resident #6's eMAR. - Vitamin D3 50mcg was not included in the medications administered. Interview with the MA on 08/27/25 at 4:45pm revealed: -She administered Resident #6's medications according to the eMAR entries. -She would check the medication overstock room if a medication was not on the medication cart. -She was nervous due to being watched by the surveyor during the morning medication pass and that was how she missed Resident #6's vitamin D3 50mcg tablet.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

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D 358	Continued From page 21 Review of Resident #6's August 2025 eMAR revealed: -There was an entry for vitamin D3 50mcg take 1 tablet every day scheduled for administration at 8:00am. -There was documentation vitamin D3 50mcg was administered on 08/27/25 at 8:00am. Observation of Resident #6's medications on hand on 08/27/25 at 2:07pm revealed: -There was no vitamin D3 50mcg available to be given on the medication cart. -In the medication overstock room, there was a bubble pack for 28 tablets of vitamin D3 50mcg available for administration and was dispensed 08/14/25. Telephone interview with Resident #6's PCP on 08/27/25 at 11:04am revealed: -Resident #6 was ordered vitamin D3 50mcg 1 tablet every day. -She expected the facility to administer Resident #6's vitamin D3 as she ordered. -She expected a possible outcome of worsening symptoms of vitamin D3 deficiency if Resident #6 did not receive his vitamin D3 as ordered. Interview with the RCC on 08/27/25 at 5:00pm revealed if a medication was not available on the medication cart, her expectation was that the MAs would check the medication overstock room and if not there they would reorder the medication from the facility's contracted pharmacy. Interview with the Administrator on 08/27/25 at 5:09pm revealed: -He expected the MAs to follow the PCP orders in a timely manner. -Medications were to be checked off the eMAR after they were popped into a medication cup.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 22 -His expectation was that if a medication was missing on the medication cart, the MAs would check the medication overstock room. Based on observation, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #4's FL2 dated 02/19/25 revealed diagnosis included atrial fibrillation, vascular dementia, constipation, and hypertension. a. Review of Resident #4's current physician's orders dated 08/26/25 revealed there was an order for digoxin (a medication used to control the heart rate) 125mcg take 1 tablet every day, hold if the heart rate was less than 60 beats per minute. According to the American Heart Association (AHA) and the American College of Cardiology (ACC) for atrial fibrillation, a maintenance dose of digoxin was used to control symptoms and required careful monitoring due to digoxin being a medication that had a small margin between a safe, effective dose and a toxic dose. For digoxin, a small increase in blood concentration could have led to toxicity, while a small decrease could have led to a loss of efficacy. Because of this small therapeutic window, administering digoxin required careful dosage adjustments and close patient monitoring to avoid serious adverse effects or therapeutic failure. Telephone interview with Resident #4's primary care provider (PCP) on 08/28/25 at 12:54pm revealed: -Resident #4 was ordered digoxin 125mcg take 1 tablet every day, hold if heart rate was less than 60 beats per minute.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

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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 358	Continued From page 23	D 358		

-She expected the facility to administer Resident #4's digoxin as ordered.
-She expected a possible outcome of an extremely low heart rate if digoxin was given when the heart rate was below 60 beats per minute.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for digoxin 125mcg take 1 tablet every day, hold if heart rate was less than 60 beats per minute, scheduled for administration at 9:00am.
-There was a blank space for documenting Resident #4's heart rate when administering digoxin 125mcg.
-Digoxin 125mcg was not administered as ordered on 07/06/25, 07/15/25, and 07/16/25.
-On 07/06/25 Resident #4's heart rate was 60 and digoxin 125mcg was documented as not administered.
-On 07/15/25, Resident #4's heart rate was 55 and digoxin 125mcg was documented as administered.
-On 07/16/25, Resident #4's heart rate was 56 and digoxin 125mcg was documented as administered.
-Resident #4's heart rate was documented as ranging from 55 (07/15/25) to 161 (07/02/25).

Review of Resident #4's laboratory results for digoxin revealed:
-The reference range for digoxin was 0.8 - 2.0.
-On 10/08/24, the result was 0.8.
-On 01/07/25, the result was 1.0.
-On 07/10/25, the result was 0.7.

Observation of Resident #4's medication on hand on 08/26/25 at 2:36pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24 -There was a bubble pack containing 16 tablets of digoxin 125mcg remaining for administration from a quantity of 28 tablets dispensed on 08/14/25. -The directions on the label was for digoxin 125mcg take 1 tablet every day, hold if heart rate was less than 60 beats per minute. Interview with a medication aide (MA) on 08/28/25 at 9:15am revealed: -She was aware of Resident #4's digoxin order parameters. -She did not give digoxin if Resident #4's heart rate was less than 60 beats per minute. -She could not speak to why other MAs gave digoxin when Resident #4's heart rate was less than 60 beats per minute. Interview with the Special Care Unit Coordinator (SCUC) on 08/28/25 at 10:00am revealed: -She did not conduct eMAR audits. -She expected the MAs to hold digoxin if Resident #4's heart rate was less than 60 beats per minute and inform the PCP. -She was not sure why the hold parameters were being overlooked by the MAs. Interview with the Resident Care Coordinator (RCC) on 08/28/25 at 11:00am revealed she expected the MAs to administer or hold medications as ordered. Interview with the Administrator on 08/28/25 at 11:30pm revealed he expected the MAs to implement orders thoroughly and ask the SCUC or RCC questions if there was any confusion. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 25 b. Review of Resident #4's current physician's orders dated 02/19/25 revealed there was an order for polyethylene glycol 3350 (a medication used to treat constipation) 1 capful to be administered every day. Review of Resident #4's June 2025 eMAR revealed: -There was an entry for polyethylene glycol 3350 take 1 capful every day scheduled for administration at 9:00am. -There was documentation polyethylene glycol 3350 was administered daily from 06/01/25 to 06/30/25. Review of Resident #4's July 2025 eMAR revealed: -There was an entry for polyethylene glycol take 1 capful every day scheduled for administration at 9:00am. -There was documentation polyethylene glycol 3350 was administered daily from 07/01/25 to 07/31/25. Review of Resident #4's August 2025 eMAR from 08/01/25 to 08/26/25 revealed: -There was an entry for polyethylene glycol take 1 capful every day scheduled for administration at 9:00am. -There was documentation polyethylene glycol 3350 was administered daily from 08/01/25 to 08/26/25. Observation of Resident #4's medication on hand on 08/26/25 at 2:36pm revealed polyethylene glycol 3350 was not available for administration. Telephone interview with Resident #4's PCP on 08/28/25 at 12:54pm revealed: - Resident #4 was ordered polyethylene glycol 1	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 capful every day. - She expected the facility to administer Resident #4's polyethylene glycol 3350 as ordered. -If polyethylene glycol 3350 was not administered, she expected documentation to reflect that. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/25 at 4:07pm revealed: -There was a current order on file for polyethylene glycol 3350 1 capful to be administered every day for Resident #4. -Polyethylene glycol 3350 was last dispensed on 04/11/25 for a 14 day supply and had not been dispensed since. - Polyethylene glycol 3350 was not on cycle fill and had to be reordered by staff. Interview with a MA on 08/28/25 at 9:15am revealed: -Resident #4 had severe constipation. -She was aware of Resident #4's polyethylene glycol 3350 order. -She was aware Resident #4 did not have any more polyethylene glycol 3350 on hand. -She was aware the last bottle of polyethylene glycol 3350 was dispensed on 04/11/25. -She had requested a refill of polyethylene glycol 3350 from the pharmacy on the morning of 08/28/25. -If the pharmacy did not fax confirmation of receiving the refill request by 12:00pm on 08/28/25, she would call them directly. -She did not know why other MAs documented that polyethylene glycol 3350 was administered when it had not been available since early May 2025. -It was possible Resident #4 was using another resident's polyethylene glycol 3350.	D 358		

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D 358	Continued From page 27 Interview with the SCUC on 08/28/25 at 10:00am revealed: -If a medication was not on the medication cart, the MAs were to inform her. -She was in charge of medication cart audits on the Special Care Unit. -She had not yet completed a medication cart audit for the month of August and was not sure if she completed one in July 2025. -There was no reason Resident #4 would be using another resident's polyethylene glycol 3350 multiple months in a row. -No one had informed her that Resident #4's polyethylene glycol 3350 had an issue being reordered. -Her expectation was that each resident with an order for polyethylene glycol 3350 had their own bottle with the resident's name labeled on the bottle. Interview with the Director of Clinical Services (DCS) on 08/28/25 at 10:43am revealed: -She expected the MAs to administer medications as ordered. -If a medication was not available, the MAs had the ability to reorder the medication. -If the medication reorder was not being filled, the MAs were to inform her, the RCC, or the SCUC so they could investigate it. -No one informed her that there was an issue when reordering Resident #4's polyethylene glycol 3350. -No one had informed her that Resident #4 had severe constipation. Interview with the RCC on 08/28/25 at 11:05am revealed: -She expected the MAs to administer medications as ordered. -If a medication was not in stock, she expected	D 358		

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D 358	Continued From page 28	D 358		

the MAs to reorder the medication.
-No one informed her that there was an issue when reordering Resident #4's polyethylene glycol 3350.

Interview with the Administrator on 08/28/25 at 11:30pm if medications were being ordered and not delivered, the MAs would inform the SCUC, RCC or the DCS so a call could be made to the facility's contracted pharmacy and investigate why the medication was not able to be delivered.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

3. Review of Resident #3's current FL2 dated 02/06/25 revealed:
-Diagnoses included dementia, increased confusion, and schizoaffective disorder.
-There was an order for melatonin 5mg (used to treat insomnia) at bedtime.

Review of Resident #3's physician's orders dated 05/21/25 revealed there was an order for melatonin 5mg at bedtime.

Review of Resident #3's Mental Health Provider's (MHP) electronically signed psychiatric follow-up evaluation dated 06/11/25 revealed melatonin 5mg every night at bedtime was included in current medications ordered by the MHP for Resident #3.

Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for melatonin 5mg at bedtime scheduled for administration at 9:00pm daily.

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D 358	Continued From page 29	D 358		

-There were 6 days with documentation melatonin 5mg was not administered as ordered from 06/17/25 to 06/30/25.
-There was documentation melatonin 5mg was not administered as ordered due to "faxed and called" the facility's contracted pharmacy to deliver stat (immediately) on 06/17/25, 06/23/25, 06/24/25, 06/24/25, 06/28/25, and 06/29/25.

Review of Resident #3's July 2025 eMAR revealed:
-There was an entry for melatonin 5mg at bedtime scheduled for administration at 9:00pm daily.
-There were 12 of 31 opportunities melatonin 5mg was documented as not administered from 07/01/25 to 07/31/25.
-Dates when there was documentation melatonin 5mg was no administered due to "faxed and called" the facility's contracted pharmacy to deliver stat were as follows: daily from 07/04/25 to 07/10/25, 07/14/25, 07/22/25, 07/23/25, 07/30/25 and 07/31/25.

Review of Resident #3's August 2025 eMAR from 08/01/25 to 08/25/25 revealed:
-There was an entry for melatonin 5mg at bedtime scheduled for administration at 9:00pm daily.
-There were 2 of 25 opportunities melatonin 5mg was documented as not administered.
-There was documentation melatonin 5mg was not administered due to "faxed and called" the facility's contracted pharmacy to deliver stat on 08/15/25 and 08/19/25.

Observation of Resident #3's medication on hand for administration on 08/27/25 revealed there was no melatonin 5mg available for administration to Resident #3 on the medication cart or in the

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D 358	Continued From page 30 medication overstock. Interview with a medication aide (MA) on 08/27/25 at 11:00am revealed: -She routinely worked the evening shift in the Special Care Unit (SCU) where Resident #3 resided as a MA and personal care aide (PCA). -She administered Resident #3's evening medications, including melatonin 5mg, when she worked as the MA. -Resident #3's melatonin 5mg was dispensed in bulk quantity in a large brown plastic container containing 200 tablets. -The bulk container of melatonin 5mg was stored in a slot on the medication cart along with the rest of Resident #3's oral medications. -She had not been able to locate the bulk container of melatonin 5mg for several days when she was administering her 9:00pm medications. -She reordered Resident #3's melatonin 5mg through the contracted pharmacy's eMAR system per normal procedure multiple times. -She had contacted the facility's contracted pharmacy reorder department by phone on multiple occasions requesting stat delivery with the next order as documented on the eMAR exceptions section. -She had advised the Special Care Unit Coordinator (SCUC) more than once but could not provide exact dates when she had informed the SCUC there was no melatonin 5mg available for administration for Resident #3. -She did not recall seeing the large bulk container containing 5mg melatonin in July 2025 or August 2025. -She thought she documented melatonin 5mg as not administered each time she worked but may have overlooked documenting "not available" a few times in July 2025 and August 2025.	D 358		

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D 358	Continued From page 31 Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/27/25 at 3:07pm revealed: -Resident #3's melatonin 5mg was dispensed by the pharmacy. -Melatonin 5mg was a medication that could be purchased over-the-counter (OTC). -The pharmacy routinely dispensed medication available OTC in a large bulk brown plastic container for cost saving to the residents. -Resident #3 was dispensed 5mg melatonin for a bulk quantity of 200 tablets on 04/18/25 which should last 200 nights or until November 2025. -There was documentation the facility had reordered melatonin 5mg for Resident #3 on several occasions. -The pharmacy's procedure for processing reorder for medications that were too early to be refilled was send the facility a typed "too early to refill" notification document with the next medication delivery to the facility. -There was documentation in pharmacy's computer system specific to the pharmacy's notification to the facility dated 07/31/25 and 08/08/25 advising Resident #3's was too early to refill. -There was no documentation the pharmacy had processed a return of Resident #3's melatonin 5mg since April 2025. Interview with the Administrator on 08/27/25 at 5:10pm revealed: -Medications should be administered as ordered. -The MAs were responsible for ensuring medications were available for administration as ordered. -The clinical staff, consisting of the SCUC, Resident Care Coordinator (RCC), and Director of Clinical Services (DCS), should be contacted by the MA for assistance with any medications not	D 358		

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D 358	Continued From page 32	D 358		

available for administration.

Interview with a morning shift MA on 08/28/25 at 9:30am revealed:
-She did not administer Resident #3's melatonin 5mg scheduled for 9:00pm.
-At 9:45am, the MA rechecked the medication cart and overstock stored in the medication room for Resident #3's bulk container of 5mg melatonin but found none.
-Review of the eMAR computer's reorder tracking revealed Resident #3's melatonin 5mg was documented as reordered on 17 occasions from 06/17/25 to 08/19/25.
-She staffed, on some of her days from MA duties, a few times each month as an evening or night shift PCA to help with residents' care.
-Resident #3 routinely got dressed in her nighttime sleep attire and went to bed.
-She had not witnessed Resident #3 having insomnia and being up during the night.
-Resident #3 usually slept late and had to be aroused for breakfast in the mornings.

Interview with the SCUC on 08/28/25 at 9:50am revealed:
-When a medication was not available, the MA on duty should reorder the medication.
-If a medication had been reordered but was not available for administration the MA should let the SCUC, RCC, or DCS know that there was an issue obtaining the medication.
-No staff had informed her Resident #3 was out of melatonin 5mg in June 2025, July 2025, or August 2025.
-No staff had informed her Resident #3 had difficulty sleeping at night.
-Resident #3 had no documented behaviors related to nighttime wandering or insomnia.
-She was responsible for performing medication

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D 358	Continued From page 33	D 358		

carts audits for availability of medications for administration weekly.
-She had not audited Resident #3's medications on the cart for administration compared to the medications ordered on the eMAR in several weeks.
-She did not know Resident #3 had no melatonin 5mg on hand for administration.

Interview with the RCC on 08/28/25 at 11:00am revealed:
-The facility's previous DCS left unexpectedly in July 2025.
-A new DCS began working 2 days ago (08/25/25).
-She had recently become the RCC.
-She did not currently have a system in place to routinely monitor residents' eMARs for medications not administered due to the medication not being available for administration.
-She expected all MAs to administer medications as ordered.
-MAs should inform the RCC, SCUC, or DCS if the facility's contracted pharmacy was not sending a scheduled medication.
-She did not know Resident #3 had missed doses of melatonin 5mg due to the medication not being available to administer.

Interview with the DCS on 08/28/25 at 10:23am revealed:
-She began employment as the DCS on 08/25/25.
-She expected MAs to administer medications as ordered.
-The MAs ordered medication through the contracted pharmacy's eMAR reorder system.
-If a medication was not available for administration after the MA had reordered, either the RCC, SCC or the DCS should be informed for

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D 358	Continued From page 34	D 358		

assistance obtaining the medication.
-She would implement MA training for reading and understanding eMAR order entries.

Interview with the Administrator on 08/28/25 at 11:30am revealed the RCC, SCC, and DCS should be auditing residents' eMARs for missed medications.

Telephone interview with the assistant to the MPH on 08/28/25 at 1:45pm revealed:
-Resident #3 was seen by the MHP at the facility on 08/27/25.
-There were no documented inappropriate behaviors like wandering at night or insomnia reported by the facility and reviewed by the MHP.
-Resident #3 was ordered melatonin 5mg for sleep 4 or 5 years ago and the resident had remained on the medication.
-The only notable side effect from not receiving melatonin would be if the resident had trouble sleeping at night.
-Resident #3 should be monitored for insomnia and the melatonin 5mg mat be discontinued since the resident had not been receiving the medication and was sleeping well at night without the medication.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

_____

The facility failed to ensure medications were administered as ordered for 3 of 3 residents observed during medication administration pass including: a resident not administered a diabetic medication putting the resident at riskfor high blood glucose and not administering an antipsychotic putting the resident at risk for

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D 358	Continued From page 35 anxiety and adverse behaviors (#1), a resident not administered iron and vitamin D, putting the resident at risk for iron and vitamin D deficiency (#6), and crushing a delayed release medication, putting the resident at risk for inappropriate absorption resulting in adverse behaviors (#7); and 2 of 5 sampled residents for record review including a resident who was not administered a sleep aide putting her at risk for sleep depravation (#3) and a resident not administered a laxative putting her at risk for constipation and who was administered a cardiac medication when her pulse was below 60, with parameters to hold when pulse was less than 60 placing the resident at risk for lowered heart rate and possible heart damage (#4). This failure was detrimental to health, safety, and welfare of the residents which constitutes a Type B Violation. This facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 12, 2025.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by:	D 371		

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D 371	Continued From page 36 Based on observations and interviews, the facility failed to ensure that medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection for 3 of 3 residents (#1, #6, and #7) observed during the medication administration pass. The findings are: Observation of the morning medication administration pass on 08/27/25 at 7:39am revealed: -A medication aide (MA) began preparing medication for Resident #6. -The MA did not don gloves or perform hand hygiene. -The MA popped Resident #6's medication tablets from the blister pack directly into her hand. -The MA placed the tablets from her hand into a medication cup. -The MA administered the medication to Resident #6. Observation of the morning medication administration pass on 08/27/25 at 7:45am revealed: -A MA began preparing medication for Resident #1. -The MA did not don gloves or perform hand hygiene. -The MA popped Resident #1's medication tablets from the blister pack directly into her hand. -The MA placed the tablets from her hand into a medication cup. -The MA administered the medication to Resident #6. Observation of the morning medication administration pass on 08/27/25 at 8:00am	D 371	Plan of Correction for 10A NCAC 13F .1004(n) Medication Administration During the staff meeting on September 3, 2025, all medication technicians were re-educated on proper infection control practices during medication administration, including the requirement to perform hand hygiene and use gloves appropriately. The Director of Clinical Services will observe medication passes routinely to ensure that infection control procedures are being followed consistently. Any staff found out of compliance will be corrected immediately and re-educated as needed. All corrective measures will be completed by October 15, 2025, and monitoring will continue thereafter.	10/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 371	Continued From page 37	D 371		

revealed:
-A MA opened the special care units locked door for the surveyor.
-The MA began preparing medication for Resident #7.
-The MA did not don gloves or perform hand hygiene.
-The MA popped Resident #7's medication tablets from the blister pack directly into her hand.
-The MA placed the tablets from her hand into a medication cup.
-The MA administered the medication to Resident #6.

Interview with a MA on 08/28/25 at 2:30pm revealed:
-When she administered any medication, she performed hand hygiene prior to preparing the medications.
-When on the medication cart, she trained new employees on infection prevention.

Interview with a second MA on 08/28/25 at 2:35pm revealed:
-She completed an infection prevention course when she began working at the facility.
-When she administered medications, she used hand sanitizer prior to preparing the medications.
-She performed hand hygiene in-between each resident she prepared medication for.

Interview with the Director of Clinical Services (DCS) on 08/28/25 at 2:48pm revealed:
-She began working at the facility on 08/25/25.
-Her expectation was that MA's performed hand hygiene prior to preparing medication, and in-between each resident.

Interview with the Special Care Unit Coordinator (SCUC) on 08/28/25 at 2:50pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 371	Continued From page 38 -Her expectation was that MA's performed hand hygiene prior to preparing medication, and in-between each resident. -When preparing medication, MA's were to pop tablets from the medication blister pack directly into a medication cup. -An employee from a third-party healthcare provider, completed infection control training for new employees at the facility. Interview with the Resident Care Coordinator (RCC) on 08/28/25 at 3:00pm revealed: -Infection prevention training was completed every three months by a nurse. -She expected MA's to pop tablets from the medication blister pack directly into a medication cup. -She expected MA's to perform hand hygiene after every three residents. Interview with the Administrator on 08/28/25 at 3:90pm revealed: -He was not aware MA's were not performing hand hygiene prior to preparing medications. -He expected all employees who administer medications to follow infection prevention protocols.	D 371		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 39 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sample resident (#1) had a physician's order and assessment completed to self-administer medications related to a hair growth treatment and a dandruff shampoo. The findings are: Review of Resident #1's current FL2 dated 11/06/24 revealed diagnoses included diabetes, right below knee amputation, third toe amputation and osteomyelitis. Observation of Resident #1's room on 08/26/25 at 9:48am revealed: -There was a box of ketoconazole (scalp treatment for dandruff) on residents # 1's bedside table dispensed 08/07/25. -There was a bottle of minoxidil (used to promote hair growth) on residents # 1's bedside table that was 50% full. Interview with Resident # 1 on 08/26/25 at 9:50am revealed: -She administered her own ketoconazole and minoxidil. -No staff assisted her when using the ketoconazole and minoxidil. -She thought she had an order to self-administer	D 375	Plan of Correction for 10A NCAC 13F .1005(a) Self-Administration of Medications The facility does not allow self-administration of medications unless approved by the provider with a physician's order and assessment on file. Prescription shampoos, creams, and similar treatments are to be kept on the medication cart, provided under the supervision of a medication technician, and returned to the cart after use. The Director of Clinical Services will monitor medication administration practices to ensure compliance. All corrective measures will be completed by October 15, 2025, and monitoring will continue thereafter.	10/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

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D 375	Continued From page 40 the ketoconazole and minoxidil. Review of Resident #1's signed physician's orders dated 07/21/25 revealed: -There was an order for minoxidil 5% solution apply to scalp twice a day. -There was no order for Resident #1 to self-administer minoxidil. Review of Resident #1's record on 08/26/25 revealed: -There was an order for ketoconazole A-D apply to scalp 1-2 times per week, leave on 10 minutes and rinse. -There was no order for Resident #1 to self-administer ketoconazole. Interview with the medication aide (MA) on 08/26/25 at 3:30 pm revealed: -She could not locate Resident #1's ketoconazole and minoxidil.on the medication cart. -She thought resident had a self-administer order for ketoconazole and minoxidil.. Observation of the MA on 08/26/25 at 3:30pm revealed: -She went to Resident # 1's room to look for Resident #1's ketoconazole and minoxidil. -Resident # 1 came back to the medication cart with the MA and had ketoconazole and minoxidil.in her hand. Review of the facility's Resident Self-Administration policy revealed: -Residents must have a completed assessment conducted by the Resident Care Coordinator (RCC) or a registered nurse to demonstrate understanding of medication regimen. -Residents must demonstrate the ability to safely store medications in his or her room.	D 375		

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D 375	Continued From page 41 -There must be a physician's signed self-administer order in the resident's record. Interview with Resident #1's Primary Care Provider (PCP) on 08/27/25 at 11:10am revealed: -She was not aware Resident # 1 had ketoconazole and minoxidil.in her room. -Resident #1 did not have an assessment and / or order to self-administer ketoconazole and minoxidil. -She did not want Resident # 1 to self-administer ketoconazole and minoxidil. -She expected medications to be administered as ordered and not be in a resident's room without an order to self-administer their medication. Interview with Director of Clinical Services (DCS) on 08/27/25 at 11:42am revealed: -She was not aware Resident #1 had medications in her room with no self-administer order. -She would expect the medication to be on the cart if the resident did not have an order to self-administer the medication. Interview with the RCC on 08/27/25 at 11:50am revealed: -She was not aware Resident # 1 had medications in her room. -She had removed medication from Resident # 1's room in the past because she did not have a self-administer order for them. -It was her responsibility to do electronic medication administration record (eMAR) and cart reviews. -She was not sure of the last time she did eMAR and cart reviews. -Her expectation was for all MAs to administer medications as ordered and remove medications from residents' rooms if they do not have a self-administration order.	D 375		

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D 375	Continued From page 42 Interview with the Administrator on 08/27/25 at 2:30pm revealed: -He was aware that Resident #1 had medications in her room in the past without a self-administration order. -Resident #1 had a history of trying to keep medications in her room without a self-administer order. -He was aware that residents needed a self-administer order to have medications in their rooms. -He would expect medications to be administered as ordered by staff and not be left in residents' rooms without a self-administer order.	D 375		