

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/04/2025
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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and a complaint investigation on December 2, 2025 through December 4, 2025. The complaint investigations were initiated by the Wake County Department of Social Services on November 13, 2025 and November 25, 2025. A State involved complaint was initiated on December 2, 2025.	D 000		
D 075	10A NCAC 13F .0306 (a)(2) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no persistent and recurring odors that are considered by the residents to be unpleasant; 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 which was free from persistent and recurring odors. The findings are: Review of the facility's census report on 12/02/25 revealed there were 44 residents living in the Special Care Unit Facility.	D 075	Meeting was conducted with PCA & Housekeeping staff on proper cleaning and trash removal. Housekeeping will conduct more frequent & thorough cleaning with the appropriate odor eliminating cleaning agents. PCA staff will increase the frequency of trash removal on hallways after personal care tasks. Administrative staff will alternate making routine and random rounds to monitor and observe for potential unpleasant odors and address as needed. Meeting was conducted with all staff on maintaining a safe environment, including placing personal care products within a secure space following personal care tasks, placing soiled items in the appropriate locations and keeping areas clear and free from clutter. Administrative staff will alternate making routine and random rounds to observe that areas are free and clear of clutter as well as personal care products and/or soiled items are being placed in the appropriate locations.	12/7/2025

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X6) DATE

12/29/2025

STATE FORM

6899

6VXB11

If continuation sheet 1 of 53

Reviewed and acknowledged on 01/02/2026 by *Joyce Johnston*

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D 075	Continued From page 1 Observation of room 125 located on the west hall on 12/02/25 at 9:11am revealed a strong smell of feces, the bathroom was clean, and the resident not in the room. Observation of room 101 located on the east hall on 12/02/25 at 9:32am revealed a strong smell of urine, the bathroom was clean, and resident was not in the room. Observation of the facility on 12/02/25 at 9:26am revealed a strong smell of urine from the main hallway down the length of the east hallway. Observation of the television (TV) room located on the main hall on 12/02/25 at 9:55am revealed: -There was a strong odor of urine. -There were 10 residents and 1 staff member in the TV room. Second observation of the TV room on 12/03/25 at 11:05am revealed: -There was a strong odor of urine. -There were 10 residents and 1 staff member in the TV room. Second observation of the east hall on 12/02/25 at 3:50pm revealed the east hall had a strong odor of urine the length of the hallway. Third observation of the facility on 12/03/25 at 7:50am revealed: -The east hall had a strong odor of urine the length of the hallway. -Two of 3 ceiling fans were running on the east hall. Fourth observation of the facility on 12/04/25 at 12:00pm revealed:	D 075		

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D 075	Continued From page 2 -The east hall had a strong odor of urine down the length of the hallway. -Rooms 109, 110, 111, 112, 113, 114, 115, and 116 had a strong odor of urine and the residents were not in the rooms. Interview with a resident's family member on 12/03/25 at 2:00pm revealed the odors could be unpleasant. Interview with another resident's family member on 12/03/25 at 2:20pm revealed the odors could be intense. Interview with a personal care aide (PCA) on 12/02/25 at 8:40am revealed: -She provided incontinence care at least every 30 to 45 minutes. -When a resident was "a little wet" she still provided incontinent care. Interview with a second PCA on 12/03/25 at 2:35pm revealed: -The east hall always had strong odors. -It was mainly the last 3 rooms on each side of the hall. -She would raise the windows in the resident's room to help air them out. -Some days the odors are worse than others. -The resident's clothes always smell like urine even after they are washed. -Bathing the residents does not get rid of the odor. -The odor was also in the linen. Interview with laundry staff on 12/04/25 at 8:30am revealed she had never smelled odors in the laundry after it was washed. Interview with the housekeeping supervisor on	D 075			

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D 075	Continued From page 3 12/03/25 at 2:40pm revealed: -The resident rooms were cleaned daily, furniture, walls if stained, and closets. -Bedding was supposed to be changed daily. -The pillows, mattresses, and box springs had a waterproof protector on them. -The residents were not bathed like they should be. -The PCAs had a shower schedule but the staff could not make a resident take a shower. Second interview with the housekeeping supervisor on 12/04/25 at 8:35am revealed: -The filter on the dryer was cleaned every 3 loads. -Laundry detergent is added into the washing machines automatically. -The resident's clothes were washed separately and in a different washing machine than the linens. -The facility used a detergent, softener and bleach for the linens. -The facility used an encapsulated laundry detergent with enzymes. Interview with the Administrator/Resident Care Coordinator (RCC) on 12/04/25 at 5:00pm revealed: -The trash was not taken out of the resident's rooms enough. -The trash should be removed after each change of soiled briefs. -Enzyme cleaners and air fresheners were used. -Housekeeping had a protocol they followed for cleaning. -The east hall was where male residents resided. -Caulking around the toilets were removed regularly and replaced. -It had been a struggle on the east hall to control the odors.	D 075			

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D 075	Continued From page 4 Attempted telephone interview with the facility's contracted primary care provider (PCP) on 12/04/25 at 9:51am, 11:50am and 1:47pm were unsuccessful.	D 075			
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 ensure the Special Care Unit (SCU) was uncluttered, clean and free of hazards in 14 resident rooms and 2 community shower rooms with personal care items that were accessible to residents on the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed as a Special Care Unit (SCU) effective 01/01/25 for a capacity of 60	D 079			

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D 079	Continued From page 5 residents. -The expiration date of the facility's license was 12/31/25. Review of the facility's census report on 12/02/25 revealed the facility's census in the SCU was 44 residents. Observation of community shower room #1 on 12/02/25 at 9:04am revealed: -The door was unlocked and standing open. -There were spots of a dried substance near the shower floor near and under the shower chair, there were more spots of a dried brown substance on the shower floor along with several bath towels covered in a dried brown substance, and there was a cloth laying on the shower counter with a dried brown substance. -There was a bottle of lotion labeled that if ingested may cause mild stomach upset, nausea or diarrhea and for external use only. -There were 2 bottles of body wash labeled for external use only, keep out of reach of children, and if swallowed get medical help or call the poison control center right away. Observation of resident room 131 on 12/02/25 at 9:05am revealed: -There was deodorant sitting on the sink labeled for external use only and if swallowed get medical help or call the poison control center right away. -There was a bottle of lotion sitting on the sink labeled for external use only. -There was a bottle of shampoo & body wash combination sitting on the back of the toilet labeled for external use only. -There was a bottle of body wash sitting in the shower labeled for external use only, keep out of reach of children.	D 079			

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D 079	Continued From page 6 Based on observations, interviews, and record reviews it was determined the resident that resided in room 131 was not interviewable. Observation of resident room 125 on 12/02/25 at 9:11am revealed: -There was a bottle of body wash labeled for external use only and keep out of reach of children sitting on the nightstand by the window. -There was a tube of barrier paste sitting on the nightstand by the door labeled for external use only, keep out of reach of children. Based on observations, interviews, and record reviews it was determined the resident that resided in room 125 was not interviewable. Observation of resident room 121 on 12/02/25 at 9:19am revealed there was a bottle of lotion sitting on the nightstand by the window labeled for external use only, keep out of reach of children and if swallowed get medical help or call the poison control center right away. Based on observations, interviews, and record reviews it was determined the resident that resided in room 121 was not interviewable. Observation of resident room 126 on 12/02/25 at 9:20am revealed: -There was a 1.6 ounce container of deodorant on the bathroom sink. -There was a warning to keep out of reach of children, if swallowed get medical help or contact a poison control center right away. -There was a 33 ounce bottle of lotion on the bathroom sink. Based on observations, interviews, and record reviews it was determined the resident that	D 079		

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D 079	Continued From page 7 resided in room 126 was not interviewable. Observation of resident room 120 on 12/02/25 at 9:21am revealed there was a bottle of body wash sitting on top of the built-in chest of drawers labeled for external use only. Based on observations, interviews, and record reviews it was determined the resident that resided in room 120 was not interviewable. Observation of resident room 130 on 12/02/25 at 9:22am revealed there was a 4 ounce tube of zinc oxide paste skin protectant on a nightstand beside the resident's bed. Based on observations, interviews, and record reviews it was determined the resident that resided in room 130 was not interviewable. Observation of resident room 122 on 12/02/25 at 9:23am revealed: -There were 2 bottles of body lotion sitting on the closet shelf labeled for external use only. -There was a bottle of shampoo & body wash combination sitting on the closet shelf labeled for external use only. Based on observations, interviews, and record reviews it was determined the resident that resided in room 122 was not interviewable. Observation of a community shower room #3 on 12/02/25 at 9:25am revealed: -The door was unlocked and standing open. -The shower had a counter space on the right side of the shower that had several personal care products sitting on the counter space of the shower stall. -There was a 21 ounce bottle of lotion on the	D 079			

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D 079	Continued From page 8 shower counter space. -There was a 23 ounce bottle of body wash on the shower counter space. -There was a 20 ounce bottle of body wash on the shower counter space with a warning to avoid contact with eyes. -There was an 8 ounce bottle of shampoo and body wash on the counter space with a warning to avoid contact with eyes. Observation of resident room 124 on 12/02/25 at 9:26am revealed there was an air freshener sitting on top of the built-in chest of drawers labeled keep out of reach of children and contents are not for ingestion. Based on observations, interviews, and record reviews it was determined the resident that resided in room 124 was not interviewable. Observation of community shower room #4 on 12/02/25 at 9:32am revealed there was a dried brown substance on the toilet seat. Observation of resident room 107 on 12/02/25 at 9:34am revealed: -The closet door was opened and there was an 11.7 ounce aerosol spray can of sheen spray on the closet shelf. -There was a warning on the sheen spray to keep out of reach of children, the product was flammable and to avoid spraying in the eyes. Based on observations, interviews, and record reviews it was determined the resident that resided in room 107 was not interviewable. Observation of resident room 105 on 12/02/25 at 9:35am revealed there was a bottle of body lotion sitting on top of the built-in chest of drawers	D 079		

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D 079	Continued From page 9 labeled for external use only. Based on observations, interviews, and record reviews it was determined the resident that resided in room 105 was not interviewable. Interview with a personal care aide (PCA) on 12/02/25 at 9:20am revealed: -The personal care items in community shower room #3 should not have contained personal care items. -Resident's personal care items were labeled with the resident's name and kept in a locked closet in their bedroom. -Personal care items and any hazards were supposed to be locked up so residents would not ingest them. -There were at least five residents who were known for wandering into other residents' rooms and taking items. Observation of community shower room #1 on 12/03/25 at 8:26am revealed: -The door was unlocked and standing open. -There was a bottle of shampoo labeled for external use only. -There was a bottle of conditioner labeled for external use only. Observation of resident room 124 on 02/03/25 at 8:29am revealed there was an air freshener sitting on top of the built-in chest of drawers labeled keep out of reach of children and contents are not for ingestion. Observation of community shower room #3 on 12/03/25 at 8:30am revealed: -The door was unlocked and standing open. -There was a bottle of body wash labeled for external use only.	D 079		

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D 079	Continued From page 10 -There was a tube of skin protectant labeled for external use only and keep out of reach of children. Observation of resident room 131 on 12/03/25 at 8:34am revealed: -There was deodorant sitting on the sink labeled for external use only and if swallowed get medical help or call the poison control center right away. -There was a bottle of lotion sitting on the sink labeled for external use only. -There was a bottle of shampoo & body wash combination sitting on the back of the toilet labeled for external use only. -There was a bottle of body wash sitting in the shower labeled for external use only, keep out of reach of children. Observation of resident room 125 on 12/03/25 at 8:36am revealed: -There was a bottle of body wash labeled for external use only and keep out of reach of children sitting on the nightstand by the window. -There was a tube of barrier paste sitting on the nightstand by the door labeled for external use only, keep out of reach of children. Observation of resident room 121 on 12/03/25 at 8:38am revealed there was a bottle of lotion sitting on the nightstand by the window labeled for external use only, keep out of reach of children and if swallowed get medical help or call the poison control center right away. Observation of resident room 107 on 12/03/25 at 8:43am revealed: -There was a bottle of shampoo & body wash combination labeled for external use only. -There was a bottle of lotion labeled for external use only, keep out of reach of children and if	D 079			

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D 079	Continued From page 11 swallowed get medical help or call the poison control center right away. -There was a container of powder labeled keep out of reach of children. Observation of resident room 109 on 12/03/25 at 8:46am revealed: -There were 2 bottles of shampoo & body wash combination labeled for external use only. -There was a pump container of foot cream labeled for external use only and keep out of reach of children. Based on observations, interviews, and record reviews it was determined the resident that resided in room 109 was not interviewable. Observation of resident room 111 on 12/03/25 at 8:47am revealed: -There was deodorant sitting on the sink labeled for external use only and if swallowed get medical help or call the poison control center right away. -There was a bottle of hand sanitizer on the windowsill labeled for external use only, keep out of reach of children, and if swallowed get medical help or call the poison control center right away. -There was a bottle of shampoo & conditioner combination labeled for external use only. -There were 2 bottles of lotion labeled for external use only and keep out of reach of children. Based on observations, interviews, and record reviews it was determined the resident that resided in room 111 was not interviewable. Observation of resident room 113 on 12/03/25 at 8:52am revealed: -There was a tube of prevent cream for external use only. -There was a bottle of body wash sitting in the	D 079		

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D 079	Continued From page 12 shower labeled for external use only, keep out of reach of children. -There were 2 solid deodorants labeled for external use only and if swallowed get medical help or call the poison control center right away. -There were 2 bottles of lotion labeled for external use only and keep out of reach of children. -There was a bottle of after shave labeled keep out of reach of children, flammable until dry, and avoid eye contact. Based on observations, interviews, and record reviews it was determined the resident that resided in room 113 was not interviewable. Interview with a second PCA on 12/03/25 2:35pm revealed: -She had worked at the facility for one month. -The resident's personal care products were supposed to be placed in the residents closet and locked. -She was not sure why there were personal care products out and not placed in their closet. Interview with the Co-Administrator on 12/03/25 at 3:30pm revealed: -Resident's personal care products were supposed to be locked up. -Personal care products should be removed from the shower after the shower was completed. -The facility was a dementia unit and the residents could ingest the personal care products. -We had never had a resident that ingested personal care products. -The staff have a key to the resident's closet. -Residents family could purchase a key to their closet. Observation of community shower room #1 on 12/04/25 at 8:07am revealed:	D 079			

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D 079	Continued From page 13 -The door was unlocked and standing open. -There was a bottle of shampoo labeled for external use only. Observation of resident room 124 on 12/04/25 at 8:08am revealed there was an air freshener sitting on top of the built-in chest of drawers labeled keep out of reach of children and contents are not for ingestion. Observation of resident room 126 on 12/04/25 at 8:09am revealed there was a bottle of lotion labeled for external use only, keep out of reach of children and if swallowed get medical help or call the poison control center right away. Observation of resident room 130 on 12/04/25 at 8:11am revealed: -There was a tube of prevent cream for external use only. -There was a tube of skin protectant labeled for external use only and keep out of reach of children. Observation of resident room 131 on 12/04/25 at 8:12am revealed: -There was deodorant sitting on the sink labeled for external use only and if swallowed get medical help or call the poison control center right away. -There was a bottle of lotion sitting on the sink labeled for external use only. -There was a bottle of shampoo & body wash combination sitting on the back of the toilet labeled for external use only. -There was a bottle of body wash sitting in the shower labeled for external use only, keep out of reach of children. Observation of resident room 129 on 12/04/25 at 8:14am revealed:	D 079			

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D 079	Continued From page 14 -There was a tube of prevent cream for external use only. -There were 2 bottles of shampoo & body wash combination labeled for external use only. -There was a bottle of lotion labeled for external use only, keep out of reach of children and if swallowed get medical help or call the poison control center right away. Based on observations, interviews, and record reviews it was determined the resident that resided in room 129 was not interviewable. Observation of resident room 125 on 12/04/25 at 8:17am revealed: -There was a bottle of body wash labeled for external use only and keep out of reach of children sitting on the nightstand by the window. -There was a tube of barrier paste sitting on the nightstand by the door labeled for external use only, keep out of reach of children. Observation of the community shower room #2 on 12/04/25 at 8:19am revealed: -Ther door was unlocked and standing open. -There was a bottle of conditioner labeled for external use only. Observation of resident room 121 on 12/04/25 at 8:20am revealed there was a bottle of lotion sitting on the nightstand by the window labeled for external use only, keep out of reach of children and if swallowed get medical help or call the poison control center right away. Observation of resident room 113 on 12/04/25 at 8:32am revealed: -There was a 32 ounce bottle of lotion on the resident's nightstand. -There was a 30 ounce bottle of lotion on the	D 079		

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D 079	Continued From page 15 resident's nightstand with a warning to keep out of reach of children, avoid contact with eyes, if contact with eyes occurs, rinse thoroughly with water. -There was a 2.6 ounce and 0.8 ounce containers of deodorant on the resident's nightstand. -There was an 8 ounce tube of lotion on the resident's nightstand. -There was a 5 ounce bottle of after shave with a warning label to not use when smoking or near fire, flames, or heat. Observation of resident room 111 on 12/04/25 at 8:35am revealed: -There was a 13.5 ounce bottle of shampoo with a warning label to keep out of reach of children, if swallowed get medical help or contact a poison control center right away. -There was a 20 ounce bottle of lotion with a warning to keep out of reach of children, avoid contact with eyes, if contact with eyes wash thoroughly with water. Observation of resident room 108 on 12/04/25 at 8:37am revealed there was an 8 ounce bottle of lotion on the resident's nightstand with a warning to keep out of reach of children, avoid contact with eyes, if accidental ingestion seek professional assistance or contact a poison control center immediately. Based on observations, interviews, and record reviews it was determined the resident that resided in room 129 was not interviewable. Observation of resident room 107 on 12/04/25 at 8:39am revealed: -There was a 1.5 ounce container of baby powder on the resident's nightstand. -There was a 1.7 ounce container of lotion on the	D 079		

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D 079	Continued From page 16 nightstand. -There was an 8 ounce shampoo and body wash bottle on the nightstand. -There was a stack of four small plastic cups with lotion in each cup. Interview with the Co-Administrator on 12/04/25 at 2:30pm revealed: -All staff are responsible for making sure personal care products are locked up. -She spoke with all three shifts on 12/03/25 to make sure all personal care products were locked up. -She did not make rounds on 12/04/25 to make sure the personal care products were locked up. -She normally made a walk through twice daily. -She did not look thoroughly in the residents' rooms when performing her walk through. -She expected that all personal care products were to be locked up. -The resident's closet had a lock on it and the staff had a key. Interview with the Administrator/RCC on 12/04/25 at 4:05pm revealed: -Personal care products should be secured properly. -She was concerned that the residents could ingest them and for the safety of the residents. -The residents had a locked area to store their personal care products. -The administrative staff were expected to make daily rounds to look for personal care products. -The PCAs should have been looking for personal care products and if they found them to address them by securing them. -The PCAs were responsible for ensuring all personal care products were secured. -Personal care products should not have been left in the community showers or the resident's room.	D 079		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WAKE ASSISTED LIVING

**2800 KIDD ROAD
RALEIGH, NC 27610**

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D 079	Continued From page 17 Interview with the facility's contracted primary care provider (PCP) on 12/02/25 at 11:02am revealed: -Residents on the SCU wandered and sometimes removed items from other residents' rooms. -The facility staff should ensure there were no personal care items or any other hazards accessible to reduce the risk of a resident ingesting an item that could cause them harm.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#5) including failing to notify the primary care provider (PCP) immediately of the resident having falls requiring emergency treatment on three occasions. The findings are: Review of Resident #5's current FL2 dated 07/08/25 revealed: -Diagnoses included dementia, Parkinson's Disease, and hypotension. -His level of care was Special Care Unit. Review of Resident #5's Incident/Accident (I/A) report dated 11/16/25 revealed: -The date and time of the I/A was 11/16/25 at	D 273	Meeting was conducted with all Med-Tech/SIC's concerning Provider notifications for incident/accident reports. Staff will be responsible for notifying the Administrator or designee for all incident/accident reports. Administrator or designee will be responsible for follow-through instructions with Med-Tech/SIC during the notification process. The Administrator will fax the incident/accident report(s) to the provider the following business day as an additional follow-up.	12/7/2025

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D 273	Continued From page 18 5:25am. -The description of events was documented as the resident lost his balance and fell causing him to hit his forehead. -The description of injury was documented as stitches on forehead reopened. -Staff action taken was documented as Power of Attorney (POA), primary care provider (PCP) and emergency medical services (EMS) was called and the resident was transported to the emergency department (ED) for further evaluation. -The Responsible Party (RP) was notified on 11/16/25 at 5:22am. -The PCP was notified on 11/16/25 at 5:30am. -In the box labeled "For Physician Use Only", under physician orders was a note "not notified at time of fall" and was signed by Resident #5's PCP on 11/18/25. Review of Resident #5's I/A report dated 11/28/25 revealed: -The date and time of the I/A was 11/28/25 at 12:30pm. -The description of events was documented as the resident was found on the floor by the personal care aide (PCA) trying to get out of bed. -The description of injury was documented as "no injury". -Staff action taken was documented as checked vitals, called 911 and called family, the resident was sent to the ED. -The RP was notified on 11/28/25 at 1:00pm. -The PCP was notified on 11/28/25 at 12:45pm. -In the box labeled "For Physician Use Only" under physician orders was a note "not notified at time" and was signed by Resident #5's PCP on 12/02/25. Review of Resident #5's I/A report dated 11/29/25	D 273		

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D 273	Continued From page 19 revealed: -The date and time of the I/A was 11/29/25 at 8:15am. -The description of injury was documented as the resident was seen on the bathroom floor and complained his side was hurting. -The description of injury was documented as "no injury". -Staff action taken was documented as POA notified, EMS called, the resident was transported to ED for further evaluation. -The RP was notified on 11/29/25 at 8:25am. -The PCP was notified on 11/29/25 at 8:20am. -In the box labeled "For Physician Use Only" under physician orders was a note "not notified at time" and was signed by Resident #5's PCP on 12/02/25. Interview with a medication aide (MA) on 12/03/25 at 2:54pm revealed: -When a resident fell, the resident was assessed for any injuries and if they hit their head or complained of pain, they were sent to the ED. -The MA notified the residents' RP and PCP immediately of any falls and completed an I/A report and gave it to the RCC (Resident Care Coordinator) or the Co-Administrator. Interview with a second MA on 12/04/25 at 4:03pm revealed: -Resident #5 was a fall risk because he tried to get up without assistance. -When a resident fell, the MAs notified the resident's PCP and RP. -An I/A report was completed also and given to the RCC or Co-Administrator. -She was not sure why Resident #5's PCP was not notified of immediately of his falls on 11/28/25, 11/29/25, and 11/16/25.	D 273			

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D 273	Continued From page 20 Interview with the Co-Administrator on 12/04/25 at 2:51pm revealed: -If a resident had a fall and hit their head they were automatically sent out to the ED. -The MA also completed an I/A and were to notify the residents PCP and RP immediately. -The PCP could be contacted electronically through the Tele medic system. -Resident #5 was a fall risk due to Parkinson's Disease and he tried to get up without assistance from staff. -She was certain the MAs had notified Resident #5's PCP of his recent falls at the time of the incidents. Interview with the Owner/Administrator on 12/04/25 at 4:05pm revealed: -If a resident fell, she expected the resident 's PCP to be notified immediately through the facility's telehealth system. -She was not aware that Resident #5's PCP had not been notified immediately of his last 3 falls. Interview with Resident #5's PCP on 12/02/25 at 11:04am revealed: -She was at the facility every Tuesday. -Resident #5 had Parkinson's Disease and had frequent falls. -If a resident fell, she expected to be notified at the time of the fall. -The facility could easily notify through a paging type system, and she could tell in her computer system if staff had used this system. -When she visited the facility weekly on Tuesdays, I/A reports were placed in a file for her to review and that was how she found out about Resident #5's last 3 falls. -She found out about Resident #5's falls on 11/28/25 and 11/29/25 today (12/02/25) on her visit to the facility and about Resident #5's	D 273		

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D 273	Continued From page 21 11/16/25 fall when she visited the facility on 11/18/25. -If a resident fell and hit their head, they were automatically sent out but she expected to be notified of Resident #5's falls in real time. Attempted telephone interview with Resident #5's RP on 12/03/25 at 4:07pm was unsuccessful.	D 273	Meeting was conducted with Med-Tech staff addressing the following: a.) Faxing any new orders to the pharmacy after hours & weekends. b.) Notifying Administrator/RCC of the return of a resident with any new orders. c.) Thoroughly reviewing MARs for perimeters. d.) Follow-up with pharmacy on new orders. e.) Approval of new orders to the MAR. All Med-Tech staff completed additional in-service training on Medication administration. Meeting was conducted with the RN on completing med error reports as needed. Administrator and/or RCC will be Responsible for random and routine audits of new orders and MARs, as well as auditing orders with perimeters. Administrator and/or RCC will follow up on new orders for delivery from the pharmacy.	12/7/2025
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 2 of 5 residents (#4, #5) sampled for record review including errors with medications used to treat bacterial infections, hypertension (#4), and orthostatic hypotension (low blood pressure when standing up) (#5). The findings are: Review of the facility's undated medication administration policy revealed: -The facility will ensure medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing	D 358		

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D 358	Continued From page 22 primary care provider's orders. -Documentation will be provided for each dose of medication and treatments that are administered or performed by staff to the residents on the facility electronic medication administration record (eMAR). -In the event of medication errors and adverse reactions to medications, the facility staff will notify the resident primary care provider (PCP) or appropriate health professional, notify the Administrator and the Resident Care Coordinator (RCC), document any orders or instructions given by the PCP or health professional and the actions taken by the facility to comply with the order, documentation will identify the cause that may have lead to the error (i.e. documentation error, unavailability of medications, or resident's refusal of medication). 1. Review of Resident #4's current FL2 dated 06/17/25 revealed: -Diagnoses included dementia and left hip fracture. -Her level of care was special care unit (SCU). Review of Resident #4's Resident Register revealed she was admitted to the facility on 06/03/24. a. Review of Resident #4's emergency department (ED) after visit summary (AVS) dated 11/21/25 revealed: -The reason for the visit was a fall. -Diagnoses for the visit was fall from standing, closed fracture of left condylar process of the mandible (jaw fracture) and unequal pupils. -Start taking these medications, amoxicillin-clavulanate (amoxicillin is an antibiotic used to treat bacterial infections) 875-125mg was prescribed to take one tablet two times per day	D 358			

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D 358	Continued From page 23 for seven days. -Start taking these medications, ciprofloxacin-dexamethasone otic suspension (an antibiotic and steroid combination ear drop used to treat bacterial ear infections), four drops in left ear two times daily for seven days. Review of Resident #4's primary care provider's (PCP) progress note dated 11/25/25 revealed medications ordered from hospital sent to pharmacy included ciprofloxacin 0.3%-dexamethasone 0.1% suspension (ear drops), administer four drops into left ear twice a day for seven days and amoxicillin 875mg-potassium clavulanate 125mg, take one tablet twice a day for seven days. Review of Resident #4's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for amoxicillin clavulanate 875-125mg, take one tablet twice a day for seven days, scheduled at 8:00am and 8:00pm. -Amoxicillin clavulanate 875-125mg was documented as administered at 8:00am and 8:00pm on 11/26/25 through 11/30/25. -There was an entry for ciprofloxacin-dexamethasone 0.3%-0.1% administer four drops into left ear twice a day for seven days scheduled at 8:00am and 8:00pm. -Ciprofloxacin-dexamethasone 0.3%-0.1% was documented as administered at 8:00am and 8:00pm on 11/26/25 through 11/30/25. Review of Resident #4's December 2025 eMAR revealed: -There was an entry for amoxicillin clavulanate 875-125mg, take one tablet twice a day for seven days, scheduled at 8:00am and 8:00pm. -Amoxicillin clavulanate 875-125mg was	D 358			

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D 358	Continued From page 24 documented as administered at 8:00am and 8:00pm on 12/01/25 and 12/02/25. -There was an entry for ciprofloxacin-dexamethasone 0.3%-0.1% administer four drops into left ear twice a day for seven days scheduled at 8:00am and 8:00pm. -Ciprofloxacin-dexamethasone 0.3%-0.1% was documented as administered at 8:00am and 8:00pm on 12/01/25 and 12/02/25. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/04/25 at 1:39pm revealed: -An order was received for amoxicillin-clavulanate 875-125mg for Resident #4 to take one tablet twice daily for seven days. -Amoxicillin-clavulanate 875-125mg was dispensed on 11/25/25 for Resident #4 for 14 tablets for a seven-day supply to take one tablet twice a day for seven days. -An order was received for ciprofloxacin-dexamethasone 0.3%-0.1% suspension for Resident #4 to administer four drops to the left ear twice a day for seven days. -Ciprofloxacin-dexamethasone 0.3%-0.1% otic suspension was dispensed for Resident #4 for 7.5ml for a seven-day supply to administer four drops to the left ear twice a day on 11/25/25. -Amoxicillin-clavulanate is an antibiotic used to treat bacterial infections and a delay in starting antibiotic therapy could lead to a delay in treating a potential bacterial infection. -Ciprofloxacin-dexamethasone was combination of an antibiotic and a steroid used to treat ear infections, a delay in treatment could result in continued infection of the ear and ear pain. Interview with Resident #4 on 12/04/25 at 10:02am revealed: -About a week or so ago, she was trying to get to	D 358		

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D 358	Continued From page 25 her seat in the dining room for lunch and fell and hit her on a table then the floor. -She had to go to the ED and was diagnosed with a broken jaw and a cut in her ear and thought she was given some ear drops. -Her jaw was sore for a few days especially with eating but seemed fine now. Interview with a medication aide (MA) on 12/03/25 at 2:34pm revealed the Resident Care Coordinator (RCC) or the Administrator were responsible for reviewing the ED AVS for orders. Interview with a second MA on 12/04/25 at 4:03pm revealed: -She was on duty on 11/21/25 for the 3:00pm to 11:00pm shift when Resident #4 returned from the ED. -She reviewed Resident #4's ED AVS on 11/21/25 but did not realize the AVS listed medications that were ordered at the ED visit. -No hard copy prescriptions were returned with Resident #4 from her 11/21/25 ED visit. -The ED nurse had not notified her that Resident #4 was to have prescriptions for an antibiotic and ear drops. -She reviewed Resident #4's 11/21/25 ED AVS and placed it in the Administrator's box for review when she returned. Interview with the Co-Administrator on 12/04/25 at 3:50pm revealed: -When a resident returned from the ED, she or the RCC were responsible for reviewing the residents' AVS for medication orders and follow up visits. -If a resident returned after hours or over the weekend when she or the RCC were not in the facility, the MAs were responsible to review the ED AVS for orders and if there were medication	D 358			

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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 26 orders, the MAs faxed the orders to the pharmacy and then placed the AVS for review by the RCC or her. -Also, the MAs were to call the RCC or her when a resident returned from the ED after hours or over the weekend. -She was not notified by the MA when Resident #4 returned from the ED on the evening of 11/21/25 which was a Friday. -She reviewed Resident #4's AVS summary when she returned to work on Monday morning 11/24/25 and saw there were orders for amoxicillin tablets and ciprofloxacin-dexamethasone drops for Resident #4. -She faxed Resident #4's 11/21/25 AVS to the pharmacy on 11/24/25. -She received a fax from the pharmacy on 11/25/25 noting that a prescription was needed for Resident #4's amoxicillin and ciprofloxacin-dexamethasone ear drops. -The facility's primary care provider (PCP) came to the facility on 11/25/25 for her weekly visit and sent a prescription to the pharmacy for Resident #4's amoxicillin and ciprofloxacin-dexamethasone ear drops. -The MA should have called her when Resident #4 returned from the ED. -The MA should have faxed Resident #4's ED AVS to the pharmacy when she returned from the ED on 11/21/25. -There should not have been a 4-day delay in Resident #4 receiving her amoxicillin and ciprofloxacin-dexamethasone. Interview with the Owner/Administrator on 12/04/25 at 4:05pm revealed: -The previous RCC left about a week ago and she assumed the RCC position on 12/01/25. -The RCC or the Co-Administrator were	D 358			

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D 358	Continued From page 27 responsible for reviewing the residents' ED AVSs. -If the RCC or the Co-Administrator were not in the facility, the MAs were responsible for reviewing the ED AVS and to contact either the RCC or the Co-Administrator when a resident returned from the ED. -When Resident #4 returned from the ED, the MA should have contacted the Co-Administrator so she could walk her through review of her AVS to look for orders. -Resident #4's 11/21/25 AVS should have been faxed to the pharmacy on 11/21/25. -If there were issues with Resident #4's orders on the 11/21/25 AVS, Resident #4's primary care provider (PCP) could have been contacted if prescriptions were needed. Telephone interview with the triage nurse at Resident #4's ear, nose and throat (ENT) specialist's office on 12/04/25 at 9:24am revealed: -Resident #4 was prescribed amoxicillin-clavulanate tablets and ciprofloxacin-dexamethasone ear drops by the ED provider for an external auditory canal laceration as a prophylactic (preventative) measure. -There were no concerns for the delay in starting the amoxicillin and ciprofloxacin unless Resident #4 had symptoms such as pain, drainage in the ear or fever. -Resident #4 had a follow-up appointment at the ENT office on 12/03/25 and was to follow-up on an as needed basis. Attempted telephone interview with Resident #4's ENT specialist on 12/04/25 at 9:24am was unsuccessful. Attempted telephone interview with Resident #4's	D 358			

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D 358	Continued From page 28 primary care provider (PCP) on 12/04/25 at 1:41pm was unsuccessful. b. Review of Resident #4's signed physicians order sheet dated 10/28/25 revealed an order for metoprolol tartrate (metoprolol is a medication used to treat high blood pressure) 25mg, take one tablet twice a day, hold for systolic blood pressure less than 110 and/or heart rate less than 60. Review of Resident #4's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg, take one tablet twice a day, hold for systolic blood pressure less than 110 and/or heart rate less than 60, scheduled at 8:00am and 9:00pm. -Metoprolol tartrate 25mg was documented as not administered at 8:00am on 11/15/25 with the exception documented as "waiting on pharmacy". -Metoprolol tartrate 25mg was documented as not administered at 9:00pm on 11/15/25 with the exception documented as "patient unable to take". -Metoprolol tartrate 25mg was documented as not administered at 8:00am and 9:00pm on 11/16/25 with the exception documented as "waiting on pharmacy". -Metoprolol tartrate 25mg was documented as administered at 8:00am on 11/17/25. -Metoprolol tartrate 25mg was documented as not administered at 9:00pm on 11/17/25 with the exception documented as "patient unable to take". -Metoprolol tartrate 25mg was documented as not administered at 8:00am on 11/18/25 with the exception documented as "waiting on pharmacy". Observation of Resident #4's medications on	D 358			

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D 358	Continued From page 29 hand on 12/04/25 at 1:26pm revealed a bubble card of metoprolol tartrate 25mg, labeled to take one tablet twice daily, hold for systolic blood pressure less than 110 and/or heart rate less than 60, quantity of 56 tablets with a start date of 11/19/25 and 22 metoprolol tablets remained in the bubble card. Telephone interview with a representative at the facility's contracted pharmacy on 12/03/25 at 4:13pm revealed: -An order for metoprolol tartrate 25mg, take one tablet twice a day, hold for systolic blood pressure less than 110 and/or heart rate less than 60 was originally received for Resident #4 on 11/12/24. -Resident #4's metoprolol tartrate 25mg was on cycle fill meaning it was automatically filled every 28 days. -56 tablets of metoprolol tartrate 25mg, take one tablet twice a day, hold for systolic blood pressure less than 110 and/or heart rate less than 60, were dispensed and delivered to the facility on 10/17/25 for Resident #4 with a start date of 10/22/25 for a 28-day supply. -56 tablets of metoprolol tartrate 25mg, take one tablet twice a day, hold for systolic blood pressure less than 110 and/or heart rate less than 60, were dispensed and delivered to the facility on 11/14/25 for Resident #4 with a start date of 11/19/25 for a 28-day supply. Review of the facility's pharmacy packing slip dated 11/14/25 included 56 tablets of metoprolol tartrate 25mg for Resident#4. Interview with a medication aide (MA) on 12/03/25 at 2:34pm revealed: -The MAs were responsible to make sure medications were on the medication cart for the residents.	D 358			

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D 358	Continued From page 30 -If a medication was not available for a resident, a call was placed to the pharmacy. -She usually allowed the pharmacy 2 days to get a medication to them. -She thought the Resident Care Coordinator (RCC) or the Co-Administrator performed medication cart audits twice a month. Interview with a second MA on 12/04/25 at 4:03pm revealed: -The RCC or the Co-Administrator were responsible for making sure all medications were on the medication cart for the residents. -If a medication was not available for a resident on the medication cart for resident, she notified the RCC, the Co-Administrator or the pharmacy. -She remembered that Resident #4's metoprolol was not available for a few days in November 2025 but was not sure why. Interview with the Co-Administrator on 12/04/25 at 3:44pm revealed: -The RCC was responsible to make sure medications were on the medication cart and available for the residents. -The previous RCC had left employment at the facility. -The RCC was responsible for medication cart audits monthly. -She was currently training the MAs on medication cart audits. -She thought Resident #4's metoprolol was probably misplaced on the medication cart when the November 2025 batch cycle came in and that the MA overlooked Resident #4's metoprolol. -If a medication could not be located for a resident, the MA should have notified her. -She had not been notified that metoprolol was not available for Resident #4 for a time in November 2025.	D 358			

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D 358	Continued From page 31 -It was important for Resident #4 to receive her metoprolol as ordered to prevent elevated blood pressure. Interview with the Owner/Administrator on 12/04/25 at 4:05pm revealed: -The previous RCC left employment about a month ago, and a second RCC left about 1 week ago, and she stepped into the RCC role as of 12/01/25. -The MA should report to the RCC or the Co-Administrator if a medication was not available on the medication cart for a resident. -Their job was to make sure medications were administered to the residents as ordered. Attempted telephone interview with Resident #4's primary care provider (PCP) on 12/04/25 at 1:41pm was unsuccessful. 2. Review of Resident #5's current FL2 dated 07/08/25 revealed: -Diagnoses included dementia, Parkinson's Disease. And hypotension. -His level of care was Special Care Unit. Review of a signed provider triage note date 08/28/25 revealed an order to resume fludrocortisone (a corticosteroid medication that can be used to treat orthostatic hypotension, low blood pressure when standing up) 0.1mg, take one tablet three times a day, hold if systolic blood pressure is greater than 130, obtain blood pressure prior to being given. Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for fludrocortisone 0.1mg, take one tablet three times a day, hold if systolic	D 358			

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D 358	Continued From page 32 blood pressure is greater than 130, scheduled at 8:00am, 12:00pm, and 4:00pm. -Fludrocortisone 0.1mg was documented as administered at 8:00am and 12:00pm on 10/01/25 through 10/31/25. -Fludrocortisone 0.1mg was documented as administered at 4:00pm on 10/01/25. -Fludrocortisone 0.1mg was documented as not administered at 4:00pm on 10/02/25 with the exception documented as "patient unable to take medication". -Fludrocortisone 0.1mg was documented as administered at 4:00pm on 10/03/25 through 10/31/25. -There was no documentation of Resident #5's blood pressure at 8:00am, 12:00pm or 4:00pm on 10/01/25 through 10/31/25. Review of Resident #5's November 2025 eMAR revealed: -There was an entry for fludrocortisone 0.1mg, take one tablet three times a day, hold if systolic blood pressure is greater than 130, scheduled at 8:00am, 12:00pm, and 4:00pm. -Fludrocortisone 0.1mg was documented as administered at 8:00am, 12:00pm and 4:00pm on 11/01/25 through 11/04/25. -There was no documentation of Resident #5's blood pressure at 8:00am, 12:00pm or 4:00pm 11/01/25 through 11/04/25, Resident #5's blood pressures were documented starting at 8:00am on 11/05/25. -Fludrocortisone 0.1mg was documented as administered on 10 occasions at 8:00am when his systolic blood pressure was documented as greater than 130 from 11/05/25 through 11/30/25. -Fludrocortisone 0.1mg was documented as administered on 14 occasions at 12:00pm when his systolic blood pressure was documented as greater than 130 from 11/05/25 to 11/30/25.	D 358			

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D 358	Continued From page 33 -Fludrocortisone 0.1mg was documented as administered on 9 occasions at 4:00pm when his systolic blood pressure was documented as greater than 130 from 11/05/25 through 11/30/25. Review of Resident #5's December 2025 eMAR revealed: -There was an entry for fludrocortisone 0.1mg, take one tablet three times a day, hold if systolic blood pressure is greater than 130, scheduled at 8:00am, 12:00pm, and 4:00pm. -Fludrocortisone 0.1mg was documented as administered on 2 occasions at 8:00am when his systolic blood pressure was documented as greater than 130 from 12/01/25 through 12/04/25. Observation of Resident #5's medications on hand on 12/03/25 at 2:35pm revealed: -There were 2 bubble cards of fludrocortisone 0.1mg, with a start date of 11/19/25 for 84 tablets dispensed to take one tablet three times a day, hold if systolic blood pressure is greater than 130. -There were 19 tablets of fludrocortisone 0.1mg remaining on the first bubble card. -There were 28 tablets of fludrocortisone 0.1mg remaining on the second bubble card. Telephone interview with a representative with the facility's contracted pharmacy on 12/03/25 at 4:14pm revealed: -An order was received for Resident #5 for fludrocortisone 0.1mg, take one tablet three times a day, hold for systolic blood pressure greater than 130 on 08/29/25. -Fludrocortisone 0.1mg, take one tablet three times a day, hold for systolic blood pressure greater than 130 was dispensed for Resident #5 on 09/24/25, 10/22/25 and 11/19/25 for 84 tablets for a 28-day supply each time for Resident #5. -The facility could add the box on Resident #5's	D 358			

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D 358	Continued From page 34 eMAR to record his blood pressure. Interview with a medication aide (MA) at 2:34pm revealed -The MAs always compared the resident's medication to the eMAR. -Resident #5 should not receive the fludrocortisone 0.1mg if the top number of his blood pressure was greater than 130. -Resident #5's blood pressure was always checked before receiving his fludrocortisone. -The MA was not sure why Resident #5 received fludrocortisone when his systolic blood pressure was above 130. Interview with a second MA on 12/04/25 at 4:03pm revealed: -The resident's medication package should always be compared to the eMAR. -Medications were to be administered as ordered. -She thought Resident #5's blood pressure was being checked in October 2025 and early November 2025 but there was no place on the eMAR to record his blood pressure readings. -Once the blood pressure box was added to Resident #5's eMAR, his blood pressures were recorded. -Resident #5 should not have received fludrocortisone 0.1mg when his systolic blood pressure was greater than 130. Interview with the Co-Administrator on 12/04/25 at 3:24pm revealed: -The MAs pulled the residents' medications from the medication cart and were expected to review each medication package and compared the medication package to the eMAR to make sure it was the correct resident, correct medication, correct dosage and correct directions. -If a medication had parameters such as blood	D 358			

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D 358	Continued From page 35 pressure checks, the blood pressure was checked prior to administration of the medication, and the parameters were reviewed by the MA. -She was not sure why Resident #5's blood pressures were not recorded in October 2025 and early November 2025. -She or the Resident Care Coordinator (RCC) could add a space on Resident #5's eMAR to record his blood pressure for the fludrocortisone. -She was not sure who added the blood pressure box to Resident #5's November 2025 eMAR. -She thought the previous RCC performed eMAR audits, but she was not sure. -The RCC left about one month ago and a second RCC left about one week ago. -She was not aware that Resident #5 had received fludrocortisone when his systolic blood pressures were greater than 130. Interview with the Owner/Administrator on 12/04/25 at 4:05pm revealed: -She stepped into the RCC role on 12/01/25. -The previous RCC performed random eMAR audits. -Each resident should have an eMAR audit quarterly. -The MAs were to compare the medication package to the eMAR for administration. -If a medication had parameters for administration, she expected the orders to be followed. -The RCC should have noticed that Resident #5 did not have blood pressures recorded in October 2025 and that fludrocortisone was administered outside of parameters when eMAR audits were performed. -The previous RCC may not have known how to add the space to record Resident #5's eMAR to record his blood pressure. -It was the MA's job to administer medications as	D 358		

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NAME OF PROVIDER OR SUPPLIER
WAKE ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
**2800 KIDD ROAD
RALEIGH, NC 27610**

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D 358	Continued From page 36 ordered to the residents. Attempted telephone interview with Resident #5's primary care provider (PCP) on 12/04/25 at 1:41pm was unsuccessful.	D 358		
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 interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 6	D 367	Meeting was conducted with Med-Tech staff to include proper documentation when administering medications and narcotics. Facility implemented a medication availability form to complete each shift (see attached). All Med-tech staff completed additional medication administration in service training. Administrator and RCC will conduct routine monitoring and audits of narcotic count sheets and medication availability forms for proper documentation and follow up as needed.	12/7/2025

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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610			
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D 367	Continued From page 37 sampled residents (#2, #6) including inaccurate documentation of a controlled substance. The findings are: Review of an undated facility policy for controlled medication count off sheets revealed: -The facility should ensure that all controlled medications were counted and the medication administration records (MARS) were checked every shift. -Each medication aide (MA) was responsible to sign the narcotic count off sheet in front of the narcotic book indicating that they had counted all narcotics and checked the MAR and received them in acceptable condition. -In the event there were any discrepancies in the controlled medication count it must be reported to the Administrator or Resident Care Coordinator (RCC) immediately. -Documentation of controlled medications should be maintained and kept by the facility and should be available for review. -Documentation of receipt of the controlled medication by the pharmacy should be maintained by the facility for a minimum of three years. 1. Review of Resident #6's current FL-2 dated 11/04/25 revealed- -Diagnoses included dementia, lung cancer, and chronic obstructive pulmonary disease. -There was an order for Oxycodone/Acetaminophen (APAP) 5-325mg take one tablet every 4 hours as needed for pain (Oxycodone/Acetaminophen is used to treat moderate to severe pain). Review of Resident #6's physician order dated 11/04/25 revealed there was an order for	D 367	RCC will continue to audit all resident charts and clarify medications and orders as well as follow-up with med cart audits. These audits will be conducted initially and then randomly and routinely after initial audit is completed. Administrator and RCC will conduct monthly Med-Tech meetings with the Med-Tech staff to cover medication administration topics, policies and procedures.	12/14/2025	

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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
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D 367	Continued From page 38 Oxycodone/AAPAP 5-325mg tablet, take one tablet every four hours as needed for pain. Review of Resident #6's September 2025 controlled substance log (CSL) revealed: -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed. -There was an entry that 9 Oxycodone/APAP 5-325mg were received. -Oxycodone/APAP 5-325mg was documented as administered on 09/22/25 at 6:41pm. -Oxycodone/APAP 5-325mg was documented as administered on "06/23/25" at 7:00am. -Oxycodone/APAP 5-325mg was documented as administered on 09/23/25 at 8:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/24/25 at 3:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/28/25 at 8:00am. -Oxycodone/APAP 5-325mg was documented as administered on 09/29/25 at 8:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/30/25 at 12:00pm. -There was an entry that 0 Oxycodone/APAP 5-325mg remained on hand. Review of Resident #6's September 2025 MAR revealed: -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain. -Oxycodone/APAP 5-325mg was documented as administered on 09/15/25 at 8:16pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/17/25 at 4:15pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/29/25 at 7:10pm. Review of Resident #6's October 2025 CSL revealed:	D 367			

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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
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D 367	Continued From page 39 -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed. -There was an entry that 30 Oxycodone/APAP 5-325mg were received. -Oxycodone/APAP 5-325mg was documented as administered on 10/04/25 at 4:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/05/25 at 1:00am. -Oxycodone/APAP 5-325mg was documented as administered on 10/23/25 at 8:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/23/25 at 11:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/24/25 at 2:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/24/25 at 6:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/24/25 at 11:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/28/25 at 6:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/28/25 at 9:13pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/29/25 at 4:13pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/30/25 at 4:13pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/30/25 at 4:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/30/25 at 4:00pm. -Oxycodone/APAP 5-325mg was documented as administered on 10/30/25 at 8:00pm. -There was an entry that 3 Oxycodone/APAP 5-325mg remained on hand. Review of Resident #6's October 2025 MAR revealed: -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain.	D 367		

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D 367	Continued From page 40 -Oxycodone/APAP 5-325mg was documented as administered on 10/29/25 at 4:13pm. Telephone interview with a pharmacist with the facility's contracted pharmacy on 12/04/25 at 2:27pm revealed: -The pharmacy dispensed medications on a batch cycle. -The pharmacy dispensed Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain with a quantity of 30 tablets on 09/05/25. -The pharmacy dispensed Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain with a quantity of 30 tablets on 10/21/25. Interview with a medication aide (MA) on 12/04/25 at 4:45pm revealed: -When she administered a controlled substance to a resident, she did not document on the eMAR or the CSL until the resident had taken the medication. -She compared the eMAR with the CSL log and the bubble card directions for the controlled substance before administering the medication. -MAs were expected to document accurately and complete a count off of medications with the next MA that came onto their shift before giving the new MA the keys to the cart. Interview with the Co-Administrator on 12/04/25 at 2:17pm revealed: -MAs were supposed to document the administration of any medication on the eMAR. -If the resident had a controlled substance the MAs were expected to document on the CSL and the eMAR. -The eMAR and the CSL should have documentation that matched. -She had recently completed an audit comparing the eMAR with the CSL and must have missed	D 367			

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D 367	Continued From page 41 Resident #6's chart in her review. -She often held trainings with the MAs and reinforced with them to slow down and to pay attention to prevent inaccuracy of eMARS. Interview with the Administrator on 12/04/25 at 4:05pm revealed: -MAs were expected to follow the state MA test when administering medications. -MAs should have ensured that Resident #6's eMAR was accurate. -Chart audits were completed for each resident by her and the Co-Administrator on a quarterly basis to identify any problems with documentation on the eMARS. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/04/25 at 1:47pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 09/02/25 revealed: -Diagnoses included hypertension, sleep apnea, and Alzheimer's disease. -There was an order for Tamsulosin 0.4mg daily (Tamsulosin is used to treat enlarged prostate). Review of Resident #2's Resident Register revealed an admission date of 05/06/24. Review of Resident #2's September 2025 eMAR revealed: -There was an entry for Tamsulosin 0.4mg to be administered daily at 8:00am. -Tamsulosin 0.4mg was documented as administered at 8:00am on 09/01/25. -Tamsulosin 0.4mg was documented as discontinued at 11:44am on 09/01/25. -Tamsulosin was not documented as administered from 09/02/25 to 09/30/25.	D 367		

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D 367	Continued From page 42 Review of Resident #2's October 2025 eMAR revealed there was not an entry for Tamsulosin 0.4mg to be administered daily. Review of Resident #2's November 2025 eMAR revealed there was not an entry for Tamsulosin 0.4mg to be administered daily. Review of Resident #2's December 2025 eMAR revealed there was not an entry for Tamsulosin 0.4mg to be administered daily. Observation of Resident #2's medications on hand on 12/03/25 at 2:53pm revealed: -There was a medication card for Tamsulosin 0.4mg capsules to be administered daily. -Tamsulosin 0.4mg medication card had a start date of 11/19/25 and 28 capsules were dispensed. -There were 21 capsules of Tamsulosin 0.4mg remaining on the medication card. Interview with Resident #2 on 12/04/25 at 9:20am revealed: -He had lived at the facility for over a year. -He had been having difficulty urinating for a while and it had gotten worse over the past few months. -He had been urinating frequently and he had to get up several times at night to urinate. -He thought that he had discussed this with his primary care provider (PCP). Telephone interview with the facility's contracted pharmacist on 12/03/25 at 2:20pm revealed: -The pharmacy had a current order for Resident #2's Tamsulosin 0.4mg dated 04/25/25. -The pharmacy entered new orders into the facility's eMAR. -The facility could enter orders and discontinue	D 367			

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D 367	Continued From page 43 orders. -Resident #2's Tamsulosin 0.4mg were included in the facility's monthly on the cycle fill. -The cycle fill medications were sent to the facility at least 5 days before the cycle began. -Tamsulosin 0.4mg cycle date to begin administration was 08/27/25 for a 28-day supply. -Tamsulosin 0.4mg cycle date to begin administration was 09/24/25 for a 28-day supply. -Tamsulosin 0.4mg cycle date to begin administration was 10/22/25 for a 28-day supply. -Tamsulosin 0.4mg cycle date to begin administration was 11/19/25 for a 28-day supply. Second telephone interview with the facility's contracted pharmacist on 12/04/25 at 1:30pm revealed: -Tamsulosin 0.4mg was ordered for benign prostatic hyperplasia (BPH). -BPH caused the prostate to swell and reduced the urine flow. -It was rare to ever stop taking Tamsulosin 0.4mg once they began taking this medication. Interview with a medication aide (MA) on 12/03/25 at 2:53pm revealed: -The Resident Care Coordinator (RCC) was responsible for discontinuing medication orders. -Tamsulosin 0.4mg was not on the eMAR. -The MA was not sure if there was an order to discontinue the tamsulosin 0.4mg for Resident #4. -She worked on the evening shift with an occasional night shift, but did not work day shift. Interview with the Co-Administrator on 12/02/25 at 4:05pm revealed: -The PCP sent new and discontinued medications orders to the pharmacy the RCC or herself also faxed the orders to pharmacy.	D 367		

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D 367	Continued From page 44 -Pharmacy entered orders into the eMAR and her or the RCC accepted the orders to activate them on the eMAR. -The previous RCC left their position about one month ago. -Another RCC was hired and worked for one week and resigned. -Medications should not be discontinued without a PCP order. Second interview with the Co-Administrator on 12/03/25 at 9:05am revealed: -She did not know why the Tamsulosin for Resident #2 was discontinued. -She was unable to find a discontinue order from Resident #2's PCP. -She was able to review the eMAR and saw that the previous RCC had discontinued Resident #2's Tamsulosin 0.4mg on 09/01/25. -Resident #2's Tamsulosin 0.4mg was discontinued out of the system and a discontinue order was not sent to pharmacy. -The previous RCC did not enter a reason that the Tamsulosin 0.4mg had been discontinued. -She was concerned that Resident #2 was not receiving the Tamsulosin 0.4mg that the primary care provider (PCP) had ordered. -Resident #2 could have increased urination problems. -She was not sure if Resident #2 had any increased urination problems. Interview with the Administrator on 12/04/25 at 4:05pm revealed: -She did not know that the Tamsulosin 0.4mg had been discontinued. -Tamsulosin 0.4mg should not have been on the medication cart if it was not on the eMAR. -She did not know who discontinued the Tamsulosin 0.4mg or why.	D 367			

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D 367	Continued From page 45 -Medications should be administered as ordered by the PCP. -Medication on the eMARs are reviewed quarterly by the RCC. -Cycle medications start on a specific day each month. -The Co-Administrator helped the MA on first shift place the cycle medications on one of the medication carts and the MA on evening shift placed cycle medications on the second medication cart. -The MA should report to the RCC or Administrator if medication arrived and there was not an order. Attempted telephone interview with the facility's PCP on 12/04/25 at 1:47pm was unsuccessful.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the administration of a controlled substance for 1 of 1 resident (#6) sampled residents. The findings are: Review of an undated facility policy for controlled	D 392		

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D 392	Continued From page 46 medication count off sheets revealed: -The facility should ensure that all controlled medications were counted and the medication administration records (MARS) were checked every shift. -Each medication aide (MA) was responsible to sign the narcotic count off sheet in front of the narcotic book indicating that they had counted all narcotics and checked the MAR and received them in acceptable condition. -In the event there were any discrepancies in the controlled medication count it must be reported to the Administrator or Resident Care Coordinator (RCC) immediately. -Documentation of controlled medications should be maintained and kept by the facility and should be available for review. -Documentation of receipt of the controlled medication by the pharmacy should be maintained by the facility for a minimum of three years. 1. Review of Resident #6's current FL-2 dated 11/04/25 revealed- -Diagnoses included dementia, lung cancer, and chronic obstructive pulmonary disease. -There was an order for Oxycodone/Acetaminophen (APAP) 5-325mg take one tablet every 4 hours as needed for pain (Oxycodone/Acetaminophen is used to treat moderate to severe pain). Review of Resident #6's physician order dated 11/04/25 revealed there was an order for Oxycodone/AAPAP 5-325mg tablet, take one tablet every four hours as needed for pain. Review of Resident #6's controlled substance log (CSL) for September 2025 to 10/05/25 revealed: -The prescription number, and prescription were	D 392		

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D 392	Continued From page 47 handwritten. -There was a handwritten entry for Oxycodone/APAP 5-325mg, take 1 tablet every 12 hours as needed for pain. -There was a handwritten note that there were 9 tablets of Oxycodone/APAP dispensed; there was no date on the entry. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/22/25 at 6:41am. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 8 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on "06/23/25" at 7:00am. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 7 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/23/25 at 8:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 6 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/24/25 at 3:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 5 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/28/25 at 8:00am. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 4 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/29/25 at 8:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 3 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 09/30/25 at 12:00am.	D 392			

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D 392	Continued From page 48 -The amount of Oxycodone/APAP 5-325mg remaining was documented as 2 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/04/25 at 2:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 1 tablet. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/05/25 at 1:00am. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 0 tablets. Review of Resident #6's September 2025 MAR revealed: -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain. -Oxycodone/APAP 5-325mg was documented as administered on 09/15/25 at 8:16pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/17/25 at 4:15pm. -Oxycodone/APAP 5-325mg was documented as administered on 09/29/25 at 7:10pm. Review of the CSL from September 2025 to 10/05/25 and the September 2025 eMAR revealed: -There was documentation on the eMAR that 3 Oxycodone/APAP 5-325mg tablets were administered. -There was documentation on the CSL that 9 Oxycodone/APAP 5-325mg tablets were administered. Review of Resident #6's CSL for October 2025 revealed: -There was a pharmacy label with a dispense date of 10/21/25 for a quantity of 30 Oxycodone/APAP 5-325mg, take 1 tablet every 4	D 392			

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NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
(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 392	Continued From page 49 hours as needed for pain. -There was a handwritten entry that 30 tablets of Oxycodone/APAP 5-325mg were received. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/23/25 at 6:30pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 29 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/23/25 at 11:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 28 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/24/25 at 2:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 27 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/24/25 at 6:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 26 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/24/25 at 11:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 25 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/28/25 at 6:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 24 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/28/25 at 4:13pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 23 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/04/2025
NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
(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 392	Continued From page 50 10/29/25 at 4:13pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 22 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/30/25 at 4:13pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 21 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/30/25 at 4:00pm -The amount of Oxycodone/APAP 5-325mg remaining was documented as 20 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/30/25 at 4:00pm. -The amount of Oxycodone/APAP 5-325mg remaining was documented as 19 tablets. -There was an entry that 1 tablet of Oxycodone/APAP 5-325mg was administered on 10/30/25 at 8:00pm -The amount of Oxycodone/APAP 5-325mg remaining was documented as 18 tablets. -There was an entry "Family" of Oxycodone/APAP 5-325mg was given to the resident's family. -There was no date on the entry for "Family." -The amount of Oxycodone/APAP 5-325mg remaining was documented as 17 tablets. Review of Resident #6's October 2025 MAR revealed: -There was an entry for Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain. -Oxycodone/APAP 5-325mg was documented as administered on 10/29/25 at 4:13pm. Review of the CSL from October 2025 and the October 2025 eMAR revealed: -There was documentation on the eMAR that 1	D 392			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/04/2025
NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
(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 392	Continued From page 51 Oxycodone/APAP 5-325mg tablet was administered. -There was documentation on the CSL that 13 Oxycodone/APAP 5-325mg tablets were administered. Telephone interview with a pharmacist with the facility's contracted pharmacy on 12/04/25 at 2:27pm revealed: -The pharmacy dispensed medications on a batch cycle. -The pharmacy dispensed Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain with a quantity of 30 tablets on 09/05/25. -The pharmacy dispensed Oxycodone/APAP 5-325mg, take 1 tablet every 4 hours as needed for pain with a quantity of 30 tablets on 10/21/25. Interview with a medication aide (MA) on 12/04/25 at 4:45pm revealed: -She documented on the CSL and the eMAR that a controlled substance had been administered only after she administered the medication to a resident. -She was not sure why Resident #6's CSL and eMAR did not match. -When medications were administered correctly and documentation was completed correctly, the CSL and the eMAR should match. Interview with the Co-Administrator on 12/04/25 at 2:17pm revealed: -Resident #6 was discharged to a family members home and the remaining Oxycodone/APAP 5-325mg (17 tablets) that were sent home with the resident's family member. -When a resident had a controlled substance, the MAs were supposed to document the administration of the controlled substance on the eMAR and the CSL.	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/04/2025
NAME OF PROVIDER OR SUPPLIER WAKE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 KIDD ROAD RALEIGH, NC 27610		
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D 392	Continued From page 52 -She expected the eMAR and the CSL to match. -She was not sure why the eMAR did not match the CSL for Resident #6. -She completed audits and compared the eMAR with physician orders and the CSL to ensure resident's medications were administered correctly. Interview with the Administrator on 12/04/25 at 4:05pm revealed: -Resident #6's eMAR and CSL should match. -She and the Co-Administrator completed audits on each resident on a quarterly basis, and the mistake should have been identified. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/04/25 at 1:47pm was unsuccessful.	D 392			