STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	R 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD 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 follow-up survey on 12/16/25 - 12/18/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 3 of 4 exit doors which were accessible to residents who resided on the assisted living (AL) side of the facility and were intermittently disoriented or had wandering behaviors (#1, #6, #10), had audible alarms activated when the exit doors were	D 067		

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D 067	Continued From page 1	D 067		

opened.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 84 beds of which 38 were on the assisted living (AL) side of the facility.

Observations of the facility's front door entrance on the AL side of the facility at various times on 12/16/25 from 8:30am - 4:45pm, on 12/17/25 from 7:15am to 6:45pm, and on 12/18/25 from 8:00am to 9:30am revealed visitors and staff were observed entering and exiting through the front entrance and there was not an audible alarm sound at the door when it opened.

Observation of the A Hall exit door on 12/16/25 at 9:30am revealed the hall door was on the AL side of the facility and there was not an audible alarm sound at the door when it opened.

Observation of the D Hall exit door on 12/16/25 at 10:00am revealed the hall door was on the AL side of the facility and there was not an audible alarm sound at the door when it opened.

1. Review of Resident #10's current FL-2 dated 09/23/25 revealed:
-Diagnoses included acute encephalopathy, osteoporosis, depression, difficulty walking, hypertension, panic disorder, thrombosis, and urinary retention.
-The resident was intermittently disoriented and ambulated with a rollator.
-The resident's level of care was Assisted Living (AL).

Review of Resident #10's Resident Register

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revealed the resident's admission date was 04/20/22.

Review of Resident #10's current care plan dated 12/01/25 revealed:
-Resident #10 exhibited wandering behaviors.
-The resident was sometimes disoriented, and ambulatory with a walker.
-The resident required supervision with toileting, and ambulation.
-The resident required extensive assistance with bathing and limited assistance with dressing, and grooming.
-The resident was in hospice care.
-The facility, family, and primary care provider (PCP) were in agreement of a memory care placement.

Review of Resident #10's facility progress note dated 09/25/25 revealed that Resident #10 was found outside without his walker, and he said that he was going home to another state.

Review of Resident #10's facility progress note dated 10/28/25 revealed:
-Resident #10 was seen walking outside saying he was going home.
-He was escorted back inside where he became very agitated and could not be redirected.
-He was going in and out of resident's rooms and calling staff names.
-He refused to take his medications.
-His family member was called, and she came to calm him down.

Review of Resident #10's facility progress note dated 11/07/25 revealed:
-Resident #10 refused to take his medications and became verbally aggressive.
-He kept spitting the medications out and trying to

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hide them between the couch cushion.
-Resident #10 did not know where he was and kept asking to go home to another state.

Review of Resident #10's facility progress note dated 11/11/25 revealed:
-After dinner, Resident #10 walked into a female resident's room on another hall.
-When redirected back to his room he became agitated and said it was not his.
-While personal care aides (PCA) were making their rounds, Resident #10 was in other resident's rooms including another female resident and a couple's room.
-He attempted to push past a female resident who was on oxygen and raised his voice at a male resident.
-The male resident said that Resident #10 came into their room three times the night before.

Review of Resident #10's facility progress note dated 12/05/25 revealed:
-Resident #10 was trying to find his wife and children.
-He was going in other residents' rooms, walking around without his walker .
-Resident #10 could not be easily redirected.
-Resident #10 went outside without his walker saying he was going home to another state.

Interview with a medication aide (MA) on 12/17/25 at 5:16pm revealed: -Resident #10 had walked out of the facility's front entrance several times during second shift around dinner time.
-She saw Resident #10 walk out of the facility's front entrance last week twice within a 30 to 45 minute time period, but she could not give exact date or time the resident walked outside.
-Resident #10 said that he was trying to go home to another state.

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-She did not know why the doors did not sound.
-The front door was locked between 7:00pm to 8:00pm each night.
-She documented the information in the facility's progress notes.
-She did not submit an incident report.

Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 5:45pm revealed:
-There were no reports of residents walking out of the door in the last six months to her knowledge.
-She did not know why the front entrance door on the AL did not alarm when it opened.
-The Special Care Coordinator (SCC) unlocked the front door at 7:00am when she got to work.
-The front door was unlocked for staff's shift changed.
-If a resident went out the door, it was reported to the SCC.
-When a resident exhibited a decline in cognitive health she notified the PCP and called a care plan meeting with the family to move a resident to the Special Care Unit (SCU) side.

Interview with Resident #10's Hospice registered nurse (RN) on 12/18/25 at 9:00am revealed:
-She saw Resident #10 two times a week to check his vital signs, assess his skin and feet, and change his catheter once a month.
-He had dementia and acute urinary tract infections (UTI).
-Resident #10 knew his name and sometimes his birthday.
-She was aware of his wandering.
-She was not aware that he wandered outside of the facility.
-His guardian had placed cameras in his room because he became busy during the night hours going in and out of his room.
-She had noticed that the front door was unlocked

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between the hours of 8:00am to 5:00pm when she came to visit.
-She saw an increase in Resident #10's agitation around the hours of 3:00pm to 4:00pm.
-He was on Ativan 0.5mg four times a day and 1mg as needed to manage his anxiety and for agitation (used to treat anxiety).
-Due to his wandering and agitation, he was more appropriate for the SCU.

Interview with the Administrator on 12/18/25 at 10:40am revealed:
-She was not aware that Resident #10 had walked out of the front door last week.
-Resident #10 went outside to sit on the porch often.
-She had not read the MA's progress notes about Resident #10 walking outside after hours.
-The MAs were to notify the RCC when they saw any changes in a resident.
-There was a communication book kept outside of the RCC's office regarding changes in resident conditions or if a resident was out on leave.
-The RCC should be notified of changes in behaviors.
-The RCC and the SCC were responsible for chart audits.
-They were to ensure staff were documenting the progress notes and in the communication book every day.

Attempted telephone interview with Resident #10's legal guardian on 12/18/25 at 11:03am was unsuccessful.

Attempted telephone interview with Resident #10's PCP on 12/18/25 at 8:17am was unsuccessful.

Based on observations, interviews, and record

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reviews, it was determined that Resident #10 was not interviewable.

Refer to the interview with the maintenance staff on 12/18/25 at 2:37pm.

Refer to interview with the Administrator on 12/18/25 at 9:01am.

Refer to the second interview with the Administrator on 12/18/25 at 10:20am.

Refer to the third interview with the Administrator on 12/18/25 at 2:54pm.

2. Review of Resident #1's current FL-2 dated 09/24/25 revealed:
-Diagnoses included osteoporosis, hypertension, diabetes, hyperlipidemia, and depression.
-The resident was intermittently disoriented and was ambulatory.
-The resident's current level of care was Assisted Living (AL).

Review of Resident #1's Resident Register revealed the resident's admission date was 11/04/24.

Telephone interview with Resident #1's legal guardian on 12/18/25 at 11:07am revealed:
-Resident #1 had not bounced back fully from a fall that happened on 12/31/24.
-Resident #1 was confused and showed paranoid behaviors and thought the facility had gone bankrupt and she had no place to live.
-Resident #1 was forgetful of her family member's names.
-Resident #1 did not know where she was.
-On 12/10/25, she requested a care plan meeting to discuss Resident #1.

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D 067	Continued From page 7 Interview with a personal care aide (PCA) on 12/18/25 at 10:15am revealed: -She had observed Resident #1 with some confusion such as not remembering the day of the week. -Last week, she could not remember the date, Resident #1 asked her where the dining hall was located. Interview with a medication aide (MA) on 12/17/25 at 5:16pm revealed: -Resident #1 was confused and she did not remember the day of the week or where she lived. -Resident #1 had a fall a month ago, could not remember the exact date, and when she returned she was more confused. -She went into room to check Resident #1's blood sugar and she said she was getting ready for her husband to pick her up for dinner but, he had been dead for years. Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 5:45pm revealed: -Resident #1 was pleasantly confused which meant she exhibited confusion of the day of the week or if the girl scouts were going to pick her up to sell cookies. -Resident #1 did not exhibit wandering behaviors. Attempted telephone interview with Resident #1's primary care provider (PCP) on 12/18/25 at 8:17am was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Refer to the interview with the maintenance staff on 12/18/25 at 2:37pm.	D 067		

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D 067	Continued From page 8 Refer to interview with the Administrator on 12/18/25 at 9:01am. Refer to the second interview with the Administrator on 12/18/25 at 10:20am. Refer to the third interview with the Administrator on 12/18/25 at 2:54pm. 3. Review of Resident #6's current FL-2 dated 10/22/25 revealed: -Diagnoses included atrial fibrillation, asthma, hypertension, and chronic obstructive pulmonary disease. -There was a checkmark placed next to "constantly" in the section titled "disoriented". Observation of the D hall exit door on 12/17/25 at 9:40am revealed: -The exit door was close to Resident #6's room and led to an enclosed screened porch. -The exit door from the facility was unlocked. -The door to the enclosed screened porch was unlocked. -There were no audible sounds heard when the doors were opened or closed. Review of Resident #6's Resident Register dated 10/27/25 revealed: -Resident #6 was admitted to the facility on 10/31/25. -There was no information documented in the section for "memory". Review of Resident #6's history and physical dated 11/05/25 revealed: -Resident #6 was seen by the primary care provider (PCP) to establish care. -Resident #6 was oriented. -Resident #6's insight was "impaired".	D 067		

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D 067	Continued From page 9 Interview with Resident #6 on 12/17/25 at 9:31am revealed: -She did not go outside. -She did not do much each day because her vision was not good. -She did not know how long she had been living at the facility, but it had been less than a year. Interview with a personal care aide (PCA) on 12/17/25 at 5:19pm revealed: -She worked with Resident #6. -Resident #6 always went to and from the dining room for meals without assistance from staff. -She did not consider Resident #6 to be confused or disoriented. Interview with a second PCA on 12/18/25 at 9:07am revealed: -She did not consider Resident #6 to be confused. -Resident #6 knew how to get around in the facility. -Sometimes she walked outside with Resident #6. Interview with the Resident Care Coordinator (RCC) on 12/18/25 at 10:10am revealed: -She was responsible for reviewing the FL-2 when a resident moved into the facility. -She reviewed the FL-2 for diagnoses, medications, and orientation status. -She reviewed the orientation status to determine a resident's suitable placement at the facility. -If the first diagnosis on the FL-2 was dementia or Alzheimer's, the Memory Care Director (SCC) would complete the assessment. -She did not feel that Resident #6 was constantly disoriented. -She thought Resident #6 was intermittently disoriented.	D 067		

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-She thought Resident #6 was "as clear as can be" and knew where she was.
-She was not sure she aware of a rule regarding door alarms.
-The facility doors had always alarmed.
-Facility staff used to carry pagers that were connected to the facility call system, but the pagers were lost and there was only one pager remaining.

Interview with Resident #6's primary care provider (PCP) on 12/17/25 at 12:02pm revealed:
-She had not completed an FL-2 for Resident #6.
-She saw Resident #6 two or three times since admission to the facility.
-Resident #6 had some forgetfulness and needed some "prodding" which meant questions needed to be asked in different ways.
-She would not consider Resident #6 to be constantly disoriented.
-Resident #6 knew where she was and who she was.
-Resident #6 was "definitely" forgetful.
-Constantly disoriented would mean the resident did not know the year or where she was.

Observations of the maintenance staff on 12/18/25 at 8:59am revealed:
-The exit door in the activity room on the A hall was opened at 8:59am and there was no audible sound heard.
-The exit door in the breakroom on the A hall was opened at 9:00am and there was no audible sound heard.

Refer to the interview with the maintenance staff on 12/18/25 at 2:37pm.

Refer to the interview with the Administrator on 12/18/25 at 9:01am.

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D 067	Continued From page 11 Refer to the second interview with the Administrator on 12/18/25 at 10:20am. Refer to the third interview with the Administrator on 12/18/25 at 2:54pm. _____ Interview with the maintenance staff on 12/18/25 at 2:37pm revealed: -He spoke to the company that monitors the facility call system on 12/18/25. -Prior to today, 12/18/25, the doors alarms only worked from 7:00pm - 7:00am each day. -The only way staff would know a door alarm was activated would be if staff were in front of the call system screen. -There were censors on some of the facility doors (specific door not identified) that were not working properly. Interview with the Administrator on 12/18/25 at 9:01am revealed she could not see that the facility call system was connected to the exit door to alert staff when an exit door was opened. Second interview with the Administrator on 12/18/25 at 10:20am revealed: -She was aware the front door alarm did not sound out loud. -She changed the alarm system to a different system by using the pager method. -She moved the computer screen where the MAs were located so they had better access. -When the alarm alerts staff, it shows on the computer screen with a sound and shows the location of the open door. -There was an alert application that the Administrator, the RCC, and MAs could use on their phones to get the alerts. -When a door opens, it came to her and the MA's	D 067		

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D 067	Continued From page 12 phones. -They communicated through walkie talkies where the MAs would announce on the facility sound system what resident room needed attention. -The doors were locked at 7:00pm each night. Third interview with the Administrator on 12/18/25 at 2:54pm revealed: -She expected staff to respond to the door alarms. -She needed to order more pagers for staff. -Every care staff should have a pager. -She did not know about the requirement for an audible sounding device on exit doors for any resident assessed to be confused or disoriented. _____ The facility failed to ensure 3 of 4 exit doors had a sounding device when activated to alert staff for 3 residents, known to be disoriented (#1, #3, #10). Resident #10 was assessed as intermittently disoriented, walked from the front entrance door of the facility and walked to the parking lot. This failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 1, 2026.	D 067		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and	D 079		

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D 079	Continued From page 13 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 and interviews the facility failed to ensure the facility was free from hazards evidenced by unsecured oxygen cylinders in a resident's room. The findings are: Observation of resident room D5 on 12/16/25 at 9:56am revealed: -There were four portable oxygen cylinders sitting upright on the floor next to a wall. -There was one oxygen concentrator sitting on the floor next to the portable oxygen cylinders. -There were three out of four oxygen cylinders with green tabs. -All four oxygen cylinders were not secured in a rack, cart, or holder. Interview with the resident in room D5 on 12/16/25 at 9:56am revealed: -The oxygen concentrator and portable oxygen cylinders came with her from the hospital a year ago.	D 079		

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-She did not use the oxygen.
-She did not have any breathing problems to need the oxygen.

Interview with the Maintenance Director on 12/16/25 at 12:40pm revealed:
-He was not aware that oxygen cylinders were not secured in a resident's room on the AL.
-He did not check for oxygen tanks in the residents' rooms but if he saw an oxygen tank without a crate, he would report it to the head nurse.

Interview with the medication aide (MA) on 12/17/25 at 2:45pm revealed:
-She was not aware that the oxygen cylinders were not secured in a resident's room on the AL.
-The resident did not use the oxygen during the day but could not say if she used it at night.
-The oxygen cylinders should be stored inside of a crate or holder to prevent an accident.
-If she saw any oxygen cylinders not secured, she reported it to the Resident Care Coordinator (RCC).

Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 3:00pm revealed:
-She was not aware that oxygen cylinders were not secured in a resident's room on the AL.
-She did a walk through every two months of all residents' rooms to ensure oxygen cylinders were secured and she was not sure how she missed the four unsecured oxygen cylinders.
-She was responsible to check the oxygen cylinders to be sure they were secured.
-She was responsible to call the supply company about a secure crate for all oxygen cylinders.

Interview with the Administrator on 12/18/25 at 10:40am revealed:

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D 079	Continued From page 15 -She was not aware that oxygen cylinders were not secured in a resident's room on the AL. -She was aware that the oxygen cylinders should be secured safely in crates or a holder. -The green tabs on the oxygen cylinders meant the tank was full. -If the oxygen cylinders fell, they could explode and hurt residents.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 sampled medication aides (MA) who administered medications to residents had completed the medication aide clinical skills competency validation checklist and 5-hour and 10-hour or 15-hour medication aide training (Staff A) and passed the NC medication aide test (Staff C) prior to administering medications. The findings are: 1. Review of Staff A's personnel record revealed:	D 125		

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-Staff A was hired as a medication aide (MA) on 09/15/21.
-There was documentation Staff A passed the medication aide test on 02/19/09.
-There was no documentation of an employment verification form for Staff A.
-There was no documentation Staff A completed the 5-hour, 10-hour or 15-hour medication aide training.
-There was no documentation of Staff A's medication clinical skills competency validation checklist.

Observation of Staff A on 12/16/25 at 10:24am revealed she prepared and administered six medications to a resident.

Review of resident's electronic medication administration records (eMARs) for 12/2025 revealed Staff A documented administration of medication on 12/02/25 - 12/05/25, 12/08/25 - 12/10/25, 12/12/25 -12/14/25, and 12/16/25.

Interview with Staff A on 12/18/25 at 2:24pm revealed:
-She was a MA at the facility.
-She had been employed at the facility for four years.
-She passed the MA test in 2009.
-She could remember being observed administering medications by a nurse "long ago".
-She did not remember if she signed any documents when the nurse observed her administer medications.
-She had never heard of the 5-hour and 10-hour, or 15-hour medication aide training.
-She did not have any copies of training documents she participated in at the facility except cardio-pulmonary resuscitation.
-She remembered participating in a class with a

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nurse for medication recertification and signing an attendance sheet (date not specified).
-She did not remember performing any return demonstrations with the nurse during the medication recertification.

Interview with the Administrator on 12/18/25 at 1:53pm revealed:
-She could not find documentation for 5-hour and 10-hour,15-hour medication aide training, or a medication aide clinical skills checklist completed for Staff A.
-She knew Staff A had completed the 5-hour and 10-hour or 15-hour medication aide training and a medication aide clinical skills checklist had been completed because she (Administrator) was at the facility when Staff A took the class.
-She was responsible for ensuring training documents were completed and in the staff personnel records.
-The Business Office Director (BOD) was responsible for keeping the staff training records current.
-She did not have any established timeframes for auditing staff personnel records.

Refer to the interview with the BOD on 12/18/25 at 3:06pm.

2. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 05/09/24.
-There was documentation Staff C completed the 15-hour medication aide training on 04/08/24.
-There was documentation of Staff C's medication clinical skills competency validation checklist on 05/10/24.
-There was no documentation Staff C passed the medication aide test prior to 07/05/25.
-There was no documentation for an employment

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D 125	Continued From page 18 verification form for Staff C. Telephone interview with Staff C on 12/18/25 at 12:54pm revealed: -She was a MA. -She passed the state medication aide test for adult care homes in 2025. -She had not taken the state medication aide test prior to 07/05/25. -She worked as a medication aide in a group home and had a medication aide certificate. -She provided a copy of the certificate to the facility upon hire in 2024. -She had been administering medications at the facility since she was hired in 2024. Review of resident's electronic medication administration records (eMARs) for 06/2025 revealed Staff C documented administration of medication on 06/01/25, 06/03/25, 06/04/25, 06/10/25 - 06/12/25, 06/24/25, 06/25/25, and 06/27/25. Interview with the Administrator on 12/18/25 at 2:07pm revealed: -Staff C passed the medication aide test for adult care homes on 07/05/25. -She did not think Staff C started administering medications at the facility until July 2025. -The Resident Care Coordinator (RCC) was responsible for scheduling staff assignments. -She was responsible for ensuring training documents were completed and in staff personnel records. -The Business Office Director (BOD) was responsible for keeping staff training records current. -She did not have any established timeframes for auditing staff personnel records.	D 125		

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D 125	Continued From page 19 Interview with the RCC on 12/18/25 at 2:15pm revealed: -She was unsure when she started assigning Staff C to administer medications. -Staff C's initials would be on the eMARs if she administered medications to residents. -Staff C stopped working at the facility in July 2025 and returned in August 2025. Refer to the interview with the BOD on 12/18/25 at 3:06pm. _____ Interview with the Business Office Director (BOD) on 12/18/25 at 3:06pm revealed: -She was responsible for auditing personnel records. -She checked personnel records when staff received training. -She audited personnel records monthly for "different things". -She was not sure why she needed to check personnel files because once certifications were in the personnel record, there was no need to check the personnel record for the same document, and she did not go back into the personnel record and recheck for the same document. -She only needed to make sure training was completed.	D 125		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage	D 286		

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D 286	Continued From page 20 containers. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. The findings are: Observation of a resident in her room on 12/17/25 at 8:44am revealed: -The resident was eating her breakfast meal. -The resident's breakfast was served on a styrofoam plate with a plastic spoon, fork, and knife. -The meal included biscuits and gravy, bacon, whole grain toast, and water in a disposable cup. Interview with the resident on 12/17/25 at 8:45am revealed: -The facility used styrofoam plates and disposable products when residents ate in their bedrooms. -She did not ask if there was an option to use dinnerware but did not mind using the disposable dinnerware. Observation of a second resident in her room on 12/17/25 at 8:48am revealed: -The resident was eating her breakfast meal. -The resident's breakfast was served on a	D 286		

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styrofoam plate with a plastic spoon, fork, and knife.
-The meal included grits and fresh fruit, whole grain toast, coffee, and water in a disposable cup.

Interview with the second resident on 12/17/25 at 8:48am revealed:
-The facility used styrofoam plates and disposable products when residents ate in their bedrooms.
-She did not eat many meals in her room.

Observation of a third resident in her room on 12/17/25 at 8:51am revealed:
-The resident's breakfast was served on a styrofoam plate with a plastic spoon, fork, and knife.
-The meal included fresh fruit, bacon, whole grain toast, coffee, and water in a disposable cup.

Observation of a fourth resident in her room on 12/17/25 at 8:54am revealed:
-The resident was eating her breakfast meal.
-The resident's breakfast was served on a styrofoam plate with a plastic spoon, fork, and knife.
-The meal included fresh fruit, bacon, whole grain toast, coffee, orange juice, and water in a disposable cup.

Interview with the resident on 12/17/25 at 8:45am revealed the facility served meals on styrofoam plates and disposable products when she ate meals in her bedroom.

Observation of a utility cart with lunch meals to residents' rooms on B hall on 12/17/25 at 11:57am revealed:
-There were four styrofoam plates with food covered in plastic wrap with a plastic spoon, fork,

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and knife.
-There were twelve paper cups containing coffee.
-There were seven styrofoam bowls with lids.
-There were sheets with the residents' names and some of the styrofoam bowls with lids labeled with the names of residents.

Observation of a utility cart with lunch meals to residents' rooms on D hall on 12/17/25 at 12:09pm revealed:
-There were three styrofoam plates with food covered in plastic wrap with a plastic spoon, fork, and knife.
-There were eight paper cups containing coffee.
-There were four styrofoam bowls with lids.
-There were sheets of paper with the residents' names and some of the styrofoam bowls with lids labeled with the names of residents.

Interview with the dietary manager on 12/16/25 at 8:30am revealed:
-She was not aware she was not to serve meals to residents on disposable products.
-All meals served in residents' room were served on disposable plates for easy disposal.
-She was trained to provide disposable products to those eating in their rooms.

Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 3:00pm revealed:
-She was not aware she was not to serve meals to residents on disposable products.
-All three meals per day were served on disposable products if a resident wished to eat in their room.
-There had never been an option between disposable and non-disposable place settings for residents who ate in their room.

Interview with the Administrator on 12/17/25 at

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D 286	Continued From page 23 10:40am revealed: -She was not aware the facility was not to serve meals to residents on disposable products. -The facility began using disposable products to serve meals to residents in their room during the COVID-19 pandemic and she thought using disposable products were acceptable.	D 286		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) including a medication used to treat hormone balance. The findings are: Review of the facility's undated medication administration policy revealed: -All medication staff members will pour the medication they are giving and verify the medication three times during the pour process. -All medications are administered per physician orders. -The MARs are signed/initialed at the time the medication is poured.	D 358		

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D 358	Continued From page 24 -If a medication cannot be poured, the Medication Aide will note this in the MAR until the problem is rectified. Review of Resident #2's current FL-2 dated 09/22/25 revealed diagnoses included hypertension, chronic kidney disease (CKD), necrotizing vasculopathy and anemia. Review of Resident #2's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Estradiol 0.01% cream, insert 2 grams (gm) into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. (Estradiol is a form of estrogen used for hormone replacement therapy.) -There was no stop date for the Estradiol 0.01% cream 2gm dose. -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 11/05/25 to 11/30/25. -There was an entry for Estradiol 0.01% cream, insert 1gm vaginally 3 times per week, to be administered at 8:00am with a start date of 11/18/25. -Estradiol 0.01% cream 1gm was documented as administered daily at 8:00am from 11/18/25 to 11/30/25. Review of Resident #2's December 2025 eMAR revealed: -There was an entry for Estradiol 0.01% cream, insert 2gm into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 12/01/25 to 12/16/25. -There was an entry for Estradiol 0.01% cream,	D 358		

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insert 1gm vaginally 3 times per week, to be administered at 8:00am with a start date of 11/18/25.
-Estradiol 0.01% cream 1gm was documented as administered daily at 8:00am from 12/01/25 to 12/16/25.

Observation of Resident #2's medication on hand on 12/18/25 revealed there was no Estradiol 0.01% cream on the cart for Resident #2.

Observation of Resident #2's room on 12/16/25 at 5:36pm revealed:
-Resident #2 had an unopened box of Estradiol 0.01% cream in her bathroom.
-The prescription label on the box was dated 11/03/25 with instructions to Insert 2GM into vagina once daily for 2 weeks.
-The facility's contracted pharmacy filled the medication.

Interview with Resident #2 on 12/16/25 at 9:10am revealed:
-Estradiol 0.01% cream was prescribed to her by her primary care provider (PCP).
-She did not know why the cream was sent because she no longer used it and had not needed it in 6 or 7 months.

Second interview with Resident #2 on 12/18/25 at 12:59pm revealed:
-She no longer used the Estradiol 0.01% cream.
-Staff did not administer the cream and she would not allow them to do so.
-The cream was given to her in the summer when she was swimming and going to the beach a lot.
-Staff removed the medication from her room (date unknown).

Interview with the medication aide (MA) on

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D 358	Continued From page 26 12/18/25 at 12:25pm revealed: -Estradiol 0.01% 2gm was on Resident #2's eMAR dated 11/03/25 and was to be administered for 2 weeks. -Estradiol 0.01% 2gm was still showing on the eMAR along with the Estradiol 0.01% 1GM 3 times per week with the same date of 11/03/25. -Neither dose of Estradiol 0.01% had been discontinued. -Estradiol 0.01% was not on the medication cart. -Staff should have discontinued the Estradiol 0.01% 2gm on the eMAR instead of documenting it as administered. -She did not look at the entry for Estradiol 0.01% 1gm 3 times per week. -She used the eMAR to administer medication but only read the entry for Estradiol 0.01% 2gm for 2 weeks. -She was supposed to match the medication with the eMAR. -She mistook the Estradiol 0.01% 1gm for the Estradiol 0.01% 2gm. -She should have reported the Estradiol 0.01% 2gm still showing on the eMAR to the Resident Care Coordinator (RCC). Interview with the MA Supervisor on 12/18/25 at 2:30pm revealed: -He was responsible for supervising the MAs and assisting the RCC and Special Care Coordinator (SCC). -He conducted cart audits bi-weekly which included going through all medications and records to ensure medications matched physicians orders. -He used the physician's orders that were in the computer because they were the most up to date. -The last cart audit for Resident #2's hall (A hall) was completed last week by an MA. -When the new batch of medications arrived, he	D 358		

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matched the medications with the physician's orders.
-He did not enter orders onto the eMAR.
-The RCC and SCC were responsible for approving the eMARs.
-The person responsible for entering orders onto the eMAR was supposed to enter stop dates for medications.
-If Estradiol 0.01% for Resident #2 was ordered to be administered 3 times per week, the medication should have been entered on the eMAR in a way that it could only be documented as administered 3 times per week so the medication would only show up on the screen for the MA to administer on those days.
-The person responsible for approving the eMARs was supposed to enter the Estradiol 0.01% with only the 3 days per week to show on the screen.
-He did not know why staff documented Estradiol 0.01% as administered.
-When administering medications, the MAs were to review the eMAR before arriving at the resident's room to see all the medications.
-MAs were to match the medication with the order on the screen at least 3 times.
-If a resident refused medication, the MA was supposed to let the PCP know.
-MAs were expected to follow orders as prescribed.
-MAs were supposed to reorder a medication or report to the RCC when a medication was not available.

Interview with the RCC on 12/18/25 at 3:02pm revealed:
-Orders were sent by e-script or fax to the pharmacy.
-The pharmacy entered the orders on the eMAR.
-She was responsible for approving the orders on

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the eMAR.
-When administering medication, the MA was to look at each medication on the eMAR and administer the medication.
-She expected MAs to let her know when medications were low and to do carts audits daily.
-No one told her the Estradiol 0.01% was not on the cart for Resident #2.
-The MA Supervisor had been conducting cart audits for MAs at the beginning of the cycle refill, which was the 25th of the month.
-At the beginning of the cycle, the MA Supervisor printed out eMARs for each resident and made sure all medications were received.
-The MA Supervisor checked behind the MAs.
-She did not check behind the MA Supervisor.
-She was unsure how Resident #2's Estradiol 0.01% was missed.
-If Resident #2 refused the medication, the refusal should have been documented on the eMAR.
-She found Resident #2's Estradiol 0.01% cream that was removed from her room in the medication room today, 12/18/25.
-The Estradiol 0.01% cream that was removed from Resident #2's room had not been opened.

Interview with the Administrator on 12/18/25 at 1:05pm and 2:48pm revealed:
-She received the residents' medication orders.
-When administering medication, the MA was supposed to compare the medication to the eMAR and follow the eMAR.
-The MAs were responsible for informing the RCC if medication was not available.
-If there was a medication on the eMAR that was not on the medication cart, the MA could not document that the medication was not available.
-If the RCC or Administrator were not available, the MA should have called the pharmacy to get

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the medication.
-The MA could have contacted the PCP for an order to hold the medication.
-The RCC was responsible for discontinuing an order and sending it to the pharmacy.
-The pharmacy did not put a stop date on medications.
-She did not know why the MAs did not notify the RCC that the Estradiol 0.01% was not available for Resident #2.
-MAs were able to get medications the same day as requested so there was no reason for medication to not be administered.
-If a resident refused medication, staff would get the medication discontinued.
-Medication cart and eMAR audits were done by the MA Supervisor as well as on a nightly rotation by MAs.
-Cart audits included checking expiration dates and for tablets that may have fallen out of the packs.
-The MA Supervisor did a thorough audit monthly on cycle fill dates.
-MAs were expected to follow the orders on the eMAR.
-Medications were to be given exactly as detailed on the eMAR.
-She did not know where the Estradiol 0.01% cream was but knew the MA took the medication out of Resident #2's room 12/16/25.
-She was not aware the Estradiol 0.01% cream was in Resident #2's room prior to the removal of the medication from the room.

Telephone interview with the Medical Assistant at Resident #2's PCP office on 12/17/25 at 2:54pm revealed Estradiol 0.01% cream was on Resident #2's list of medications.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 12/18/25 at 1:37pm revealed:
-The order for Resident #2's Estradiol 0.01% was dated 11/03/25 with instructions to insert 2gm into vagina once daily for 2 weeks followed by a maintenance dose of 1gm 3 times per week.
-Estradiol 0.01% was Estrogen.
-Estradiol 0.01% 2gm was to be administered to Resident #2 for 2 weeks and should have been administered from 11/03/25 to 11/17/25.
-Estradiol 0.01% 1gm was supposed to start after the 2 weeks of Estradiol 0.01% 2gm on 11/18/25.
-The pharmacy entered orders on the eMAR with the correct dates and instructions.
-The facility should have put a stop date on the eMAR for Resident #2's Estradiol 0.01% 2gm dose.
-She was unsure why Resident #2's Estradiol orders on the eMAR were not written the same as the original order.
-The dates on the eMAR should have prompted staff on when to start and stop administering the medication.
-She was unsure why Estradiol 0.01% 2gm was still on the eMAR.
-Staff should have been administering Estradiol 0.01% 1gm to Resident #2.
-One tube of Estradiol 0.01% was dispensed on 11/03/25.
-Estradiol 0.01% was delivered to the facility on 11/03/25.
-Refills for Estradiol 0.01% would have needed to be requested by the facility.
-There had been no request for refills of Estradiol 0.01% for Resident #2.
-One tube of Estradiol 0.01% contained 42gm.
-Administering 2gm of Estradiol 0.01% daily would cause the medication to run out in 21 days.
-Missing doses of Estradiol 0.01% would cause Resident #2 to have more menopause

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D 358	Continued From page 31 symptoms, which varied from person to person. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 2:54pm was unsuccessful.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the staff observation of the resident actually taking their medication for 1 of 1 sampled residents (#2). The findings are: Review of the facility's undated medication administration policy revealed: -The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another residence	D 366		

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medication.
-All medications that staff members handle, store and assist with will be documented on the eMAR in accordance with state regulations.

Review of Resident #2's current FL-2 dated 09/22/25 revealed diagnoses included hypertension, chronic kidney disease (CKD), necrotizing vasculopathy and anemia.

Review of Resident #2's Resident Register revealed the resident was admitted 06/19/25.

Review of Resident #2's physician orders dated 09/22/25 revealed:
-There was an order for Vitamin D2 1.24mg one capsule weekly to be administered at 8:00am. (Vitamin D2 is used to treat low vitamin D levels.)
-There was an order for Carvedilol 12.5mg one tablet twice daily to be administered at 9:00am and 4:00pm. (Carvedilol is used to treat heart and circulatory conditions.)
-There was an order for Levothyroxine 125mcg one tablet daily to be administered at 7:00am. (Levothyroxine is used to treat hypothyroidism.)

Observation of Resident #2's room on 12/16/25 at 9:10am revealed:
-There were 2 clear medicine cups next to a cup of water in front of the television on the dresser.
-The clear medicine cup to the left of the cup of water contained 3 pills (2 round white pills and 1 oval shaped gel pill).
-The clear medicine cup to the right of the cup of water was empty.
-Resident #2 was sitting in her recliner.

Interview with Resident #2 on 12/16/25 at 9:10am revealed:
-She took her medications early.

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D 366	Continued From page 33 -The medication on her dresser was given to her by the medication aide (MA). -She was unsure what medications were in the cup on her dresser, but they were the second half of her medications. -The medications on her dresser were left for her to take most of the time. -She was awake when the medications were brought to her. -She was unsure if she had a self-administration order. Review of Resident #2's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D2 1.24mg one capsule weekly documented as administered at 8:00am on 12/16/25. -There was an entry for Carvedilol 12.5mg one tablet twice daily documented as administered at 9:00am on 12/16/25. -There was an entry for Levothyroxine 125mcg one tablet daily documented as administered at 7:00am on 12/16/25. Interview with the MA on 12/17/25 at 11:47am revealed: -Resident #2 did not have a self-administer order. -She administered Resident #2's medication. -She put Resident #2's medication on the table in her room. -Resident #2 took the medication and then she left the room. -Other residents took their medication at the medication cart but Resident #2 wanted her medication left in the medication cup on her table. -The medications left in Resident #2's room were Vitamin D2, Carvedilol and Levothyroxine. -She always observed Resident #2 take her medication.	D 366		

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D 366	Continued From page 34 -Normally, Resident #2 picked the cup up to take the medication as she was leaving the room. -Resident #2 must not have picked the cup up to take the medication. -She observed Resident #2 pick the medication cup up but did not watch her take the medication. -She documented that the medications had been administered on the eMAR after she saw Resident #2 pick the medicine cup up. -Resident #2 preferred her medication in 2 separate cups. -She saw Resident #2 take the medications in the first cup. -As she walked out of the room, Resident #2 was picking the second cup up. -She was aware medication staff were supposed to observe residents taking the medication. -Resident #2 had memory issues sometimes but always took her medication. -She went back to Resident #2's room before lunch to make sure the medications had been taken. Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 12:09pm revealed: -She was not aware that the MA was leaving Resident #2's medication on her dresser and not observing her take them. -MAs were responsible for administering medications. -MAs were expected to observe residents take their medication. -If the resident did not take the medication, the MA was expected to take the medication out of the room. -The MA was supposed to wait for Resident #2 to take her medication before leaving the room. -Resident #2 did not have a self-administration order.	D 366		

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D 366	Continued From page 35 Interview with the Administrator on 12/17/25 at 12:33pm revealed: -The MAs were supposed to observe residents take their medications. -If the resident refused the medication, the MA was supposed to take the medication out of the room. -She was unsure why the MA left Resident #2's medication in her room. -Resident #2 did not have a self-administration order. Telephone interview with a Medical Assistant at Resident #2's PCP office on 12/17/25 at 2:54pm revealed Resident #2 did not have a self-administration order. Attempted interview with Resident #2's primary care provider (PCP) on 12/17/25 at 2:54pm was unsuccessful.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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D 367	Continued From page 36 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 that the electronic medication administration records (eMAR) were complete and accurate for 1 of 5 sampled residents (#2) related to a medication for hormone balance. The findings are: Review of the facility's undated medication administration policy revealed: -Medication Aides will document medication refusal and medication unavailable on the electronic medication administration record (eMAR). -All medications that staff members handle, store and assist with will be documented on the eMAR in accordance with state regulations. -The eMARs are signed/initialed at the time the medication is poured. -If a medication cannot be poured, the medication aide will note this in the MAR until the problem is rectified. Review of Resident #2's current FL-2 dated 09/22/25 revealed diagnoses included hypertension, chronic kidney disease (CKD), necrotizing vasculopathy and anemia.	D 367		

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D 367	Continued From page 37 Review of Resident #2's Resident Register revealed the resident was admitted on 06/19/25. Review of Resident #2's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Estradiol 0.01% cream, insert 2 gram (gm) into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. (Estradiol is a form of estrogen used for hormone replacement therapy.) -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 11/05/25 to 11/30/25. -There was an entry for Estradiol 0.01% cream, insert 1gm vaginally 3 times per week, to be administered at 8:00am with a start date of 11/18/25. -Estradiol 0.01% cream 1gm was documented as administered daily at 8:00am from 11/18/25 to 11/30//25. Review of Resident #2's December 2025 eMAR revealed: -There was an entry for Estradiol 0.01% cream, insert 2gm into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 12/01/25 to 12/16/25. -There was an entry for Estradiol 0.01% cream, insert 1gm vaginally 3 times per week, to be administered at 8:00am with a start date of 11/18/25. -Estradiol 0.01% cream 1gm was documented as administered daily at 8:00am from 12/01/25 to 12/16/25.	D 367		

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D 367	Continued From page 38 Observation of Resident #2's medication on hand on 12/17/25 revealed there was no Estradiol 0.01% cream on the cart for Resident #2. Observation of Resident #2's room on 12/16/25 at 5:36pm revealed: -Resident #2 had an unopened box of Estradiol 0.01% cream in her bathroom. -The prescription label on the box was dated 11/03/25 with instructions to Insert 2gm into vagina once daily for 2 weeks. -The facility's contracted pharmacy filled the medication. Interview with Resident #2 on 12/16/25 at 9:10am revealed: -Estradiol 0.01% cream was prescribed to her by her primary care provider (PCP). -She did not know why the cream was sent because she no longer used it and had not needed it in 6 or 7 months. Second interview with Resident #2 on 12/18/25 at 12:59pm revealed: -She no longer used the Estradiol 0.01% cream. -Staff did not administer the cream and she would not allow staff to do so either. Interview with the medication aide (MA) on 12/18/25 at 12:25pm revealed: -Estradiol 0.01% 2gm was on Resident #2's eMAR dated 11/03/25 and was to be administered for 2 weeks. -Estradiol 0.01% 2gm was still showing on the eMAR along with the Estradiol 0.01% 1gm 3 times per week with the same date of 11/03/25. -Neither dose of Estradiol 0.01% had been discontinued. -Estradiol 0.01% was not on the medication cart. -Staff knew the Estradiol 0.01% 2gm stopped and	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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should have put discontinued on the eMAR instead of documenting it as administered.
-She made a mistake and documented Estradiol 0.01% as administered but should have documented that the medication was discontinued.
-She did not report to anyone that the 2 weeks for administering Estradiol 0.01% 2gm ended but was still showing on the eMAR.
-She did not look at the entry for Estradiol 0.01% 1gm 3 times per week.
-She used the eMAR to administer medication but only read the entry for Estradiol 0.01% 2gm for 2 weeks.
-She was supposed to match the medication with the eMAR.
-She mistook the Estradiol 0.01% 1gm for the Estradiol 0.01% 2gm.

Interview with the MA Supervisor on 12/18/25 at 2:30pm revealed:
-He was responsible for supervising the MAs and assisting the Resident Care Coordinator (RCC) and Special Care Coordinator (SCC).
-He did not enter orders onto the eMAR.
-The RCC and SCC were responsible for approving the eMARs.
-The person responsible for entering orders onto the eMAR was supposed to enter stop dates for medications.
-If Estradiol 0.01% for Resident #2 was ordered to be administered 3 times per week, the medication should have been entered on the eMAR in a way that it could only be documented as administered 3 times per week so the medication would show up on the screen for the MA on those days.
-The person responsible for approving the eMARs was supposed to enter the Estradiol 0.01% with only the 3 days per week showing on

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the screen.
-He did not know why staff documented Estradiol 0.01% as administered.
-When administering medications, the MAs were to review the eMAR before arriving at the resident's room to see all the medications.
-MAs were to match the medication with the order on the screen at least 3 times.
-If a resident refused medication, the MA was supposed to let the PCP know.

Interview with the RCC on 12/18/25 at 3:02pm revealed:
-Orders were sent by e-script or fax to the pharmacy.
-The pharmacy entered the orders on the eMAR.
-She was responsible for approving the orders on the eMAR.
-The MA Supervisor checked behind the MAs.
-She did not check behind the MA Supervisor.
-She did not know why Estradiol 0.01% was documented as administered for Resident #2.
-If Resident #2 refused the medication, the refusal should have been documented on the eMAR.
-The Estradiol 0.01% cream that was removed from Resident #2's room had not been opened.

Interview with the Administrator on 12/18/25 at 1:05pm and 2:48pm revealed:
-She received all resident medication orders.
-When administering medication, the MA was supposed to compare the medication to the eMAR and follow the eMAR.
-The MAs were responsible for informing the RCC if medication was not available.
-If there was a medication on the eMAR that was not on the medication cart, the MA could not document that the medication was not available.
-The pharmacy did not put a stop date on

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medications.
-The RCC was responsible for entering the stop date for the medications.
-She did not know why the MAs documented Estradiol 0.01% as administered.
-Documenting that the medication was administered when it was not, was false documentation.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/18/25 at 1:37pm revealed:
-Resident #2's order for Estradiol 0.01% was dated 11/03/25 with instructions to insert 2gm into vagina once daily for 2 weeks followed by a maintenance dose of 1gm 3 times per week.
-Estradiol 0.01% was Estrogen.
-Estradiol 0.01% 2gm was to be administered to Resident #2 for 2 weeks and should have been administered from 11/03/25 to 11/17/25.
-Estradiol 0.01% 1gm was supposed to start after the 2 weeks of Estradiol 0.01% 2gm.
-Pharmacy entered orders on the eMAR with the correct dates and instructions.
-The facility should have put a stop date on the eMAR.
-She was unsure why the orders on the eMAR were not written the same as the original order.
-Dates on the eMAR should have prompted staff on when to start and stop administering the medication.
-She was unsure why Estradiol 0.01% 2gm was still on the eMAR.
-Staff should have been administering Estradiol 0.01% 1gm to Resident #2.
-One tube of Estradiol 0.01% was dispensed on 11/03/25.
-Estradiol 0.01% was delivered to the facility on 11/03/25.
-Refills for Estradiol 0.01% would have needed to

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D 367	Continued From page 42 be requested by the facility. -There had been no request for refills of Estradiol 0.01% for Resident #2. -One tube of Estradiol 0.01% contained 42gm. -Administering 2gm of Estradiol 0.01% daily would cause the medication to run out in 21 days. Telephone interview with the Medical Assistant at Resident #2's PCP office on 12/17/25 at 2:54pm revealed Estradiol 0.01% cream was on Resident #2's list of medications. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 2:54pm was unsuccessful.	D 367		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 375		

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reviews, the facility failed to ensure 3 of 7 sampled residents (#2, #6, #7) had physicians' orders to self-administer medications to include medications for arthritis, allergies, inflammation and hormone balance (#2), constipation (#6), and allergies (#7).

The findings are:

Review of the facility's undated Medication administration policy revealed:
-Residents will be placed into one of three medication assistance categories: Independent, Assistance, and Administration.
-The independent resident is able to safely self-manage their own medications including storage, administration, and reordering.
-Residents that require assistance are aware they are taking medication but require and need coaching, reminders, assistance with containers, may use an enabler, and needs/request assistance with medication storage and reordering.
-Residents in the administration category are completely incapable of self-directing their own medication care.
-The required level of assistance and who is responsible for providing the assistance will be documented in the Resident Care Plan.

1. Review of Resident #2's current FL-2 dated 09/22/25 revealed diagnoses included hypertension, chronic kidney disease (CKD), necrotizing vasculopathy and anemia.

Review of Resident #2's Resident Register revealed the resident was admitted 06/19/25.

Review of Resident #2's current care plan dated 06/20/25 revealed:

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D 375	Continued From page 44 -She was oriented. -Her memory was adequate. -She had no problems with ambulation. -She required limited assistance with bathing. -She was independent for eating, toileting, ambulation, dressing, grooming and transfer. -Staff were to administer her medications. Review of Resident #2's record revealed there was no assessment or order for self-administration of medication. Observations of Resident #2's room on 12/16/25 at 9:10am revealed: -Resident #2 was sitting in her recliner. -On the bathroom sink was a manuafactured label of Tylenol Arthritis (used to treat minor aches and pains associated with arthritis), a manufactured labled bottle of Benadryl 25mg (used to treat allergies), a prescription bottle of Meloxicam 15mg dispensed 05/29/21(used to treat inflammation), a prescription bottle of Amoxicillin 500mg dispensed 01/11/25 (used to treat bacterial infections), Advil (used to treat pain and inflammation), Pepcid (used to treat stomach acid), Tylenol 8-hour Arthritis (used to treat minor aches and pains associated with arthritis), and Aleve (used to treat minor aches and pains). -In the bathroom medicine cabinet was a tube of Estradiol 0.01% cream, Anefrin nasal spray, Nose Better natural mist and Bacitracin Ointment (all shown to the surveyor by the resident). (Estradiol is used to treat hormone balance. Anefrin is used to treat sinus congestion and allergies. Nose Better natrual mist is used to treat dry nasal passages.) Interview of Resident #2 on 12/16/25 at 9:10am revealed: -She thought she had only been at the facility for	D 375		

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D 375	Continued From page 45 3 weeks. -She thought staff knew she had the medication in her room. -The medication was packed in her belongings when she was admitted to the facility. -She did not take any of the medication because it was old. -She did not take the Advil and Pepcid because she did not need it. -The Estradiol 0.01% cream was prescribed to her by her primary care provider (PCP). -She did not know why the cream was sent because she no longer used it and had not needed it in 6 or 7 months. -She had an outside PCP and did not switch to the facility PCP. -She did not know how to discard the medication at the facility. -She was a nurse and always administered her own medication. -She was unsure if she had a self-administration order. -She took a lot of medication. Interview with Resident #2's family member on 12/17/25 at 2:42pm revealed: -The over the counter (OTC) medications Resident #2 had in her room were medications she took with her to the facility because she did not realize she could not have the medications in her room. -She did not know where the prescription medications came from because she turned all prescription medications into the facility. -The prescription medications may have been in Resident #2's belongings when she moved in. Review of Resident #2's October 2025 electronic medication administration records (eMARs) revealed there were no entries for Estradiol	D 375		

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D 375	Continued From page 46 0.01%, Tylenol Arthritis, Benadryl 25mg, Meloxicam 15mg, Amoxicillin 500mg, Advil, Pepcid, Tylenol 8-hour Arthritis, Aleve, Anefrin nasal spray, Nose Better natural mist and Bacitracin Ointment. Review of Resident #2's November 2025 eMARs revealed: -There were no entries for Tylenol Arthritis, Benadryl 25mg, Meloxicam 15mg, Amoxicillin 500mg, Advil, Pepcid, Tylenol 8-hour Arthritis, Aleve, Anefrin nasal spray, Nose Better natural mist and Bacitracin Ointment. -There was an entry for Estradiol 0.01% cream, insert 2gm into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. (Estradiol is a form of estrogen used for hormone replacement therapy.) -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 11/05/25 to 11/30/25. Review of Resident #2's December 2025 eMARs revealed: -There were no entries for Tylenol Arthritis, Benadryl 25mg, Meloxicam 15mg, Amoxicillin 500mg, Advil, Pepcid, Tylenol 8-hour Arthritis, Aleve, Anefrin nasal spray, Nose Better natural mist and Bacitracin Ointment. -There was an entry for Estradiol 0.01% cream, insert 2gm into vagina once daily for 2 weeks, to be administered at 7:00pm with a start date of 11/04/25. -Estradiol 0.01% cream 2gm was documented as administered daily at 7:00pm from 12/01/25 to 12/16/25. -There was an entry for Estradiol 0.01% cream, insert 1gm vaginally 3 times per week, to be administered at 8:00am with a start date of 11/18/25.	D 375		

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D 375	Continued From page 47 -Estradiol 0.01% cream 1gm was documented as administered daily at 8:00am from 12/01/25 to 12/16/25. Telephone interview with a Pharmacy Technician at Resident #2's pharmacy on 12/17/25 at 3:10pm revealed: -Amoxicillin 500mg was prescribed 01/11/25 with instructions to take 4 tablets before dental treatment. -Meloxicam was used to treat pain and was not on Resident #2's medication list. -Tylenol Arthritis, Benadryl, Aleve, Pepcid, Bacitracin ointment, Anefrin Nasal Spray, and Nose Better Natural Mist were not on Resident #2's medication list. -A pharmacist was not available to discuss the indications for the medications, self-administration and concerns about the medications. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/18/25 at 1:37pm revealed: -Resident #2's order for Estradiol 0.01% was dated 11/03/25 with instructions to insert 2gm into vagina once daily for 2 weeks followed by a maintenance dose of 1gm 3 times per week. -Estradiol 0.01% was Estrogen. -Meloxicam was used to treat inflammation and pain and was not good to take with Eliquis because it would thin the blood more, which could cause Resident #2 to bleed more if she got a cut. -Resident #2 was not prescribed Meloxicam. -There was no order for Aleve and should not be taken by Resident #2 for the same reasons listed for Meloxicam. -There was no order for Amoxicillin and no known interaction with any of Resident #2's prescribed medications.	D 375		

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D 375	Continued From page 48 -There was no order for Tylenol Arthritis and no known risk with Resident #2 taking the medication. -There was no order for Pepcid and no known risk to Resident #2. -There was no order for Bacitracin ointment, Anefrin Nasal Spray, and Nose Better Natural Mist and no noted risk. Interview with the medication aide (MA) on 12/17/25 at 11:47am revealed: -Resident #2 did not have a self-administration order. -Resident #2 was not supposed to have any medications in her room. -She was not aware Resident #2 had prescription and OTC medications in her room. -She was unsure when Resident #2's room was last checked for medications. -She did not know Resident #2 had prescription and OTC medications in her room. Interview with the Resident Care Coordinato (RCC) on 12/17/25 at 12:09pm revealed: -She was not aware Resident #2 had prescription and OTC medications in her room. -Resident #2's family was informed that she needed a self-administration order and lock box to keep medications in her room. -Resident #2 did not have a self-administration order. Interview with the Administrator on 12/17/25 at 12:33pm revealed: -She was not aware Resident #2 had prescription and OTC medications in her room. -Resident #2 did not have a self-administration order. -Resident #2 mentioned having the medications in her room yesterday and the medications were	D 375		

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removed.

Interview with the Medical Assistant at Resident #2's PCP office on 12/17/25 at 2:54pm revealed:
-Tylenol Arthritis, Benadryl 25mg, Meloxicam 15mg, Amoxicillin 500mg, Advil, Pepcid, Tylenol 8-hour Arthritis, Aleve, Anefrin nasal spray, Nose Better natural mist and Bacitracin Ointment were not on Resident #2's medication list.
-Estradiol 0.01% cream was on her medication list.
-Resident #2 did not have a self-administration order.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 2:54pm was unsuccessful.

Refer to interview with the medication aide (MA) on 12/17/25 at 11:47am.

Refer to interview with the RCC on 12/17/25 at 12:09pm.

Refer to interview with the Administrator on 12/17/25 at 12:33pm.

2. Review of Resident #7's current FL-2 dated 11/13/25 revealed diagnoses included hypertension and hyperlipidemia.

Review of Resident #7's physician's orders dated 11/13/25 revealed:
-There was an order for Deep Sea 0.65% Nose Spray instill 2 sprays into each nostril as needed for congestion. (Deep Sea 0.65% Nose Spray is used to treat congestion.)
-There was an order for Fluticasone Propionate 50mcg Spray instill 1 spray into each nostri twice daily. (Fluticasone Propionate is used to treat

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D 375	Continued From page 50 allergies and congestion.) Review of Resident #7's Resident Register revealed the resident was admitted 06/26/23. Review of Resident #7's current care plan dated 12/30/24 revealed: -He was oriented. -His memory was adequate. -He had no problems with ambulation. -He required supervision while bathing. -He was independent for eating, toileting, ambulation, dressing, grooming and transfer. -There was no documentation regarding administering of medication. Review of Resident #7's record revealed there was no assessment or order for self-administration of medication. Observations of Resident #7's room on 12/16/25 at 9:46am revealed: -Resident #7 was lying on his bed awake. -On the table beside his recliner was an empty prescription box labeled Fluticasone Propionate 50mcg with instructions to use twice a day. -Beside the Fluticasone Propionate box, there was a bottle of prescription Sodium Chloride 0.65% Nasal Spray with instructions to spray 2 sprays into each nostril every 4 hours as needed for congestion. Interview of Resident #7 on 12/16/25 at 9:46am revealed: -He called the nasal spray an inhaler. -He used the nasal spray when he was short of breath walking around the building Review of Resident #7's October 2025 electronic medication administration records (eMARs)	D 375		

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revealed there was an entry for Deep Sea 0.65% Nose Spray instill 2 sprays into each nostril as needed for congestion.

Review of Resident #7's November 2025 electronic medication administration records (eMARs) revealed there was an entry for Deep Sea 0.65% Nose Spray instill 2 sprays into each nostril as needed for congestion.

Review of Resident #7's December 2025 electronic medication administration records (eMARs) revealed there was an entry for Deep Sea 0.65% Nose Spray instill 2 sprays into each nostril as needed for congestion.

Interview with the medication aide (MA) on 12/17/25 at 11:47am revealed:
-Resident #7 did not have a self-administration order.
-Resident #7 should not have had nasal spray in his room.
-She was unsure how the Sodium Chloride 0.65% Nasal Spray got in Resident #7's room.
-All prescribed nasal sprays for Resident #7 were locked on the medication cart.
-Resident #7's medications were administered at the medication cart.
-She did not go into Resident #7's room to administer medications.

Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 12:09pm revealed:
-She was not aware Resident #7 had Sodium Chloride 0.65% Nasal Spray in his room.
-She was unsure how the nasal spray got in Resident #7's room.

Interview with the Administrator on 12/17/25 at 12:33pm revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD 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 375	Continued From page 52	D 375		

-She was not aware Resident #7 had Sodium Chloride 0.65% Nasal Spray in his room.
-Resident #7's medications came from Veteran's Affairs (VA) and were mailed to the facility most of the time.
-Sometimes, Resident #7 brought medications back with him from appointments that a family member transported him to.
-She did not know why Resident #7 had Sodium Chloride 0.65% Nasal Spray in his room.

Attempted telephone contact with Resident #7's pharmacy on 12/18/25 at 11:39am was unsuccessful.

Attempted telephone contact with Resident #7's primary care provicer (PCP) on 12/18/25 at 11:39am was unsuccessful.

Refer to interview with the Medication Aide (MA) on 12/17/25 at 11:47am.

Refer to interview with the RCC on 12/17/25 at 12:09pm.

Refer to interview with the Administrator on 12/17/25 at 12:33pm.

3. Review of Resident #6's current FL-2 dated 10/22/25 revealed:
-Diagnoses included atrial fibrillation, asthma, hypertension, and chronic obstructive pulmonary disease.
-There was no physician's order for Lactulose (used to treat constipation).
-There were no physician orders for Resident #6 to self-administer medication of any kind.

Review of Resident #6's Resident Register dated 10/27/25 revealed the resident was admitted on

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D 375	Continued From page 53 10/31/25 from another facility. Review of Resident #6's care plan assessment dated 10/30/25 revealed there was a handwritten entry that "staff administers medications". Review of Resident #6's record revealed there was no assessment of the resident to self-administer medication of any kind. Observation of Resident #6's bathroom on 12/16/25 at 10:01am revealed there was a prescription bottle of Lactulose SOL 10mg to be administered each day as needed (a medication used to treat constipation) sitting on top of the sink in the bathroom. Interview with Resident #6 on 12/16/25 at 10:01am revealed: -She was unaware that the medication Lactulose SOL was in her bathroom. -She had not used the medication Lacutolose SOL. -All of her medications had been given to her by the facility staff. Interview with Resident #6 on 12/17/25 at 9:31am revealed: -Staff administered her medications. -She could not take any medications herself because she could not see very good because of macular degeneration (a disorder of the eye causing blurry or dark spots and difficulty with reading). Review of Resident #6's October 2025 electronic medication administration records (eMARs) revealed there was no entry printed to the eMARs for Lactulose Solution.	D 375		

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D 375	Continued From page 54 Review of Resident #6's November 2025 eMARs revealed there was no entry printed to the eMARs for Lactulose Solution. Review of Resident #6's December 2025 eMARs revealed there was no entry printed to the eMARs for Lactulose Solution. Interview with the Resident Care Coordinator (RCC) on 12/18/25 at 4:02pm revealed: -She spoke to Resident #6 about the bottle of Lactulose Solution. -The resident told the RCC that she did not know where the Lactulose came from, and she thought it was a mouthwash. -The Lactulose was removed from Resident #6's room on 12/16/25 by the medication aide (MA). Interview with Resident #6's Primary Care Provider (PCP) on 12/17/25 at 12:02pm revealed: -She saw Resident #6 two or three times since admission to the facility. -Resident #6 had some forgetfulness and needed some "prodding" which meant questions needed to be asked in different ways. -She had not completed an FL-2 for Resident #6. -She did not recall ever prescribing Lactulose for Resident #6. -She did not often prescribe Lactulose. -She did not know if Resident #6 self-administered medication. -She would not want Resident #6 to have a full bottle of Lactulose because the resident might take it twice. -The resident had some concerns about constipation. -The Lactulose came from the prior facility for Resident #6, and family members would bring medications into resident rooms. _____	D 375		

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D 375	Continued From page 55 Interview with the medication aide (MA) on 12/17/25 at 11:47am revealed: -All medications were supposed to be kept on the medication cart. -All medications were supposed to be ordered by a provider. -Room checks were conducted once per month. -During room checks, staff looked for medications in the room, bathroom and drawers (with the resident's permission). -If medications were found in a resident's room, the medication was removed and secured, and the resident was informed that the provider would be contacted for an order. Interview with the Resident Care Coordinator (RCC) on 12/17/25 at 12:09pm revealed: -She conducted room checks every 2 months. -During room checks, she checked the bathroom and medicine cabinet; she did not look in the drawers. Interview with the Administrator on 12/17/25 at 12:33pm revealed: -Room checks were conducted once per week by the MAs and RCC. -MAs and personal care aides (PCA) were supposed to look for medications anytime they were in residents' rooms. -During room checks, cabinets and bedside tables were checked for medication. -All medications were supposed to be locked on the medication cart.	D 375		