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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 from 01/06/26 to 01/08/26.	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 8 of 9 exit doors which were accessible to 4 of 8 sampled residents who resided in the facility and who were identified as intermittently disoriented (#2, #6, #7, #8) had audible alarms activated when the exit doors were opened to alert staff.	D 067		

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D 067	Continued From page 1 The findings are: Review of the facility's current license, effective 01/01/26 revealed the facility was licensed as an assisted living facility with a capacity of 91 beds, 57 assisted living (AL), and 34 special care unit (SCU). Review of the facility's census on 01/06/26 revealed there were 35 residents residing in the AL. Observation of the front entrance on 01/06/26 at 8:15am revealed: -The double doors automatically opened when anyone approached the door, and no alarm sounded when the door was opened. -There was no alarm box on either entry door. Observation of hallway C on 01/06/26 at 8:27am revealed: -There was an exit door in the hallway, and no alarm sounded when the door was opened -There was a second exit door that had a sign that read do not open, alarm will sound; the door was not opened to check the alarm. -Both doors had an alarm box in the upper right-hand corner of the door. Observation of hallway A on 01/06/26 at 9:46am revealed: -There was an exit door at the end of the hallway, and no alarm sounded when the door was opened. -Both doors had an alarm box in the upper right-hand corner of the door. Observation of hallway B on 01/06/26 at 9:49am revealed:	D 067		

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-There was a living room halfway down the hallway, and inside the room, there was an exit door, and no alarm sounded when the door was opened.
-There was an exit door at the end of the hallway, and no alarm sounded when the door was opened.
-Both doors had an alarm box in the upper right-hand corner of the door.

Observation of the dining room on 01/06/26 at 12:31pm revealed:
-There were two exit doors, and no alarm sounded when both doors were opened.
-Both doors had an alarm box in the upper right-hand corner of the door.

Observation of the front entrance on 01/07/26 at 7:50am revealed there was no alarm sound when the door was opened.

Observation of hallway C on 01/07/26 at 8:01am revealed:
-There was an exit door on the hallway, and no alarm sounded when the door was opened.
-There was a second exit door that had a sign that read do not open, alarm will sound.
-When the door was opened, there was an audible alarm that sounded.
-The alarm was activated at 8:03am, and it was no longer audible at 8:04am.
-A medication aide (MA) responded to the alarm after exiting a resident's room; the alarm had already stopped sounding when she returned to the hallway with a key to turn the alarm off.

Observation of hallway B on 01/07/26 at 8:06am revealed:
-There was a library halfway down the hallway, and inside the room, there was an exit door, and

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no alarm sounded when the door was opened.
-There was an exit door at the end of the hallway, and no alarm sounded when the door was opened.

Observation of hallway A on 01/07/26 at 8:08am revealed:
-There was an exit door at the end of the hallway, and no alarm sounded when the door was opened.
-There was a therapy room that had an exit door, and no alarm sounded when the door was opened.

Observation of the dining room on 01/07/26 at 8:12am revealed there were two exit doors, and no alarm sounded when both doors were opened.

Telephone interview with the county's Adult Home Specialist (AHS) on 01/07/26 at 10:18am revealed:
-She was aware of a resident who had walked away from the facility in September 2025, and the resident was moved to the SCU.
-She had not received any incident reports for an elopement.

Interview with a MA on 01/07/26 at 10:25am revealed:
-She had never heard an alarm on the front door.
-The front doors were locked at 9:00pm, but the door could be pulled apart to open the doors.
-All other exit doors were alarmed.
-Maintenance usually went around and checked the exit doors to ensure the doors were alarmed.
-She had not heard the door alarms "go off" often.
-If a door alarm was heard, staff went and checked to see who went outside and turned the alarm off with a key.
-Maintenance staff, the MAs, and the Resident

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Care Coordinator (RCC) all had a key to the door alarms.

Interview with the Maintenance Director on 01/07/26 at 10:50am revealed:
-All managers were responsible for the door alarms, but "mainly" him.
-He checked the door alarms every morning between 8:30am and 9:30am.
-He checked the door alarms every day before he left the facility between 5:00pm and 7:30pm.
-He checked all the exit doors in the hallways to ensure the alarms were turned on.
-If an alarm sounded, the alarm would have to be turned off by a manager with a key.
-The doors were alarmed to alert staff when a resident went outside.
-All staff should respond to the door alarm to see who was going outside.
-The residents were not supposed to use the exit doors on the hallways unless there was an emergency and should only exit and enter the facility through the front door.
-All the door alarms were checked today, 01/07/26, but not before 8:30am because he was running late.
-He saw today, 01/07/26, that one of the exit door alarms in the dining room was corroded inside the battery compartment and needed to be replaced.

Observation of the door alarms with the Maintenance Director on 01/07/26 between 10:50-11:00am revealed:
-The exit door on hallway A was turned off, and even after the alarm was turned on, there was no audible alarm.
-The exit door in the physical therapy room was turned off, and even after the alarm was turned on, there was no audible alarm.
-The exit door in the library room was turned off,

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and even after the alarm was turned on, there was no audible alarm.
-The exit door on hallway C was turned on, but when the door was opened, the alarm was not audible; the Maintenance Director was able to make the alarm audible before leaving the hallway.
-All other hallway exit doors had an audible alarm heard when the doors were opened.

Second observation of the door alarms with the Maintenance Director on 01/07/26 at 12:35pm revealed:
-The exit door on hallway A had an audible alarm when opened.
-The exit door in the physical therapy room had an audible alarm when opened.
-The exit door in the library room had an audible alarm when opened.

Interview with a second MA on 01/07/26 at 11:05am revealed:
-The exit doors had alarms that could be heard everywhere in the facility.
-No one should be exiting the doors in the hallways.
-Residents and staff were only supposed to exit and enter the facility through the front entrance.
-The doors were alarmed so staff would know when someone went out a door.
-If a resident went out of the hallway exit door, no one would see the resident go out, and the resident could have a fall.
-If a resident wandered outside without anyone knowing, it was a "fall waiting to happen."
-Residents were supposed to go in and out of the front door so staff could see the residents coming and going.

Interview with the RCC on 01/07/26 at 11:25am

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revealed:
-All the exit doors had alarms.
-The Maintenance Director was responsible for checking to make sure the alarms were working; she did not know how often he checked the doors.
-The doors were alarmed as a precaution to know who went outside.
-Doors were alarmed for safety concerns, knowing where all the residents were and keeping others out.
-There were no incidents of any residents going out the exit doors after dark.
-If a resident became a "wander" risk, the resident would be moved to the SCU or be required to have a 24-hour sitter.
-There were no residents she had concerns about "right now" for wandering.
-No residents had wandered away from the facility.
-No one needed supervision to be outside the facility.

Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed:
-All the exit doors had alarms.
-She was notified that one of the exit door alarms had the batteries missing today, 01/07/26.
-The side door on hallway C was where the staff took the trash out, and today, 01/07/26, a new resident was moving in, but the door should have been re-alarmed when they were finished.
-The door alarms were to notify staff when a resident went outside, in case the resident was unsteady and needed assistance.
-There were no residents who needed supervision to be outside.
-The Maintenance Director was responsible for door alarms.
-She did not know why the front door was not

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D 067	Continued From page 7 alarmed. Interview with the Administrator on 01/07/26 at 12:35pm revealed: -All exit doors were alarmed. -The exit doors were alarmed to alert a team member when the door was opened. -The team member was responsible for seeing why the resident was going out a side exit door. -Residents were supposed to only use the front entrance for safety reasons. -If the exit doors were not alarmed, a resident could have a fall, and staff would not know. -If a resident said they were going home and the exit doors were not alarmed it would be concerning. -It was a safety concern, especially if the doors were not alarmed to alert staff when a resident went outside. -The Maintenance Director was assigned to check the door alarms, but all staff should check the exit doors to ensure the doors were secure and alarms were working. Interview with the Administrator on 01/08/26 at 1:05pm revealed: -He did not know why the front entrance door was not alarmed. -There was a concierge at the front desk 7 days a week from 9:00am-5:00pm. -The facility did not have a policy related to door alarms. Interview with the Maintenance Director on 01/08/26 at 12:13pm revealed there had never been an alarm on the front door since he had been there, but he did not know why. 1. Review of Resident #8's current FL2 dated 12/31/25 revealed:	D 067		

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-Diagnoses included mild cognitive impairment, history of cardiac arrest, and hypertension.
-She was intermittently disoriented.

Review of Resident #8's Resident Register revealed:
-There was no admission date, and the signature was not dated.
-Resident #8 had significant memory loss and had to be directed.

Review of Resident #8's care plan dated 12/31/25 revealed:
-She was sometimes disoriented, forgetful, and needed reminders.
-She was independent with transferring and ambulation.

Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed:
-Resident #8 was forgetful.
-Resident #8 would forget where her room was.
-Resident #8 did not require supervision to go outside.
-Resident #8 would go outside, but she usually came right back in.

Interview with a second MA on 01/07/26 at 11:05am revealed:
-Resident #8 had very progressive memory loss.
-Resident #8 would leave her door open and then accuse someone else of going into the room.
-Resident #8 would forget she ate and "things like that".
-Resident #8 could go outside unsupervised, because she was not an elopement risk.

Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:25am revealed:
-She had questioned Resident #8's memory a

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"couple of times" and made the family aware that she had noted the changes.
-Resident #8 might open the door but would not go outside.

Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed:
-Staff had been looking at possibly moving Resident #8 to the SCU because of changes in her cognition.
-She was not consistently disoriented but had good and bad days.
-She thought that within the next 6 months, Resident #8 would be transferred to the SCU.
-Resident #8 was not going to go outside.

Telephone interview with Resident #8's family member on 01/07/26 at 3:58pm revealed:
-She had never heard an alarm when she entered and exited the front door of the facility.
-Resident #8's room was close to an exit door.
-She thought the hallway exit doors should be alarmed.
-She would like staff to know when Resident #8 went outside, especially if she went out the back door.
-Resident #8 had a diagnosis of mild cognitive impairment.
-Resident #8 had no short-term memory at all.

Interview with Resident #8 on 01/08/26 at 8:25am revealed:
-She did not recall how long she had lived at the facility.
-She liked to go outside when it was nice.
-She was not supposed to go out that door, indicating the exit door by her room.

Telephone interview with Resident #8's primary care provider (PCP) on 01/08/26 at 12:21pm

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revealed:
-Resident #8's short-term memory was not "wonderful".
-She had completed a recent cognitive screening test.
-If it were a state regulation for the exit doors to be alarmed, then the alarms should be in place.
-She had no concern that Resident #8 would wander, but it could happen, she "guessed," but she was not concerned.
-She thought all the exit doors at the facility were alarmed except for the front entrance door.

2. Review of Resident #7's current FL2 dated 10/29/25 revealed:
-Diagnoses included mild cognitive impairment, major depressive disorder, and hearing loss.
-There was no information for orientation or ambulatory status.

Review of Resident #7's previous FL2 dated 08/01/24 revealed the resident was constantly disoriented and ambulatory.

Review of Resident #7's Resident Register dated 06/11/18:
-Resident #7 was admitted to the facility on 06/11/18.
-Resident #7 was forgetful needed reminders, and had significant memory loss, and must be directed, which were both checked with a handwritten note, "somewhere between these two".

Review of Resident #7's pre-screening questionnaire dated 06/07/18 revealed:
-Resident #7 had been diagnosed with dementia.
-Resident #7 was sometimes forgetful.

Review of Resident #7's care plan dated 02/16/25

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revealed:
-He was forgetful and needed reminders.
-He was independent with transferring and ambulation.

Review of Resident #7's primary care provider's (PCP) after-visit summary dated 10/01/25 revealed:
-Resident #7 was seen for acute lethargy.
-Physical exam was unrevealing.
-Changes could be a possible progression of the resident's dementia.

Observation of Resident #7 at various times between 8:15am-3:00pm from 01/06/26-01/08/26 revealed:
-He was walking up and down the hallways.
-He wore the same shirt every day.

Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed:
-Resident #7 walked inside and outside of the facility.
-Resident #7 did not require supervision to walk outside the facility.

Interview with a second MA on 01/07/26 at 11:05am revealed:
-Resident #7 did not communicate with staff; he only refused showers.
-Resident #7 just wandered around, meaning he walked.
-Resident #7 could come and go freely.

Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:25am revealed:
-Resident #7 did not talk to her, so she could not say if there had been any changes in his memory.
-Resident #7 walked a lot.

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D 067	Continued From page 12 Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed: -Resident #7 had a "little" issue with his memory. -Resident #7 did not speak often. -If Resident #7 was having a good day, he was cognitively intact. Telephone interview with Resident #7's family member on 01/07/26 at 3:33pm revealed: -Resident #7 was admitted to the facility because of his memory loss. -Resident #7 started having noted memory loss in 2017 and was diagnosed with memory loss in 2018. -She gave multiple examples of Resident #7 being forgetful. -Resident #7 stayed inside the facility, mostly. -Resident #7 had never wandered and never had any falls. Observation of Resident #7 on 01/07/26 at 3:52pm revealed: -Resident #7 would not answer any questions. -Resident #7 stared at the surveyor. -Resident #7 walked away. Telephone interview with Resident #7's PCP on 01/08/26 at 4:45pm revealed: -Ideally, Resident #7 would need supervision from staff to know if he went outside. -If Resident #7 did go outside, she would want staff to know. -Resident #7 did not need to be in a locked unit but she would want staff to be aware if the resident went outside. 3. Review of Resident #6's current FL2 dated 12/17/25 revealed: -Diagnoses included macular degeneration, anemia, and vitamin B12 deficiency.	D 067		

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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
D 067	Continued From page 13 -She was intermittently disoriented. Review of Resident #6's previous FL2 dated 09/24/25 revealed: -Diagnoses included Alzheimer's disease and delirium due to a known physiological condition. -She was intermittently disoriented. Review of Resident #6's Resident Register revealed an admission date of 11/04/20. Review of Resident #6's care plan dated 10/03/25 revealed: -She was always disoriented. -She was forgetful and needed reminders. -She was independent with transferring and ambulation. Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed: -Resident #6's memory was "sometimes here and sometimes not". -Resident #6 could not find her room sometimes. -Resident #6 was very disoriented after surgery in September 2025. -Resident #6 was still disoriented sometimes. Interview with a second MA on 01/07/26 at 11:05am revealed Resident #6, at one time, was getting forgetful after she had been sick, but her memory had improved. Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:25am revealed: -Resident #6 had a fall, and her family member wanted her to go to the SCU because of her mental decline, but the resident got back into her routine and was at her baseline and was fine in AL. -Resident #6 was okay one day and "off" the next	D 067		

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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 067	Continued From page 14 day. Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed: -Resident #6 had good and bad days. -She had seen a decline in Resident #6's memory; she was forgetful, like she would forget where she put her socks, or she would forget to put on her shoes. -Resident #6 was not going to go outside. Interview with Resident #6 on 01/08/26 at 8:32am revealed: -She seemed confused when asked questions, such as she had multiple jugs of water on her counter, and when asked why she had the jugs of water, she said she did not know. -She liked to go outside when it was warm. Telephone interview with Resident #6's primary care provider (PCP) on 01/08/26 at 12:21pm revealed: -Resident #6 was scheduled to see a neurologist for further cognitive testing. -Resident #6 had a noted cognitive decline after a fall. -She was not concerned about Resident #6 wandering. -She had no concern that Resident #6 would wander, but it could happen, she "guessed," but she was not concerned. -She thought all the exit doors at the facility were alarmed except for the front entrance door. Attempted telephone interview with Resident #6's family member on 01/07/26 at 2:56pm was unsuccessful. 4. Review of Resident #2's current FL2 dated 12/31/25 revealed:	D 067		

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D 067	Continued From page 15 -Diagnosis was unspecified fracture of the 5th lumbar vertebra. -She was intermittently disoriented. -She was ambulatory. Review of Resident #2's Resident Register revealed an admission date of 01/10/17. Review of Resident #2's care plan dated 02/05/25 revealed: -She was sometimes disoriented, forgetful, and needed reminders. -She was independent with transferring and ambulation. Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed: -Resident #2 forgot when the MAs had already administered her medication. -Resident #2 did not need supervision to go outside. Interview with a second MA on 01/07/26 at 11:05am revealed: -Resident #2 was "getting a little forgetful." -Resident #2 would ask if she had eaten when she just ate or ask if she had taken her medication when she just took it. Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:25am revealed: -Resident #2 was "pretty with it"; she could articulate what was going on. -Resident #2 did get her medications confused. -Resident #2 complained of a cough to the physical therapist, and when the MA was then giving the cough medication, the resident asked why she was taking the medication. -Resident #2 would forget something just happened.	D 067		

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D 067	Continued From page 16 Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed: -Resident #2 was very independent. -Resident #2's memory was good, but she would put something down and forget where she put it. Telephone interview with Resident #2's family member on 01/08/26 at 11:34am revealed: -Resident #2 was very forgetful. -Resident #2 was paranoid and thought people were taking her things. -If Resident #2 had a urinary tract infection (UTI), she would get very "loopy" and sundown (a syndrome known as sundowning, a cluster of behavioral and emotional changes, like increased confusion, agitation, anxiety, and restlessness, that worsen in the late afternoon and evening in people with dementia). -She recalled one time when Resident #2 had a UTI, and she had packed her things up and was going down the hall, and said she was going home. -She had seen the exit door in her family member's hallway propped open but had not heard an alarm. -Resident #2 used to go outside and walk "way across the parking lot," but she did not go outside much anymore. Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/07/26 at 3:44pm was unsuccessful. _____ The facility failed to ensure that 8 of 9 of the facility's exit doors were alarmed with an audible sounding device when the doors were opened. The door alarms were necessary to prevent 4 residents who were identified as intermittently disoriented, one resident who was diagnosed with	D 067		

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D 067	Continued From page 17 Alzheimer's disease, and two residents who were diagnosed with cognitive impairment from exiting the facility without the staff's knowledge. One of the residents, who became more confused when she had a UTI, had packed her belongings and was talking about going home. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/07/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 22, 2026.	D 067		
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: Based on observations, interviews, and record reviews, the facility failed to clarify medications	D 344		

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and treatment orders for 2 of 5 sampled residents (#1 and #2) including a topical cream (#1) and a stool softener and blood pressure (BP) check (#2).

The findings are:

1. Review of Resident #2's current FL2 dated 12/31/25 revealed:
-Diagnosis was unspecified fracture of the 5th lumbar vertebra.
-There was documentation to see attached document for the medications.

Review of Resident #2's electronic communication record revealed:
-Resident #2's family member had called the primary care provider's (PCP) office to request the daily senna order be discontinued due to the resident having too many bowel movements.
-There was a circle around the words "discontinuing the daily senna order" and was dated and initialed by the PCP on 12/10/25.

Review of a signed physician's order dated 12/16/25 revealed an order to discontinue senna 8.6mg scheduled nightly.

Review of Resident #2's signed physician's orders dated 12/31/25 revealed:
-The physician's orders had been printed from the electronic medication administration record (eMAR) on 12/09/25 and signed by the primary care provider (PCP) on 12/31/25.
-There was an order for senna 8.6mg take one tablet at bedtime.

Review of Resident #2's December 2025 eMAR revealed:
-There was an entry for senna 8.6mg take one

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tablet at bedtime with a scheduled administration time of 8:00pm.
-There was documentation senna was administered daily from 12/01/25-12/15/25 with exceptions documented on 12/10/25, 12/13/25, and 12/15/25 as refused.
-There was no documentation senna was administered from 12/15/25-12/31/25.
Review of Resident #2's January 2026 eMAR from 01/01/26-01/06/26 revealed:
-There was no entry for senna 8.6mg take one tablet at bedtime with a scheduled administration time of 8:00pm.
-There was no documentation senna was administered daily from 01/01/26-01/06/26.

Observation of Resident #2's medications on hand on 01/06/26 at 11:46am revealed no senna 8.6mg on hand.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/06/26 at 3:02pm revealed:
-Resident #2's senna 8.6mg was discontinued on 12/16/25.
-Most of the time a copy of the signed physician's orders was sent to the pharmacy.
-She did not see a copy of Resident #2's signed physician's order dated 12/31/25.
-If the signed physician's orders dated 12/31/25 were received at the pharmacy, they would have matched the orders to the current medication list and if there were any discrepancies they would have reached out to the facility for clarification.

Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed:
-The Resident Care Coordinator (RCC) and the MAs were responsible for making sure the FL-2, any signed physicians orders match the

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medications on hand and the MARS when a resident returned from outside of the facility.
-The pharmacy entered medication orders on the MAR.
-Orders for vital signs were entered by the MAs, the RCC, or the Clinical Nurse.
-Signed orders were faxed to the pharmacy by the RCC and the Clinical Nurse.

Interview with the RCC on 01/07/26 at 11:25am revealed:
-She and the Clinical Nurse were responsible for updating FL2s annually.
-She would make sure the FL2s were completed and the signed physicians order (SPO) were printed to be signed.
-When the SPO was printed on 12/09/25, the PCP did not come for about 2 weeks because of the holidays.
-She had not compared the current SPO, MARS, FL2s, and medication on hand.
-The signed FL2s and SPO were always sent to the pharmacy.
-She was 100% sure the SPO were always sent to the pharmacy.
-If a discrepancy was seen after the FL2s and physician's orders were signed, she would have printed out new physician's orders and had them signed.

Refer to the interview with the Clinical Nurse on 01/08/26 at 1:59pm.

Refer to the interview with the Administrator on 01/08/26 at 1:17pm.

b. Review of Resident #2's current FL2 dated 12/31/25 revealed:
-Diagnosis was unspecified fracture of the 5th lumbar vertebra.

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-There was documentation to see attached document for the medications.
Review of Resident #2's signed physician's orders dated 12/31/25 revealed:
-The physician's orders had been printed from the eMAR on 12/09/25 and signed by the PCP on 12/31/25.
-There was an order to check blood pressure; there was no frequency documented.

Review of Resident #2's December 2025 eMAR revealed:
-There was an entry for blood pressure checks with a scheduled administration time of 10:00am.
-There was documentation her BP was checked on was checked on Mondays, Wednesdays, and Fridays 12/01/25-12/31/25.

Review of Resident #2's January 2026 eMAR from 01/01/26-01/06/26 revealed:
-There was an entry for blood pressure checks with a scheduled administration time of 10:00am.
-There was documentation her BP was checked on was checked on Mondays, Wednesdays, and Fridays from 01/01/26-01/06/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/06/26 at 3:02pm revealed they did not enter vitals on the eMAR unless it was to be checked with medication administration.

Interview with a MA on 01/07/26 at 10:25am revealed:
-If she saw a BP order and there were no other specific directions she would check the residents' blood pressure every day.
-If there was no end date on the order she would ask the PCP.

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D 344	Continued From page 22 Interview with the RCC on 01/07/26 at 11:25am revealed: -Resident #2's BP order in the MAR was entered as on Mondays, Wednesdays and Fridays and was dated as 12/17/25. -If she had seen an order for blood pressure checks with no frequency she would have gotten the order clarified. Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed an order that read blood pressure checks, would need to be clarified as to how often. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:59pm. Refer to the interview with the Administrator on 01/08/26 at 1:17pm. 2. Review of Resident #1's current FL-2 dated 12/17/25 revealed: -Diagnoses of dementia, diabetes type 2, peripheral vascular disease, and dysphagia. -There were no medications listed; there was a statement that read, see attached. Review of Resident #1's signed physician orders dated 12/17/25 revealed there was an order for Z-bum cream 22% (used for skin irritation) apply to shins daily. Review of Resident #1's signed physician order dated 12/05/25 revealed an order to discontinue Z-bum cream. Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Z-bum cream 22% apply	D 344		

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to shins daily with a scheduled administration time of 8:00am.
-There was documentation that Z-bum cream was administered daily from 12/01/25 to 12/09/25.
-There was documentation that Z-bum cream was discontinued on the eMAR on 12/10/25.

Observation of Resident #1's medications on hand on 01/06/26 at 11:35am revealed there was no Z-bum cream available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 01/08/26 at 8:30am and 11:15am revealed:
-Resident #1 had an order to discontinue Z-bum cream dated 12/05/25.
-The pharmacy entered the discontinued orders into the system.
-The pharmacy did not have an active order for Z-bum cream.
-The pharmacy did not receive the FL-2 or the signed physician orders dated 12/17/25.
-If the pharmacy had received the signed physician orders dated 12/17/25, they would have notified the Primary Care Provider (PCP) for clarification.

Interview with the medication aide on 01/06/26 at 11:39am revealed:
-Resident #1's Z-bum cream was discontinued a month ago.
-Resident #1 no longer needed the cream to be applied to his shins.

Telephone interview with the PCP on 01/08/26 at 1:59pm revealed:
-She reviewed the list of medications before she signed the FL-2 and the physician orders.
-She discontinued the Z-bum cream on 12/05/25.

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D 344	Continued From page 24 -She did not realize the Z-bum cream was on the current list of medications that was signed on 12/17/25. Interview with the Special Care Unit Coordinator(SCC) on 01/07/26 at 3:31pm revealed: -The signed FL-2 and physician orders were placed in the residents record. -She audited the medication cart monthly and compared the medications on the medication cart with the medication orders. -If she noticed a discrepancy, she would notify the PCP. -She did not compare the signed FL-2 and physician orders with the current orders on the eMAR for accuracy when the FL-2 and physician orders were signed. -She did not fax the FL-2 and physician orders to the pharmacy. -She did not know the Z-bum cream was an active order again as of 12/17/25. -She did not notify the PCP of the active order for Z-bum to verify if it was to restart. Interview with the Clinical Nurse on 01/08/26 at 1:59pm revealed the list of medications were printed for the PCP to sign before the Z-bum cream was discontinued on the eMAR. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:59pm. Refer to the interview with the Administrator on 01/08/26 at 1:17pm. _____ Interview with the Clinical Nurse on 01/08/26 at 12:01pm and 1:59pm revealed: -There was no process in place to review the signed FL-2 and physician orders if the list of	D 344		

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D 344	Continued From page 25 medications were generated from the facility's computer system. -The signed FL-2's and physician orders should be compared to the eMAR for accuracy. -She was responsible for the FL2 verification form. -The FL2s were always faxed to the pharmacy and if there were any changes, the pharmacy would let her know. Interview with the Administrator on 01/08/26 at 1:17pm revealed: -The Clinical Nurse should review the signed FL-2's and physician orders for accuracy. -The Clinical Nurse should contact the PCP for any discrepancies identified.	D 344		
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:	D 375		

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Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 6 residents (#6, #7, #9, #10, and #11) had a physician's order to self-administer medications observed during the 8:00am medication pass on 01/07/26 (#6) and in the residents' rooms in the Assisted Living (AL) (#7, #9, #10, and #11).

The findings are:

Review of the facility's Resident Self Administration of Medication policy and procedures dated 08/01/18 revealed:
-The clinical nurse or designee would assess the resident's ability to self-medicate by utilizing the self-administration of medication assessment upon admission and on a quarterly basis, or per state regulations to ensure ongoing competency.
-The facility must maintain an electronic medication administration record (eMAR) for all residents who self-administer.

1. Review of Resident #6's current FL2 dated 12/17/25 revealed:
-Diagnoses of macular degeneration, anemia, and vitamin B12 deficiency.
-She was intermittently disoriented.

Review of Resident #6's previous FL2 dated 09/24/25 revealed:
-Diagnoses of Alzheimer's disease and delirium due to a known physiological condition.
-She was intermittently disoriented.

Review of Resident #6's care plan dated 10/03/25 revealed:
-She was always disoriented.
-She was forgetful and needed reminders.

Review of Resident #6's signed physician orders

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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 27 dated 12/17/25 revealed: -There was an order for metronidazole lotion 0.75% apply to face twice daily. -There was no order to self-administer medications. Review of Resident #6's record revealed there was no current self-administration of medication assessment available for review. Review of Resident #6's January 2026 eMAR from 01/01/26 to 01/07/26 revealed: -There was an entry for metronidazole lotion 0.75% apply twice daily to face with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that metronidazole lotion was applied at 8:00am on 01/07/26. -There was no documentation that metronidazole lotion could be self-administered. Observation of the 8:00am medication pass on 01/07/26 revealed: -The medication aide (MA) retrieved the bottle of metronidazole lotion 0.75% from the top drawer of the medication cart. -The MA poured 10mls into a medication cup and handed the medication cup to Resident #6. -Resident #6 took the medication cup and walked to her room. -The MA stated, "Resident #6 has an order to self-administer her lotion to her face. Telephone interview with a representative from the facility's contracted pharmacy on 01/07/26 at 10:43am revealed: -Resident #6 had an order for metronidazole lotion 0.75% apply to face twice daily dated 08/02/24. -Resident #6 did not have a self-administration order to apply metronidazole lotion to her face.	D 375		

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-The pharmacy would type, may self-administer, on the eMAR for any medications that had a self-administration order.

Interview with Resident #6 on 01/07/26 at 9:35am revealed:
-The MA gave Resident #6 a cup of lotion to be placed on her face when she came out of the dining room.
-She took the cup of lotion to her room and applied the lotion to her face.
-She always applied the lotion to her face; the MAs did not apply the lotion to her face.

Interview with a MA on 01/07/26 at 10:25am revealed:
-Resident #6 could not self-administer her own medications because she would forget to take them.
-Resident #6 could not be given her face cream because she would not remember to apply it later.

Interview with a second MA on 01/07/25 at 11:05am revealed:
-At one time, she would give Resident #6 her face cream to apply herself when she got to her room, but when she went to the resident's room to check it later, the face cream had not been applied; she forgot what it was for.
-She could not trust Resident #6 to take her face cream to her room and apply it.

Interview with the Primary Care Provider (PCP) on 01/08/26 at 12:15pm revealed:
-Resident #6 did not have an order to self-administer the metronidazole lotion to her face.
-She did not think that Resident could apply the metronidazole lotion to her face correctly.

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D 375	Continued From page 29 Interview with the Resident Care Coordinator (RCC) on 01/07/25 at 3:13pm revealed: -Resident #6 did not have an order to self-administer medications. -Resident #6 should not be applying the medicated lotion to her face without a self-administration order. -The MAs should be applying the medicated lotion to Resident #6's face. Interview with the Clinical Nurse on 01/08/26 at 1:59pm revealed: -The MAs should apply the medicated lotion to Resident #6's face as ordered if there was no self-administration order. -She expected the MAs to administer medications that did not have a self-administration order. Interview with the Administrator on 01/08/26 at 1:17pm revealed Resident #6 should not apply the lotion to her face unless she had an order to self-administer and a self-administer assessment had been completed and the resident was competent to administer the medication. Refer to the interview with a MA on 01/07/26 at 10:45am. Refer to the interview with the RCC on 01/07/26 at 11:25am. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:15pm. Refer to the interview with Administrator on 01/08/26 at 1:05pm. 2. Review of Resident #9's current FL-2 dated 12/17/25 revealed diagnoses included hearing	D 375		

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D 375	Continued From page 30 loss, hypothyroidism, and osteoporosis. Review of resident #9's record revealed she did not have an order for chlorhexidine gluconate, and she did not have an order to self-administer any medications. Review of Resident #9's January 2026 electronic medication administration record (eMAR) from 01/01/26 to 01/08/26 revealed there was no entry for chlorhexidine gluconate. Observations of Resident #9's room on 01/06/26 at 9:32am and 01/07/26 at 9:55am revealed there was a bottle of chlorhexidine gluconate on the counter next to the sink in the bathroom; the bottle was one-thirds full. Interview with Resident #9 on 01/07/26 at 10:38am revealed: -A family member gave her the mouth wash [chlorhexidine gluconate] to use. -She used it every morning and she kept it in the bathroom on the counter. -She did not know if the facility staff knew she had the mouth wash. Telephone interview with Resident #9's power of attorney (POA) on 01/08/26 at 2:38pm revealed: -She brought the chlorhexidine gluconate to Resident #9; it was a sample from Resident #9's dentist. -She knew she should have let the Clinical Nurse know about the chlorhexidine gluconate when she brought it in for Resident #9 to use. -She forgot to tell the Clinical Nurse about the chlorhexidine gluconate. -She wanted Resident #9 to use the chlorhexidine gluconate at least once daily. -Resident #9 could keep the mouth rinse in her	D 375		

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room and use it or the facility staff administered it to her.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/08/26 at 8:25am revealed:
-Resident #9 did not have an order for chlorhexidine gluconate.
-Resident #9 did not have an order to self-administer any medications.
-When a resident had an order to self-administer a medication the pharmacy put the medication on the eMAR and the order for self-administering the medication on the label.
-Chlorhexidine gluconate was an oral rinse and should not be swallowed.

Telephone interview with Resident #9's primary care provider (PCP) on 01/08/26 at 12:45pm revealed:
-Resident #9 could self-administer medications but she did not currently have an order to self-administer any medications.
-Resident #9 would remember to use the chlorhexidine gluconate and spit it out.
-Chlorhexidine gluconate would not be harmful if swallowed.

Interview with a medication aide (MA) on 01/07/26 at 10:45am revealed:
-Resident #9 did not have an order to self-administer medications.
-Resident #9 could remember times and was not disoriented or confused.
-Resident #9 did not have an order for a mouthwash [chlorhexidine gluconate].
-She thought Resident #9 could use a medicated mouthwash on her own and not swallow it.
-She had not seen the chlorhexidine gluconate in Resident #9's bathroom.

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D 375	Continued From page 32 Interview with the Resident Care Coordinator (RCC) on 01/08/26 at 2:20pm revealed: -She did not know if Resident #9 had an order to self-administer her own medications. -Resident #9 would know not to swallow the chlorhexidine gluconate mouthwash. -Resident #9 was alert and oriented enough to take her own medications. Interview with the Clinical Nurse on 01/08/26 at 1:15pm revealed: -She was not aware there was chlorhexidine gluconate mouthwash in Resident #9's bathroom. -Resident #9 did not have an order to self-administer the chlorhexidine gluconate mouthwash. -She thought Resident #9 could administer the mouthwash herself and not swallow it. -She would get an order for the mouthwash and then see if the resident wanted to continue to self-administer before she tested her. Refer to the interview with a MA on 01/07/26 at 10:45am. Refer to the interview with the RCC on 01/07/26 at 11:25am. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:15pm. Refer to the interview with Administrator on 01/08/26 at 1:05pm. 3. Review of Resident #10's current FI-2 dated 01/08/26 revealed: -Diagnoses included hypertension, anemia due to chronic kidney disease, depression and osteoporosis.	D 375		

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-There was an order for Robitussin-DM2 (used to treat chest congestion and cough) 20mg/ml take 5ml at night.

Review of Resident #10's record revealed there was no self-administration of medication assessment available.

Review of Resident #10's January 2026 electronic medication administration record (eMAR) from 01/01/26 to 01/08/26 revealed there was no entry for Robitussin-DM2.

Observations of Resident #10's room on 01/06/26 at and 01/07/26 at 9:54am revealed there was a bottle of Robitussin DM on the nightstand; the bottle was three-fourths full.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/08/26 at 8:25am revealed:
-Resident #10 did not have an order for Robitussin-DM2.
-Resident #10 did not have an order to self-administer any medications.
-When a resident had an order to self-administer a medication the pharmacy put the medication on the eMAR and the order for self-administering the medication on the label.
-Robitussin-DM2 was used to relieve cough and congestion.
-If more than the recommended dose was taken it would cause sedation.

Telephone interview with Resident #10's primary care provider (PCP) on 01/08/26 at 12:45pm revealed:
-She had not seen Resident #10 because she was sent to the hospital before she could see the resident.

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-Robitussin-DM was an over-the-counter (OTC) medication used to treat cough and chest congestion.
-Robitussin-DM contained alcohol but there was not enough to cause any outcomes if too much was consumed.
-She would have to assess Resident #10 to see if she could self-administer medications.

Interview with a medication aide (MA) on 01/07/26 at 10:45am revealed:
-She did not know if Resident #10 had an order to self-administer medications.
-Resident #10 was newly admitted and had only been at the facility for two days before she was sent to the hospital.
-She had not seen the Robitussin DM2 in Resident #10's room, but she had not been in the resident's room since the day the resident left for the hospital.

Interview with the Resident Care Coordinator (RCC) on 01/08/26 at 2:20pm revealed:
-Resident #10 had only been admitted to the facility a couple of days before she was sent to the hospital.
-She had not looked for medications in Resident #10's room yet.
-She thought Resident #10 could self-administer her own medications if she wanted too.
-Resident #10 had not been tested to see if she could self-administer her medications because she went to the hospital so quickly.

Interview with the Clinical Nurse on 01/08/26 at 1:00pm revealed:
-She was not aware there was a bottle of Robitussin-DM in Resident #10's room.
-The staff should have found the bottle if it was on the nightstand and removed it because Resident

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D 375	Continued From page 35 #10 was in the hospital. -Resident #10 had an order for the Robitussin but she did not have an order to self-administer the medication. -Resident #10 could self-administer her own medications but had only been at the facility for a couple of days before she was sent to the hospital; she had not had the self-administer test before she was sent to the hospital. Based on observations, interviews and record reviews, Resident #10 was not interviewable. Refer to the interview with a MA on 01/07/26 at 10:45am. Refer to the interview with the RCC on 01/07/26 at 11:25am. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:15pm. Refer to the interview with Administrator on 01/08/26 at 1:05pm. 4. Review of Resident #11's current FL-2 dated 11/26/25 revealed diagnoses included hyperlipidemia, insomnia, and chronic atrial fibrillation. Review of Resident #11's record revealed there was no order for bismuth subsalicylate and no order for self-administration of medication assessment. Review of Resident #10's January 2026 electronic medication administration record (eMAR) from 01/01/26 to 01/08/26 revealed there was no entry for Robitussin-DM2.	D 375		

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D 375	Continued From page 36 Observations of Resident #11's room on 01/06/26 at 9:05am and 01/07/26 at 9:58am revealed there was a bottle of bismuth subsalicylate on the counter by the sink in the bathroom; the bottle was half full. Interview with Resident #11 on 01/07/26 at 10:00am revealed: -He had only resided at the facility for a couple of months. -The staff took an over-the-counter (OTC) supplement out of his room over the weekend when they saw it on his desk. -He had an OTC brand of bismuth subsalicylate on the counter in his bathroom, and the staff had not taken it out of his room. -He had taken the bismuth subsalicylate last night, 01/06/26, because he had an upset stomach. -A family member brought the bismuth subsalicylate to him because he asked for it. -He did not tell the staff when he took the bismuth subsalicylate. Interview with Resident #11's family member on 01/07/26 at 12:05pm revealed: -She brought Resident #11 the OTC bismuth subsalicylate. -Resident #11 used the bismuth subsalicylate when he had an upset stomach. -She did not let anyone know she had brought Resident #11 the bismuth subsalicylate. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/08/26 at 8:25am revealed: -Resident #11 did not have an order for bismuth subsalicylate. -Resident #11 did not have an order to self-administer any medications.	D 375		

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D 375	Continued From page 37 -When a resident had an order to self-administer a medication the pharmacy put the medication on the eMAR and the order for self-administering the medication on the label. -Bismuth subsalicylate was used to treat upset stomach and if too much was taken then it could cause an upset stomach. Telephone interview with Resident #11's primary care provider (PCP) on 01/08/26 revealed: -She had not seen Resident #11 because he was in the process of changing physicians. -Bismuth subsalicylate was used to treat upset stomach but if a resident drank too much it would cause diarrhea. Interview with a medication aide (MA) on 01/07/26 at 10:45am revealed: -Resident #11 did not have an order to self-administer his medications. -Resident #11 was independent and she had not seen him confused or forgetful. -She had not seen the bismuth subsalicylate Resident #11's room. -She thought Resident #11 could self-administer his own medications. Interview with the Resident Care Coordinator (RCC) on 01/08/26 at 2:20pm revealed: -She did not know Resident #11 had bismuth subsalicylate in his room. -He did not have an order to self-administer any of his medications. -He had expressed interest in self-administering his own medications. -He had not been tested yet for self-administering medications. -She did not have any concerns about him forgetting to take medications or drinking too much of the bismuth.	D 375		

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D 375	Continued From page 38 Interview with the Clinical Nurse on 01/08/26 at 1:10pm revealed: -She was not aware Resident #11 had a bottle of OTC bismuth subsalicylate in his bathroom. -The staff should have removed the bottle if they saw it. -She did not know if Resident #11 had an order for the bismuth. -He did not have an order to self-administer any medications. -She would test Resident #11 to see if he could self-administer his medications. -She thought he would be able to self-administer the bismuth subsalicylate if he wanted to keep it in his room. Refer to the interview with a MA on 01/07/26 at 10:45am. Refer to the interview with the RCC on 01/07/26 at 11:25am. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:15pm. Refer to the interview with Administrator on 01/08/26 at 1:05pm. 5. Review of Resident #7's current FL2 dated 10/29/25 revealed: -Diagnoses included mild cognitive impairment, major depressive disorder, and hearing loss. -There was no order for kaopectate (medication used for relief from diarrhea, upset stomach, indigestion, heartburn, gas, and nausea). Review of Resident #7's Resident Register dated 06/11/18: -Resident #7 was admitted to the facility on	D 375		

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D 375	Continued From page 39 06/11/18. -Resident #7 was forgetful needed reminders, had significant memory loss, and must be directed, which were both checked with a handwritten note, "somewhere between these two". Review of Resident #7's pre-screening questionnaire dated 06/07/18 revealed: -Resident #7 had been diagnosed with dementia. -Resident #7 was sometimes forgetful. Review of Resident #7's care plan dated 02/16/25 revealed he was forgetful and needed reminders. Observation of Resident #7's room on 01/06/26 at 9:26am revealed a bottle of kaopectate; it was half empty. Review of Resident #7's record revealed there was no self-administration of medication assessment available for review. Review of Resident #7's January 2026 eMAR from 01/01/26 to 01/07/26 revealed there was no entry for kaopectate and no documentation that the medication could be self-administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/08/26 at 12:20pm revealed if a resident took too much kaopectate the resident could experience constipation. Interview with Resident #7 on 01/06/26 at 9:35am revealed: -He used the kaopectate for an upset stomach. -He used the kaopectate when he needed it. -It had been a while since he used the kaopectate, but he did not know how long.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019023	A. BUILDING: _____ B. WING _____	R 01/08/2026

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D 375	Continued From page 40 -He would not answer any additional questions. Interview with a medication aide (MA) on 01/07/26 at 10:25am revealed: -Resident #7 did not have a medication self-administration order. -She did not think Resident #7 could self-administer kaopectate because he would not recall when he took the medication or how much he took. Interview with a second MA on 01/07/26 at 11:05am revealed: -She did not think Resident #7 could self-administer his prescribed medication because she would worry that he would not take it. -If Resident #7 needed kaopectate, he would not tell the MA he needed it, so he could manage the kaopectate himself. Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:25am revealed: -Resident #7 did have one staff member she had heard the resident conversing with and answered questions appropriately, so she thought he could self-administer the kaopectate. Interview with the Clinical Nurse on 01/07/26 at 12:01pm revealed: -Resident #7 had a "little" issue with his memory. -Resident #7 did not speak often. -If Resident #7 was having a good day, he was cognitively intact. -Resident #7 did not self-administer his own medications. -Resident #7 did not have an order for kaopectate. -Resident #7 should not have kaopectate in his room.	D 375		

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D 375	Continued From page 41 -The concern would be Resident #7 might take too much of the kaopectate. Telephone interview with Resident #7's family member on 01/07/26 at 3:33pm revealed: -Resident #7 told her he was having diarrhea and asked her to get him some medication for it. -She purchased the kaopectate and gave him a dose of the medication. -She did not think Resident #7 would take the medication again. -She left the kaopectate in Resident #7's room and doubted the resident ever took another dose. Telephone interview with Resident #7's primary care provider (PCP) on 01/08/26 at 4:45pm revealed: -Resident #7 would need staff supervision for kaopectate. -She would be surprised if Resident #7 knew when and how to administer the kaopectate. Refer to the interview with a MA on 01/07/26 at 10:45am. Refer to the interview with the RCC on 01/07/26 at 11:25am. Refer to the interview with the Clinical Nurse on 01/08/26 at 1:15pm. Refer to the interview with Administrator on 01/08/26 at 1:05pm. _____ Interview with a MA on 01/07/26 at 10:45am revealed: -If she saw medication in a resident's room and she knew they did not have an order to self-administer the medication she would remove the medication from the room and tell the RCC.	D 375		

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D 375	Continued From page 42	D 375		

-The PCA's and the MAs were always supposed to keep an eye out for medications in the residents' rooms.
-If a PCA saw a medication in a resident room then they would let the MAs know about the medication.
-When a MA saw any medication in a resident's room, they were supposed to remove it, let the resident know why they were removing it and give it to the RCC or the Clinical Nurse.
-If a resident needed or wanted to take the medication then she would let the PCP know about the medication so the resident could have an order.
-The RCC and the Clinical Nurse did the resident assessments for self-administered medications.

Interview with the RCC on 01/07/26 at 11:25am revealed:
-For a resident to self-administer their medication, the Clinical Nurse would have to do a medication self-administration assessment.
-The residents would also have to have an order from the PCP that they could self-administer the medication.
-If a resident had an order to self-administer their medication, staff would know because the medication would be entered in the MAR as self-administered.
-All staff were responsible for checking residents' rooms to ensure all medications in the room had an order to self-administer, and the medication was secure in a lockbox or at least out of sight so not accessible to other residents.
-If medication was seen in a resident's room, the MAs and RCC should be notified so they could confirm an order to self-administer the medication.

Interview with the Clinical Nurse on 01/08/26 at

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D 375	Continued From page 43 1:15pm revealed: -She or the RCC would do an assessment with a resident to determine if they could self-administer medications. -The assessment was basically a test with a list of questions for the resident to respond to. -If the resident passed the assessment test, then they would get an order from the physician for the resident to self-administer their medications. -Every three months the resident would be reassessed by the facility and if there was a change then the facility would begin to administer the resident's medications. -The residents and their families were told they could not bring in medications without orders when they were admitted to the facility. -The residents and the families had been told to bring medications to her or the RCC and they would make sure there were orders to self-administer if needed. -The PCAs and MAs were supposed to look around the residents' rooms for medications while they were providing care. -There needed to be ongoing communication with the residents, their families and the staff about medications, self-administering orders and OTC medications without orders. Interview with the Administrator on 01/08/26 at 1:05pm revealed: -The only time a resident should have medication in their room was if the resident had an order to self-administer the medication. -For a resident to self-administer their medication, the Clinical Nurse would have to evaluate the resident annually to ensure the resident could administer their own medication.	D 375		