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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow-up survey and complaint investigation on 02/18/26-02/19/26. The complaint investigation was initiated by the Macon County Department of Social Services on 01/14/26, 01/15/26, 02/06/26, and 02/13/26.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was tested for tuberculosis (TB) disease upon employment in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of Staff B, personal care aide (PCA), personnel record revealed: -Staff B was hired on 09/18/24. -There was documentation of a negative step one TB skin test dated 09/30/24. -There was no documentation of a step two TB skin test.	D 131		

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D 131	Continued From page 1 -Staff B left employment 10/13/25. -Staff B was rehired on 02/02/26. -There was no documentation of a step one TB skin test upon rehire. Interview with the Administrator on 02/19/26 at 9:30am revealed: -Staff B started work at the facility on 09/18/24. -She did not know if a step two TB skin test was completed for Staff B. -Staff B left employment on 10/13/25. -Staff B was rehired as a PCA on 02/02/26. Interview with the Human Resources staff on 02/19/26 at 11:02am revealed: -She started her role in Human Resources three weeks prior. -She maintained staff qualifications in the personnel records. -She rehired Staff B on 02/02/26. -Staff B had a step one TB skin test dated 09/18/24 in his personnel record. -She did not know Staff B was required to have a step one TB skin test upon rehire prior to starting work in the facility. Interview with the Administrator on 02/19/26 at 12:00pm revealed: -The Human Resources staff was new to her role. -It was the facility's policy to have employees obtain a TB skin test and have it read prior to starting work in the facility. -The did not know they could not reuse the TB skin test result form 09/18/24. -She failed to monitor the Human Resources staff to ensure the TB skin tests were being completed.	D 131		

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D 139	Continued From page 2	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure there was documentation of a consent for criminal background check for 1 of 3 sampled staff (Staff B). The findings are: Review of Staff B, personal care aide (PCA), personnel record revealed: -Staff B was hired on 9/18/24. -There was a signed consent for a criminal background check completed on 09/18/24. -There was a criminal background check completed on 09/18/24. -Staff B left employment 10/13/25. -Staff B was rehired on 02/02/26. -There was no signed a consent for a criminal background check upon rehire on 02/02/26. Review of Staff B's Health Care Personnel Registry (HCPR) dated 01/23/26 revealed there were no pending or substantiated findings. Interview with the Administrator on 02/19/26 at 9:30am revealed: -Staff B started work at the facility on 09/18/24. -Staff B left employment on 10/13/25 after	D 139		

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allegations of resident abuse.
-Staff B was reported to the HCPR for the allegations of resident abuse.
-The Owner completed an investigation of the allegations of resident abuse.
-Staff B was rehired by the Human Resources staff as a PCA on 02/02/26.

Interview with the Human Resources staff on 02/19/26 at 11:02am revealed:
-She started her role in Human Resources three weeks prior.
-She maintained staff qualifications in the personnel records.
-She rehired Staff B as a PCA on 02/02/26.
-Staff B had a criminal background check in his personnel file dated 09/18/24.
-She did not ask Staff B to complete a consent for criminal background check upon rehire.
-She did not know she needed to obtain a consent for a criminal background check and a new criminal background check for a rehire.
-The facility used an online service to complete criminal background checks.
-She did not have a log-in to access the online service for one and a half weeks after she started in her role.

Interview with the Administrator on 02/19/26 at 12:00pm revealed:
-The Human Resources staff was new to her role.
-She did not know when the Human Resources staff was given access to the online service to check criminal backgrounds.
-She had access to the online criminal background check service.
-She would have been responsible for obtaining criminal background checks when the Human Resources staff was unable to access the online criminal background check service.

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D 139	Continued From page 4 -She did not obtain a a consent for a criminal background check on Staff B upon rehire. -She did not obtain a criminal background check on Staff B upon rehire. -She failed to monitor the Human Resources staff to ensure consents for criminal background checks were being completed. -She failed to monitor the Human Resources staff to ensure criminal background checks were being completed. _____ The facility failed to obtain a consent for a criminal background check prior to rehiring a staff member. This 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 02/19/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2026.	D 139		
D 140	10A NCAC 13F .0407(a)(8) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION	D 140		

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D 140	Continued From page 5 Based on interviews and record reviews, the facility failed to ensure documentation of signed consent for the examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (Staff B, D, and E). The findings are: 1. Review of Staff B, personal care aide (PCA), personnel record revealed: -Staff B was hired on 9/18/24. -There was documentation of a negative controlled substance screening completed 09/20/24. -Staff B left employment 10/13/25. -Staff B was rehired on 02/02/26. -There was no documentation Staff B completed a consent for a controlled substance screening upon rehire. -There was no documentation Staff B completed a controlled substance screening upon rehire. Interview with the Human Resources staff on 02/19/26 at 11:02am revealed: -She rehired Staff B as a PCA on 02/02/26. -Staff B had a negative controlled substance screening dated 09/20/24 in his personnel record. -She did not get a signed consent for controlled substance screening for Staff B upon rehire. -She did not get another controlled substance screening for Staff B upon rehire. -She did not know she needed to obtain a signed consent for controlled substance screening for Staff B upon rehire. -She did not know she needed to complete another controlled substance screening upon rehire.	D 140		

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D 140	Continued From page 6 Refer to the interview with the Human Resources staff on 02/19/26 at 11:05am. Refer to the interview with the Administrator on 02/19/26 at 12:00pm. 2. Review of Staff D, personal care aide (PCA), personnel record revealed: -Staff D was hired on 01/26/26. -There was no documentation Staff D completed a signed consent for controlled substance screening upon hire. -There was no documentation Staff D completed a controlled substance screening upon hire. Interview with the Human Resources staff on 02/19/26 at 11:02am revealed: -She did not obtain a signed consent from Staff D for a controlled substance screening prior to hire. -She did not screen Staff D for controlled substances prior to hiring her because the facility did not have any controlled substance tests on hand. Refer to the interview with the Human Resources staff on 02/19/26 at 11:05am. Refer to the interview with the Administrator on 02/19/26 at 12:00pm. 3. Review of Staff E, personal care aide (PCA) personnel record revealed: -Staff E was hired on 02/03/26. -There was no documentation Staff E completed a signed consent for controlled substance screening upon hire. -There was no documentation Staff E completed a controlled substance screening upon hire. Interview with the Human Resources staff on	D 140		

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D 140	Continued From page 7 02/19/26 at 11:02am revealed: -She did not obtain a signed consent from Staff E for a controlled substance screening prior to hire. -She did not complete a controlled substance screening for Staff E prior to hiring her because the facility did not have any controlled substance tests on hand. Refer to the interview with the Human Resources staff on 02/19/26 at 11:05am. Refer to the interview with the Administrator on 02/19/26 at 12:00pm. _____ Interview with the Human Resources staff on 02/19/26 at 11:05am revealed: -She started working in Human Resources three weeks prior. -She maintained staff qualifications in the personnel records. -There were only three controlled substance screening tests available at the facility when she started in her new role. -She told the Administrator they needed more controlled substance screening tests. -The Administrator told her she would order more controlled substance screening tests. -The facility did not have any controlled substance screening tests available in the facility. Interview with the Administrator on 02/19/26 at 12:00pm revealed: -The Human Resources staff had been in her role a short period of time. -The Human Resources staff had not been adequately trained. -The Human Resources staff informed her they were out of controlled substance screening tests. -She ordered a supply of controlled substance screening tests "yesterday" (02/18/26).	D 140		

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D 140	Continued From page 8 -The controlled substance screening tests had not yet arrived. _____ The facility failed to obtain a signed consents for controlled substance screening and controlled substance screening prior to hiring three personal care aides. This 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 02/19/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2026.	D 140		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to serve a therapeutic diet as ordered to 1 of 3 sampled residents (#9) related to a mechanical soft ground meat diet with gravy. The findings are:	D 310		

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D 310	Continued From page 9 Review of Resident #9's current FL2 dated 04/08/25 revealed: -Diagnoses included senile degeneration of the brain, dementia and abnormal weight loss. -There was documentation she was intermittently disoriented. Review of Resident #9's Resident Register dated 04/17/25 revealed: -She was admitted to the facility on 04/17/25. -There was documentation she had no teeth. Review of Resident #9's current Care Plan dated 04/29/25 revealed she required limited assistance with meals. Review of Resident #9's physician's order dated 10/31/25 revealed a mechanical soft diet with ground meat with gravy. Review on 02/18/26 of the resident diet orders posted on a kitchen bulletin board revealed Resident #9 was ordered a mechanical soft diet with ground meat with gravy. Review of the facility's therapeutic diet menu revealed the lunch menu for 02/18/26 was documented as ground barbeque pork with barbeque sauce, Texas toast, baked beans and spiced apples. Observation of the lunch meal service on 02/18/26 at 12:09pm revealed: -The meal consisted of barbeque pork, Texas toast, baked beans, spiced apples and beverage of choice. -The barbeque pork was distributed from the kitchen in three consistencies: shredded, chopped and ground.	D 310		

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-Resident #9 was seated at the table with 2 other residents.
-A dietary aide delivered meals to the residents at the table.
-Resident #9 was served a mechanical soft diet with chopped barbeque with sauce on top.
-The resident seated next to her at the table was served a mechanical soft diet with ground barbeque with sauce on top.
-A medication aide (MA) assisted Resident #9 with her meal.
-The meal service was stopped until the correct meal was served to Resident #9.

Interview with a dietary aide on 02/18/26 at 12:09pm and 12:21pm revealed:
-The cook plated the meals and he was responsible for serving the meals to the residents.
-He got confused when he was serving the meals and accidentally served the wrong consistency to Resident #9.

Interview with the MA on 02/18/26 at 12:10pm and 2:15pm revealed:
-When she worked, she assisted Resident #9 with her meals.
-Resident #9 did not have any teeth and needed to have her meat ground to safely eat.
-Resident #9 was frequently served a meal that had mechanical soft meat, but the meat was not always ground.
-When Resident #9 was served the incorrect meat consistency she had to go to the kitchen to request the correct meat.
-The dietary aide frequently argued with her about the consistency of the meat.
-She mentioned the problem she had with Resident #9 receiving the wrong meat consistency to the Executive Director and was

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D 310	Continued From page 11 told she would handle it. Telephone interview with Resident #9's hospice nurse on 02/19/26 at 12:42pm revealed: -Resident #9 did not have teeth, pocketed food when she ate and was at high risk for aspiration. -Resident #9 should only be served ground meat because any other consistency could result in aspiration. Interview with the Administrator on 02/19/26 at 11:13am revealed: -The dietary aide made an error when he served chopped meat to Resident #9. -She expected the dietary staff to know the residents' diet orders and refer to the list in the kitchen when serving meals. _____ The facility failed to serve Resident #9 a mechanical soft diet with ground meat and gravy as ordered. She did not have any teeth and was at high risk of aspiration and when she was served chopped meat instead of ground meat, her risk of aspiration increased which was detrimental to her health and safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/26 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 05, 2026.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) was free from neglect related to being left in a wheelchair overnight.

The findings are:

Review of Resident #1's current FL2 dated 10/31/25 revealed:
-Diagnoses included Alzheimer's Disease (a progressive brain disorder that causes a decline in memory, thinking, and daily functioning), high blood pressure, and kidney disease.
-The recommended level of care was Special Care Unit (SCU).
-The resident was constantly disoriented, had wandering behavior, and was incontinent bowel and bladder.

Review of Resident #1's Resident Register revealed an admission date of 07/11/23.

Review of Resident #1's Care Plan dated 10/31/25 revealed:
-She had significant memory loss and required direction.
-She was incontinent of bowel and bladder, required total assistance with eating, toileting, bathing, dressing, and grooming and extensive assistance with transfers.
-She used a wheelchair with an easy release

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alarm belt.

Review of Resident #1's SCU quarterly Care Plan assessment dated 02/06/26 revealed:
-She was only able to verbalize 1 or 2 words.
-She sat in her wheelchair and wandered without purpose.
-She had severe cognitive impairment.

Observation of Resident #1 during the initial tour on 02/18/26 at 9:18am revealed:
-She was seated a wheelchair in the hall of the SCU and propelled herself with her feet.
-Her head was bent down and she did not respond to questions.
-There was an alarm on the wheelchair attached with a clip to the resident.
-There was a quick release seat belt around the resident's waist.

Telephone interview with a 1st shift personal care aide (PCA) on 02/18/26 at 4:04pm revealed:
-Residents' beds were always made up by the 1st shift staff after breakfast.
-She checked Resident #1's room the morning of 01/13/26 and found her bed was made up but that task was done after breakfast by the dayshift staff and she thought the resident had been up all night.
-At 8:00am the resident was in the hall in her wheelchair and more sleepy than normal.
-She provided incontinence care to the resident, assisted her to her recliner, covered her up with a blanket and she went to sleep.
-She thought the resident had been up in her wheelchair all night and she reported it to management.

Review of Care Notes for Resident #1 dated 01/13/26 revealed there was documentation that

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the resident was lethargic and slept all day in her recliner and ate little for breakfast and lunch.

Review of the video from a SCU camera from the evening of 01/12/26 revealed:
-At 8:00pm Resident #1 was in her nightgown sitting in her wheelchair in the hall.
-At 8:15pm she was using her feet to spin the wheelchair around in the hall.
-At 8:30pm two PCAs walked by Resident #1 and went into the Spa room.
-At 9:12pm Resident #1's roommate went into the hall and pushed Resident #1's WC into the resident's room and shut the door.
-At 9:18pm a PCA came out of the spa room, spoke to Resident #1's roommate in the resident's doorway, then went back into the spa room.
-The video showed a partial view of Resident #1's room when the door was open including her bed.
-At 10:22pm a second PCA entered the resident's room, left the room, and Resident #1 was not in her bed.
-At 2:36am Resident #1's roommate came out of the room and then went back into the room.
-At 4:11am a PCA walked down the hall and entered the spa room or an office.
-At 4:48am a PCA opened Resident #1's door, looked inside, and then returned to the spa room.
-At 5:42am the two PCAs went into Resident #1's room and Resident #1 was no longer in her nightgown, she was in day clothes and still in her wheelchair.

Telephone interview with one 3rd shift PCA on 02/18/26 at 3:40pm revealed:
-The evening of 01/12/26 the resident talked a lot, and she knew that the resident would not go to sleep, so she asked the medication aide (MA) if there was a medication the resident could have

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for sleep but there was not any.
-The only option was to let the resident "hang out" in her wheelchair or in her recliner.
-The PCA did not assist the resident into her recliner because the PCA was having a "rough night".
-Another PCA normally assisted the resident to bed and stayed with the resident until she fell asleep and she assumed that had happened.
-The PCA fell asleep in the SCU at 2:00am for 2 hours.
-She should have conducted rounds every two hours at 1:00am, 3:00am, and 5:00am but she did not.
-She did not know why the 2nd PCA did not conduct rounds.
-The MA supervisor worked on the assisted living (AL) side of the facility on 01/12/26, and she came to the SCU at 11:00pm and did not come back to the SCU until between 5:00am - 6:00am.

Interview with the 3rd shift MA Supervisor on 01/15/26 at 1:15pm and 02/18/26 at 7:20pm revealed:
-When she started her shift at the facility at 11:00pm on 01/12/26 she instructed the two PCAs on the SCU to assist Resident #1 to bed.
-She thought the PCAs assisted the resident to bed as instructed because she did not see Resident #1 in the hall later during her shift.
-She assisted Resident #1 to bed in the past and would sit with her until she went to sleep.
-She noticed staff were leaving the resident in the hall in her wheelchair during the night and she instructed the staff to assist Resident #1 to bed and to stay with her until she went to sleep.
-She did not hear any call bells during the night, so she assumed the PCA's were making rounds on the residents.
-She reported it to the Executive Director (ED) in

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the past that Resident #1 had been up in her wheelchair all night on third shift, but nothing would change because the PCAs would not comply.
-The two PCAs did not make any rounds during their shift on 01/12/26 and they should have conducted rounds on all the residents every two hours.

Confidential interview with one staff revealed:
-It was reported by a 1st shift PCA that Resident #1 was more tired than normal and her bed was made up on the morning of 01/13/26.
-Staff thought the resident had been up in her wheelchair all night but the staff were informed by the ED that they made assumptions.
-The roommate went into the hall between 12:00am - 1:00am and pushed Resident #1 in her wheelchair into the room and shut the door.
-Several times during the night staff opened the door but did not assist the resident to bed.
-Staff did not touch a single resident until 5:00am.
-Resident #1 would not be able to get into bed unassisted.
-Resident #1 was not able to verbalize her needs.
-Resident #1 sat in her wheelchair from 8:00pm on 01/12/26 to after breakfast on 01/13/26 at 8:00am.
-The staff on 2nd shift conducted rounds at 10:30pm and the 3rd shift supervisor did a walk through the SCU at 11:00pm.
-The staff on 3rd shift were required to conduct rounds at 1:00am, 3:00am, and start getting residents up at 5:00am.

Interview with Resident #1's Power of Attorney (POA) on 02/18/26 at 11:00am revealed:
-Staff notified her the evening of 01/13/26 that the resident had been up all night on 01/12/26.
-She was upset that the resident was left in the

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D 338	Continued From page 17 wheelchair all night and not in bed to rest. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 02/19/26 at 10:55am revealed: -Residents in wheelchairs should be repositioned periodically. -Sitting in a wheelchair for extended periods of time increased the risk of skin breakdown and pain. Interview with the Special Care Coordinator (SCC) on 02/18/26 at 2:20pm revealed: -It was reported to her that staff did not complete rounds during 3rd shift on 01/12/26. -She did not review the SCU video from that night or speak to staff that worked that shift. -She did not know what time the PCAs were supposed to conduct rounds. -She did not know what time 3rd shift staff conducted rounds. -She would expect staff to make rounds on all residents in the SCU. Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 3:30pm revealed a PCA brought it to her attention that on the morning of 01/13/26, Resident #1's bed was not made up and she was sitting in her wheelchair. Interview with the ED on 01/15/26 at 2:30pm revealed: -The incident was reported to her, and she instructed the Administrator and RCC to review the SCU video. -It was clear from the video that the two PCAs missed rounds at 1:00am and 3:00am. -The housekeeper came to work in the SCU between 4:30am-5:30am and reported that Resident #1 was in her wheelchair.	D 338		

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-Resident #1 was sleepy due to being up in her wheelchair all night.
-She was administered Ativan (medication used for anxiety related insomnia) on 01/12/26 between 7:00pm - 8:00pm and staff were supposed to assist Resident #1 into her bed.
-The shift supervisor was on duty and did not check on the resident either.

Interview with the Administrator on 01/15/26 at 11:00am revealed:
-The two PCAs on the SCU did not complete any rounds all night.
-They should have conducted rounds at 1:00am, 3:00am, and 5:00am and then should have started getting residents up for the day.

Interview with the Administrator on 02/19/26 at 10:46am revealed:
-The 1st shift staff reported to her that Resident #1 seemed very tired and her bed was made up and 1st shift made up the beds.
-The 1st shift staff suspected the resident had been up in her wheelchair all night.
-She observed the video from the SCU camera from the evening of 01/12/26.
-She observed Resident #1 in the hall in her wheelchair in the evening and her roommate pushed the wheelchair into the room and shut the door.
-The staff did not go into the room until 4:30am - 5:00am on 01/13/26.
-She expected staff to conduct rounds and incontinence care every two hours in the SCU.

Request for the facility's Policy and Procedure on Resident Rights was not provided.

Attempted telephone interview with the 2nd third shift PCA on 02/18/26 at 2:32pm was

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D 338	Continued From page 19 unsuccessful. Based on observations, interviews, and record review Resident #1 was not interviewable. _____ The facilty failed to ensure Resident #1 was free from neglect when staff left the resident, who had a diagnosis of Alzheimer's Disease and required total care and unable to verbalize her needs, in her wheelchair overnight, putting the resident at risk of skin breakdown and pain. This failure was serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/16/26 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 21, 2026.	D 338		
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 observation, interviews and record reviews the facility failed to administer medications as ordered to 1 of 1 sampled	D 358		

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residents (#7) related to two nutritional supplements the resident kept in her room.

The findings are:

Review of Resident #7's current FL2 dated 8/10/25 revealed diagnoses included schizoaffective disorder hyperlipidemia and chronic kidney disease.

Review of Resident #7's Resident Register dated 08/29/25 revealed Resident #7 was admitted to the facility on 08/29/25.

Observation during initial tour on 02/18/25 at 9:26am revealed:
-There was an over the counter bottle of cinnamon capsules, 1000mg, on the resident's bedside table.
-There was an over the counter bottle of omega-3 capsules, 1000mg, on the resident's bedside table.

Interview with Resident #7 on 02/18/26 at 9:26am and 2:22pm revealed:
-She purchased the cinnamon and omega-3 capsules.
-The doctor gave her permission to kept them in her room and self-administer them.
-She took them twice a day.

Review of Resident #7's record revealed:
-There was a note requesting clarification dated 09/09/25 asking the physician if Resident #7 was allowed to self administer cinnamon 1000mg and omega-3, 1000mg.
-There was an order dated 09/09/25 to discontinue cinnamon, 1000mg.
-There was an order dated 09/09/25 to discontinue Omega-3, 1000mg.

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D 358	Continued From page 21 Interview with the medication aide (MA) supervisor on 02/18/26 at 2:08pm revealed: -Resident #7 brought cinnamon and omega-3 supplements with her when she was admitted to the facility. -She asked the physician, shortly after she moved in, if the resident could self administer them and he wrote an order to discontinue them and they were removed from her room. -She did not know Resident #7 had them again in her room. Telephone interview with the office manager at Resident #7's physician's office on 02/18/26 at 2:36pm revealed the cinnamon and omega-3 were discontinued on 09/09/25 and Resident #7 should not be taking them any more. Interview with the Administrator on 02/19/26 at 11:13am revealed: -Residents should not keep medications or supplements in their rooms if they did not have an order for self administration. -She did not know Resident #7 had the cinnamon and omega-3 in her room.	D 358		