STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 12/16/25 to 12/17/25.	D 000	In response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged of the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance of State Law.	
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the floors were kept clean in residents' rooms in the Special Care Unit (SCU). The findings are: Observations of resident room #501 on 12/16/25 at 9:05am and 12/17/25 at 9:30am revealed:	D 074	10A NCAC 13F.0306(a)(1) Housekeeping and Furnishings The Bridges on Parview will ensure that resident rooms are swept and kept clean. All housekeeping have been in-serviced on the housekeeping cleaning schedules. The Facility Managers will round daily to ensure that resident rooms are kept in a clean and orderly fashion. Any issues or concerns will be brought to housekeeping staff attention for follow up. The Maintenance Tech and/or Executive Director will review and monitor the housekeeping schedules daily to ensure that housekeeping staff is adhering to schedules.	01/26/25 01/26/25 01/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Reviewed and acknowledged.

PD 02/13/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 074	Continued From page 1	D 074		

-There were pieces of black debris, clumps of dust, and pieces of candy on the floor behind the headboard, in the corners and along the baseboards in the room.
-There were clumps of dust, and black, brown, and white pieces of debris on the floor under a dresser, under the bed, and under the heating and cooling unit in the room.

Interview with the resident who resided in room #501 on 12/16/25 at 9:05am revealed:
-She ate candy in her room and sometimes she dropped pieces on the floor.
-When pieces of candy hit the floor, they would bounce in all directions.
-She cleaned her own room.
-Housekeeping would clean her floor once weekly.

Observations of resident room #503 on 12/16/25 at 9:13am and 12/17/25 at 9:32am revealed:
-There were black and white pieces of debris, clumps of dust, food wrappers, small bits of tissue, and paper on the floor along the baseboards, corners, under, behind and between furniture, under the bed, and under the heating and cooling unit in the room.
-There were multiple dried quarter-sized drops of liquid that had dust and debris stuck to them on the floor between the bed and the wall.
-There was a walker with dust and debris underneath it.
-There were cobwebs with dust and debris caught in them in the corners of the room and between a trashcan and the wall.
-There was a thick layer of cobwebs along the front edge of the dresser near the floor with dust caught in them.

Observations of resident room #504 on 12/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 2	D 074		

at 9:10am and 12/17/25 at 9:35am revealed there were black, brown, and white pieces of debris, pieces of tissues, crumbs of food, and dust on the floors along the baseboards, between furniture, under the bed, and under the heating and cooling unit in the room.

Observations of resident room #505 on 12/16/25 at 9:17am and 12/17/25 at 9:36am revealed there were pieces of debris, clumps of dust, and marks on the floor along the baseboards, in the corners, behind the door, in the bathroom, under the bed, and under the heating and cooling unit in the room.

Interview with the housekeeper on 12/17/25 at 8:55am revealed:
-He did not have a cleaning schedule to follow.
-The previous housekeeping manager left and there had not been a cleaning list for about a month.
-He used to have a cleaning list, so he cleaned based on what he remembered from the list.
-He swept and mopped the residents' rooms once a day.
-He deep cleaned four residents' rooms a day.
-He would clean under furniture, beds, and the corners of the rooms when he did a deep cleaning.
-The facility had hired new housekeepers who were still in the training process.
-If he saw it [dirt], he was supposed to clean it.
-Sometimes the residents would not let him in their room to clean so he would wait until they were out of their room eating or in the day room, and he would then clean their room.

Interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 11:50am revealed:
-The housekeepers were supposed to sweep and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 074	Continued From page 3 mop residents' rooms every day. -She did not know if there was a list for the housekeepers when they cleaned resident rooms. -She knew the housekeeping staff was cleaning because she saw them in the residents' rooms. -She did not inspect resident rooms very often; about every two weeks. -She did not have a list of things that she looked at but she would look at the floors when she went to inspect residents' rooms. -She only had to get housekeeping twice so they could touch up the floors in resident rooms. -She could not recall which rooms needed to be touched up. Interview with the Administrator on 12/17/25 at 4:29pm revealed: -The housekeepers were supposed to deep clean four residents' rooms a day. -Deep cleaning involved moving furniture and sweeping and mopping under the furniture. -They were supposed to sweep and mop every day. -The housekeepers had a list that they used as a guide when cleaning the rooms. -The last time she monitored the rooms in this SCU was a couple of weeks ago. -The management team took turns monitoring residents' rooms for cleanliness. -Her expectation was for the housekeeping staff to keep the floors and the residents' rooms clean and that included under and around furniture.	D 074		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic	D 296	10NCAC 13F .0904(c)(7) Nutrition and Food Service The Bridges on Parkview will ensure that all residents receiving a therapeutic diet will have a matching diet specific to physicians orders. All dietary staff were in-serviced on therapeutic diet menus to include extensions to ensure appropriate guidance to therapeutic diets.	12/22/25 12/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 296	Continued From page 4 diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service staff guidance for 1 of 1 sampled residents (#2) who had a physician's order for a mechanical soft (MS) diet. The findings are: Review of Resident #2's current FL2 dated 07/18/25 revealed: -Diagnoses included dementia, hypertension, and hyperlipidemia. -There was an order for a MS diet entire meal with ground consistency. Review of the regular diet lunch menu for 12/16/25 revealed fried chicken, baked potato, green beans, a roll, and ice cream sundae were to be served. Observation of the kitchen on 12/16/25 at 10:10am revealed there was no therapeutic diet menu available for food service staff guidance for a MS diet. Observation of the lunch meal on 12/16/25 at 12:50pm revealed: -Resident #2 was served mashed potatoes	D 296	All dietary menus are reviewed by the dietary manager at the start of every week to ensure therapeutic diet extensions are included for the prep of each meal.	12/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 296	Continued From page 5	D 296		

without gravy, and whole green beans.
-Resident #2's dinner roll and chicken were cut to a fine consistency that had the appearance of sawdust and there was no broth or gravy.
-At 12:58pm, Resident #2 was removed from the dining room by the staff and did not eat any of her meal.

Interview with Resident #2's primary care provider (PCP) on 12/17/25 at 3:30pm revealed Resident #2 was ordered a MS diet for the entire meal with ground consistency by speech therapy because of swallowing issues.

Interview with the Dietary Manager (DM) on 12/16/25 at 10:05am revealed:
-The only diets the facility offered were a regular diet and a MS diet and Resident #2 was the only resident with the for a MS diet with a ground consistency.
-The kitchen staff did not have a therapeutic diet menu for the MS diet.
-The food items for the MS with ground meat consistency meal was the same as a regular diet just ground up.
-The MS diet was a ground consistency, and the entire meal was MS not just the meat.
-The bottom of the recipes had instructions on how to prepare the item for a MS diet with a ground consistency.
-She used the recipes to prepare food, so she did not need a therapeutic diet menu.
-She followed the regular menu when she prepared food for the MS diet.

Interview with a cook on 12/17/25 at 7:50am revealed:
-He used the blender in the kitchen to grind food for the MS diet.
-He prepared the same food for the MS diet as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 296	Continued From page 6	D 296		

the regular diet.
-He put the roll in the blender without water or broth (liquid).
-He placed the chicken in the blender without a liquid to cut it up; it would be a fine constancy but not ground like ground beef.
-He did not always use the recipes for guidance when preparing the MS diet, only if it was something new and he did not know how to make it.
-He had a regular menu he followed but he did not have a therapeutic diet menu to follow.

Interview with the DM on 12/17/25 at 11:25am revealed:
-There were no therapeutic diet menus in the kitchen.
-She followed the instructions on the recipe for each item every day.
-She ground the chicken in the blender and added a little water or butter to moisten it.
-She did not add liquid to the roll because it would turn to a puree if she did.
-She had to add a little moisture to the chicken because if it was too dry, the resident could choke.

Interview with the Administrator on 12/17/25 at 4:29pm revealed:
-The kitchen staff had a therapeutic diet menu to follow; they referred to it as the extension sheet.
-The therapeutic diet menu was part of the facility's electronic menu program.
-The DM was responsible for going into the electronic menu program and printing the therapeutic diet menus each week.
-She expected the DM to make sure the therapeutic diet menus were available and used by the dietary staff when preparing the meals for the MS diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 296	Continued From page 7 Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	D 296	dddd	
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 to 1 of 5 sampled residents (#5) related to a patch to relieve pain. The findings are: Review of Resident #5's current FL-2 dated 07/18/25 revealed: -Diagnoses included dementia. -There was an order for a lidocaine 4% patch (used to treat pain) to apply to left hip on for 12 hours and off for 12 hours once daily. Review of Resident #5's electronic medication administration record (eMAR) for October 2025 revealed: -There was an entry for lidocaine 4% patch apply 1 patch topically to left hip, on for 12 hours off for 12 hours daily scheduled at 8:00am and 8:00pm.	D 358	10A NCAC 13F .1004(a) Medication Administration The Bridges on Parkview will ensure that medications are administered as ordered to all residents. The RCD, RN in-serviced Med Techs on medication administration to include the 6 Rights to Med Administration. The Care Coordinators will audit at a minimum of 2 resident charts per week to ensure proper administration and maintaining of resident records. Any descrepancies or inaccuracy will be reported to prescribing physician. The Care Coordinators will completed a physician order, to EMAR to cart audit on the facility schedule weekly. The Executive Director will review each week. Any descrepancies will be reported to the prescribing physician.	01/07/25 01/07/25 01/07/25 01/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 358	Continued From page 8	D 358		

-There was documentation Resident #5's lidocaine 4% patch was applied and removed daily from 10/01/25 to 10/31/25.

Review of Resident #5's eMAR for November 2025 revealed:
-There was an entry for lidocaine 4% patch apply 1 patch topically to left hip, on for 12 hours off for 12 hours daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #5's lidocaine 4% patch was applied and removed daily from 11/01/25 to 11/30/25.
-There was documentation Resident #5 was out of the facility on 11/26/25 and 11/27/25.

Review of Resident #5's eMAR for December 2025 from 12/01/25 to 12/17/25 revealed:
-There was an entry for lidocaine 4% patch apply 1 patch topically to left hip, on for 12 hours off for 12 hours daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #5's lidocaine 4% patch was applied and removed daily from 12/01/25 to 12/17/25.

Observation of Resident #5's medication on hand on 12/17/25 at 12:30pm revealed:
-There was a box of 30 lidocaine 4% patches dispensed on 12/16/25; 30 patches were available for administration.
-There were instructions to apply one patch topically on for 12 hours and off for 12 hours daily to the left hip.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/17/25 at 2:30pm revealed:
-Resident #5 had an order for a lidocaine 4% patch to be applied to the left hip every morning, on for 12 hours and off for 12 hours.
-Thirty lidocaine 4% patches were dispensed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 358	Continued From page 9 07/16/25, 08/13/25, 09/18/25, 10/13/25, and 12/16/25; each a thirty-day supply. -Lidocaine patches were not on a cycle fill, and refills had to be requested by the facility staff. -Lidocaine patches were used to treat localized pain that could be caused by arthritis; Resident #5's lidocaine patches were specifically ordered for left hip pain. Telephone interview with Resident #5's primary care provider (PCP) on 12/17/25 at 3:30pm revealed: -Resident #5 had an order for a lidocaine 4% patch due to hip pain. -Resident #5 had bad arthritis. -Resident #5 could not complain of hip pain due to her cognitive level but would be able to communicate she had hip pain if she was prompted by questions. -Resident #5 had complained of hip pain in the past. -She had not looked for the lidocaine patch on Resident #5 when she saw her. -If Resident #5's lidocaine patches were not applied as ordered, she could experience increased hip pain. -She expected her orders for Resident #5's lidocaine patch to be followed. Interview with a medication aide (MA) on 12/17/25 at 12:35pm revealed: -Resident #5's lidocaine patches had just been ordered because she must have ran out of them. -She had not used the new box because Resident #5 had one patch left on the medication cart. -Lidocaine patches had to be ordered by the MAs when they were needed because they were not on cycle fill. -She always applied Resident #5's lidocaine	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10	D 358		

patch.
-There were no over stock medications including lidocaine patches for Resident #5.

Interviews with a second MA on 12/17/25 at 5:05pm and 5:35pm revealed:
-She applied Resident #5's lidocaine patch every day when she worked first shift.
-The MAs removed the lidocaine patches in the evenings.
-Resident #5 had not run out of lidocaine patches on the medication cart.
-She had not borrowed lidocaine patches from other residents.
-She had not gone to the Special Care Unit Coordinator (SCC) to get lidocaine patches from her.

Interview with the SCC on 12/17/25 at 5:15pm revealed:
-She did medication cart audits at least once a week.
-As part of the audit she made sure there was enough medication for the residents and ordered it if there was not.
-She looked at expiration dates and open dates but not the dispense dates.
-The MAs were responsible for ordering medications that were not on cycle fill before they ran out.
-When the medication was getting low, less than 5 days' worth of medication available the MAs would reorder the medication through the eMAR.
-The lidocaine patches dispensed on 10/13/25 would not have lasted until today, 12/17/25.
-She had a container of overstock items under her desk.
-The MAs knew she had the overstock items and would come to her for medications that had run out on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11 -Different MAs had come to her at different times and asked for lidocaine patches for Resident #5. -She would give the MAs more than one lidocaine patch at a time so they would not keep coming to her. -She could not recall how many times, who the MAs were or how many patches she had given to the MAs. -She would ask who the patches were for and the MAs would tell her they were for Resident #5. -She was not concerned Resident #5's lidocaine patches were not applied because the MAs were getting them from her overstock. -She asked one of the MAs if they had ordered Resident #5's lidocaine patches when they came to her and she was told yes, they had. Interview with the Administrator on 12/17/25 at 5:40pm revealed: -She and the other management staff audited the medication carts. -She looked at expiration dates, open dates on medications, and to see what needed to be reordered. -Medications not on a cycle fill were reordered when there were 3 to 5 days of medications remaining. -The last time she had done a medication audit was the week before last. -She thought Resident #5 had some lidocaine patches in the overstock which was locked in another room. -She was told by a MA that Resident #5 had some patches when she asked about them during her audit. -She expected the MAs to administer medications as ordered. Based on observations, interviews and record reviews it was determined Resident #5 was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 358	Continued From page 12 interviewable.	D 358	Type text here	
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 5 sampled residents (#3) including documentation for two medications used to treat diabetes.	D 367	10A NCAC 13F .1004(j) Medication Administration The Bridges on Parkview will ensure that all residents EMAR's are accurate to include appropriate documentation. The Med Techs have been in-serviced on Medication Administration to include the 6 Rights to Med Adminsitration and appropriate documentation by the Regional Clinical Director, RN. The Care Coordinators will audit at a minimum of 2 residents charts per week to ensure appropriate documentation. Any descrepancies will be reported to the prescribing physician and followed up on immediately. The Executive Director will review all chart audits weekly. The Executive Director and Care Coordinators will review the EMAR dashboard daily in stand up to ensure all follow up on residents medications to include administration, documentation and accuracy of EMAR. Any descrepancies will be reported to the prescribing physician.	01/07/25 01/07/25 01/07/25 01/07/25

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	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 367	Continued From page 13 The findings are: Review of Resident #3's current FL-2 dated 09/22/25 revealed diagnoses included hypertensive heart and chronic kidney disease with heart failure. 1. Review of Resident #3's signed physician's order dated 10/10/25 revealed an order for Novolin R Flex pen (used to control blood sugar levels) administer subcutaneously as directed per sliding scale three times daily: 0-69 = follow hypoglycemia protocol and call the primary care provider (PCP):, 70-199 = 0 units (U), 200-250 = 2U, 251-300 = 4U, 301-350 = 6U, 351-400 = 8U, 401+ = 8U and call PCP, scheduled three times daily. Review of Resident #3's signed physician's order dated 12/01/25 revealed an order to discontinue the Novolin sliding scale insulin (SSI) order. Review of Resident #3's October electronic medication administration record (eMAR) from 10/11/25 - 10/22/25 revealed: -There was an entry for Novolin R Flex pen inject -There was documentation Novolin SSI was administered 37 of 37 opportunities. -There was no documentation of the amount of insulin administered per the sliding scale 37 of 37 opportunities. Review of Resident #3's November 2025 eMAR from 11/01/25 -11/30/25 revealed: -There was an entry for Novolin R Flex pen inject subcutaneously as directed per sliding scale three times daily: 0-69 = follow hypoglycemia protocol and call PCP, 70-199 = 0U, 200-250 = 2U, 251-300 = 4U, 301-350 = 6U, 351-400 = 8U, 401+ = 8U and call PCP, scheduled at 8:00am,	D 367		

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D 367	Continued From page 14	D 367		

2:00pm, and 8:00pm.
-There was documentation Novolin R SSI was administered 62 of 90 opportunities.
-There was no documentation of the amount of insulin administered per the sliding scale 62 of 90 opportunities.
-The Novolin R SSI was not administered 28 out of 90 opportunities due to FSBS being between 70-199 per SSI order.

Refer to the interview with the medication aide (MA) on 12/17/25 at 12:28pm.

Refer to the interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 3:10pm.

Refer to the interview with Resident #3's PCP on 12/17/25 at 3:40pm.

Refer to the interview with the Administrator on 12/17/25 at 3:55pm.

2. Review of Resident #3's signed physician's order dated 10/20/25 revealed an order for Humalog insulin (used to control blood sugar levels), administer by subcutaneous injection per sliding scale: 0-200 give 0 units; 201-250 give 2 units; 251-300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; greater than 401 give 10 units: notify provider for fingerstick blood sugar (FSBS) greater than 450.

Review of Resident #3's signed physician's order dated 10/25/25 revealed an order to discontinue the Humalog sliding scale.

Review of Resident #3's signed physician's order dated 12/02/25 revealed there was an order for Humalog sliding scale insulin (SSI), inject per sliding scale: if blood sugar is 0 - 200 = 0 Units;

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D 367	Continued From page 15 250 = 2 Units; 251 - 300 = 4 Units; 301 - 350 = 6 Units; 351 - 400 = 8 Units; 401+ = 10 Units; notify provider for FSBS >450 scheduled three times daily before meals. Review of Resident #3's October 2025 electronic medication administration record (eMAR) from 10/21/25-10/25/25 revealed: -There was an entry for Humalog pen inject subcutaneously as directed per sliding scale three times daily: Inject as per sliding scale: if 0 - 150 = 0 Units; 151 - 200 = 0 Units; 250 = 2 Units; 251 - 300 = 4 Units; 301 - 350 = 6 Units; 351 - 400 = 8 Units; 401+ = 10 Units. Notify provider for FSBS >450, scheduled three times daily before meals. -There was documentation Humalog was administered 13 of 13 opportunities. -There was no documentation of the amount of insulin administered per the sliding scale 13 of 13 opportunities. Review of Resident #3's December 2025 eMAR from 12/03/25-12/16/25 revealed: -There was an entry for Humalog pen, inject subcutaneously as directed per sliding scale three times daily: Inject as per sliding scale: if 0 - 150 = 0 Units; 151 - 200 = 0 Units; 250 = 2 Units; 251 - 300 = 4 Units; 301 - 350 = 6 Units; 351 - 400 = 8 Units; 401+ = 10 Units; notify provider for FSBS >450, scheduled three times day before meals. -There was documentation Humalog was administered 32 of 32 opportunities. -There was no documentation of the amount of insulin administered per the sliding scale 32 of 32 opportunities. Refer to the interview with the medication aide (MA) on 12/17/25 at 12:28pm.	D 367		

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D 367	Continued From page 16 Refer to the interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 3:10pm. Refer to the interview with Resident #3's primary care provider (PCP) on 12/17/25 at 3:40pm. Refer to the interview with the Administrator on 12/17/25 at 3:55pm. _____ Interview with a medication aide (MA) on 12/17/25 at 12:28pm revealed: -She did not document how much insulin she gave per the sliding scale. -There was not a designated area on the eMAR to document the insulin amount. -She did not question why the eMAR did not have a place to document how much insulin was given. -She followed the directions on the sliding scale order and that was how she knew how much insulin to give. Interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 3:10pm revealed: -She was not aware the amount of insulin administered was not being documented for Resident #3. -She did not audit the eMAR to check for administration accuracy. -She was aware that the MAs should document how much insulin was administered per the sliding scale so that it could be monitored for accuracy. Interview with Resident #3's primary care provider (PCP) on 12/17/25 at 3:40pm revealed: -She was not aware that the amount of insulin administered was not being documented. -It was important to document how much insulin was given so that it could be monitored for errors.	D 367		

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D 367	Continued From page 17 -She expected the MAs to document the amount of insulin given per the sliding scale. Interview with the Administrator on 12/17/25 at 3:55pm revealed: -She was not aware that the amount of insulin being administered was not documented. -She was aware of the importance of documenting the amount of insulin being administered to monitor the correct amount being administered. -She expected the MAs to make her aware if they could not document the insulin amount administered on the eMARs.	D 367		