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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092233	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 a follow-up survey on November 4-5, 2025.	D 000		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure that residents' electrically operated call bell in their rooms could be activated with a single action and remain on until deactivated by staff at the point of origin, be within reach of the resident's bed, and when	D 118	An electrically operated call bell system has been ordered and in production as of 12/2/2025. Shipment is expected before 12/24/25. To ensure resident safety, all residents have been given hand/wrist bells and are on documented wellness checks every 30 minutes. The hand bells will be utilized, and documented wellness checks will remain active until the arrival of the new call system that has been ordered.	12/1

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Regina Hough TITLE Executive Director (X6) DATE 12/2/25

Reviewed and acknowledged on 12/17/2025 Joyce Johnston

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D 118	Continued From page 1	D 118		

activated have an audible and visual signal in a location accessible to staff for 43 residents residing in the facility.

The findings are:

Review of the facility's census on 11/04/25 revealed there were 43 residents.

Review of the resident council meeting minutes for August 2025 revealed that call bells were discussed.

Review of the resident council minutes for October 2025 revealed that call bells were discussed.

Interview with a resident who resided in room 215 on 11/05/25 at 9:00am revealed:
-She was the resident council president.
-The resident council met once a month.
-Call bells were discussed in the last two resident council meetings.
-The call bells had not been working in some of the residents' rooms.
-Her call bell by her bed had not worked for a long time.
-She had recently fallen getting up to go to the restroom before breakfast.
-She hit her left knee on the bedframe and laid there for 45 minutes to an hour; she did not go to the emergency room.
-Her roommate found her when she got up to go to the restroom and went and got help.
-This made her feel like she was being ignored and that no one cared.

Interview with a second resident who resided in room 215 on 11/05/25 at 9:11am revealed:
-She had lived there for a month.

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D 118	Continued From page 2 -Her call bell had not worked since she had lived at the facility. -She needed help getting to the bathroom and had no way to call for help. -She had found her roommate on the floor recently and had to go find help. -This made her feel like no one cared about her or her needs. Observation of room 215 on 11/05/25 at 9:15am revealed: -The bed and bathroom call bells did not work. -The call bells did not light up above their door. -The call bells did not make an audible sound or light up in the nurse's station. Observation of room 201 on 11/05/25 at 9:17am revealed: -The bed and bathroom call bells did not work. -The call bells did not light up above their door. -The call bells did not make an audible sound or light up in the nurse's station. Observation of room 202 on 11/05/25 at 9:16am revealed: -The light above the door worked for the bedroom and not for the bathroom. -The call bells did not make an audible sound or light up in the nurse's station. Observation of room 102 on 11/05/25 at 10:55am revealed: -The call bell light above the door was on all the time. -The bedroom and bathroom call bells did not work. -The call bell did not make an audible sound or light up at the nurse's station. Observation of room 207 on 11/05/25 at 11:00am	D 118		

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D 118	Continued From page 3 revealed: -The call bells did not light up above their door. -The call bells did not make an audible sound or light up in the nurse's station. -Both call bells were hanging next to one of the residents' beds. Observation of room 206 on 11/05/25 at 11:00am revealed: -The call bells did not light up above their door for one of the two call bells next to a resident's bed. -The call bells did not make an audible sound or light up in the nurse's station. -Both call bells were hanging next to one of the residents' beds. Interview with a personal care aide (PCA) on 11/05/25 at 9:15am revealed: -Some of the call bells did not work. -Some of the call bell lights came on above their doors. -The call bells did not make a noise at the nurse's station. -Both calls bells in room 215 and their bathroom did not work, except for the bathroom sometimes worked but not all the time. -There were several rooms where the call bells did not work. -She thought maintenance was working on them. -She was told by the Executive Director (ED) to watch for residents that needed help. -It was not possible to watch the residents if you were in another resident's room helping them. Interview with a second PCA on 11/05/25 at 10:55am revealed: -The call bells had not worked for several weeks. -Room 102 call light stayed on all the time so the resident yelled for help when she needed something.	D 118		

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D 118	Continued From page 4 -She had not been instructed to change anything in providing care to the residents since the call bells stopped working. Interview with a medication aide (MA) on 11/05/25 at 9:20am revealed: -The call bells had not worked for one month. -Someone came and checked the call bells last week, not sure of the day, and the call bells still did not work. -The call bells did not make a noise at the nurse's station. -The call bell light for room 102 stayed on all the time. Interview with the Maintenance Director (MD) on 11/05/25 at 9:21am revealed: -He had worked at the facility for 6 months. -There was an issue with the call bells not working correctly for 1-2 weeks. -A resident had informed him the call bells were not working correctly. -He had tested the call bells and found that they were not working. -The lights above the resident's door did not always work. -The call bells did not make a noise at the nurse's station. -Some of the call bell lights stayed on all the time. -An outside company came and checked the call bells last week. -He did not know what the outside company had found. Interview with the ED on 11/05/25 at 9:30am revealed: -A resident's family had told her that the call bells were not working, (unsure of the date). -She checked the call bells after the MD worked on the call bells and they were working correctly.	D 118		

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D 118	Continued From page 5 -The call bells had not been working correctly for about a week. -The call bells were not making a noise at the nurse's station. -Some of the call light come on and others stayed on all the time. -The MD called an outside company to check the call bells not sure of the date. -She had not received an invoice from the outside company that checked the call bells. -Staff were performing 15-30-minute checks on the residents. -The staff were not documenting the 15-30 checks. -She had instructed the staff to perform these checks. -The staff must be on the floors to see the lights come on. -The residents should have an alternate call bell to be able to call for help. -She had not provided an alternate call bell for the residents to use to call for help. -She expected that the call bells should be functioning correctly. -The facility was trying to get the call bells fixed. -She expected the MD to notify her when the call bells were not working. -There was no documentation when the MD found the call bells were not working. -There was no way to print a call bell log. -She had not increased staffing since the call bells stopped working. Interview with the Regional Director of Operations (RDO) on 11/05/25 at 9:53am revealed: -She did not know that the resident's call bells were not working. -She expected to be notified by the ED when the call bells stopped working correctly. -Staff should be performing routine checks.	D 118		

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D 118	Continued From page 6 -A resident could ask their roommate to get help if they had a roommate. -The resident could crawl to the door if they fell to get help. -The residents could scream for help. -The facility could have provided hand bells for the residents to use when the call bells stopped working. Interview with the primary care provider (PCP) on 11/05/25 at 11:30am revealed: -She was not aware that the residents' call bells were not working correctly. -This was a concern related to each resident care plan and functional status. -This was a high-risk scenario related to the resident's needs or severity of their condition. -It could place residents at severe risk and imminent danger. Attempted telephone interview with the outside electric company on 11/05/25 at 11:16am was unsuccessful. The facility failed to maintain an electrically operated call bell system that had an audible and visual signal. One resident fell and laid on the floor for 45 minutes to one hour and was unable to call for help until her roommate woke up. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/05/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 23, 2025.	D 118		

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 4 of 5 sampled residents (#1,#2, #4, #5) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health. The findings are: Review of the facility Tuberculosis (TB) policy undated revealed: -All residents are screened for TB using 2-step Mantoux method. -Screening is done upon admission for individuals who cannot provide documented skin test within preceding 12 months. 1. Review of Resident #1's current FL2 dated 08/12/24 revealed: -Diagnoses included anxiety disorder, Parkinson's disease, dementia, and hypertension.	D 234	All new admissions will have tb testing completed before move in and show documented results. ED will use new Admission check off form to ensure testing has been completed. If new admission. RCC will complete audit of charts, ensuring compliance of TB testing). All residents that do not show TB currently in chart, has been given a tb screening effective 11/7/2025. ED will confirm compliance of testing.	12/1

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 4 of 5 sampled residents (#1,#2, #4, #5) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health. The findings are: Review of the facility Tuberculosis (TB) policy undated revealed: -All residents are screened for TB using 2-step Mantoux method. -Screening is done upon admission for individuals who cannot provide documented skin test within preceding 12 months. 1. Review of Resident #1's current FL2 dated 08/12/24 revealed: -Diagnoses included anxiety disorder, Parkinson's disease, dementia, and hypertension.	D 234		

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D 234	Continued From page 8 -His level of care was documented as assisted living facility. Review of resident #1's Resident Register revealed he was admitted to the facility on 06/12/23. Review of Resident #1's records revealed: -He had a TB test given on 05/18/23 and read as negative on 05/21/25. -He did not have documentation that a second-step TB test was completed. Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am. Refer to interview with the Executive Director (ED) on 11/05/25 at 9:10am. 2. Review of Resident #4's current FL2 dated 10/21/25 revealed: -Diagnoses included coronary artery disease, cerebrovascular accident, and chronic kidney disease stage 3. -Her level of care was documented as assisted living facility. Review of Resident #4's records revealed she did not have a completed Resident Register. Review of Resident #4's records revealed she did not have documentation of a TB test having been completed upon admission. Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am. Refer to interview with the Executive Director (ED) on 11/05/25 at 9:10am.	D 234		

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D 234	Continued From page 9 3. Review of Resident #2's current FL2 dated 08/01/25 revealed diagnoses included anemia, chronic tension headache, muscle weakness, disorder of the brain, polyneuropathy, pressure ulcer left heel, and vitamin D deficiency. Review of Resident #2's Resident Register revealed Resident #2 had an admission date of 06/10/25 but was not admitted until 07/17/25. Review of Resident #2's Records revealed: -Resident #2 had a TB test administered on 06/26/25 and no read date. -Resident #2 had a TB test administered on 07/25/25 and no read date. Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am. Refer to interview with the Executive Director (ED) on 11/05/25 at 9:10am. 4. Review of Resident #5's current FL2 dated 09/09/25 revealed diagnoses included chronic kidney disease, arteriovenous fistula, end stage renal disease, transient ischemic attack, cerebral vascular atherosclerosis, infraction without residual deficits, and renal dialysis. Review of Resident #5's Resident Register revealed Resident #5 had an admission date of 08/08/25. Review of Resident 5's records revealed she did not have documentation of a TB test having been completed upon admission. Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am.	D 234		

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D 234	Continued From page 10 Refer to Interview with the Executive Director (ED) on 11/05/25 at 9:10am. Interview with the PCP on 11/05/25 at 8:40am revealed: -Each resident was required to have a 2-step TB test completed upon admission to an assisted living facility. -She was concerned that not testing a resident for TB upon admission to a facility was a public health risk due to risk of TB exposure. Interview with the ED on 11/05/25 at 9:10am revealed: -The Resident Care Coordinator (RCC) was responsible for completing TB testing for all residents upon admission. -She no longer had an RCC as of 11/04/25. -The RCC was not completing TB tests for residents. -The first step of the TB testing should have been completed before a new resident was admitted to the facility. -The second step TB testing should have been completed within 2 weeks of a resident being admitted to the facility. -She was assuming responsibility for the TB testing not being completed for each resident. -It was important for each resident to have TB testing to prevent an outbreak in the facility.	D 234	Resident Register will be completed at time of admission. ED will confirm and sign at admission as well. A guideline and check off list, governed by ED has been created and put in place to ensure compliance	12-11
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the	D 248		

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D 248	Continued From page 11 Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.	D 248		

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D 248	Continued From page 12	D 248		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 3 of 5 sampled residents (2, #4, and #5).

The findings are:

1. Review of Resident #2's current FL2 dated 08/01/25 revealed diagnoses included anemia, chronic tension headache, muscle weakness, disorder of the brain, polyneuropathy, pressure ulcer left heel, and vitamin D deficiency.

Review of Resident #2's Resident Register revealed:
-Resident #2 had an admission date of 06/10/25 but was not admitted until 07/17/25.
-Resident #2 was her own responsible person.
-Resident #2 had not dated her two signatures and did not complete signing and dating the Resident Register.
-Resident #2's Resident Register had not been signed and dated by the Administrator or designee.

Interview with the Executive Director (ED) on 11/05/25 at 9:30am revealed:
-Resident #2 was supposed to be admitted on 06/10/25 from the hospital.
-Resident #2 was admitted to rehabilitation from the hospital.
-Resident #2 was admitted to the facility from the

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	HAL092233	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 248	Continued From page 13 rehabilitation facility on 07/17/25. Refer to interview with the Executive Director on 11/05/25 at 9:30am. 2. Review of Resident #4's current FL2 dated 10/21/25 revealed: -Diagnoses included coronary artery disease, cerebrovascular accident, and chronic kidney disease stage 3. -Her level of care was documented as assisted living facility. Review of Resident #4's records revealed she did not have a Resident Register. Refer to interview with the Executive Director on 11/05/25 at 9:30am. 3. Review of Resident #5's current FL2 dated 09/09/25 revealed diagnoses included chronic kidney disease, arteriovenous fistula, end stage renal disease, transient ischemic attack, cerebral vascular atherosclerosis, infraction without residual deficits, and renal dialysis. Review of Resident #5's Resident Register revealed: -Resident #5 had an admission date of 08/08/25. -Resident #5's Resident Register had not been signed and dated by the responsible person. -Resident #5's Resident Register had been signed and dated, 08/09/25 on one signature line by the Administrator's designee. Refer to interview with the Executive Director on 11/05/25 at 9:30am Interview with the Executive Director on 11/05/25 at 9:30am revealed:	D 248		

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D 248	Continued From page 14 -She had worked at the facility since 04/17/25. -There was not a designated Business Office Manager (BOM). -The Resident Care Coordinator (RCC) was performing the BOM duties and RCC duties. -The RCC quit on 11/04/25. -The RCC was responsible for completing the Resident Registers. -She did not know that there were Resident Registers that were not completed. -She had not performed any resident chart reviews.	D 248		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living.	D 253	An initial Assesment will be completed prior to move in. Care plan assessment will be completed within 30 days of move in, and signed by medical Provider. Guidelines and check off list created to ensure compliance. ED will confirm and ensure compliance.	1211

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D 253	Continued From page 15 The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253		

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D 253	Continued From page 16	D 253		

This Rule is not met as evidenced by:
Based on interviews, and record review, the facility failed to ensure 3 of 5 sampled residents (#1, #2 and #4) had assessments completed within 30 days of admission and annually.

The findings are:

1. Review of Resident #1's current FL2 dated 08/12/24 revealed:
-Diagnoses included anxiety disorder, Parkinson's disease, dementia, and hypertension.
-His level of care was documented as assisted living facility.

Review of resident #1's Resident Register revealed he was admitted to the facility on 06/12/23.

Review of Resident #1's records revealed his most recent completed care plan was dated 08/02/24.

Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am.

Refer to interview with the Executive Director (ED) on 07/23/25 at 9:55am.

2. Review of Resident #2's current FL2 dated 08/01/25 revealed diagnoses included anemia, chronic tension headache, muscle weakness, disorder of the brain, polyneuropathy, pressure

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D 253	Continued From page 17 ulcer left heel, and vitamin D deficiency. Review of Resident #2's Resident Register revealed Resident #2 had an admission date of 07/17/25. Review of Resident #2's Care Plan dated 10/08/25 revealed: -Resident #2 was totally dependent for toileting, ambulation, bathing, dressing, and transferring. -Resident #2 needed limited assistance with personal hygiene. -Resident #2 needed supervision with eating. -The Care Plan was not signed and dated by the staff that completed the Care Plan. -The primary care provider (PCP) signed the Care Plan on 10/09/25. Refer to interview with the Primary Care Provider (PCP) on 11/05/25 at 8:40am. Refer to interview with the Executive Director (ED) on 07/23/25 at 9:55am. 3. Review of Resident #4's current FL2 dated 10/21/25 revealed: -Diagnoses included coronary artery disease, cerebrovascular accident, and chronic kidney disease stage 3. -Her level of care was documented as assisted living facility. Review of Resident #4's records revealed she did not have a completed Resident Register. Review of Resident #4's records revealed she did not have a completed care plan. Refer to interview with the Executive Director (ED) on 11/05/25 at 9:10am.	D 253		

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D 253	Continued From page 18 Refer to interview with the primary care provider (PCP) on 11/05/25 at 8:40am. Interview with the PCP on 11/05/25 at 8:40am revealed: -Each resident in the facility should have had a current care plan completed. -She was supposed to sign care plans for each resident every 6 months. -Each resident should have had a care plan signed by her within 2 weeks of her initial visit. -She asked the facility to put new resident care plans in her folder to be signed. -The facility was responsible for ensuring care plans were completed and given to her for review and signature. Interview with the ED on 11/05/25 at 9:10am revealed: -The Resident Care Coordinator (RCC) was responsible for completing the care plans timely for all residents. -She no longer had an RCC as of 11/04/25. -The RCC was not completing the care plans for residents. -Care plans should have been done annually for each resident or after any significant change. -It was important for each resident to have an updated care plan in order for staff to provide proper care for each resident. -She was assuming responsibility for the care plans not being completed for each resident.	D 253	med cart and mar audits will be completed daily. med Techs received inservice on medication Administration, and process to follow in the event that a medication is running low, or unavailble from pharmacy. medication staff has been inserviced and advised on medication timeframes and prepping of med administration. MT will make PCP aware of refills that are needed, and ensure all medications are in the building at all times. Dee will confirm and ensure compliance.	12/1/25
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358	ED will audit and make necessary adjustments to ensure med Admin safety and compliance	

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D 358	Continued From page 19 preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a medication was administered as ordered for 1 of 5 sampled residents (#2) related to a medication to treat pain. The findings are: Review of the facility's medication administration policy (undated) revealed: -The purpose of the policy is to ensure that medications are administered consistently and within appropriate timeframes to meet residents' healthcare needs. -Medications will be administered within one hour before or after the specified times, except in cases of emergencies. Review of Resident #2's current FL2 dated 08/19/25 revealed: -Diagnoses included anemia, chronic tension headache, muscle weakness, disorder of the brain, polyneuropathy, pressure ulcer on left heel, and vitamin D deficiency. -There was an order for Hydrocodone Acetaminophen 10-325mg 2 tablets twice daily. (Hydrocodone Acetaminophen is used to treat pain). -There was an order for Hydrocodone	D 358		

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D 358	Continued From page 20 Acetaminophen 10-325mg 2 tablets twice daily as needed. Review of Resident #2's Resident Register revealed an admission date of 07/17/25. Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily. -Hydrocodone Acetaminophen 10-325mg was documented as administered at 8:00am from 09/01/25 to 09/21/25, 09/25/25 to 09/26/25, and 09/29/25. -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00am on 09/22/25, 09/23/25, 09/24/25, 09/27/25, 09/28/25, and 09/30/25 (medication was not available). -Hydrocodone Acetaminophen 10-325mg was documented as administered at 8:00pm from 09/01/25 to 09/20/25, 09/21/25, and 09/27/25 to 09/28/25. -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00pm on 09/20/25 (out of medications), 09/22/25 (need refill), 09/23/25 (out of stock), 09/24/25 (order medications), 09/25/25 (no medications order them), 09/26/25 (order medications), 09/29/25 (need refill), and 09/30/25 (in hospital). -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily as needed. -Hydrocodone Acetaminophen 10-325mg as needed was documented as administered on 09/20/25 at 8:53am, 09/21/25 at 11:55am, 09/23/25 at 3:11pm, 09/24/25 at 3:11pm, 09/24/25 at 12:34am, 09/25/25 at 10:27pm, 09/25/25 at 10:01am, 09/26/25 at 2:37pm,	D 358		

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D 358	Continued From page 21 09/27/25 at 2:25pm, 09/25/25 at 1:43pm, and 09/29/25 at 10:26am. Review of Resident #2's October 2025 eMAR revealed: -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily. -Hydrocodone Acetaminophen 10-325mg was documented as administered at 8:00am from 10/04/25, 10/05/25, 10/08/25-10/22/25. -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00am on 10/01/25, 10/03/25, 10/06/25, 10/07/25, 10/25/25 to 10/31/25 (medication not available). -Hydrocodone Acetaminophen 10-325mg was documented as administered at 8:00pm on 10/02/25, and 10/06/25-10/21/25. -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00pm on 10/01/25 and 10/03/25 (need refill), 10/04/25 (order medications), 10/05/25 (medications not available), 10/22/25 (order medication), 10/23/25 (need refill), 10/24/25 (medication not available), 10/25/25 (waiting on pharmacy), 10/26/25 (medication not available), 10/27/25 (need refill), 10/28/25 (do not have), 10/29/25 (no refill), 10/30/25 and 10/31/25 (medication not available). -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily as needed. -Hydrocodone Acetaminophen 10-325mg as needed was documented as administered on 10/01/25 at 3:12pm, 10/03/25 at 1:59pm, 10/04/25 at 8:57am, 10/06/25, at 10:41am, 10/07/25 at 10:34am, 10/22/25 at 7:43pm, 10/22/25 at 8:28am, 10/23/25 at 7:34pm, 10/23/25 at 9:15am, and 10/24/25 at 7:48pm. Review of Resident #2's November 2025 eMAR	D 358	RCC will ensure that all narcotics needing pre-Auth are fill and paper work from Provider is sent to the pharmacy in a timely manner.	

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D 358	Continued From page 22 revealed: -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily. -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00am from 11/01/25 to 11/02/25 (medication not available), 11/03/25 (left blank), 11/04/25 (reason not documented). -Hydrocodone Acetaminophen 10-325mg was documented as not administered at 8:00pm on 11/01/25 and 11/02/25 (need refill), 11/03/25 (do not have medication). -There was an entry for Hydrocodone Acetaminophen 10-325mg 2 tablets to be administered twice daily as needed. -Hydrocodone Acetaminophen 10-325mg as needed was not documented as administered from 11/01/25 to 11/04/25. Observation of Resident #2's medications on hand on 11/04/25 at 1:15pm revealed that Hydrocodone Acetaminophen 10-325mg tablets scheduled or as needed were not in the medication cart. Interview with Resident #2 on 11/4/25 at 2:30pm revealed: -She had lived at the facility for about 4 months. -She was paralyzed from the waist down. -She was concerned that her pain was not controlled. -Resident #2's back pain level was a 7 out of 10. (Pain level is rated on a scale of 0-10. A pain level of 7 is considered strong pain). -She was not sure if she was receiving her medications as ordered. -The staff did not explain what medications she was administered.	D 358		

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D 358	Continued From page 23 Second interview with Resident #2 on 11/05/25 at 8:06am revealed: -She had talked with her provider about needing an as needed pain medication. -Resident #2's back pain level was an 8 out of 10. -She had not received her morning medications and was wanting to get out of bed. -She had abdominal pain, nausea, vomiting, and diarrhea for several days a few weeks ago, not sure of the dates. Interview with the facility's contracted pharmacist on 11/04/25 at 2:07pm revealed: -Hydrocodone Acetaminophen 10-325mg was a schedule II-controlled substance that required a new prescription each time it was dispensed. -Hydrocodone Acetaminophen 10-325 was dispensed on 08/08/25 for a 30-day supply, 120 tablets and a as needed for 30 tablets. -Hydrocodone Acetaminophen 10-325 was dispensed on 10/03/25 for a 15-day supply. Interview with a medication aide (MA) on 11/04/25 at 1:37pm revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring that medications were available on the medication carts. -The RCC called the pharmacy when residents were out of medications. -MAs did not normally call the pharmacy for medications. -She had notified the RCC on multiple occasions that Resident #2 was out of her pain medication. Interview with a second MA on 11/05/25 at 10:09am revealed: -If a medication was not available the RCC was notified. -The MAs did not call the pharmacy or the primary care provider (PCP) when a resident was	D 358		

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D 358	Continued From page 24 out of medication. -The RCC was responsible for notifying the pharmacy or PCP when a resident was out of their medications. Interview with the Executive Director (ED) on 11/04/25 at 10:50am revealed that the RCC had quit today, 11/04/25. Second interview with the ED on 11/04/25 at 2:19pm revealed: -The RCC was responsible for ensuring that the residents had their medications available. -The RCC would not allow the MAs to call the pharmacy or PCP. -There was not a process for the RCC to document when she called the pharmacy or PCP. -She did not know that Resident #2 was out of her pain medication. -She expected the RCC would call and request the medications to be filled. -There was no excuse for the medications not being available for Resident #2 on the medication cart. -They could have placed the medication on hold after speaking to the PCP. -The pharmacy delivered medications to the facility daily. -The facility had a backup pharmacy for emergencies. -It would be a problem for Resident #2 to go without her pain medication. -Resident #2's pain could increase. -The RCC performed medication cart audits on Mondays and Fridays, looking for expired medications, dates on medications opened like insulin and eye drops, and that the medications on the cart matched the eMARs. -She scanned the medications carts looking for dates on meds and that the medications matched	D 358		

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D 358	Continued From page 25 the eMARS. -She last worked as a MA two weeks ago on third shift. -The facility did not use the control substance logs that the pharmacy sent with narcotics. -The MAs documented in the computer. -The RCC was responsible for reviewing the control substance logs. -She was unable to provide or print the control substance logs for review. -She was unable to provide the electronic control substance logs and unable to pull them up to provide the date and time the medications were administered. Interview with the facility's contracted PCP on 11/05/25 at 8:16am revealed: -She did not know that Resident #2 was out of her pain medication. -Resident #2 took pain medication for her back pain. -She was in the facility every Thursday. -She had never been asked to refill Resident #2's pain medication. -Resident #2's Hydrocodone Acetaminophen 10-325mg was a schedule II control substance and required a new prescription each time it was ordered. -The facility should have called her when the refill was needed. -She had ordered the medication on 10/03/25 for 15 days. -The pharmacy sent her a refill request on 11/04/25. -She was concerned because of the pain medication dose Resident #2 was on and what could happen to her by stopping the medication suddenly. -Resident #2 was at risk for increased pain withdrawals, could become clammy, have body	D 358		

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	HAL092233	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 26 aches, become dizzy, or have nausea and vomiting. The facility failed to administer a pain medication to Resident #2 as ordered. This pain medication prescription was a schedule II controlled substance and had to be requested from the primary care provider each time that it needed to be filled and the facility failed to secure this prescription each time that the resident needed the pain medication refilled. The facility staff documented that Resident #2 went without their scheduled pain medication on multiple occasions in September 2025, October 2025 and 4 consecutive days in November 2025. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/05/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 23, 2025.	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;	D 367	mid staff inserviced and advised to record & document amounts of insulin being given according to order. Dce will ensure compliance and resident safety.	12/1

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D 367	Continued From page 27 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled resident (#3) including inaccurate documentation of an insulin. The findings are: Review of Resident #3's current FL-2 dated 10/31/25 revealed diagnoses included aphasia, type 2 diabetes mellitus, hyperglycemia, hyperlipidemia and chronic diastolic heart failure. Review of Resident #3's Resident Register revealed she was admitted in the facility on 10/09/25. Review of Resident #3's physician order dated 10/17/25 revealed there was an order for insulin lispro 100 unit/mL, check blood sugar 4 times daily <70 call doctor; 201-250 = inject 4 units; 251-300 = inject 6 units; 301-350 = inject 8 units; 351-400 = inject 10 units; >400 call doctor (used	D 367		

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D 367	Continued From page 28 to treat diabetes). Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro 100 unit/mL, check blood sugar 4 times daily <70 call doctor; 201-250 = inject 4 units; 251-300 = inject 6 units; 301-350 = inject 8 units; 351-400 = inject 10 units; >400 call doctor. -Insulin lispro was documented as administered four times each day at 7:30am, 11:30am, 4:30pm, and 8:00pm. -Insulin lispro was documented as administered 54 times. -There was documentation of Resident #3's blood sugar four times each day. -There was no documentation of the units of insulin lispro administered to the resident. Review of Resident #3's November 2025 eMAR revealed: -There was an entry for insulin lispro 100 unit/mL, check blood sugar 4 times daily <70 call doctor; 201-250 = inject 4 units; 251-300 = inject 6 units; 301-350 = inject 8 units; 351-400 = inject 10 units; >400 call doctor. -Insulin lispro was documented as administered four times each day at 7:30am, 11:30am, 4:30pm, and 8:00pm. -Insulin lispro was documented as administered 14 times. -There was documentation of Resident #3's blood sugar four times each day. -There was no documentation of the units of insulin lispro administered to the resident. Interview with a medication aide (MA) on 11/05/25 at 10:50am revealed: -Resident #3's blood sugar was checked four	D 367		

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D 367	Continued From page 29 times daily. -Resident #3 was administered the amount of units that matched her blood sugar. -The MAs documented Resident #3's blood sugar four times each day on the eMAR. -The MAs did not document the units of insulin they administered to Resident #3. Interview with a second MA on 11/05/25 at 11:05am revealed: -She checked Resident #3's blood sugar and administered the units of insulin matching the sliding scale numbers on the eMAR. -She documented the blood sugar on the eMAR. -She did not document the units of insulin she administered to Resident #3. -The eMAR system only had a section to add the blood sugar level. -The eMAR system did not have a section to add the units administered to the resident. Interview with the facility's contracted pharmacy on 11/05/25 at 11:15am revealed: -The pharmacy did not have access to make changes to the eMAR system for this facility. -The facility did not give the pharmacy permission to make any adjustments in the system. -In the system there should be a place to document the residents blood sugar and the units of insulin administered. -The facility should have been documenting the units of insulin that was administered. -Documenting the units of insulin administered allowed the provider to know the units of insulin the resident was receiving. -It was important for the provider to know how much insulin was being administered in case adjustments needed to be made to the residents insulin. -It was important for the facility to always	D 367		

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D 367	Continued From page 30 document the residents blood sugar and units of insulin administered. Interview with the PCP on 11/05/25 at 11:15am revealed: -The MAs were responsible for documenting medications that were administered to the residents on the eMAR. -She believed it was medically appropriate for the MAs to document the units of insulin that Resident #3 was receiving. -She needed to know the units of insulin that Resident #3 was being administered so she could make appropriate changes to insulin if needed. -She needed to know the units of insulin that Resident #3 was being administered so she could confirm that Resident #3 was getting a safe and effective dose. Interview with the Executive Director (ED) on 11/05/25 at 11:30am revealed: -There was not a place in the eMAR system that prompted the MAs to add the units of insulin that were administered. -The MAs were able to add a note in the eMAR system to document the units of insulin that was administered. -She was not aware the MAs had not been documenting the units of insulin that Resident #3 had been administered. -It was important to document the amount of insulin Resident #3 was being administered.	D 367		