STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 conducted an annual and follow up survey on 12/17/25 - 12/18/25.	D 000		
D 108	10A NCAC 13F .0311 (b)(2) Other Requirements 10A NCAC 13F .0311 Other Requirements (b) The following shall apply to heaters and cooking appliances: (2) unvented fuel burning room heaters and portable electric heaters are prohibited; This Rule is not met as evidenced by: Based on observation and interviews , the facility failed to prohibit the use of a portable electric heater used in one resident room. The findings are: Observation of room 208 during the initial tour on 12/17/25 at 9:10am revealed there was a portable electric radiator heater plugged into an electrical wall outlet, turned on and was producing heat. Interview with the resident residing in room 208 on 12/17/25 at 9:15am revealed she did not know what the heater was or where it came from. Interview with a maintenance staff on 12/17/25 at 9:20am revealed: -Sometimes families brought heaters into the facility and staff would try to discourage it. -Maintenance staff did not enter resident rooms unless there was a service call. -He did not know the heater was in room 208. Interview with the Administrator on 12/17/25 at 9:25am revealed:	D 108		

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 108	Continued From page 1 -She did not know the heater was in room 208. -She thought portable electric radiator heaters were allowed in the facility. -Staff were in the residents' rooms daily and management conducted room rounds monthly.	D 108		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this	D 259		

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D 259	Continued From page 2 physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the care plans were signed by the Primary Care Provider (PCP) within 15 days following completion for 2 of 5 sampled residents (#3 and #4). The findings are: 1. Review of Resident #4's current FL2 dated 04/15/25 revealed diagnoses included high blood pressure, chronic pain, arthritis, and anxiety. Review of Resident #4's Resident Register revealed an admission date of 12/02/20. Review of Resident #4's Care Plan dated 07/21/25 revealed: -Resident #4 required total assistance from staff for dressing and bathing and was incontinent of bowel and bladder. -Resident #4 used an electric wheelchair.	D 259		

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	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 259	Continued From page 3 -The assessor signed and dated the care plan on 07/21/25. -The care plan was not signed by the PCP. Refer to the interview with the Health Services Manager on 12/18/25 at 10:05am. Refer to the interview with the Administrator on 12/18/25 at 8:45am. 2. Review of Resident #3's current FL2 dated 11/26/25 revealed diagnoses included metastatic prostate cancer and chronic pain. Review of Resident #3"s Resident Register revealed an admission date of 12/02/24. Review of Resident #3's Care Plan dated 06/19/25 revealed: -Resident #3 was independent for all activities of daily living. -The assessor signed and dated the care plan on 06/19/25. -The care plan was not signed by the PCP. Refer to the interview with the Health Services Manager on 12/18/25 at 10:05am. Refer to the interview with the Administrator on 12/18/25 at 8:45am. _____ Interview with the Health Services Manager on 12/18/25 at 10:05am revealed: -She did not know the care plans were not signed by the PCP. -The facility's contracted PCP was in the facility weekly and she reviewed and signed care plans at that time. -She was responsible for ensuring the care plans were complete.	D 259		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 259	Continued From page 4 Interview with the Administrator on 12/18/25 at 8:45am revealed: -The Health Services Manager was responsible for ensuring care plans were complete. -She was in the process of conducting an audit of all care plans. -She did not know the care plans were not signed by the PCP.	D 259		
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 administer medications as ordered for 2 of 5 sampled residents (#1 and #2) related to a medication used to treat high blood pressure (#1) and a mineral supplement used to treat iron deficiency anemia (#2), and 1 of 4 residents observed during the medication pass who received an incorrect dosage of a vitamin supplement used to support bone formation (#9). The findings are: Review of the facility's Medication Administration Policy and Procedure revised January 2025	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 358	Continued From page 5	D 358		

revealed:
-Medications were administered in a safe and timely manner as prescribed.
-Medications were administered in accordance with prescriber orders.
-The individual administering the medication checked the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication.

1. Review of Resident #1's current FL2 dated 04/19/24 revealed diagnoses included muscle weakness, high blood pressure, gait abnormality, and reflux.

Review of Resident #1's Resident Register revealed an admission date of 04/22/24.

Review of Resident #1's physician's orders revealed hydrochlorothiazide (HCTZ) 25mg daily (used to treat high blood pressure), hold for systolic blood pressure (SBP) <130, or heart rate (HR) <70.

Review of Resident #1's electronic medication administration record (eMAR) for October 2025 revealed:
-There was an entry for HCTZ 25mg daily hold for SBP <130 or HR <70.
-There was documentation the HCTZ was administered on 10/05/25 with SBP 116, 10/07/25 with SBP 124, 10/08/25 with SBP 113, 10/09/25 with SBP 113, 10/10/25 with SBP 113, 10/18/25 with SBP 111, and 10/19/25 with SBP 120.

Review of Resident #1's eMAR for November 2025 revealed:
-There was an entry for HCTZ 25mg daily hold for SBP <130 or HR <70.

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	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 358	Continued From page 6	D 358		

-There was documentation the HCTZ was administered on 11/16/25 with HR 61, 11/17/25 with HR 61, 11/18/25 with HR of 61, 11/19/25 with HR of 61, 11/20/25 with HR of 61, and 11/30/25 with HR of 60.

Review of Resident #1's eMAR for 12/01/25 - 12/17/25 revealed:
-There was an entry for HCTZ 25mg daily hold for SBP <130 or HR <70.
-There was documentation the HCTZ was administered on 12/01/25 with HR 68, 12/02/25 with HR 68, 12/03/25 with HR 68, 12/04/25 with HR 68, 12/11/25 with SBP 127, and 12/17/25 with HR 64.

Observation of Resident #1's medications available for administration on 12/17/25 at 1:56pm revealed there was one bubble pack labeled HCTZ 25mg daily hold for SBP <130 or HR <70 and 30 tablets were dispensed on 10/23/25 with 3 tablets remaining.

Interview with a medication aide (MA) on 12/17/25 at 11:15am revealed:
-It was an error to administer the HCTZ outside of ordered parameters.
-He received MA training and knew to look closely at the orders.
-He was not paying close attention to the order and should have done so.

Interview with a second MA on 12/17/25 at 12:31pm revealed:
-She did not remember administering the HCTZ to Resident #1.
-She thought it must have been a documentation error when she documented she administered the HCTZ outside of parameters.

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	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 358	Continued From page 7 Interview with the Health Services Manager on 12/17/25 at 11:25am revealed: -The MAs received online training and in person training with a nurse from the pharmacy. -She knew there were pharmacy medication reviews every quarter, and the MARs were reviewed at that time. -The facility did not have any staff responsible for reviewing MARs for accuracy. -The MAs should administer medications as ordered. Interview with the Administrator on 12/17/25 at 12:40pm revealed: -The MAs training consisted of a 15-hour class and exam then a nurse from the contracted pharmacy validated the MAs. -She knew that the pharmacy audited the MARs and medication carts every quarter and there were no other MAR and medication cart audits. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 12/17/25 at 1:52pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 09/02/25 revealed: -Diagnoses included iron deficiency anemia, acute cystitis, osteomyelitis of the left ankle and foot, pressure ulcer of the left heel, chronic kidney disease stage 3, chronic obstructive pulmonary disease, and muscle weakness. -There was an order for ferrous sulfate (an iron supplement used to treat or prevent low blood levels of iron) 325mg take 1 tablet every other day. Review of Resident #2's Resident Register revealed an admission date of 09/29/25.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 358	Continued From page 8 Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed there was no entry for ferrous sulfate 325mg take 1 tablet every other day. Review of Resident #2's October 2025 eMAR revealed there was no entry for ferrous sulfate 325mg take 1 tablet every other day. Review of Resident #2's November 2025 eMAR revealed: -There was an entry for ferrous sulfate 325mg take 1 tablet every other day. -There was documentation ferrous sulfate was administered on 11/23/25, 11/25/25, 11/27/25, and 11/29/25 at 8:00am. -There was no documentation ferrous sulfate was administered prior to 11/23/25. Review of Resident #2's December 2025 eMAR revealed: -There was an entry for ferrous sulfate 325mg take 1 tablet every other day. -There was documentation ferrous sulfate was administered on 12/01/25, 12/03/25, 12/05/25, 12/07/25, 12/09/25, 12/11/25, 12/13/25, 12/15/25, and 12/17/25 at 8:00am. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/17/25 at 2:20pm revealed: -On 09/27/25, the pharmacy received a faxed copy of Resident #2's FL2 dated 09/02/25 that included an order for ferrous sulfate 325mg take 1 tablet every other day. -The pharmacy dispensed Resident #2's ferrous sulfate 325mg in the quantity of 30 tablets on 09/27/25 and was delivered to the facility on 09/27/25.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 9	D 358		

-The pharmacy dispensed ferrous sulfate 325mg in the quantity of 30 tablets for Resident #2 on 11/06/25 and 12/05/25.

Interview with Resident #2 on 12/17/25 at 4:30pm revealed she could not remember when the facility started administering ferrous sulfate to her.

Interview with a medication aide (MA) on 12/17/25 at 4:35pm revealed:
-She did not remember when Resident #2's ferrous sulfate was ordered, and she began administering it to Resident #2.
-She thought Resident #2 was administered ferrous sulfate since she was admitted to the facility.
-She could see on the eMAR that the first dose of ferrous sulfate was documented as administered to Resident #2 was on 11/23/25.

Interview with the Health Services Manager on 12/17/25 at 4:12pm revealed:
-She did not know why Resident #2's eMARs did not show ferrous sulfate 325mg was documented as administered to Resident #2 until 11/23/25.
-The facility changed the computer system to an updated version, and she thought the other doses of ferrous sulfate for Resident #2 were documented on the older version of the eMAR system.
-She did not have access to the older eMAR system.

Interview with the Administrator on 12/18/25 at 8:48am revealed:
-She was not aware Resident #2's ferrous sulfate was not documented as administered from 09/29/25-11/22/25 on the eMAR.
-She thought Resident #2's ferrous sulfate was administered every other day since admission but

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	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 10	D 358		

was not documented as administered until 11/23/25 because the other doses were documented on the older eMAR system.
-She tried to access the older eMAR system but was unsuccessful.
-The computer system including the old eMAR system was updated around June 2025.
-She expected the MAs to administer Resident #2's ferrous sulfate as ordered.
-There was currently no one responsible for completing eMAR audits to make sure medications were administered as ordered.

Attempted interview with Resident #2's primary care provider (PCP) on 12/17/25 at 1:52pm and 12/17/25 at 3:48pm was unsuccessful.

3. The medication error rate was 3.4% as evidenced by 1 error out of 29 opportunities during the 8:00am medication pass on 12/18/25.

Review of Resident #9's current FL2 dated 12/09/25 revealed diagnoses included a left elbow fracture.

Review of Resident #9s Resident Register revealed an admission date of 12/08/25.

Review of Resident #9's physician orders dated 12/09/25 revealed there was an order for vitamin D3 (a vitamin supplement to assist the body in absorption of calcium to build healthy bones) 1,000 international units (IU) take 1 capsule daily.

Observation of the mediation pass on 12/18/25 at 8:00am revealed:
-There was an unopened medication bubble pack with a dispense date on 12/11/25 for Resident #9's vitamin D3 1000 IU in the quantity of 30 capsules with instructions to administer 1 capsule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 11	D 358		

daily and 30 capsules were available for administration.
-There was a bottle of vitamin D3 2,000 IU with Resident #9's name handwritten on the bottle.
-The medication aide (MA) administered 9 medications to Resident #9 including one tablet of vitamin D3 2,000 IU.
-The MA did not administer Resident #9's vitamin D3 1,000 IU to Resident #9.

Review of Resident #9's 12/01/25-12/18/25 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D3 1,000 IU take 1 capsule daily at 8:00am.
-There was documentation vitamin D3 1,000 IU 1 capsule was administered daily on 12/12/25-12/18/25 at 8:00am.
-There was no entry for vitamin D3 2,000 IU take 1 tablet daily.

Telephone with a pharmacist from the facility's contracted pharmacy on 12/18/25 at 1:30pm revealed:
-Resident #9's vitamin D3 1,000 IU take 1 capsule daily was dispensed on 12/11/25 in the quantity of 30 capsules.
-Resident #9 should have 23 capsules remaining if the vitamin D3 1,000 IU was administered as ordered and the administration began on 12/12/25.

Interview with a MA on 12/18/25 at 1:34pm revealed:
-The facility's contracted pharmacy dispensed Resident #9's vitamin D3 when Resident #9 was admitted to the facility.
-Resident #9 was admitted from home and brought a bottle of vitamin D3 with her when she was admitted to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

(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 12 -Any time a resident brought medications with them when they were admitted to the facility the MAs administered the bottled medications before beginning the bubble packages dispensed by the facility's contracted pharmacy. -She administered the 2,000 IU of vitamin D3 to Resident #9 instead of the ordered 1,000 IU dispensed by the pharmacy because she "missed" the dosage on the bottle was different than the dosage in the bubble package for Resident #9. -The facility's policy for mediation administration included to compare the label on the medication to the eMAR to make sure the dosage was correct. -She did not check the dosage on the bottle or compare it to the eMAR before she administered the vitamin D3 to Resident #9. Interview with the Administrator on 12/18/25 at 8:48am and 1:30pm revealed: -She was not aware Resident #9 had two different dosages of vitamin D3 available for administration on the medication cart. -The only order she found for Resident #9's vitamin D3 was 1,000 IU take 1 capsule daily. -She did not know why the MAs administered Resident #9's vitamin D3 from the bottle brought from home instead of the vitamin D3 dispensed by the pharmacy. -The MAs were responsible for checking the medication dosages on the package and comparing it to the eMAR before administering medications to residents. -There was currently no one responsible for completing eMAR audits to make sure medications were administered as ordered. -She expected the MAs to check medication dosages and compare them to the eMARs before administering the medications to residents.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 358	Continued From page 13 Attempted interview with Resident #2's primary care provider (PCP) on 12/17/25 at 1:52pm and 12/17/25 at 3:48pm was unsuccessful.	D 358		
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: Based on observations, interviews, and record reviews the facility failed to ensure 2 of 2 sampled residents (#3 and #8) had orders to self administer medications for a pain medication and a medication used for muscle cramps (#3) and an allergy nasal spray (#3 and #8). The findings are: Review of the facility's policy regarding self administration of medications dated February 2025 revealed:	D 375		

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	HAL011378	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER GLEN AT ARDENWOODS	103 APPLACHIAN BLVD ARDEN, NC 28704

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D 375	Continued From page 14 -The interdisciplinary team (IDT) will assess the resident's cognitive and physical abilities to determine whether self-administering medications was safe and appropriate. -If it is deemed safe for the resident to self-administer medications, it was documented in the resident's record and care plan. -If the resident self-administers medicataions, the resident was instructed on how to complete a record indicating the administration of the medication. -Any medications found at the bedside that are not authorized for sefl-administration are turned over to the clinical staff in charge. -Staff reviewed the self-administered medication record each shift and transferred pertinent information to the medication administration record, appropriately noting that the doses were self-administered. 1. Observation of Resident #3's room during initial tour on 12/17/25 at 8:58am revealed: -A container of Ibuprofen (used to treat pain) 200mg tablets on his bedside table. -A container of Thermotab buffered salt supplement (used to treat leg cramps) was setting on his bedside table. -A container of phenylephrine HCL 1% nasal spray (used to treat nasal congestion) was on his bed. Interview with Resident #3 on 12/17/25 at 8:58am revealed: -He took one Ibuprofen 200mg tablet on 12/16/25 because he was having muscle aches. -He took one Thermotab on 12/16/25 at night before he went to bed because he had leg cramps. -He used his phenylephrine HCl 1% nasal spray on 12/16/25 because he felt congested.	D 375		

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D 375	Continued From page 15 Review of Resident #3's current FL2 dated 11/26/25 revealed: -There was no order for Ibuprofen, Thermotab, or phenylephrine HCL. -There was no order for self-administration of Ibuprofen, Thermotab, or phenylephrine HCL. Review of Resident #3's electronic medication administration record (eMAR) for October 2025 revealed: -There was no entry to administer Ibuprofen, Thermotab, or phenylephrine HCL. -There was no documentation Ibuprofen, Thermotab, or phenylephrine HCL was administered from 10/01/25 through 10/31/25. Review of Resident #3's eMAR for November 2025 revealed: -There was no entry to administer Ibuprofen, Thermotab, or phenylephrine HCL. -There was no documentation Ibuprofen, Thermotab, or phenylephrine HCL was administered from 11/01/25 through 11/30/25. Review of Resident #3's eMAR for December 2025 revealed: -There was no entry to administer Ibuprofen, Thermotab, or phenylephrine HCL. -There was no documentation Ibuprofen, Thermotab, or phenylephrine HCL was administered from 12/01/25 through 12/16/25. Interview with the medication aide (MA) on 12/17/25 at 1:54pm revealed: -Resident #3 had no orders to self-administer Ibuprofen, Thermotab, or phenylephrine HCL. -She administered his medications to him on 12/17/25. -He was very independent and seldom had staff	D 375		

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D 375	Continued From page 16	D 375		

in his room other than housekeeping.

Interview with the Health Services Manager on 12/17/25 at 2:07pm revealed:
-Resident #3 did not have orders to self-administer Ibuprofen, Thermotab, or phenylephrine HCL.
-She was unaware Resident #3 had medications in his room that he was self-administering.
-Resident #3 should not have medications in his room without a physician's order and an evaluation ensuring he could safely self-administer his medications.

Interview with the Administrator on 12/18/25 at 11:04am revealed:
-She was unaware Resident #3 had medications in his room that he was self-administering.
-Residents were not allowed to have medications in their room unless there was a physician's order and an evaluation to ensure self-administration could be performed safely by the resident.
2. Review of Resident #8's current FL2 dated 11/10/25 revealed diagnoses included seasonal allergies.

Review of Resident #8's Resident Register revealed an admission date of 11/24/25.

Review of Resident #8's physician's order dated 03/17/25 revealed:
-There was an order for fluticasone (used to treat seasonal allergies) 50mcg administer 1 spray each nostril daily.
-There was no order for Resident #8 to self-administer fluticasone.

Observation of the medication pass on 12/18/25 at 8:04am revealed:
-A medication aide (MA) removed 4 medication

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D 375	Continued From page 17	D 375		

tablets and placed them in a cup for Resident #8.
-The MA opened and closed several drawers on the medication cart.
-The MA took the medication cup to Resident #8's room and administered the 4 tablets to Resident #8.

Interview with a MA on 12/18/25 at 8:08am revealed she could not find Resident #8's fluticasone nasal spray on the medication cart and would have to order it from the pharmacy.

Observation of Resident #8's room on 12/18/25 at 8:12am revealed:
-There was a tall medication bottle setting on Resident #8's bedside table.
-Resident #8 picked up the bottle, removed the spray bottle, and administered 1 spray into each nostril.
-The medication label on the bottle was for fluticasone 50mcg, spray 1 spray in each nostril once daily.

Interview with Resident #8 on 12/18/25 at 8:12am revealed:
-The staff kept leaving her fluticasone nasal spray in her room and she had to remind them to take it back to the medication cart.
-She did not think she had an order to self-administer medications.
-She thought the MA that worked day shift on 12/17/25 and administered her medications had left the fluticasone in her room.

Second interview with a MA on 12/18/25 at 8:16am revealed:
-Resident #8's fluticasone nasal spray should be stored on the medication cart and not in Resident #8's room.
-Resident #8 did not have an order to

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D 375	Continued From page 18	D 375		

self-administer medications.
-She did not know Resident #8's fluticasone nasal spray was in Resident #8's room and did not ask Resident #8 about the fluticasone when she administered Resident #8's morning medications.

Interview with a day shift MA on 12/18/25 at 8:38am revealed:
-She worked on 12/17/25 and administered Resident #8's morning medications to Resident #8.
-She administered Resident #8's fluticasone nasal spray and put it back on the medication cart.
-She did not know how the fluticasone nasal spray ended up being in Resident #8's room on 12/18/25 since it was only administered daily.
-Resident #8 did not have an order to self-administer any medications.
-The facility's policy for medication administration was to not leave any medications in the residents' room if there was not an order to self-administer medications.

Interview with the Administrator on 12/18/25 at 8:48am revealed:
-Resident #8 did not have an order to self-administer medications.
-She was unaware staff left Resident #8's fluticasone nasal spray in her room.
-The facility's policy included not leaving medications in a resident's room unless the resident had orders to self-administer.
-The MAs should have administered Resident #8's fluticasone nasal spray and then stored the medication back on the medication cart.

Attempted interview with Resident #8's primary care provider (PCP) on 12/17/25 at 1:52pm and 12/17/25 at 3:48pm was unsuccessful.

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