Received via email on 2/26/26

BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455	

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-survey on January 21, 2026 and January 22, 2026.	D 000		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations	D 259		

Division of Health Service Regulation

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director 2/26/2

STATE FORM 6899 429V11

Received and acknowledged on 2/27/26
Katherine Spencer

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warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#3 and #5) had a completed care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed.

1. Review of Resident #3's FL2 dated 11/24/25 revealed:
-Diagnoses included chronic pain, insomnia, anxiety and hypertension.
-She was semi-ambulatory.

Review of Resident #3's care plan dated 07/29/25 revealed:
-Resident #3 was totally dependent with ambulation, bathing and transferring.
-Resident #3 required extensive assistance with toileting, dressing and grooming.
-Resident #3 required moderate assistance with eating.
-The care plan was not signed by Resident #3's primary care provider (PCP).

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Interview with the Registered Nurse (RN) on 01/22/26 at 2:40pm revealed:
-She knew it was required that resident care plans must be signed by a provider within 15 days of completion.
-She did not know Resident #3's care plan was not signed by Resident #3's PCP.
-The Health and Wellness Director (HWD) was responsible to ensure resident care plans were signed by the provider within 15 days of completion.

Interview with the HWD on 01/22/26 at 3:10pm revealed:
-She knew it was required that resident care plans must be signed by a provider within 15 days of completion.
-Resident #3 had multiple providers at the time the care plan was completed but neither provider wanted to sign Resident #3's care plan.
-She was responsible to ensure resident care plans were signed by the provider within 15 days of completion.

Interview with the Administrator on 01/22/26 at 3:40pm revealed:
-She knew it was required that resident care plans must be signed by a provider within 15 days of completion.
-She did not know Resident #3's care plan was not signed by Resident #3's PCP.
-The RNs and the HWD were responsible to ensure resident care plans were signed by the provider within 15 days of completion.

Attempted telephone interview with Resident #3's PCP on 01/22/26 at 10:35am was unsuccessful.

2. Review of Resident #5's current FL2 dated 07/10/25 revealed:

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-Diagnoses included unspecified dementia, intracranial hemorrhage, chronic kidney disease, hyperlipidemia, and dysphagia following cerebral infarction.
-He was admitted to the facility on 07/02/24.

Review of Resident #5's care plan dated 09/05/25 revealed:
-Resident #5 required limited assistance with bathing, dressing, and grooming.
-Resident #5 was semi-ambulatory using a rolling walker.
-The care plan was not signed by Resident #5's Primary Care Provider (PCP).

Telephone interview with the Clinical Manager at Resident #5's PCP's office on 01/22/26 at 1:30pm revealed:
-The medical records department at the PCP's office received all faxes and emails from outside facilities and forwarded them to the appropriate staff members, including the PCP, and kept copies of all completed documents.
-She had received order approval forms and other documentation from the facility for Resident #5 but had never received a care plan for Resident #5.

Interview with the Health and Wellness Director (HWD) on 01/22/26 at 1:56pm revealed:
-She had been employed at the facility for two years.
-She was responsible for completing care plans for all assisted living residents and for obtaining PCP signatures on the care plans.
-She was aware that care plans must be signed within 15 days of completion by a resident's physician or physician extender.
-She had left a hard copy of Resident #5's most recent care plan in a binder after completion on

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D 259	Continued From page 4 09/22/25 for the PCP's nurse to hand deliver to the PCP for a signature, but the care plan was never returned. -She sent the care plan via email to the PCP's nurse on 01/22/26 as a second attempt to get a signature but it was not returned. Interview with the Administrator on 01/22/26 at 3:41pm revealed: - She was aware that care plans must be signed within 15 days of completion by a resident's physician or physician extender. -The HWD was responsible for completion of resident care plans and both the HWD and RNs were responsible to ensure care plans were signed by the PCP. -She was not aware Resident #5's care plan was not signed by the PCP. -It was her expectation that all resident care plans be completed timely and PCP signatures obtained within the 15-day timeframe. Attempted telephone interview with Resident #5's PCP on 01/22/26 at 11:25am was unsuccessful.	D 259		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs of 2 of 5 sampled residents (#1 and #2) related to a podiatry referral (#1) and weekly weights (#2).	D 273		

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The findings are:

1. Review of Resident #1's current FL2 dated 07/02/25 revealed:
-Diagnoses included hypertensive heart disease, type 2 diabetes, pain related to osteoarthritis, peripheral vascular disease, major depression, chronic fatigue, pulmonary fibrosis, gastroesophageal reflux disease.
-She was admitted to the facility on 03/02/21.

Interview with Resident #1 on 01/21/26 at 10:01am revealed:
-She was wearing a shoe on her left foot, but her right foot was bare.
-She pointed to the second toe on her right foot to reveal a long, thickened, deformed toenail.
-She had reported the toenail to several staff members at the end of November 2025.
-She was told she would need podiatry services to take care of the toenail.
-She had been a resident of the facility for almost five years and received podiatry services from an outside provider in the past.

Review of Resident #1's record revealed:
-There was a progress note by Resident #1's Primary Care Physician's (PCP) dated 12/08/25 that read "Under assessment and plan: "chronic, ongoing onychogryphosis. Patient with long, thickened toenails. Specifically, the toenail on her right foot; second toe is thick and deformed. Plan: Refer patient to podiatry to be seen for evaluation and nail trimming".
-There was an order dated 12/08/25 to refer Resident #1 to the facility's podiatry for evaluation and toenail trimming and to notify the PCP of next scheduled visit date.
-There was a note dated 01/21/26 at 3:43pm that

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read "Resident requested for podiatry service on 01/14/26; consent form signed by resident; waiting to be seen by podiatrist".
-There were 2 podiatry consent forms signed by Resident #1 dated 11/28/22 and 01/20/26.

Interview with a personal care assistant (PCA) on 01/22/26 at 3:07pm revealed she had been employed at the facility for one month and was unaware of Resident #1's deformed toenail.

Interview with the Resident Care Coordinator (RCC) on 01/22/26 at 3:01pm revealed:
-She had been employed at the facility for four years.
-She was unaware of Resident #1's request for podiatry or the condition of her toe until she received a text message from a second shift medication aide (MA) on 01/14/26.
-She and the Health and Wellness Director (HWD) attempted to locate podiatry consent forms in the medication room on 01/14/26 but were unsuccessful.
-She left a voicemail for Resident #1's Responsible Party (RP) on 01/14/26 but never heard back.
-She was unaware of the PCP's order for Resident #1 to be seen by the facility's podiatrist.

Interview with the Registered Nurse (RN) on 01/22/26 at 2:39pm revealed:
-She had been employed at the facility for one year but was also assigned to three other buildings.
-A MA reported the condition of Resident #1's toe on 01/20/26 and she conducted an assessment.
-She was unaware of Resident #1's podiatry referral and became aware of the PCP's order on 01/22/26.
-She met with the PCP on Mondays if she was in

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the building and the PCP would report her findings from her rounds.
-The PCP usually wrote new orders in the PCP book and would also email them at a later date.
-PCP visit notes were sent electronically and faxed to the RCC, HWD and RN.
-She was supposed to implement order changes following each PCP visit.
-All nurses were responsible for obtaining consent for podiatry services and consent was obtained from Resident #1 on 01/20/26.
-After consents and insurance information were scanned and emailed to the billing department of the podiatry provider, the provider would generate a list of residents to be seen and would then visit the facility based on need.

Interview with the HWD on 01/21/26 at 4:06pm revealed:
-She had been employed at the facility for two years.
-She was unaware of Resident #1's deformed toenail until 01/21/26 and was unaware of the PCP's order for Resident #1 to be seen by the in-house podiatrist.
-The RN reviewed PCP progress notes and met with the PCP each Monday after her weekly visits.
-A PCA should have completed a skin card notating the condition of Resident #1's feet and reported to the HWD.
-Resident #1 signed a consent for podiatry on 01/14/26 which was then emailed to the podiatry provider.
-The facility's podiatrist visited twice per month, and her last visit was on 01/13/26.
-Podiatry consents were emailed to the podiatry provider who made the schedule after insurance approval was obtained which could take up to three weeks.

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Interview with the Administrator on 01/22/26 at 3:41pm revealed:
-She became aware that Resident #1 was having issues with her feet when the HWD reported it to her on 01/13/26.
-The RN and the HWD were responsible for following up on PCP orders.
-It was her expectation that all progress notes were to be reviewed and follow up to occur if ordered by the PCP.

Attempted telephone interview with Resident #1's PCP on 01/22/26 at 10:35am was unsuccessful.

Attempted telephone interview with Resident #1's RP on 01/22/26 at 8:50am was unsuccessful.

2. Review of Resident #2's current FL-2 dated 11/17/25 revealed diagnoses included chronic congestion and heart failure and fractures of the humerus and pelvis.

Review of Resident #2's signed physician orders dated 12/01/25 there was an order for weekly weights.

Observation of Resident #2's weight on 01/22/26 at 10:35am revealed she weighed 74.2 pounds.

Review of Resident #2's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Resident #2's weight to be obtained weekly with a scheduled time of 6:00am.
-There was documentation that Resident #2's weight was obtained 1 of 4 opportunities from 12/01/25 to 12/31/25.
-There was documentation that Resident #2 refused to weigh 3 of 4 opportunities from

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12/01/25 to 12/31/25.

Review of Resident #2's January 2026 eMAR from 01/01/26 to 01/21/26 revealed:
-There was an entry for Resident #2's weight to be obtained weekly with a scheduled time of 6:00am.
-There was documentation that Resident #2's weight was obtained 1 of 3 opportunities from 01/01/26 to 01/21/26.
-There was documentation that Resident #2 refused to weigh 2 of 3 opportunities from 01/01/26 to 01/21/26.

Review of Resident #2's weight summary report revealed:
-On 11/21/25, the weight recorded was 71.6 pounds.
-On 12/06/25, the weight recorded was 70.8 pounds.
-On 12/26/25 the weight recorded was 72 4 pounds.
-On 01/02/26 the weight recorded was 71.8 pounds.

Review of Resident #2's Primary Care Physicians' (PCP) after visit summary dated 12/01/25 revealed
-There was an order to weigh Resident #2 weekly and to monitor weight closely.
-Resident #2's current weight was 71.6 pounds

Review of Resident #2's PCP's after visit summary dated 12/30/25 revealed
-Continue to obtain and record Resident #2's weekly weights.
-Resident #2's current weight was 71 pounds.

Review of Resident #2's PCP after visit summary dated 01/06/26 revealed

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-Resident #2's weight was 72.4 pounds.
-Continue to weigh Resident #2 weekly and record weights.

Interview with Resident #2 on 01/21/26 at 1:10pm revealed:
-She did not remember the last time she was weighed.
-She did not know how often she was to be weighed.

Telephone interview with a medication aide (MA) on 01/22/26 at 11:45am revealed:
-She obtained Resident #2's weight when Resident #2 let her.
-The weight was scheduled for 6:00am and sometimes Resident #2 did not want to get up and weigh.
-She had not notified the PCP of Resident #2 refusing to weigh every week.
-She had not spoken with the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) about changing the time of obtaining Resident #2's weight.
-She had told the on coming MA during morning report when Resident #2 refused to weigh.

Interview with the RCC on 01/22/26 at 11:00am revealed:
-Resident #2 had an order for monthly weights.
-She did not realize Resident #2 had orders for weekly weights.
-Resident #2 never refused to be weighed.
-She did not know Resident #2 had refused weekly weights as documented on the eMAR.
-She expected the MAs to obtain weekly weights as ordered and if there were multiple refusals the MA should notify the RCC, the HWD, and the PCP.

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D 273	Continued From page 11 Interview with the HWD on 01/22/26 at 2:50pm revealed: -The MA should notify the PCP when there were multiple refusals. -The PCP should have been notified of Resident #2 refusing her weights. -When the MA notified the PCP, the MA should document in the electronic progress notes. Interview with the Administrator on 01/22/26 at 3:24pm revealed: -She expected the PCP to be notified when there were multiple refusals. -Resident #2's PCP should have been notified of the weights being refused. -The MAs should document all notifications to the PCP in the electronic progress notes. Attempted telephone interview with Resident #2's PCP on 01/22/26 at 10:35am was unsuccessful.	D 273		
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: Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered for 1 of 1 sampled residents (#2). The findings are:	D 310		

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Review of Resident #2's current FL2 dated 11/17/25 revealed:
-Diagnoses included chronic congestion and heart failure and fractures of the humerus and pelvis.
-There was an order for a nutritional supplement 237mls three times daily with meals.

Observation of the lunch meal service on 01/21/26 between 12:03pm and 12:35pm revealed Resident #2 was not served a nutritional supplement.

Observation of the breakfast meal service on 01/22/26 between 8:15am and 8:40am revealed Resident #2 was not served a nutritional supplement.

Observation of the medication room on 01/22/26 at 10:51am revealed:
-There were 23 bottles of nutritional shakes on a shelf in a cabinet available for administration.
-There was no name on the nutritional shakes.
-There was a hand written note with Resident #2's name taped to the shelf.

Review of Resident #2's November 2025 electronic medication administration record (eMAR) from 11/21/25 to 11/30/25 revealed:
-There was an entry for a nutritional supplement 237ml three times daily with meals with a scheduled administration time of 8:00am, 12:00pm, and 5:00pm.
-There was documentation a nutritional supplement was administered three times daily from 11/22/25 to 11/30/25.

Review of Resident #2's December 2025 eMAR revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-There was an entry for a nutritional supplement 237ml three times daily with meals with a scheduled administration time of 8:00am, 12:00pm, and 5:00pm.
-There was documentation a nutritional supplement was administered three times daily from 12/01/25 to 12/31/25.

Review of Resident #2's January 2026 eMAR from 01/01/26 to 01/20/26 revealed:
-There was an entry for a nutritional supplement 237ml three times daily with meals with a scheduled administration time of 8:00am, 12:00pm, and 5:00pm.
-There was documentation a nutritional supplement was administered three times daily from 01/01/26 to 01/20/26.

Review of Resident #2's electronic progress noted dated 01/07/26 revealed:
-The RCC notified the pharmacy inquiring about Resident #2's nutritional supplements.
-The pharmacy stated, Resident #2's Power of Attorney (POA) notified the pharmacy and informed them not to send nutritional shakes to the facility; the facility was providing nutritional shakes for Resident #2.

Interview with Resident #2 on 01/21/26 at 12:35pm revealed:
-She did not receive nutritional supplements with meals.
-She received a nutritional supplement when she was in her room, but not regularly.
-She did not receive nutritional supplements daily.

Telephone interview with Resident #2's POA on 01/22/26 at 2:32pm revealed:
-She notified the pharmacy a few months ago and asked them not to send the nutritional

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supplements; it was too expensive.
-She had spoken with someone in management at the facility and Resident #2 was to receive the nutritional shakes the facility provided.

Telephone interview with a representative from the facility's contracted pharmacy on 01/22/26 at 10:40am revealed:
-Resident #2 had an order for nutritional supplements three times daily with meals.
-The pharmacy sent one case of nutritional supplements on 11/20/25.
-A case of nutritional supplements had 24 bottles which would last 8 days.
-Resident #2's POA notified the pharmacy on 12/19/25 that she could not afford the nutritional supplements and asked the pharmacy not to send the nutritional supplements anymore.
-The POA stated she had spoken with a manager at the facility and Resident #2 would receive a nutritional shake proved by the facility.
-The POA did not recall who she spoke with at the facility about the nutritional shakes.
-The pharmacy did not send anymore nutritional supplements after 11/20/26 as the POA requested.

Interview with a medication aide (MA) on 01/22/26 at 10:34am revealed:
-She gave Resident #2 a nutritional supplement after breakfast and lunch.
-She gave Resident #2 her nutritional supplement after meals when she was in her room.
-The nutritional supplement for Resident #2 was ordered from the pharmacy.
-The MAs or Resident Care Coordinator (RCC) could order the nutritional supplements when they were needed.
-She had ordered nutritional supplements from the pharmacy, but it had been a month ago.

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D 310	Continued From page 15 -Resident #2 had nutritional supplements in the medication room for administration. Interview with another MA on 01/22/26 at 3:03pm revealed: -She administered a nutritional supplement to Resident #2 after dinner each evening. -The nutritional supplement was kept in the medication room. -The nutritional supplement was ordered from the pharmacy, but she had never ordered it. Interview with the Dietary Manager (DM) on 01/21/26 at 12:51pm revealed: -She ordered the nutritional shakes for the clinical staff to administer to the residents as ordered. -She did not order any other nutritional supplements; the clinical staff was responsible for ordering any other type of nutritional supplements. Interview with the RCC on 01/22/26 at 11:00am revealed: -The nutritional supplements were ordered from the pharmacy. -She had not ordered nutritional supplements for Resident #2. -The MAs could order the nutritional supplements when they were needed. -The pharmacy had not notified her that the nutritional supplement could no longer be sent due to the POA's request until yesterday, 01/21/26. -She called the pharmacy yesterday, 01/21/26, and she was told the POA had called the pharmacy and requested the nutritional supplement not be sent, that Resident #2 would be receiving the nutritional shake the facility provided.	D 310		

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D 310	Continued From page 16 Interview with the Health and Wellness Director (HWD) on 01/22/26 at 11:22am revealed: -The nutritional supplements were ordered from the pharmacy. -The RCC was responsible for ordering the nutritional supplements. -She did not know until last week, that the pharmacy was not sending the nutritional supplements to the facility for Resident #2. -Resident #2 should have been getting nutritional shakes supplied by the facility. -She did not know the order had not been changed from nutritional supplements to nutritional shakes on the eMAR. -She did not know the MAs were documenting that the nutritional supplements were being administered when they were not in the facility and available for administration. Interview with the Administrator on 01/22/26 at 3:24pm revealed: -She thought the clinical staff ordered nutritional supplements from the pharmacy. -If the pharmacy did not send the nutritional supplements, the facility should be purchasing them from another place. -She expected nutritional supplements to be administered as ordered. Attempted telephone with Resident #2's Primary Care Provider (PCP) on 01/22/26 at 10:35 was unsuccessful.	D 310		
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	D 367		

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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, record reviews, and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#2) including a protein supplement.

The findings are:

Review of Resident #2's current FL2 dated 11/17/25 revealed:
-Diagnoses included chronic congestive heart failure and fractures of the humerus and pelvis.
-There was an order for Pro-stat AWC 30 ml (a protein supplement) twice daily in between meals.

Review of Resident #2's November 2025

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electronic medication administration record (eMAR) from 11/20/25 to 11/30/25 revealed:
-There was an entry for Pro-stat AWC 30ml every morning and at bedtime with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation that Pro-stat AWC was administered 6 of 21 opportunities from 11/20/25 to 11/30/25.

Review of Resident #2's December 2025 eMAR revealed:
-There was an entry for Pro-stat AWC 30ml every morning and at bedtime with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation that Pro-stat AWC was administered 18 of 62 opportunities from 12/01/25 to 12/31/25.

Review of Resident #2's January 2026 eMAR from 01/01/26 to 01/21/26 revealed:
-There was an entry for Pro-stat AWC 30ml every morning and at bedtime with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation that Pro-stat AWC was administered 12 of 41 opportunities from 01/01/26 to 01/21/26.

Telephone interview with a representative from the facility's contracted pharmacy on 01/21/26 at 2:58pm revealed:
-Resident #2 had an order for Pro-stat 30ml twice daily between meals dated 11/20/26.
-Resident #2's insurance would not pay for Pro-stat, so the Power of Attorney (POA) was notified.
-The POA stated she could not pay for it and not to fill it.
-Pro-stat AWC had never been dispensed from the pharmacy for administration.

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Interview with Resident #2 on 01/21/26 at 1:10pm revealed she had never received Pro-stat.

Telephone interview with Resident #2's POA on 01/22/26 at 2:32pm revealed:
-The pharmacy notified her when Resident #2 was admitted to the facility.
-She had an order for Pro-stat twice daily and the insurance would not pay for it.
-She told the pharmacy she could not afford to pay for it and not to send it.
-She had spoken to the Health and Wellness Director (HWD) about the Pro-stat.

Interview with a medication aide (MA) on 01/21/26 at 2:34pm revealed:
-She had not administered Pro-stat to Resident #2; the POA would not pay for it.
-Resident #2 never had Pro-stat available for administration.
-She documented on the eMAR that Pro-stat was unavailable .
-She did not realize she had documented a few times that she had administered Pro-stat.
-The documentation of administration was done in error; she had never administered Pro-stat.

Interview with another MA on 01/22/26 at 3:03pm revealed:
-She did not realize she had documented on the eMAR that she had administered the Pro-stat AWC.
-She knew the Pro-stat AWC was not in the facility for administration.
-The days she documented that she administered the Pro-stat AWC was a mistake; she did not administer the supplement.

Interview with the Resident Care Coordinator (RCC) on 01/22/26 at 11:00am revealed:

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-She knew the Pro-stat AWC was not in the facility and available for administration to Resident #2.
-She had spoken to someone in management about not having the Pro-stat AWC, but she could not remember when.
-She did not know the MAs documented on the eMAR that Pro-stat AWC was being administered when it was not available for administration.

Interview with the HWD on 01/22/26 at 2:50pm revealed:
-She did not know the MAs were documenting the administration of Pro-stat AWC twice daily.
-She expected the MAs to document correctly on the eMARs.

Interview with the Administrator on 01/22/26 at 3:24pm revealed:
-The MAs should document correctly on the eMARs.
-If a supplement was not administered the eMAR should reflect that.
-If the supplement was not available for administration the MAs should notify the pharmacy, RCC or HWD.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 01/22/26 at 10:35am was unsuccessful.

The following is a summary of the Plan of Correction for Brookdale Lawndale Park. This Plan of Correction is in regards to the Annual Follow up Survey completed on January 22, 2026. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .0802 Resident Care Plan

(a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this section. The care plan is an individualized, written program of personal care for each resident.
plan.

(c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

- The Executive Director or designee will in-service the Health & Wellness Director/Coordinator or designee on resident care plans & assessments by March 28, 2026. The Health & Wellness Director or designee will complete assessments with in thirty days of move, annually and according to policy. To assist with ongoing compliance, the Health & Wellness Director/Coordinator/Executive Director/designee will review resident care plans and assessments weekly for four weeks, then biweekly for one month and random thereafter. Plan of correction to be completed by April 23, 2026.

10A NCAC 13F .0902(b) Health Care

The facility shall assure referral and follow-up to meet the routine and acute health care needs of the residents.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct retraining for care associates on referral and follow up of physician's orders. The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on current resident records to verify that physician orders are being followed as ordered. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will provide weekly monitoring of physician orders for three (3) months, with the Health & Wellness Director/designee to monitor routinely thereafter. Plan of correction to be completed by May 26, 2026.

10A NCAC 13F .0904(e)(4) 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.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on current residents prescribed diet orders to verify the Dining Services Manager and dining staff have the current physician ordered diet. The Health & Wellness Director/Nurse/Executive Director/designee and/or Dining Services Manager will provide retraining on diets for associates who serve resident meals. Dining associates will be trained on the preparation of therapeutic diets per our menu manager platform. The Health & Wellness Director will also provide a copy of the nutrition tracker and diet orders to the dining department monthly. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review resident diets weekly for 6 weeks. Plan of correction to be completed by April 9, 2026.

10A NCAC 13F. 1004 Medication Administration

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: (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).

- The Health & Wellness Director/Nurse/Executive Director or designee will re-in-service medication aids & Resident Care Coordinator's on the 7 rights of medication administration; along with an eMAR to medication cart audit to ensure that physician orders and eMAR match. To assist with ongoing compliance the Health & Wellness Director/Nurse/Executive Director or designee will review the New Order Tracking forms to ensure accurate documentation and timely completion of medication receipt, verify accuracy and transcription of physician orders twice weekly for 6 weeks and then randomly thereafter. Plan of correction to be completed by April 9, 2026.

2/26/2026

Reonna Hargrave, Executive Director II