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
	HAL025040	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN MEMORY CAR	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on December 09, 2025 and December 10, 2025.	D 000		
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 review the facility failed to ensure the Special Care Unit (SCU) was free of hazards in seven resident rooms including toiletries such as shampoo, body wash, body lotion, skin cleansers, soap, mouthwash, and disposable razors that were accessible to residents in the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed as a SCU effective 01/01/25 for a capacity of 25 residents. -The expiration date of the facility's license was	D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings To immediately be in coimpliance with this regulation, the Garden House Director (Special Care Coordinator) will complete a detailed room check and remove all hazards in resident rooms including toiletries such as shampoo, body wash, body lotion, skin cleaners, soap, mouth wash, and disposabe razors accessible to residents in their rooms and/or bathrooms. The items will be put into each residents individual toilitries container that is secured in a locked closet which care staff have the key to access for each resident. The Garden House Director will secure the door of the soiled linen and eye wash closet To prevent hazards being left in places accessible to the residents, the Resident Care Director will conduct trainings for all staff in the Special Care Unit including care staff, dining staff and housekeeping staff on regulation 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings requiring the SCU to be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards. The signed training forms will be signed and kept in the employee training section of the employee administration file.	12.11.2025 12.11.2025 12.11.2025 Starting 12.11.2025 Completed: 12.13.2025

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lara Williams	Senior General Manager	12.22.2025

Reviewed and Acknowledged MW 01/08/26

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D 079	Continued From page 1 12/31/25. Review of the facility's census on 12/09/25 revealed the facility's census was 19 residents. Observation of the soiled linen and eye wash station room on 12/09/25 at 8:35am revealed: -The door was unlocked and cracked open. -There was a biohazard sign on the door. -There was a 9 ounce bottle of foaming body cleanser that was labeled for external use only. Observation of resident room #10 on 12/09/25 at 8:51am revealed: -There was a 35 ounce bottle of liquid body wash in the shower. -There was a 25 gram tube of toothpaste. Observation of resident room #14 on 12/09/25 at 9:12am revealed: -There was a 6.2 ounce automatic aerosol spray can of air freshener on the resident's dresser with a warning that contents were under pressure, the product was an eye irritant and contained acetone, avoid contact with eyes, if contact occurs with eyes rinse, if irritation persists get medical attention, and to keep out of reach of children. -There was a 9 ounce bottle of foaming cleanser that was labeled for external use only. Observation of resident room #18 at 9:14am revealed: -The room was vacant. -There was an 11 ounce can of shaving cream on the back of the toilet with a warning that the contents were under pressure and to keep out of reach of children. Observation of resident room #5 on 12/09/25 at	D 079		

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D 079	Continued From page 2 9:19am revealed two plastic disposable razors in the wall medicine cabinet in the bathroom. Observation of room #8 on 12/09/25 at 9:24am revealed: -There was a plastic container of solid deodorant/antiperspirant on the bathroom vanity counter. -There were two disposable plastic razors in the bathroom vanity cabinet. -There was an 11 ounce can of shaving cream labeled to keep out of reach of children in the bathroom vanity cabinet. Observation of room #9 on 12/09/25 at 9:26am revealed: -There were two 8-ounce bottles of shampoo/body wash, labeled for external use only on the bathroom vanity counter. -There was an 8.5-ounce bottle of curl defining spay gel on the bathroom vanity counter. -There was a 3-ounce bottle of dandruff shampoo labeled for external use only on the bathroom vanity counter. -There was 0.75-ounce travel size bottle of hair conditioner labeled for external use only, avoid contact with eyes on the bathroom vanity counter. -There was a bottle of body wash in the bathroom vanity cabinet. Observation of room #20 on 12/09/25 at 9:57am revealed: -There was a 13.5 ounce bottle of body lotion on a dresser with a warning to keep out of reach of children and to avoid contact with eyes -There was a 25.36 ounce bottle of conditioner on a dresser. -There was a 25.36 ounce bottle of shampoo on a dresser. -There was a 33.8 ounce bottle of body wash on	D 079		

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a dresser.
-There was 4.4 ounce tube of facial cleanser on a dresser.
-There was a 2.6 ounce plastic container of deodorant with a warning to keep out of reach of children, for external use only, and if swallowed get medical help or contact a poison control center.
-There was a 2.95 ounce plastic container of deodorant with a warning to keep out of reach of children.
-There was a 16.9 ounce bottle of mouth wash on the bathroom sink with a warning to keep out of reach of children and in case of accidental ingestion, seek professional assistance or contact a poison control center immediately.
-There was a 7.05 ounce tube of toothpaste on the bathroom sink with a warning to keep out of reach of children and if more than used for brushing is accidentally swallowed, get medical help or contact a poison control center immediately.

Interview with a personal care aide (PCA) on 12/09/25 at 9:41am revealed:
-The residents' personal care items were kept in bins in a locked closet.
-The residents were not to have razors or personal care items in their rooms.
-The residents' family sometimes brought in personal care items without the staff's knowledge.

Interview with a second PCA on 12/09/25 at 9:48am revealed:
-Staff were supposed to get a resident's personal care products out of the locked storage closet that had individuals' products in a plastic bin with their name written on the bin with a black permanent marker.
-PCAs had a key to the locked storage closet.

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D 079	Continued From page 4 -PCAs were supposed to keep all personal care products locked in the storage closet to ensure the safety of residents. -No residents had ingested any products that she was aware of, however several years ago a resident used toothpaste for facial cream and complained that her face felt like it was tingling and burning. -Personal care products and cleaning products were secured in locked closets to keep the residents safe. -PCAs made rounds at the beginning of their shift to make sure there were not any personal care products that were not stored in a locked area. Interview with a medication aide (MA) on 12/09/25 at 9:53am revealed: -The residents were not to have personal care items in their rooms without staff supervision. -Family members brought in personal care items for the residents. -She thought any personal care items in the residents' rooms must have been left out by the previous shift. Interview with the Special Care Coordinator (SCC) on 12/09/25 at 10:12am revealed: -Staff assisted the residents or supervised activities of daily living (ADLs) and hygiene and then were to remove and secure all personal care products. -Staff were to do a room sweep daily on each shift to make sure there were no personal care items in the residents' rooms. -Unattended personal care products could be ingested. -There were no residents in the facility that had ingested any personal care products. -She was not aware there were personal care items and razors in resident rooms.	D 079		

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D 079	Continued From page 5 Interview with the Administrator on 12/10/25 at 2:10pm revealed: -The residents in the Special Care Unit were not to have personal care products or razors in their room. -Personal care items and razors were locked in a closet on the Special Care Unit. -Residents could potentially ingest personal care items and harm themselves. -Anything labeled "keep out of the reach of children" should be secured. -There were some residents that wandered in and out of rooms. -She knew staff performed room sweeps at least every quarter. -She expected personal care items and razors to be locked up and secured when not in use or supervised by staff.	D 079		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by:	D 344	10A NCAC 13F .1002(a) Medication Orders To immediately be in compliance with this regulation, the Garden House Director will contact the physicin for a clarification order. The physycians order is for potassium chloride ER 20meq. The medication on hand and administered is potassium chloride ER 20meq. The electronic medication administration record (eMAR) was not updated and continued to reflect chloride potassium ER 10 meq The clarification order will be submitted to the communities contracted pharmacy to profile the correct dosage of potassium and reflect the accurate dosage on the electronic medication administration record (eMAR).	12.11.2025 12.11.2025

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D 344	Continued From page 6 Based on observation, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 4 residents (#6) observed during the morning medication pass for a medication used to treat low potassium levels. The findings are: Review of Resident #6's current FL-2 dated 04/12/25 revealed: -Diagnoses included vascular dementia, cerebral infarction, dysarthria and anarthria (a speech disturbance due to impaired motor control of the speech muscles), and hemiplegia affecting the dominant side (right). -His level of care was special care unit (SCU). -There was an order for potassium chloride (potassium chloride is used to treat low potassium levels in the blood) 10meq, 2 tablets every day. Review of Resident #6's signed physician's sheet order dated 05/13/25 revealed there was an order for potassium chloride extended release (ER) 10 meq, take one tablet every day. Review of a copy of a signed prescription order for Resident #6 dated 10/28/25 revealed potassium chloride ER 20meq, ninety tablets, to take one tablet every day, was sent electronically to a local extended care pharmacy on 10/28/25 at 10:17am. Observation of the 8:00am medication pass on 12/10/25 revealed: -The medication aide (MA) prepared 8 oral medications in a medication cup for Resident #6 which included one potassium chloride ER 20meq tablet at 7:28am. -The MA administered the 8 prepared oral	D 344	10A NCAC 13F .1002(a) Medication Orders To ensure future compliance with this regulation, each Medication Aid (MA) will attend additional Medication Management and Medication Administration training provided by the communities contracted pharmacy. The signed training forms will be filed in the employee training section of the employee administration file and will count towards the annual required medication continuing education credits.	1.5.2026

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medications that included one potassium chloride ER 20meq tablet to Resident #6 with a cup of water at 7:31am.

Review of Resident #6's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for potassium chloride ER 10meq, take one tablet every day, scheduled at 8:00am.
-Potassium chloride ER 10meq was documented as administered at 8:00am on 12/01/25 through 12/10/25.

Observation of Resident #6's medications on hand on 12/10/25 at 9:15am revealed a bubble card of potassium chloride ER 20meq, take one tablet every day with 23 of 28 tablets remaining from a local extended care pharmacy with a start date of 12/14/25.

Telephone interview with a representative for the facility's contracted pharmacy on 12/10/25 at 9:29am revealed:
-An order was received for Resident #6 for potassium chloride ER 10meq, take one tablet daily on 04/16/25.
-The order for Resident #6's potassium chloride ER 10meq dated 04/16/25 was profiled only and there was no dispensing history.
-No potassium chloride ER 10meq was dispensed for Resident #6.
-There was no order on file for Resident #6 for potassium chloride ER 20meq.

Telephone interview with a pharmacist with the local extended care pharmacy on 12/10/25 at 9:40am revealed:
-An order was received for Resident #6's potassium chloride 10meq, take 2 tablets daily on

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D 344	Continued From page 8 04/16/25. -An electronic prescription was received for Resident #6 for potassium chloride ER 20meq, take one tablet daily on 10/28/25. -Potassium chloride ER 20meq was last dispensed for Resident #6 for 28 tablets, to take one tablet daily on 11/20/25 for a 28 day supply. Interview with the MA on 12/10/25 at 10:30am revealed: -During the medication pass, he pulled the residents' medication cards from the medication cart drawer and compared the medication labels to the residents' eMAR for the right resident, the right dose, and the right time. -If a resident's medication card label did not match the eMAR, he contacted the pharmacy and/or the resident's primary care provider (PCP) for clarification. -He changed out the batch filled medications on the medication cart this past weekend and had not noticed the discrepancy with Resident #6's potassium chloride ER. -He had not noticed until today (12/10/25) that Resident #6's potassium chloride ER medication label was for 20meq, take one tablet daily and the eMAR noted potassium chloride ER 10meq, tale one tablet daily. -He was not sure why he had noticed the different dosage for Resident #6's potassium chloride ER. Interview with the Special Care Coordinator (SCC) on 12/10/25 at 10:54am revealed: -The MAs were expected to check each resident's medication label to their eMAR before administering their medication. -If there was any question or if the medication label did not match the eMAR, the MA was to call the pharmacy first then the PCP if needed for clarification.	D 344		

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D 344	Continued From page 9 -The MA should have noticed Resident #6's potassium chloride ER medication label differed from the potassium chloride ER entry on the eMAR and should have contacted the pharmacy and/or the PCP for clarification of the order. Interview with the Administrator on 12/10/25 at 1:57pm revealed: -The MAs were expected to always compare a resident's medication label to their eMAR to be sure they had the right resident, the right route, the right medication, the right dose, and the right time. -If a medication label did not match the eMAR, the MA was expected to contact the pharmacy first then the resident's PCP if needed for clarification. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/10/25 at 10:15am was unsuccessful.	D 344		