PRINTED: 09/22/2025
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
	HAL065020	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow up survey and a complaint investigation on September 3-5, 2025. New Hanover Department of Social Services initiated the complaint investigation on August 15, 2025.	D 000	Champions Assisted Living acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of residents. The plan of correction is submitted as a written assertion of compliance. Responses to the stated deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Champions Assisted Living reserves the right to refute and incorporates by reference any rebuttal of deficiencies that it submits through informal dispute resolution, formal appeal and/or other administrative or legal procedures.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including personal care items in unlocked cabinets in residents' rooms that were accessible to residents in the special care unit (SCU), a thick black stain in the ceiling of the shower in a resident's room on the SCU, and a large hunting knife on a shelf in a resident's room (#4).. The findings are:	D 079	NCAC 13F .0306 Housekeeping and Furnishings At time of discovery, all rooms were searched thoroughly. Combination Locks were applied to all remaining bathroom cabinets	9/3/25 9/15/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Laura Leonard TITLE Executive Director (X6) DATE 10/09/25

STATE FORM 6899 6L1D11 If continuation sheet 1 of 56

Reviewed and acknowledged on 10/13/2025 by Joyce Johnston

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D 079	Continued From page 1 Review of the facility's Policy and Procedure Regarding Secure Personal Care Items/Ingestible/Secure Unit dated 09/03/25 revealed: -All personal care items with a warning label regarding ingestion was a hazardous item and were to be locked in a secure space in the resident room for those residents residing in the special care unit. -The purpose of the policy was to ensure the facility was providing a safe environment to ensure residents in the special care unit did not have access to potentially hazardous items. -The procedure for following the policy was: Upon admission all items would be checked in by designated staff and placed in the locked storage cabinet in the resident room and staff were to ensure that items were locked at the completion of rendering care. Review of the facility's census report received on 09/03/25 revealed 19 residents resided in the special care unit (SCU) of the facility. 1. Observations on the SCU on 09/03/25 during the initial tour from 9:02am to 10:25am revealed residents ambulated freely in the halls to and from their rooms to the other areas of the SCU. Observations in room 111 on 09/03/25 at 9:29am revealed: -The room door was open. -The resident was ambulating independently in the room. -There were no staff present in the room. -The cabinet above the sink had a child proof lock on it and the lock was open. -The bottom cabinet had a child proof lock on it and the lock was open.	D 079	Staff were inserviced on the locks in Memory Care Room checks performed daily by Care Manager/designee Families received notifications on items needing to be locked up in cabinets and not left on counters	9/15/25 9/6/25 and ongoing 9/8/25 and ongoing

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D 079	Continued From page 2 -There were personal care items in both cabinets. -The top cabinet contained lotions, body washes, and solid deodorants. -The bottom cabinet contained shampoos. -The warning label on the shampoos and deodorants advised to keep the product out of the reach of children. If swallowed, get medical help or contact the Poison Control Center right away. -The warning label on the body washes and lotions advised to keep the product out of the reach of children. Interview with the resident in room 111 on 09/03/25 at 9:29am revealed: -Someone had just given her a shower. -She opened the cabinet locks on her own. -It took her a while to learn how to open the locks. -All she had to do was push the top and bottom buttons on the lock to unlock the cabinets. Observations in room 110 on 09/03/25 at 9:47am revealed: -The resident was in bed. -There were no staff present in the room. -The bottom cabinet lock was broken. -There were personal care products in the bottom cabinet to include shampoos, conditioners, body wash, body powder, and a bar of soap. -The warning label on the powder advised to keep out of the reach of children. -The shampoos included alcohol. -There was a bottle of body wash in the shower. -Ingredients listed on the shampoo bottle that was in the shower included alcohol. -The ceiling was made up of ceiling tiles. -There was a thick black stain in the shower on the ceiling tile that contained the shower light fixture; that was about 4 inches in diameter, with dark brown water marks surrounding it.	D 079		

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D 079	Continued From page 3 Based on observations, interviews, and record reviews, it was determined that the resident in room 110 was not interviewable. Interview with a personal care aide (PCA) on 09/03/25 at 9:10am revealed: -All personal care products were kept in the residents' bathrooms in the cabinets that were locked with child proof locks. -Residents had not been able to get into the cabinets that she was aware of. -All resident room doors were locked when the residents were not in the room because the they had several residents that had wandering behaviors. Interview with a second PCA on 09/03/25 at 10:00am revealed: -Personal care products were supposed to be locked in the medicine cabinet or under the sink in the residents' rooms. -She was not aware of any residents that had been able to get into the locked cabinets. -PCAs provided personal care to the residents. -After personal care was provided to the residents, the personal care products were locked up immediately. -Family sometimes brought personal care products in without staff knowing. -Medication aides (MAs) were supposed to check behind PCAs to ensure personal care products were not accessible to the residents. -She was unsure how often the MAs were supposed to check behind the PCAs for accessible personal care products, but it had to be before the end of the shift. -She would be concerned if residents had access to personal care products because of the risk of them trying to drink the products. -No residents had ingested personal care	D 079		

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D 079	Continued From page 4 products that she was aware of. -She was sure any of the residents on the SCU were capable of ingesting personal care products at any given time because they had dementia. -There were several residents that had wandering behavior in the SCU. -She informed maintenance last week of the black stain on the shower ceiling in room 110. -Last week was the third time she reported the black stain on the shower ceiling in room 110 to the SCC and the MA but she was unsure which MA she informed. -The Special Care Coordinator (SCC) and MA were responsible for reporting the black stain on the shower ceiling in room 110 to the receptionist. -The resident in room 110 had a very short memory. -The resident complained about the black stain and asked what was being done about it every time she went into the shower. -The resident did not complain of an odor from the black stain in the shower ceiling. -The resident did not complain of headaches or respiratory symptoms. Second interview with a PCA on 09/05/25 at 8:47am revealed: -Metal locks were purchased by the previous Administrator, but she was unsure why they had not been installed. -She was not aware of residents getting into the personal care products. Interview with the Activity Director on 09/03/25 at 2:53pm revealed: -She was filling in for the receptionist today (09/03/25). -When she was given a work order, she entered the order into their computer system for maintenance to respond.	D 079	NCAC 13F .0306 Housekeeping and Furnishings - Black Stain on Ceiling Area identified was cleaned immediately Housekeeping to monitor rooms/ceilings during routine cleaning Housekeeping Supervisor to be notified of any discolorations on the ceilings Housekeeping Supervisor to complete on line request in MaintainX which generates a ticket to Maintenance and cc'd to administrator	09/05/25 9/8/25 and ongoing

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D 079	Continued From page 5 -Maintenance was located on campus and received notification of work orders through their computer system. -She was not aware of the black stain on the shower ceiling of room 110. Interview with a receptionist on 09/04/25 at 7:30am revealed: -When a work order was needed, staff informed her in writing or verbally. -She submitted the work order into the computer system for maintenance to respond. -If staff informed her a few days later that maintenance had not addressed the issue, she submitted the work order again through the computer system. -No one had come to her in the past 30 days about a black stain on the shower ceiling in room 110 on the SCU. -She could only see work orders that she entered. Interview with a MA on 09/03/25 at 10:25am and 2:45pm revealed: -Personal care products were required to be locked up either in the medicine cabinet or under the sink in the resident's room. -Residents broke the locks so they were in the process of getting locks that screwed into the cabinets and had a code. -Some of the residents were at risk of ingesting the personal care products because of memory issues. -They had not had any issues with any residents ingesting personal care products. -She was not aware that the bottom cabinet lock was broken in room 110. -She was aware that the top cabinet and bottom cabinet in room 111 were left unlocked. -The resident in room 111 dressed herself and was frequently checked on.	D 079		

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D 079	Continued From page 6 -The resident in room 111 did not open the locks herself; staff opened the locks and left them open for her, but she was unsure which staff member did so. -There were residents with wandering behaviors in the SCU. -She was aware of the black stain on the shower ceiling in room 110 because the PCA's told her about it. -The ceiling tile was previously replaced by maintenance, but she was unsure when; but the black area kept reappearing. -The resident in room 110 had not complained about the black stain in the shower ceiling that she was aware of. -There were two ways to report something like the black stain in the ceiling shower in room 110; the PCA reported to her, and she reported it to the receptionist who submitted a work order on the computer or the PCAs reported the problem directly to the receptionist and a work order was submitted. Interview with the Maintenance Supervisor on 09/05/25 at 8:19am revealed: -If black stains like the one in the shower ceiling of room 110 were found, the area was tested, cleaned and tested again. -When water stains were found, the ceiling and attic were checked for leaking pipes. -Cabinet locks had been replaced throughout the facility, but he could not say which rooms the locks were changed in. -He purchased a bag of locks but was never given a clear explanation on what type of locks were needed. Interview with the Resident Care Director (RCD) on 09/03/25 at 2:58pm revealed: -Personal care products were supposed to be	D 079		

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D 079	Continued From page 7 locked up so residents could not get to them to eat or drink them. -He was not aware that the bottom cabinet lock was broken in room 110. -He was not aware that both cabinets were left unlocked in room 111. -It was not acceptable for the locks to the cabinets for any resident's personal care items in the SCU to be left open. -Residents in the SCU could poison themselves if they ingested personal care products. -He was not aware of any residents ingesting personal care products. -The facility's human resources department reviewed personal care storage in the SCU with all staff upon hire. -All rooms on the SCU were supposed to be checked by MAs and PCAs daily, every time they entered the room. -Maintenance was replacing locks because residents had been damaging the locks, but he was unsure how they were damaging them. -He was not aware of the black stain on the shower ceiling in room 110. -A work order should have been put in to address the black stain on the shower ceiling in room 110. -If a PCA saw the black stain on the shower ceiling in room 110, it should have been reported to the MA and the MA would have reported to him, the SCC or Administrator immediately so that a work order could have been submitted. -The black stain on the shower ceiling in room 110 should have been reported because the resident lived in that space and if the stain was "mold" it could make the resident sick by causing a runny nose or infection in the lungs. -He was not aware of the resident complaining about the black stain on the shower ceiling in room 110.	D 079		

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D 079	Continued From page 8 Second interview with the RCD on 09/04/25 at 7:47am revealed: -He spoke with the Maintenance Supervisor yesterday and was advised maintenance never received a work order for the black stain in the shower ceiling of room 110 and that they were not aware of it. -He saw all work order approvals and had not seen an approval for a work order for the black stain in the shower ceiling of room 110. Interview with the Special Care Coordinator (SCC) on 09/04/25 at 10:27am revealed: -All personal care products were to be locked in the top or bottom cabinets. -After assisting residents with personal care, the PCA's were supposed to put the products away immediately and lock the cabinets. -She talked to staff several times about how to handle personal care products and they also reviewed products that could be ingested during audits. -The audit involved going around daily to resident rooms to ensure that products that could be ingested were put away and locked up. -The audit was to be done every time staff were in the residents' rooms; staff were to scan the rooms for ingestible products each time they were in the room. -She completed audit sheets once daily, in the morning. -Personal care products could have been toxic if ingested. -Due to the cognition impairment and dementia of the SCU residents, they never knew who would ingest personal care products. -They never had any residents to ingest personal care products. -She was not aware the bottom cabinet lock in room 110 was broken until staff told her when she	D 079		

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D 079	Continued From page 9 came in to work yesterday (09/03/25). -Staff told her the lock was just broken yesterday (09/03/25). -She found out both cabinet locks were left unlocked in room 111 when she came in to work yesterday (09/03/25). -She was told that the PCA had not gone back in to lock the cabinets in room 111 yesterday (09/03/25). -She was not aware of the black stain on the shower ceiling of room 110. -She was made aware of the black stain on the shower ceiling of room 110 yesterday (09/03/25) and she immediately submitted a work order. -She should have been made aware of the issues as soon as they were identified. -When informed of an issue, she submitted a work order from her computer. -All members of management had access to the online application they used to submit work orders. -She was unsure why staff did not report the broken lock, unlocked cabinets and black stain in the shower ceiling to her. Interview with the Administrator on 09/03/25 at 4:43pm revealed: -Personal care products should have been in locked cabinets when not in use. -She was not aware of the broken cabinet lock and personal care product left in the shower in room 110. -She was made aware of the cabinets being unlocked in room 111 when staff told her about it while surveyor was on the SCU today (09/03/25). -The cabinets in room 111 were not to be left unlocked just because the resident dressed herself. -She did not know why staff did not report the broken lock in room 110 or lock the cabinets back	D 079		

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D 079	Continued From page 10 in room 111. -The residents ingesting products and the alcohol content in some of the personal care products was a concern. -They had not had any residents to ingest personal care products. -Staff were supposed to inform any manager or the Administrator if they found personal care products in a resident's room. -There was no way the resident in room 111 could have opened the current locks on her own. -The locks on the residents' bathroom cabinets were the same locks that were in place during the previous survey on 07/03/25. -She was not aware of the black stain in the ceiling of the shower in room 110 until today when staff informed her. -Staff were supposed to inform the Administrator, Receptionist, RCD, or SCC so that a work order could be submitted in the system to address the black stain in the shower ceiling. -Staff were in and out of resident rooms multiple times per day but they were not looking for things that were not supposed to be in the room. -She was concerned that no one saw the black stain in the shower ceiling in room 110. -Staff had not been trained and there was no process in place for staff to identify personal care products that were accessible to residents. -Staff had not been trained to identify stains like the one in the shower ceiling of room 110. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 3:11pm revealed: -She did not know the resident in room 111 so she could not answer any questions about her. -She had not seen the resident in room 110 since April. -The resident in room 110 suffered from short	D 079		

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D 079	Continued From page 11 term memory issues. -The concern for residents in the SCU having access to personal care products depended on each individual resident. -She could not answer any questions regarding the black stain on the shower ceiling in room 111 because she did not know what it was, and it had not been mentioned to her. Review of the facility's undated tobacco-free and weapon-free policy revealed: -The possession, use, or storage of any weapons, including but not limited to firearms, knives, explosives, and other dangerous objects was prohibited on property owned, leased, or controlled by the facility. -The administration was responsible for the enforcement of the policy. -Any violations were to be reported to the administration immediately. -The administration was to investigate all reports of violations and to take appropriate action. Review of admission records revealed Resident #4's power of attorney (POA) signed a tobacco-free and firearm-free policy acknowledgement on 10/28/24. Review of Resident #4's FL-2 dated 10/30/24 revealed: -The resident was admitted with diagnoses of abdominal aortic aneurysm, hypothyroidism, anorexia, elevated prostate-specific antigen, hyperlipidemia, mitral valve disease, peripheral arterial disease, diabetes mellitus type II. -The resident was intermittently disoriented. -There was an order for Eliquis 5 mg, one pill, twice a day (a medication to thin the blood).	D 079	NCAC 13F .0306 Housekeeping and Furnishings - Weapons Upon notification of knife discovery - knife was removed. Family made aware of knife in room and it being removed Policy re: weapons in facility was reviewed with family and resident Room search's will take place to ensure policy for weapons remain in compliance New admissions will receive a review on this policy as outlined in the admission packet	9/3/25 9/3/25 9/8/25 9/8/25 and ongoing 9/8/25 and ongoing

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D 079	Continued From page 12 Review of Resident #4's Resident Register revealed: -The resident was admitted 11/04/24. -The resident was forgetful, needed reminders. Observation of Resident #4's room on 09/03/25 at 9:48am revealed: -There was a large knife with a green handle on a shelf next to the resident's chair. -There was no protective sheath or covering on the knife blade. -The lower front part of the blade had teeth. -The tip of the blade had a clip point shape. Interview with Resident #4 on 09/03/25 at 11:40am revealed: -The knife was a hunting knife. -He used it to open things. Interview with Resident #4 on 09/05/25 at 9:20am revealed: -He felt fortunate he was not bothered by dementia. -He recognized there were other residents with dementia in the building. Interview with a Medication Aide (MA) on 09/05/25 at 11:45am revealed: -When she went into the room to administer medications, Resident #4 did not want her to move around the room, but she tried to observe. -She had difficulty inspecting rooms during administration when residents did not want her in the room. -She did not look too much because she had to have permission from residents to look around. -She had observed forgetfulness with Resident #4. -Sometimes he could not remember that he ate.	D 079		

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	HAL065020	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

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D 079	Continued From page 13 Interview with a Personal Care Aide (PCA) for Resident #4 on 09/05/25 at 8:37am revealed: -She never saw a knife in Resident #4's room. -She did not think a knife would be allowed. -She found a pocket knife in his laundry once and returned it to the resident with his family member present. -Staff was trained to turn in information to the social worker or Resident Care Coordinator (RCC) if they were unsure about items. -There was no scheduled process to check for hazards on that floor. -She thought residents should not have weapons due to concerns about their mental status. Interview with the RCC on 09/05/25 at 2:12pm revealed: -Facility staff were responsible for scanning the room for weapons. -Everyone was responsible to make sure contraband was not in the rooms. -Staff was trained on the weapons policy during orientation. -He worked with the clinical nurse if he received reports about contraband. -He would remove hazards if they were reported to him. -Staff should be trained to remove things that were not in compliance with facility policies. Interview with the clinical nurse on 09/05/25 at 4:00pm revealed: -The knife should not be in the facility because Resident #4 could unintentionally hurt himself. -He told her he peeled apples with the knife. -He could cut his finger peeling an apple. -She was also concerned that he could lose his balance because of his feet. Interview with the Administrator on 09/03/25 at	D 079		

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D 079	Continued From page 14 11:27am and at 4:33pm revealed: -The knife should not be allowed in the facility. -The item found by the surveyor was a very sharp knife. -The knife was removed. -She did not have an answer for why the knife was not removed earlier. -She did not know of any concerns for self-harm for any residents in the facility. -There should be a signed weapons policy for Resident #4. Telephone interview with the Administrator on 09/05/25 at 3:02pm revealed family was educated on the facility's policies (refer to the facility's undated tobacco-free and weapon-free policy). Interview with Resident #4's primary care provider (PCP) on 09/04/25 at 3:12pm revealed: -The knife should not be in the room. Telephone interview with Resident #4's psychiatry provider on 09/05/25 at 3:24pm revealed: -She did not think he should have access to the knife. -He had had some agitation. -Initially he was sad about being there, was getting angry about the food there. -She did not feel he was cognitively impaired. -She was concerned about his mood with the knife situation. -She did not think he would stab someone, and she did not think he would hurt himself intentionally. -She was concerned about unintentional harm with the hunting knife. -She was concerned about his age and coordination. -Resident #4's reported dizziness could cause accidental harm with the knife.	D 079		

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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 interviews, and record reviews the facility failed to ensure that 2 of 3 sampled staff who administered medications to residents had the required documentation of the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff B, Staff E) for adult care homes and 1 of 3 did not have a completed medication administration skills validation form (Staff B) prior to administering medications to residents. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 07/08/25 as a medication aide (MA). -She passed the MA test on 07/11/16. -There was a continuing education certificate dated 08/05/25 for 15 continuing education hours for a medication course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes.	D 125	10A NCAC 13 F .0403 Qualifications of Medication Staff Records of 5/10 hour training sent to DOH 9/8/25 Employee Skills check off and other onboarding records will be kept in Champions Administrators off to ensure compliance Employee Tickler has been created and will be kept updated by administrator/designee for auditing purposes	09/08/25 9/12/25 and ongoing 10/1/25 and ongoing

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D 125	Continued From page 16 -There was no documentation for the medication administration skills validation form. 2. Review of Staff E's personnel record revealed: -Staff E was hired on 02/28/19 as a MA. -Staff E passed the MA test on 09/19/11. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. -There was documentation that Staff E completed her medication skills validation form on 03/25/25. Interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:20pm revealed: -The staff development nurse provided education to the registered nurses and the licensed practical nurses. -Staff education was performed by the staff development nurse. -She would have completed the medication administration skills validation form. -The Clinical Nurse (CN) and the RCC were responsible for maintaining the staff's education record. Interview with the CN on 09/05/25 at 4:30pm revealed: -Human Resources (HR) should make sure all the required education was completed on hire. The RCC and the Administrator were responsible for maintaining the staff's education record after the staff were hired. -All documents were sent to HR to be filed. Interview with the facility's HR Director on 09/05/25 revealed: -HR was responsible for documents upon hire, including the MA test date and the health care personnel registry (HCPR).	D 125		

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D 125	Continued From page 17 -The RCC was responsible for ensuring the certificate for the MA course and the medication administration skills validation form were in the staff's education record that was maintained in the facility. Telephone interview with the Administrator on 09/05/25 at 5:08pm revealed: -She was responsible for maintaining the staff's education record. -She assumed that Staff E's state approved 5-hour and 10-hour or 15-hour medication aide training was in their education folder. -She had not started a staff education record for Staff B because she thought HR had the file. -Staff B completed the required MA course through the facility pharmacy and she was not sure why the state approved certificate or the medication administration skills validation form was not available.	D 125		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered for 1 of 7 sampled residents (#6) related to a medication to treat high	D 358	10A NCAC 13 F .1004 (a) Medication Administration Medication Aides/Techs received an inservice on medication administration policy and procedures	09/04/25

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D 358	Continued From page 18 blood pressure. The findings are: Review of the facility's medication administration policy dated 07/22/99 and revised on 02/26/18 revealed the nurse will administer medications to residents following good professional practice including check, double check, and check again. Review of Resident #6's current FL-2 dated 12/02/24 revealed diagnoses included bipolar disorder, chronic kidney disease, myopathy, muscle spasms of the back, and repeated falls. Review of Resident #6's Resident Register had an admission date of 12/04/24. Review of Resident #6's signed physician orders dated 06/24/25 revealed there was an order for Norvasc 5mg daily. (Norvasc 5 mg is used to treat high blood pressure). Observation of Resident #6's medications on hand revealed: -There was a medication card dated 05/02/25 for Norvasc 10mg, 25 tablets dispensed, administer daily, and there were 25 tablets remaining in the medication card. -There was a medication card dated 08/19/25 for Norvasc 10mg, 28 tablets dispensed, administer daily, and there were 11 tablets remaining in the medication card. Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Norvasc 5mg to be administered daily between 7:00am and 9:00am. -Norvasc 5mg was documented as administered	D 358	Upon notification - MD notified with supporting documentation of recorded b/p. Physician stated no negative effect from resident receiving original order of 10mg vs 5mg. Order was reviewed and rewritten to reflect 5mg Shift Supervisors/designee will be checking new orders that come into the facility Families have been instructed to provide new orders to staff upon return from medical appointments Medications Aides inserviced on checking orders against medications prior to dispensing medications to residents	9/4/25 9/04/25 9/5/25 and ongoing 9/8/25 and ongoing 9/10/25 and ongoing

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D 358	Continued From page 19 daily between 7:am and 9:00am from 08/01/25-08/31/25. Review of Resident #6's September 2025 eMAR revealed: -There was an entry for Norvasc 5mg to be administered daily between 7:00am and 9:00am. -Norvasc 5mg was documented as administered daily between 7:am and 9:00am from 09/01/25-09/03/25. Review of Resident #6's vitals report revealed: -Resident #6's BP on 08/04/25 was 151/69. Resident #6's BP on 09/04/25 was 154/76 Review of Resident #6's facility progress note dated 05/05/25 at 4:15pm revealed the resident returned from a nephrology appointment with new orders for Norvasc and obtain daily blood pressures, resident is already taking Norvasc, nurse left note for primary care provider (PCP) to clarify orders tomorrow. Review of Resident #6's facility progress note dated 05/06/25 at 1:15pm revealed resident was seen by their PCP today and received a new order to keep current Norvasc order the same and to check the blood pressure prior to morning medications daily for 14 days, orders were entered into their computer system and sent to pharmacy. Interview with the medication aide (MA) on 09/04/25 at 10:19am revealed: -She administered medication according to instructions on the eMAR. -When she administered medications, she checked the medication on hand against the eMAR. -She thought she had administered Resident #6	D 358		

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D 358	Continued From page 20 the correct dosage of Norvasc. -She now saw the eMAR instructions and medication on hand did not match. -The Clinical Nurse (CN) was responsible for entering physician orders to the eMAR. Interview with a second (MA) on 09/04/25 at 3:30pm revealed: -She had worked at the facility for 6 years. -MAs did not enter medication orders into the eMAR. -Medications should be compared to the orders in the eMARs and to the medication on hand. Interview with the shift supervisor on 09/04/25 at 2:50pm revealed: -Before administering medications, the medication aide (MA) should have compared the eMAR to the medication. -She had never administered medications to Resident #6. -The MA's performed the medication cart audits. -She was not sure when the last medication cart audit was performed. Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 3:00pm revealed: -He had worked at the facility for one month. -The nurse uploaded the provider orders into the computer after rounding with the provider. -New provider orders were placed on a separate order sheet and faxed to the pharmacy on the same day they were received. -There had been no medication cart audits since he had worked for the facility. Interview with the CN on 09/04/25 at 3:15pm revealed: -The nurse entered medications into the eMAR. -The provider could call telephone orders to the	D 358		

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D 358	Continued From page 21 facility and telephone orders were written and entered int the eMAR and faxed to pharmacy, the provider would sign once they returned to the facility. -The facility updated the signed physician orders in June and December each year. -The orders were faxed to the provider and once returned they were scanned into the computer and faxed to the pharmacy. -The FL-2 was updated yearly and faxed to the pharmacy. -She was not sure why Resident #6's provider orders were not sent to the pharmacy on 06/24/25. -Before administering any medication, the MA should compare the eMAR to the medication for accuracy. -Medication cart audits were performed by the MAs. -She was not sure when the last medication cart audit was performed. Interview with a pharmacist at the facility's contracted pharmacy on 09/04/25 at 2:25pm revealed: -Norvasc 5mg was dispensed on 04/22/25 for a quantity of 28 tablets -An order for Norvasc 10mg daily was received from a provider and the facility on 05/02/25. -Norvasc 5mg was discontinued on 05/02/25 when the order for Norvasc 10mg was received. -Norvasc 10mg was dispensed on 05/02/25 for a quantity of 25 tablets. -Norvasc 10mg was dispensed on 05/20/25 for a quantity of 28 tablets. -Norvasc 10mg was dispensed on 06/17/25 for a quantity of 28 tablets. -Norvasc 10mg was dispensed on 07/15/25 for a quantity of 28 tablets. -Norvasc 10mg was dispensed on 08/12/25 for a	D 358		

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D 358	Continued From page 22 quantity of 28 tablets. -They had not received an order to discontinue Norvasc 10mg daily. -They had not received the signed physician's order for Norvasc 5mg dated 06/24/25. Interview with the Administrator on 09/05/25 at 8:45am revealed: -She had been the Administrator since July 2025. -She thought the process was that physician wrote the orders and they were uploaded into the eMAR and faxed to pharmacy but she was not sure. -New FL-2's and provider orders once signed were sent to the pharmacy. -She was not sure who entered the information into the eMAR. -MAs should have compared the medications to the eMAR before administering. -The MAs were trained on how to perform medication cart audits. -The RCC had trained the MAs on how to perform medication cart audits. -She was not sure why the signed physician orders were not faxed to pharmacy. -New physician orders were signed every six months. Interview with the primary care provider (PCP) on 09/05/25 at 2:10pm revealed: -Resident #6 had an appointment with a Nephrologist on 05/02/25 who ordered Norvasc 10mg daily. -On 05/06/25 Resident #6 was ordered to continue Norvasc 5mg daily and obtain a daily blood pressure (BP) before administering the medication for 14 days because she had not had any documented elevated BPs before. -Resident #6 probably had an elevated BP while at the nephrologist's office appointment.	D 358		

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D 358	Continued From page 23 -Resident #6's BP generally was 121/58 range. -She evaluated Resident #6 on 05/13/25 for sinus pressure and her BP was 122/67. -New signed physician orders were signed on 06/24/25 for Norvasc 5mg daily. -She did not know until 09/04/25 that Resident #6 was still receiving Norvasc 10mg daily. -Resident #6 could have had low blood pressure and fallen from receiving the higher dose of Norvasc. -Resident #6 had been asymptomatic since receiving the higher dose of Norvasc. -She was concerned that her orders for Resident #6's Norvasc were not followed as written.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recording of medication administration immediately following administration of the medication to the resident and observation of the resident actually taking the medication for 1 of 7 sampled residents (#4) as evidenced by the presence of three cups of pills	D 366	10A NCAC 13F.1004 (i) Medication Administration Medication Aides/Techs received an inservice on medication administration policy and procedures Policy and procedure for Self Administration of medications was reviewed immediately Med Staff retrained on recording med administration at the time medication is given to resident	9/6/25 ongoing 9/4/25 9/6/25 ongoing

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D 366	Continued From page 24 found in a resident's room. The findings are: Review of the facility's medication administration policy revised 02/26/18 revealed staff was to administer medications to residents following the medication administration guidelines posted in the front of each medication administration record (MAR) and follow good professional practice. Review of Resident #4's FL-2 dated 10/30/24 revealed: -Diagnoses included abdominal aortic aneurysm, hypothyroidism, anorexia, elevated prostate-specific antigen, hyperlipidemia, mitral valve disease, peripheral arterial disease, diabetes mellitus type II. -The resident was intermittently disoriented. -Assisted living facility was listed as the level of care. -There was an order for Eliquis 5mg one tablet twice per day (Eliquis is a medication that can be used to prevent blood clots). -There was an order for Linzess 72 mcg one capsule every other day (Linzess is a medication which can be used to treat constipation). -There was an order for probiotic once daily (probiotics may be used to treat constipation). -There was an order for metoprolol succinate extended release 50mg once per day (metoprolol succinate extended release is a medication that may be used to treat heart failure, high blood pressure, or chest pain). Review of Resident #4's Resident Register revealed: -The resident was admitted 11/04/24. -The resident was forgetful and needed reminders.	D 366	Staff re-inserviced on medication administration policy re: following guidelines and professional practice Skills Fair to take place for additional educational opportunity to affirm skill set competencies Partnership with Southern Pharmacy for Med pass observation	9/8/25 ongoing 10-29-25 10/20/25 and ongoing

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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 366	Continued From page 25 Review of Resident #4's physician orders dated 01/08/25 revealed: -There was an order for Eliquis 5mg one tablet twice per day. -There was an order for Linzess 72 mcg one capsule every other day. -There was an order for metoprolol succinate extended release 50 mg one tablet once per day. -There was an order for aspirin 81 mg one tablet once per day (aspirin is a medication which may be used for pain, fever, inflammation, or lower the risk of cardiovascular events). -There was an order for buspirone 5 mg one tablet twice per day (buspirone is a medication which may be used to treat anxiety). -There was an order for simethicone 125 mg 1 tablet twice per day (simethicone is a medication which may be used to treat excess gas in the stomach or intestines). -There was an order for simethicone 125 mg PRN 1 tablet twice per day for flatulence. Review of Resident #4's physician orders dated 06/04/25 revealed -There was an order for dronabinol 5 mg once per day (dronabinol is a medication which may be used to treat loss of appetite, nausea or vomiting). -There was an order to discontinue dronabinol 2.5 mg once per day. Review of Resident #4's physician orders dated 07/01/25 revealed: -There was an order for Culturelle 10 billion cell one capsule once per day (Culturelle is a probiotic). -There was an order for Eliquis 5mg one tablet twice per day.	D 366		

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D 366	Continued From page 26 -There was an order for metoprolol succinate tablet 50 mg one tablet once per day. -There was an order for aspirin 81 mg one tablet once per day. -There was an order for Linzess 72 mcg one capsule once per day. -There was an order for simethicone 125 mg 1 tablet twice a day. -There was an order for simethicone 125 mg one tablet PRN twice per day for flatulence. -There was an order for sennosides-docusate sodium tablet 8.6-50 mg one tablet twice per day (sennosides-docusate sodium is a medication that may be used to treat constipation). -There was an order for buspirone 5 mg one tablet twice per day. -There was an order for dronabinol 5 mg one capsule once per day. Review of physician's orders dated 07/14/25 revealed there was an order to continue dronabinol 5 mg one capsule once per day with special instructions to keep the medication in a refrigerator. Review of physician's orders dated 08/12/25 revealed there was an order to discontinue dronabinol 5 mg one capsule once per day because the medication was "unavailable/obsolete" per the facility's contracted pharmacy. Review of physician's orders dated 08/27/25 revealed there was an order for hydralazine 25 mg one tablet twice per day (hydralazine is a medication which may be used to treat hypertension). Observation of Resident #4's room on 09/03/25 at 09:39am revealed:	D 366		

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D 366	Continued From page 27 -There was a plastic medication cup on a shelf next to the resident that contained two round white pills, two orange round pills, one yellow round pill, one pink oval pill, and two white capsules. -Underneath the first cup there was a second plastic medication cup that contained two halves of one larger round white pill. -On the resident's windowsill there was a third plastic medication cup which contained four round brown pills. Review of Resident #4's September electronic medication administration record (eMAR) revealed: -There was an entry for Culturelle 10 billion cell one capsule once per day. -There was an entry for Eliquis 5mg one tablet twice per day. -There was an entry for metoprolol succinate tablet 50 mg one tablet once per day. -There was an entry for aspirin 81mg one tablet once per day -There was an entry for Linzess 72mcg one capsule once per day. -There was an entry for simethicone 125 mg one tablet twice per day. -There was an entry for simethicone 125 mg one tablet PRN twice per day for flatulence. -There was an entry for sennosides-docusate sodium tablet 8.6-50 mg one tablet twice per day. -There was an entry for Hydralazine 25 mg one tablet twice per day. -There was an entry for Buspirone 5mg tablet twice a day. -The MA documented in the eMAR that scheduled doses of all medications for the morning of 09/03/25 were administered. Interview with Resident #4 on 09/03/25 at	D 366	Medication Aides instructed not to leave any medications in residents rooms unless order to self administer medications	9/7/25 ongoing

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D 366	Continued From page 28 09:39am revealed: -There had been a couple of slip ups where they gave him someone else's medication. -Both times he recognized the errors when he saw someone else's name on the cup, and both times he gave the medication back to the medication aide (MA). -The error last happened about three weeks prior. -Some of the MA's watched him take his medications, but some of them did not. -He had asked staff to wait for him to eat something before he took his medicine. -He had previously had a disagreement with a staff member about receiving medication before his food. -He thought he had been in the facility about four months. Interview with a MA on 09/03/25 at 10:06am revealed: -She gave Resident #4 his medication this morning. -She did not usually walk away if residents did not take their medications right away. -She gave the medication in the first two cups. -The four brown pills in the third cup were not given by her. -She normally watched the residents take the medications she gave, but she slipped up. Observation of Resident #4's room on 09/03/25 at 10:18am revealed: -The surveyor observed Resident #4 take the medications from the first two cups with assistance from the MA. -The MA removed the third cup of medication from the room. Interview with the MA on 09/03/25 at 10:20am revealed:	D 366		

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D 366	Continued From page 29 -The third pill cup was not hers. -She would talk to the supervisor about the brown pills. Second interview with Resident #4 on 09/04/25 at 2:04pm revealed: -They watched him take the medicine about 50% of the time. -Probably 30% of the time he received his medication before his meal. -The problem was that he had to eat before his medication. -They did not observe him take the medication before moving on to the next resident. -He used to be able to identify medications by color and shape and now he could not. Interview with a second MA on 09/05/25 at 11:45am revealed: -None of the medications in the cart were the brown pills from the third cup pictured in the surveyor's photographs from 09/03/25. -She had to watch him to make sure he was actually swallowing the pills because he would hold them in his mouth. -He wanted to finish eating before the administration of medications. -She heard he liked to keep his pills if he could. -That was why she stayed in the room with him until all medications were taken. -She had observed forgetfulness with Resident #4. -Sometimes he could not remember that he ate. Interview with the Resident Care Coordinator (RCC) on 09/05/25 at 2:12pm revealed: -MA's were trained by shadowing other MA's and should learn to administer medications and to observe the residents taking their medications. -MA's also learned to administer medications and	D 366		

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FORM APPROVED

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D 366	Continued From page 30 to observe residents taking their medications in their online coursework.	D 366		
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; (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, interviews, and record reviews the facility failed to ensure the electronic medication administration records were accurate for 1 of 7 sampled residents (#6) including documentation for a medication used to treat hypertension.	D 367	10A NCAC 13F .1004 (j) Medication Administration New orders are to be reviewed by Shift Supervisor/Clinic and compared with EMAR Medication Aides were instructed to compare medications to EMAR prior to dispensing medications to resident	09/08/25 ongoing 9/8/25 ongoing

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D 367	Continued From page 31 The findings are: Review of Resident #6's current FL-2 dated 12/02/24 revealed diagnoses included bipolar disorder, chronic kidney disease, myopathy, muscle spasms of the back, and repeated falls. Review of Resident #6's Resident Register had an admission date of 12/04/24. Review of Resident #6's signed physician orders dated 06/24/25 revealed there was an order for Norvasc 5mg daily. (Norvasc 5 mg is used to treat high blood pressure). Observation of Resident #6's medications on hand revealed: -There was a medication card dated 05/02/25 for Norvasc 10mg, 25 tablets dispensed administer daily, and there were 25 tablets remaining in the medication card. -There was a medication card dated 08/19/25 for Norvasc 10mg, 28 tablets dispensed, administer daily, and there were 11 tablets remaining in the medication card. Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Norvasc 5mg to be administered daily between 7:00am and 9:00am. -Norvasc 5mg was documented as administered daily between 7:00am and 9:00am from 08/01/25 to 08/31/25. Review of Resident #6's September 2025 eMAR revealed: -There was documentation that the Norvasc 5mg was administered on 09/01/25-09/03/25.	D 367		

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D 367	Continued From page 32 -Norvasc 5mg was documented as administered daily between 7:00am and 9:00am from 09/01/25 to 09/03/25. Interview with the medication aide (MA) on 09/04/25 at 10:19am revealed: -She administered medication according to instructions on the eMAR. -When she administered medications, she checked the medication on hand against the eMAR. -She thought she had administered Resident #6 the correct dosage of Norvasc. -She now saw the eMAR instructions and medication on hand did not match. Interview with a second MA on 09/04/25 at 3:30pm revealed: -MAs do not enter medication orders into the eMAR. -Medications should be compared to the orders on the eMARs and to the medication on hand. Interview with the shift supervisor on 09/04/25 at 2:50pm revealed that before administering medications, the MA should have compared the eMAR to the medication. Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 3:00pm revealed: -He had worked at the facility for one month. -The nurse uploaded provider orders into the computer after rounding with the provider. -New provider orders were placed on a separate order sheet and faxed to the pharmacy on the same day they were received. Interview with the CN on 09/04/25 at 3:15pm revealed: -The nurse entered medications into the eMAR.	D 367		

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D 367	Continued From page 33 -The facility updated the signed physician orders in June and December each year. -The orders were faxed to the provider and once returned they were scanned into the computer and faxed to the pharmacy. -The FL-2 was updated yearly and faxed to the pharmacy. -Before administering any medication, the MA should compare the eMAR to the medication for accuracy. Interview with a pharmacist at the facility's contracted pharmacy on 09/04/25 at 2:25pm revealed: -Norvasc 5mg was dispensed on 04/22/25 for 28 tablets -An order for Norvasc 10mg daily was received from a provider and the facility on 05/02/25. -Norvasc 5mg was discontinued on 05/02/25 when the order for Norvasc 10mg was received. -Norvasc 10mg had been dispensed monthly from May 2025 to August 2025. -They had not received an order to discontinue Norvasc 10mg daily. -They had not received the signed physician's order for Norvasc 5mg dated 06/24/25. Interview with the Administrator on 09/05/25 at 8:45am revealed: -She had been the Administrator since July 2025. -She thought the process was that physician wrote the orders and they were uploaded into the eMAR and faxed to pharmacy but not sure. -New FL-2's and provider orders once signed were sent to the pharmacy. -She was not sure who entered the information into the eMAR. Interview with the primary care provider (PCP) on 09/05/25 at 2:10pm revealed:	D 367		

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D 367	Continued From page 34 -New signed physician orders were signed on 06/24/25 for Norvasc 5mg daily. -She did not know until 09/04/25 that Resident #6 was still receiving Norvasc 10mg daily. -Resident #6 could have had low blood pressure and fallen from receiving the higher dose of Norvasc. -Resident #6 had been asymptomatic since receiving the higher dose of Norvasc. -She was concerned that her orders for Resident #6's Norvasc were not followed as written.	D 367		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 7 sampled residents (#1, #2, #4) had physicians' orders to self-administer medications used to	D 375	10A NCAC 13F .1005 (a) Self Administration of Medications OTC medications removed immediately from resident rooms Rooms were immediately searched for OTC medications in residents rooms Letter sent to residents and families re: OTC Medications. OTC medications must have a self administer order from the provider Self Administer Medication assessments were completed on those who have OTC medications in room.	9/4/25 9/4/25 9/8/25 9/8/25 ongoing 9/5/25

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D 375	Continued From page 35 treat chest pain, disorders of the prostate and urinary tract, and diabetes (#1), medications used to treat glaucoma, vitamin deficiencies, allergies, and pain (#2), and medications used to treat sleep disorders, stomach disorders, and pain (#4). The findings are: Review of the medication administration policy dated 07/22/99 and revised 06/2025 provided by the facility revealed no medication shall be administered without a physician's order. Review of the facility's self-administration of medications policy dated 02/10/00 revealed: -Residents who were competent and physically able to administer their own medications were able to do so if self-administration was authorized by the physician, approved by the Resident Care Coordinator (RCC) and if specific instructions for administration were printed on the medication label. -The facility's procedure for self-administration included obtaining an order from the physician. -The facility's procedure for self-administration included instructing residents on proper use of the medication. -The facility's procedure for self-administration included a medication nurse checking with the resident on each shift for compliance. -The facility's procedure for self-administration included instructions for staff to note and document specifically any indication that the resident was not complying with prescription directions or is in any other way not appropriate for self-administration. -Staff was to report concerns to the RCC. -Residents who met requirements could self-administer medications.	D 375	Orders were sent to provider for self administer of OTC medications once assessment completed Letters went out to residents and families re: policy of medications in room Room sweeps were conducted for 14 days Weekly room sweeps are conducted to ensure no OTC medications are in rooms without a self administer order	9/8/25 ongoing 9/8/25 9/7/25 9/22/25 ongoing

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D 375	Continued From page 36 -Residents who self-administer medications should not have a condition which may interfere with the ability to safely self-administer medications. -Depression and psychiatric diagnoses were listed as examples of conditions which may interfere with the ability to safely self-administer medications. 1. Review of Resident #4's FL-2 dated 10/30/24 revealed: -Diagnoses included abdominal aortic aneurysm, hypothyroidism, anorexia, elevated prostate-specific antigen, hyperlipidemia, mitral valve disease, peripheral arterial disease, diabetes mellitus type II. -The resident was intermittently disoriented. -Assisted living facility was the recommended level of care. Review of Resident #4's Resident Register revealed: -The resident was admitted 11/04/24. -The resident was forgetful, needed reminders. Review of Resident #4's physicians orders dated 01/08/25 revealed: -There was an order for Acetaminophen 1000mg every six hours as needed (PRN) for 48 hours for fever or complaints of mild pain (Acetaminophen 1000mg is a medication commonly used for fever or pain). -There was an order for TUMS, 2 tablets every 4 hours PRN for indigestion (TUMS is a Calcium Carbonate medication commonly used for indigestion or calcium deficiency). Review of Resident #4's physician orders dated 06/27/25 revealed: -There was an order for Trazodone 50 mg tablet	D 375		

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D 375	Continued From page 37 take one tablet at bedtime (Trazodone is an antidepressant that can also be used for insomnia). -There was an order to discontinue acetaminophen 500mg/diphenhydramine HCl 25 mg,1 tablet every evening, because the resident was increased on Trazodone (Acetaminophen 500mg/diphenhydramine HCl 25 mg is a combination medicine used for occasional insomnia, fever, or pain). Review of physician orders dated 07/01/25 revealed: -There was an order for simethicone tablet 125 mg twice a day (Simethicone is a medication commonly used to treat excess gas in the stomach and intestines). -There was an order for simethicone tablet 125 mg twice a day PRN for flatulence. -There was an order for Salonpas patches, one topical, PRN once a day for neck pain (Salonpas patches are commonly used to treat pain). -There was an order for Trazodone 50 mg tablet take one tablet at bedtime. Review of Resident #4's record revealed there was no order for Resident #4 to self-administer TUMS, simethicone, Salonpas patches, herbal patches, or acetaminophen 500mg/diphenhydramine HCl 25 mg. Review of Resident #4's PCP orders dated 09/05/25 revealed: -A new order was written that the resident could self-administer the prescribed Salonpas patches and herbal patches. -This order was placed after the surveyors gave notification of the facility's noncompliance. Review of Resident #4's self-administration	D 375		

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D 375	Continued From page 38 assessment dated 07/10/25 revealed the resident could self-administer topicals (lotions, creams, gels and ointments). Review of the Resident #4's mental health provider (MHP) notes from 05/05/25 through 07/03/25 revealed: -There was a diagnosis of adjustment disorder with mixed anxiety and depressed mood. -He had a past medical history of depression, anxiety, insomnia and anorexia. -He spoke with a nurse at length about dizziness and his left foot feeling unbalanced. Observation of Resident #4's room on 09/03/25 at 9:45am revealed: -There was a package of simethicone 125mg softgels in a bowl above the resident's refrigerator. -There was a bottle of acetaminophen 500mg/diphenhydramine HCl 25 mg. -There was a container of calcium carbonate 1000mg on the windowsill (generic for TUMS). -None of these products had labels with the provider's resident-specific instructions on them. Second observation of Resident #4's room on 09/04/25 at 8:14am revealed: -There was a packet of Salonpas pain relieving patches, not labeled with the provider's resident-specific instructions, on a shelf next to the resident's chair. -There was a paper plate containing green patches that had no label or instructions on the resident's entertainment center. -The resident was wearing one of the green patches that he cut in half and applied to two places on the lower extremities. Interview with Resident #4 on 09/04/25 at 8:15am	D 375		

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D 375	Continued From page 39 revealed: -The patches on his lower extremities were herbal patches. -An orthopedic doctor recommended the patches. Second interview with Resident #4 on 09/04/25 at 2:04pm revealed: -He got Salonpas patches from a pharmacy. -He did not know what was in the herbal patches. -He did not know if the primary care provider (PCP) at the facility knew about the herbal patches. -He preferred the herbal patches to the Salonpas patches. -He used the herbal patches on his knee and foot. -He did not have pain when he used the herbal patches. -He reported that the herbal patches were over-the-counter (OTC) and did not require a prescription. -He used to be able to identify medications by color and shape and now he cannot. Third observation of Resident #4's room on 09/05/25 at 9:20am revealed: -There was a second bottle of acetaminophen 500mg/diphenhydramine HCl 25mg on his dresser. -The pills in the bottle were blue with an oblong shape. -The label on the bottle had instructions to ask a doctor or pharmacist before use if you took sedatives or tranquilizers. Third interview with Resident #4 on 09/05/25 at 9:20am revealed: -When he took acetaminophen 500mg/diphenhydramine HCl 25mg, he only took one tablet for sleep.	D 375		

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D 375	Continued From page 40 -He last took acetaminophen 500mg/diphenhydramine HCl 25mg two nights ago. -He took the medication probably four nights per week to help him sleep. -The staff administered 500mg/diphenhydramine HCl 25mg medication to relax him. -When the staff stopped administering acetaminophen 500mg/diphenhydramine HCl 25mg, he continued taking it on his own. -He woke up in the morning with a "hangover" when he took the acetaminophen 500mg/diphenhydramine HCl 25mg and that other pill together. -It took him half-a-day to get going when he took the two medicines. -He took the two medicines for a month or more. -After taking the other pill, he took the acetaminophen 500mg/diphenhydramine HCl 25mg about a half hour later while laying in bed. -He had the second bottle of acetaminophen 500mg/diphenhydramine HCl 25mg for quite a while. -He kept the medication in a green tackle box. Interview with a personal care aide (PCA) on 09/05/25 at 8:37am revealed there was no scheduled process to check for hazards on that floor. Interview with a medication aide (MA) on 09/05/25 at 11:45am revealed: -She talked to Resident #4 about possession of medications that were not ordered. -When she went into the room to administer medications, he did not want her to move around the room, but she tried to observe. -She removed acetaminophen from Resident #4's room last week. -She had difficulty inspecting rooms during	D 375		

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D 375	Continued From page 41 administration when residents did not want her in the room. -She did not look too much because she had to have permission from residents to look around. -When residents were not in the room and staff had to look for medications, then they searched in teams. -They have had to remove medication from Resident #4's room in the past. -Medications that were removed were bottled, like acetaminophen. -She had observed forgetfulness with Resident #4. -Sometimes he could not remember that he ate meals. Interview with the RCC on 09/05/25 at 2:12pm revealed: -Resident #4 had an ongoing problem with having medications in his room. -Facility staff were responsible for scanning the residents' room for medications. -He was not sure if staff were trained on the facility's self-administration policy during orientation. -He worked with the Clinical Nurse (CN) if he received reports about medications that were not supposed to be in the rooms. -He would remove inappropriate medications from residents rooms if they were reported to him. -Staff were not looking for inappropriate medications and got complacent. -Staff should be trained to remove things that were not in compliance with facility policies. -All staff were responsible to notice if residents were having adverse reactions or changes in their condition. -He did not know anything about the herbal patches in Resident #4's room.	D 375		

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D 375	Continued From page 42 Interview with the CN on 09/05/25 at 4:00pm revealed: -She did not know how Resident #4 was getting the medications in his room. -Staff removed medications from his room on several occasions. -She counseled Resident #4 on going through the right process for self-administration. -Staff removed medications from residents' rooms when they were seen, but sweeps were not regularly scheduled. -She did not hear Resident #4 verbalize concerns other than occasional weakness, but did not feel that was out of the ordinary. Telephone interview with the Administrator on 09/05/25 at 3:02pm revealed: -Staff should make a sweep to find and remove inappropriate medication from residents' rooms. -She asked staff to remove medications from Resident #4's room, but staff did not open the tacklebox in his room. Interview with Resident #4's PCP on 09/04/25 at 3:12pm revealed: -The acetaminophen 500mg/diphenhydramine HCl 25mg was not approved for Resident #4 to self-administer if the resident was only approved to self-administer topicals (lotions, creams, gels and ointments). -The acetaminophen 500mg/diphenhydramine HCl 25mg needed to be removed from Resident #4's room. -Diphenhydramine was not recommended for use in the elderly because the sedative properties were a concern. -Diphenhydramine was on the BEERS list (The American Geriatrics Society Beers Criteria is a list of potentially inappropriate medications that are	D 375		

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D 375	Continued From page 43 typically best avoided by older adults in most circumstances or under specific situations). -If acetaminophen 500mg/diphenhydramine HCl 25mg was taken in combination with Trazodone the resident could become sleepy. Telephone interview with Resident #4's MHP on 09/05/25 at 3:24pm revealed: -She was concerned he was taking the acetaminophen 500mg/diphenhydramine HCl 25mg, with or without Trazodone. -Respiratory suppression could occur and he could die in his sleep with this combination of medications. -Trazodone often gave people a hangover sensation. -The hangover was probably a combination effect if he was combining sleeping agents, and the effect was happening when medications were combined. -She thought dizziness could occur with trazodone, but could occur with other medical concerns. Attempted telephone interview with Resident 4's power of attorney (POA) on 09/04/25 at 2:46pm was unsuccessful. Refer to the interview with the Administrator on 09/03/25 at 4:27pm. Refer to the interview with the Clinical Nurse (CN) on 09/04/25 at 11:43am. Refer to second interview with the Clinical Nurse (CN) on 09/05/25 at 2:54pm. 2. Review of Resident #2's current FL-2 dated 06/06/25 revealed: -Diagnoses included muscle spasm of back,	D 375		

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D 375	Continued From page 44 flatulence, allergic rhinitis, acute sinusitis, unspecified glaucoma, heartburn, deficiency of other vitamins, and age-related osteoporosis without current pathological fracture. -There was no information related to disorientation. -The recommended level of care was domiciliary (rest home). Review of the Resident Register for Resident #2 revealed an admission date of 06/28/24. Review of the care plan for Resident #2 dated 02/06/25 revealed the resident was oriented with adequate memory. Observations of Resident #2's room on 09/03/25 from 09:20am to 09:35am during the initial tour of the facility revealed: -There were manufacturer labeled medication containers for tylenol gelcaps 500mg (used for pain), fish oil 1000mg tablets (dietary supplement), vitamin B-12 1000mcg tablets (dietary supplement), vitamin D3 1000 IU gel tablets (dietary supplement), and biotin 5000 mcg tablet (dietary supplement) on the sink countertop. -The resident removed medication containers from a basket under the table next to her chair that included antacid tablets1000mg (used to treat heartburn), refresh digital lubricant eye drops (used to treat dry eyes), and a bottle of saline nasal spray (moisturizing spray). Interview with Resident #2 on 09/03/25 at 09:20am revealed: -She administered all the dietary supplements (vitamins) "every couple of days". -She had been self-administering the vitamins for years.	D 375		

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D 375	Continued From page 45 -She brought the vitamins with her when she came to live at the facility. -She kept some medications in the basket under the table next to her chair. -She would "chew a couple" of the antacid tablets and had not self-administered them for a long time. -She used the Refresh eye drops "couple times a day". Review of Resident #2's record revealed there were no orders for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Review of Resident #2's primary care provider (PCP) orders dated 06/06/25 revealed there was an order dated 06/06/25 that the Resident #2 may self-administer icy hot and bio-freeze and keep at bedside. Review of Resident #2's PCP orders dated 07/17/25 revealed: -Resident #2 may self-administer an ice pack application twice daily to area of pain in bilateral legs, icy hot and bio-freeze (topical pain relievers), and fluticasone propionate (generic for flonase nasal spray used to treat allergies) and keep at bedside. -There were no orders for Resident #2 to self-administer and keep at bedside any other medications. Review of Resident #2's July 2025 electronic medication administration records (eMARs) revealed: -There were no entries for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. -There were no entries for self-administer orders	D 375		

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D 375	Continued From page 46 for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Review of Resident #2's August 2025 eMARs revealed: -There were no entries for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. -There were no entries for self-administer orders for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Review of Resident #2's September 2025 eMARs revealed: -There were no entries for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. -There were no entries for self-administer orders for fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Interview with the medication aide (MA) on 09/03/25 at 10:40am revealed: -A resident had to have a physician's order to self-administer medication. -Resident #2 self-administered her eye drops. -There were no other medications that she knew of that Resident #2 self-administered. -She had administered Resident #2 medications in the resident's room on the morning of 09/03/25. -She just focused on Resident #2 when she went into the room to administer Resident #2 medications. -If she had seen medications in Resident #2's room, she would have removed the medications from the room. -She did not know the fish oil, vitamin B-12,	D 375		

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D 375	Continued From page 47 vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray were in Resident #2's room. -Resident #2 did not have physician orders to self-administer the fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Interview with the Administrator on 09/03/25 at 4:27pm revealed she was in Resident #2's room "the other day (no specific day provided)" and did not see the fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray. Interview with the Clinical Nurse (CN) on 09/04/25 at 11:43am revealed: -She was not aware Resident #2 had fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray in her room. -She became aware of the medications in Resident #2's room on 09/03/25 after being notified by surveyor. Telephone interview with Resident #2's PCP on 09/04/25 at 3:10pm revealed: -Resident #2 was oriented. -Resident #2 was able to manage her medications. -She could not remember if she had given orders for Resident #2 to self-administer medications, but the fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, and saline nasal spray were not on her (PCP) list of medications. -She did not have a concern with Resident #2 taking the fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, or the saline nasal spray.	D 375		

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D 375	Continued From page 48 -Resident #2 had probably bought the medications from home and had them in her room without the facility knowledge. -The fish oil, vitamin B-12, vitamin D3, biotin, antacid tablets, refresh eye drops, and saline nasal spray would need to be reviewed with Resident #2 prior to giving an order for self-administration of the medications. Refer to the interview with the Administrator on 09/03/25 at 4:27pm. Refer to the interview with the Clinical Nurse (CN) on 09/04/25 at 11:43am. Refer to second interview with the Clinical Nurse (CN) on 09/05/25 at 2:54pm. 3. Review of Resident #1's current FL-2 dated 04/30/25 revealed: -Diagnoses included post-traumatic stress disorder, chronic nausea, benign prostatic hypertrophy with lower urinary tract symptoms, diabetes mellitus type 1 with other circulatory complications, unspecified dementia, and atherosclerotic heart disease of native coronary artery without angina pectoris. -There was no information related to disorientation. -The recommended level of care was domiciliary (rest home). Review of the Resident Register for Resident #1 revealed: -There was an admission date of 11/19/24. -Resident #1 was forgetful and needed reminders. Review of a Resident Care Assessment dated 10/30/24 for Resident #1 revealed:	D 375		

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D 375	Continued From page 49 -The nurse assessed Resident #1 to be oriented to person, place, and time continuously. -A qualified staff member would administer all medications. Review of the care plan for Resident #1 dated 02/06/25 revealed the resident was oriented with adequate memory. Observations of Resident #1's room on 09/03/25 from 10:08am to 10:35am during the initial tour of the facility revealed: -There was a pharmacy labeled medication container for tamsulosin HCL (used to treat urinary disorders) 0.4mg capsules. -There was a pharmacy labeled medication container for nitroglycerin (used to treat chest pain associated with the heart) 0.4mg sublingual tablets. -There was a medication container with a manufacturer label for basquimi nasal spray (a dry nasal spray used to treat severe low blood sugar) 3mg with a printed expiration date of 06/03/24 on the sink countertop with instructions to administer if Resident #1's sugar dropped below 50 or the resident was in a diabetic coma. Interview with Resident #1 on 09/03/25 at 10:08am revealed: -He had never had to use the Nitroglycerin sublinqual medication in his room. -He did not take the tamsulosin. -He was administered his medications "in a little plastic cup." Review of Resident #1's physician orders dated 06/24/25 revealed: -There was an order for nitroglycerin tablet sublingual 0.4mg place one tablet under for chest pain, repeat in 5 minutes if no relief, maximum	D 375		

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D 375	Continued From page 50 three tablets. Notify supervisor. -There was an order for tamsulosin 0.4mg capsule at bedtime. -There were no orders for Resident #1 to self-administer medications or keep medications at bedside. Review of Resident #1's July 2025 electronic medication administration records (eMARs) revealed: -There was an entry for Tamsulosin 0.4mg capsule at bedtime scheduled at night 7:00pm - 9:00pm. -Tamsulosin 0.4mg capsule was documented nightly at 7:00pm-9:00pm from 07/01/25 to 07/31/25. -There was an entry for nitroglycerin 0.4mg tablet, sublingual as needed, place one tablet under tongue for chest pain, repeat in 5 minutes if no relief, maximum 3 tablets, notify supervisor. -There was no documentation for administration of the nitroglycerin 0.4mg tablet from 07/01/25 to 07/31/25. -There were no entries for self-administer order for the tamsulosin 0.4mg capsule or the nitroglycerin 0.4mg tablet. Review of Resident #1's August 2025 eMARs revealed: -There was an entry for Tamsulosin 0.4mg capsule at bedtime scheduled at night 7:00pm - 9:00pm. -Tamsulosin 0.4mg capsule was documented nightly at 7:00pm-9:00pm from 08/01/25 to 08/31/25. -There was an entry for nitroglycerin 0.4mg tablet, sublingual as needed, place one tablet under tongue for chest pain, repeat in 5 minutes if no relief, maximum 3 tablets, notify supervisor. -There was no documentation for administration	D 375		

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D 375	Continued From page 51 of the nitroglycerin 0.4mg tablet from 07/01/25 to 07/31/25. -There were no entries for self-administer order for the tamsulosin 0.4mg capsule or the nitroglycerin 0.4mg tablet. Review of Resident #1's September 2025 eMARs revealed: -There was an entry for Tamsulosin 0.4mg capsule at bedtime scheduled at night 7:00pm - 9:00pm. -Tamsulosin 0.4mg capsule was documented nightly at 7:00pm-9:00pm for 09/01/25 and 09/02/25. -There was an entry for nitroglycerin 0.4mg tablet, sublingual as needed, place one tablet under tongue for chest pain, repeat in 5 minutes if no relief, maximum 3 tablets, notify supervisor. -There was no documentation for administration of the nitroglycerin 0.4mg tablet from 09/01/25 to 09/03/25. -There were no entries for self-administer order for the tamsulosin 0.4mg capsule or the nitroglycerin 0.4mg tablet. Telephone interview with Resident #1's power of attorney on 09/05/25 at 4:05pm revealed: -Any medications that Resident #1 was supposed to have administered were to be administered by the facility. -Resident #1 moved to the facility from out-of-state and may have brought the tamsulosin, nitroglycerin, and basquimi spray with him. -The medications were old and never were discarded. -He did not believe Resident #1 was taking any medications on his own. -Resident #1 had dementia.	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065020	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

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

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D 375	Continued From page 52 Interview with the medication aide (MA) on 09/03/25 at 10:50am revealed: -Resident #1 did not self-administer medications. -She was in Resident #1's room the morning of 09/03/25 to assist the resident with getting up for breakfast. -She went back to Resident #1's room a second time to see if the resident wanted his bed made. -If there were medications in Resident #1's room, she did not see them. -She usually went into Resident #1's room as far as the recliner chair that was positioned in the living area of Resident #1's room. Interview with a second MA on 09/03/25 at 11:01am revealed: -She did not know there were medications in Resident #1's room. -If staff saw medications in a resident room, the medications were removed. Interview with the Clinical Nurse (CN) on 09/05/25 at 2:54pm revealed: -Resident #1's room had been cleaned out (no specific date provided). -The medications had to have been hidden in Resident #1's room. -She could not provide a date as to when she was last in Resident #1's room. -She thought Resident #1's long term memory was better than his short-term memory. -Resident #1 was receiving mental health services. Interview with the Administrator on 09/03/25 at 11:27am revealed: -She was new in the facility and was not sure what had been allowed in the past. -Resident #1 had dementia. -Resident #1 did not self-administer medications.	D 375		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 53 -She was unsure how the medications got in Resident #1's room. Telephone interview with Resident #1's mental health provider on 09/05/25 at 3:32pm revealed: -Resident #1 "definitely" had dementia. -Resident #1 was admitted to the facility because he was dosing his medication incorrectly. -Resident #1 had a prior history of overdosing on insulin. -Resident #1 was not to manage his medications. - She did not think Resident #1 should manage his medications because of his cognition and he was "very confused." -Nitroglycerin could drop the blood pressure and cause syncope (fainting). -She had not seen any medications in Resident #1's room during monthly visits. Refer to the interview with the Administrator on 09/03/25 at 4:27pm. Refer to the interview with the Clinical Nurse (CN) on 09/04/25 at 11:43am. Refer to second interview with the Clinical Nurse (CN) on 09/05/25 at 2:54pm. Interview with the Administrator on 09/03/25 at 4:27pm revealed: -There would be a signed physician's order for a resident to self-administer medications at the facility. -She did not expect residents to have medications in their rooms to self-administer without physician orders. -She made rounds in the facility "a lot". -Staff had "probably" not been training on what to look for in a resident's room. -If staff found medications in a resident's room,	D 375		

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D 375	Continued From page 54 she would expect the staff to immediately remove the medications from the resident's room. -Staff are expected to inform their supervisors if items found in a resident's room that should not be there such as medications and weapons. Interview with the Clinical Nurse (CN) on 09/04/25 at 11:43am revealed: -Residents brought "stuff" into the facility that staff were not always aware of. -Residents were not allowed to have medications in their rooms without physician orders to self-administer the medications. -Residents had to have a self-administration of medication assessment prior to being authorized to self-administer a medication. -She was responsible for completing residents' self-administration of medication assessments. Second interview with the Clinical Nurse (CN) on 09/05/25 at :54pm revealed: -The facility tried to "do room sweeps" when something like medications were found in a resident's room and bought to management's attention. -Medications had been removed from resident rooms. The facility failed to ensure a self administration assessment was completed and physician's orders were obtained for residents prior to medications being available and in the resident's possessions to self-administer. Resident #4 self-administered an unidentifiable topical patch and an oral medication with sedating effects which was advised to be used with caution in the elderly. Resident #4 reported experiencing sedating effects as a result of taking this medication with his other scheduled medications. Two other residents (#1, #2) were observed with	D 375		

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D 375	Continued From page 55 medications in their rooms, including expired medications used to treat chest pain and low blood sugars (#1), and over-the-counter vitamins and nasal sprays (#2), which 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 September 5, 2025 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 20, 2025.	D 375		