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LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on February 10-13, 2026.	{D 000}		
D 066	10A NCAC 13F .0305 (h)(3) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (3) all exit door locks shall operate from the inside at all times by a single hand motion without keys, tools or special knowledge; and This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all exit door locks were easily operable by a single hand motion from the inside without keys. The findings are: Review of the facility's census report on 02/10/26 revealed there were 40 residents living in the facility. Observation of the theater room on 02/10/26 at 9:15am revealed: -There was a rectangular plastic object wedged behind the two metal rods that the door handles activate to open the doors. -The two doors could not be opened by pushing on the door handles. -When the plastic object was removed the doors could not be opened by pushing on the door handles. -The exit doors were missing one door closure on the left side.	D 066		

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D 066	Continued From page 1 Second observation of the exit doors in the theater room on 02/10/26 at 11:07am revealed there was a sounding device when the doors were opened. Third observation of the exit doors in the theater room on 02/10/26 at 5:15pm revealed the left side of the door could be pushed open without using the push bar to open. Interview with a personal care aide (PCA) 02/10/26 at 6:18pm revealed the alarm was showing that the two exit doors were open and she pulled on the two metal rods, bending them out toward her to close the two exit doors. Interview with the housekeeper on 02/10/26 at 9:28am revealed: -He had worked for the facility for 5 months. -The theater room entrance door was always unlocked and there was no way to lock it. -The exit doors in the theater room were not used. Interview with the Activity Director on 02/10/26 at 3:00pm revealed: -The previous smoking area was located through the exit doors in the theater room. -The exit doors in the theater room stopped working and the previous Administrator placed the plastic object behind the two metal rods there to keep the doors closed. -The exit door was supposed to have an alarm on it. -When the wind would blow outside, the wind caused the doors to open in the theater room. -The previous Administrator was supposed to have an outside company come and repair the doors.	D 066		

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D 066	Continued From page 2 Interview with the Maintenance Director on 02/10/26 at 9:20am revealed: -He had worked at the facility for 9 months. -He did not know the exit doors in the theater room were not working. -He had not been asked to repair the exit doors in the theater room. -He did not know why the plastic object was behind the two metal rods. -The top left door closure had been missing since he started to work for the facility. -It was a fire hazard with the plastic object behind the two metal rods. -The residents and staff would not have been able to exit through the doors. -When he removed the plastic object and straightened the two metal rods the handles could be pushed and the doors opened. -There was no sounding device when the doors were opened. Second interview with the Maintenance Director on 02/12/26 at 2:00pm revealed: -The exit door in the theater room was on a list to have the automatic closing mechanism fixed but there was no scheduled date for the repair. -He did not know staff were pulling on the steel bar mechanism that latched the door to close the door. -The door would not open on 02/10/26 because there was a plastic object blocking the doors and because the steel bars that latched the door were bent. Interview with the Administrator on 02/10/26 at 11:15am revealed: -She did not know that the exit doors in the theater room were not working. -She did not know why a plastic object would	D 066		

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D 066	Continued From page 3 have been placed behind the two metal rods. -It was a safety hazard if the exit doors would not open. Second interview with the Administrator on 02/13/26 at 4:00pm revealed the fire doors not being able to open were a safety hazard and a fire hazard because the residents and staff could not exit through them in case of an emergency. Interview with the Regional Director of Operations on 02/10/26 at 6:20am revealed: -He did not know that the exit doors in the theater room were not working. -He did not know that the left door's closure was not on the door. -He did not know why the plastic object would have been behind the two metal rods.	D 066		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 079		

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D 079	Continued From page 4	D 079		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain an environment free of hazards including not properly securing oxygen canisters in a storage closet.

The findings are:

Review of the facility's undated oxygen administration and safety policy revealed:
-Residents requiring oxygen therapy shall receive services in accordance with physician orders, resident assessments, manufacture guidelines, and North Carolina regulations.
-Oxygen shall be handled as a medical treatment and safety sensitive service.
-Oxygen cylinders shall be secured upright in racks or carts, stored away from heat sources, protected from tipping.
-Full and empty cylinders shall be separated and labeled.
-Storage areas shall be well ventilated.
-Oxygen shall not be stored in bathrooms, kitchens, or utility areas

Review of the facility's census report on 02/10/26 revealed there were 40 residents living in the facility.

Observation of the utility room on 02/10/26 at 8:00am revealed:
-The utility room door was open and there were three unsecured oxygen cylinders sitting on the floor.
-Each cylinder had a green tag secured around the top of the cylinder.

Interview with a personal care aide (PCA) on 02/11/26 at 11:48am revealed:
-PCA's were not allowed to change out residents'

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D 079	Continued From page 5 oxygen tanks. -The medication aide (MA) were responsible for changing out the residents' oxygen tanks. Interview with a medication aide (MA) on 02/11/26 at 11:39am revealed: -She was responsible for changing the residents' oxygen tanks. -She was not sure if the PCAs were allowed to change out the oxygen tanks. -The oxygen tanks were stored in the utility room. -The oxygen tanks were not required to be in racks for storage. -She did not know that the oxygen tanks were supposed to be stored in racks. -If the oxygen tanks fell over, they could explode and hurt someone. Interview Administrator on 02/13/26 at 4:00pm revealed: -Oxygen tanks should be stored in racks. -If an oxygen tank was knocked over it could explode and hurt residents or staff.	D 079		
{D 118}	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be	{D 118}		

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{D 118}	Continued From page 6 such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record review, the facility failed to ensure that residents' electrically operated call bell in their rooms could be activated with a single action and remain on until deactivated by staff at the point of origin, and when activated have an audible and visual signal in a location accessible to staff for 40 residents residing in the facility. The findings are: Review of the facility's license dated 01/01/26 revealed a capacity of 62 residents with no Special Care Unit (SCU). Review of the facility's census on 02/10/26 revealed there were 40 residents. Interview with a resident who resided in room 107 on 02/10/26 at 8:10am revealed: -She used to have a pendant call bell that she wore around her neck. -The pendant stopped working 3 weeks ago and	{D 118}		

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{D 118}	Continued From page 7 she gave it to a staff member and asked them to fix it. -She had not received a replacement pendant call bell and had not gotten an update about it. -She yelled when she needed help from staff. Observation of room 107 on 02/10/25 at 8:14am revealed: -The resident residing in the room was not wearing a call bell pendant. -There was one wall pull call bell with a short cord that did not reach the resident in the room or the bed and another wall pull call bell in the bathroom. -The wall call bell was pulled at 8:14am. -There was a light over the door of room 107 but it was not flashing or lit. Observation of the nurse's station on 02/10/25 at 8:18am revealed: -There was a flashing light beside 107 on a wall panel at the nurse's station. -There were no audible alarms sounding at the nurse's station. -There was no staff member monitoring the alarm wall panel. Observation of the call bell panel at the nurse's station on 02/10/25 at 8:57am revealed the red light beside room 107 was still flashing. Observation of call bell panel at nurse's station on 02/10/25 at 11:55am revealed the red light beside room 107 was still flashing. Interview with a resident who resided in room 215 on 02/12/26 at 1:20pm revealed: -She did not have a call bell pendant and did not remember how long she had been without one. -She had to transfer herself to the wheelchair and	{D 118}		

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{D 118}	Continued From page 8	{D 118}		

roll down the hall to find staff when she needed help because she had no working call bell.
-She felt horrible having to get herself up anytime she needed help.
-If she did not feel like going to get help from staff, she would just lay in bed and suffer because she had no call bell.

Interview with a second resident who resided in room 215 on 02/10/26 at 8:59am revealed:
-She did not have a way to call for help.
-The call bells did not work.
-She fell in January 2026 and laid on the floor for 30 minutes with no way to call for help except yelling until staff walked by and found her.
-She required a wheelchair for ambulation.
-It made her feel angry and bad that no one came to help her.
-She required help getting on and off the toilet and did not have a way to call for help.
-She did not have a pendant to call for help.

Observation of room 215 on 02/10/26 at 8:59am revealed:
-The call bell located in the bathroom could not be pulled by the string to activate.
-When the call bell located between the 2 resident beds was pulled, the light outside of the room did not light up.

Observation of the nurse's station on 02/10/26 at 9:05am revealed: the call bell lit up at the nurse's station beside room 215 but did not make an audible sound.

Interview with a resident who resided in room 205 on 02/10/26 at 8:45am revealed:
-She did not have a way to call for help except yell.
-She did not have a pendant.

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{D 118}	Continued From page 9 Observation of room 205 on 02/10/26 at 8:50am revealed: -There was a call bell located in the bathroom. -The call bell in the bathroom did not activate a light over the room door when pulled. Observation of a resident who resided in room 204 on 02/10/26 at 8:05am revealed: -The resident was laying in bed while many other residents were eating breakfast in the dining hall. -She was on supplemental oxygen. -There was a call cord on the wall near the foot of the bed. -The resident would have to get up to pull the cord. -She did not have a call bell pendant. Interview with the resident who resided in Room 204 on 02/10/26 at 8:05am revealed: -Her speech was difficult to understand. -She pointed to the wall cord at the foot of the bed when asked about a call bell. -She reported that she could use the call bell. Interview with a personal care aide (PCA) on 02/10/26 at 8:10am revealed: -She arrived to provide feeding assistance to the resident in room 204. -Residents had call bell pendants that went around their necks that could send notification to a computer. -The resident in Room 204 should have a call bell pendant, and they would have to get her one. -She thought the resident's call bell pendant must have been removed when the resident was given a shower and needed to be replaced. Interview with a resident who resided in room 213 on 02/10/26 at 8:55am revealed:	{D 118}		

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{D 118}	Continued From page 10 -The call bell system was not working, and she took off her call bell pendant yesterday. -Apparently the call bell pendant sent messages to the front desk computer but did not light up above the door. -Every time she tried to use it nobody came. -If nobody was sitting at the computer then staff did not recognize that there was a problem. -She had to request pain medication and could not get ahold of anybody. -When she could not get ahold of anybody she would just cry and may take Tylenol that she had but should not have (Tylenol is medication used to treat pain and fever). -She went to see pain management once a month or every two months. -She took the Tylenol when she could not get ahold of anybody but never more than once a day and did not take it every day. -She felt fine when she took the Tylenol and it took the edge off. Observation of room 213 on 02/10/26 from 9:00am to 9:10am revealed: -The call bell pendant call bell was pressed at 9:00am. -A red light began blinking on the call bell pendant after the button was pressed. Observation of the front desk and hallways on 02/10/26 from 9:11am to 9:20am -At 9:11am two employees walked past a computer at the front desk and no response was observed related to the call bell pressed. -At 9:11am there was no observable or audible notification at the front desk computers. -At 9:20am the resident in room 213 had still not been checked on by staff. Interview with a resident from room 207 on	{D 118}		

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{D 118}	Continued From page 11 02/10/26 at 9:25am revealed: -She just got a call bell pendant this morning after her other call bell pendant broke. -She did not feel like she could get help when she needed it. -The call bell cord on the wall did not work. Second interview with the resident who resided in room 207 on 02/10/26 at 12:40am revealed: -The call bells did not work, she could push a button and wait 45 minutes. -Just the other day she fell performing a wheelchair to bed transfer. -She screamed for help and it took five or ten minutes for help to arrive. -The call bell cord had been turned on but she waited 30 minutes with no response when she pulled the cord. -She had a call bell pendant button and pressed it to no avail when she fell down. -She had fallen other times and did not have a call bell. -She fell a couple days previous to that at her closet and pressed the call bell pendant to no avail. -She screamed for help and staff fussed at her for screaming because it sounded like someone dying. -It took about ten minutes for them to respond when she fell at the closet. -Not too long ago she fell another time performing a bed to chair transfer and had to wait 20 minutes for help. -She had her call button, but it did not work so she hollered and screamed. -She got fussed at for calling for help, but there was no operational call system. -She needed help transferring because her wheelchair brakes did not work. -It would be nice if staff helped her transfer every	{D 118}		

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{D 118}	Continued From page 12	{D 118}		

time, but she did not think they could.
-It would be nice if she could press a button and receive help with transfers.
-The facility had gotten much worse after ownership changed.
-She felt abandoned when she was on the floor but was glad she had not broken anything because she could die from bleeding.
-One time she was on the floor so long she had gotten cold.

Observation of room 207 on 02/10/26 at 1:29pm. revealed:
- "204" was written on the call bell pendant.
-The call button call bell pendant was pushed at 1:29pm.

Observation of the front desk on 02/10/26 at 1:29pm revealed:
-No observable or audible alarm signaled at the desk for the resident who resided in room 207.
-No staff had responded to the call bell pendant pressed by the resident in room 207 by 1:34pm

Interview with a PCA on 02/10/26 at 1:45pm revealed:
-She saw the resident in room 207 on the floor when two other staff members were already in the room.
-The call bell pendant did not work well.
-The call bell pendant alarms might alarm at the front, but sometimes the magnet to turn the alarm off did not stop the alarm.
-Staff was supposed to use a magnet to turn off the alarms on the residents' call bell pendants.
-She and other staff let the previous Administrator know it was not working.
-There was a way to get the alarms cleared on the computer.
-The alarm would say which room number called

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{D 118}	Continued From page 13	{D 118}		

the desk.
-The call bells were specific to the residents' names.
-There was something written in marker on the back.
-She had not seen any residents that had the wrong call bells.

Interview with another PCA on 02/10/26 at 1:58pm revealed:
-The resident in room 207 fell down when she would try to get up.
-The last time the resident in room 207 fell down she had tried to use the bathroom.
-The resident in 207 had the call bell pendant but she said it was not working.
-Before that they had some hand bells that were no good.
-With the old call bells it was perfect, but with the new system staff could not see who needed help unless staff were at the computer.
-She did not think the call bell pendants were working currently.

Interview with a medication aide (MA) on 02/10/26 at 2:27pm revealed:
-The residents took the call bell pendants off sometimes.
-Someone had to be at the front desk to hear the call bells.
-There was a box of call bell pendants that had to be switched out.
-The resident in 207's call bell was working and then had to be switched out.
-The resident in 204 would get a call bell.
-She did not like the call bell system.
-She found the resident in room 207 on the floor last week when the resident was trying to get things from her closet and fell.
-The resident in room 207 would yell and staff

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{D 118}	Continued From page 14 could hear her very well. -When the resident from 207 yelled for help she and the previous Executive Director (ED) went to help. -Staff would not know what the residents needed if they could not call for help. -The resident in room 207 performed some transfers independently but needed help with some dressing, transfers, showering, medications, and reaching and grabbing things. Interview with a resident in room 209 B on 02/13/26 at 8:59am revealed: -He felt pain from his legs being swollen when his legs touched the edge of the bed. -He was in so much pain he panicked; it was twelve out of ten pain, a burning, sharp, sticking pain. -He did not have a call bell since he came back from the hospital and he had not had one for about two or three weeks. -He yelled in pain and staff would come. Interview with a PCA on 02/10/26 at 1:45pm revealed: -The residents used call bell pendants when they had needs. -When the call bell pendant was pressed by a resident, the software on a computer at the nurse's station would alarm until a staff member turned the call bell pendant off using a magnet. -Nobody used the old call bell systems on the wall in the resident rooms since the new system had been installed. -She had told the former Executive Director (ED) that the call bell pendant call bells were not working in the past and nothing was fixed. Interview with a second PCA on 02/10/26 at 9:15am revealed:	{D 118}		

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{D 118}	Continued From page 15 -She did not think the call bell notification at the desk was working anymore. -She went around to resident rooms and checked to see if they needed anything. Interview with a third PCA on 02/13/25 at 9:40am revealed: -The call bell system had not been working for about 3 months. -Residents were using handbells for a while as call bells until the new pendant system was installed. -The new system sometimes worked and sometimes did not. Interview with the Maintenance Director (MD) on 02/12/25 at 2:00pm revealed: -His role in maintaining the call bell system was minimal. -A representative from the call bell system company came in and installed the system once it was purchased. -He was never told he had to install signal extenders at the facility and the extenders were recently found unassembled in a box in his office. -He had notified the Administrator more than once that residents were saying the system was not working in the past. Interview with the Administrator on 02/13/26 at 3:59pm revealed: -If residents did not have call bells then they could not get help. -Staff were not responding to the door alarms and call bells like she expected. -She did not know how long the callbells were not working because it was her 5th day working at the facility. -A broken callbell system could cause harm to residents who were unable to call for help.	{D 118}		

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{D 118}	Continued From page 16 Interview with Director of Operations on 02/10/26 at 5:25pm revealed: -The call bell system computer was not working earlier this morning until he turned it on and logged into the system. -He did not know if the staff on duty this morning knew how to log in to the call bell system or if they purposefully turned the computer off so the alarm would not sound. -He started working with the call bell company this morning to learn the system and get it working for all residents. -The wall call bells in the resident rooms and the bathrooms were supposed to alarm on the new system. -He just checked several resident call bell pendants and ensured they were working. -The facility may need additional signal extenders installed to ensure the call bell signal was working throughout the whole facility, especially at the ends of the resident hallways. Second interview with the Director of Operations on 02/11/26 at 2:15pm revealed: -He found the signal extenders in a box in the maintenance office. -The call bell company told him on the phone that the signal extenders were delivered at the time of initial call bell system setup and should have been installed in the facility then. -The call bell pendants he tested last night worked because the residents were close to the nurse's station and pendants further away and down resident halls were still not working. -He was going to have an electrician install the signal extenders to ensure call bells would work throughout the whole building. _____ The facility failed to maintain an electrically	{D 118}		

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{D 118}	Continued From page 17 operated call bell system that had an audible and visual signal. One resident was sometimes unable to get up to her wheelchair and find staff for help and reported she laid in bed and suffered, multiple residents had to yell for help when they had a need, and one resident felt abandoned, got cold, and laid on the floor for 20 minutes after a fall. 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 02/10/26 for this violation.	{D 118}		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that 3 of 3 sampled staff who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training	D 125		

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D 125	Continued From page 18	D 125		

(Staff A, Staff B, Staff C) prior to administering medications and 2 of 3 sampled staff (Staff A, Staff B) did not have the medication skills competency validation prior to administering medications.

The findings are:

1. Review of Staff A's personnel record on 02/13/26 revealed:
-Staff A was hired on 02/03/26 as a medication aide (MA).
-There was no documentation Staff A completed the state approved 5-hour and 10-hour, or 15-hour medication aide training course.
-There was no documentation of a completed medication clinical skills checklist.
-There was documentation that she completed the MA exam on 09/08/25.

Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff A administered medications on 02/07/26.

Interview with the ED on 02/13/26 at 10:00am revealed she was able to find Staff A's personnel record.

Attempted telephone interview with Staff A on 02/13/26 at 12:30pm was unsuccessful.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm.

Refer to second interview with the Administrator on 02/13/26 at 4:00pm.

2. Review of Staff B's personnel record on

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D 125	Continued From page 19	D 125		

02/13/26 revealed:
-Staff B was hired on 08/14/25 as a medication aide (MA).
-There was no documentation that Staff B completed the state approved 5-hour and 10-hour, or 15-hour medication aide training course.
-There was no documentation of a completed medication clinical skills checklist.
-There was documentation that she completed the MA exam on 08/13/25.

Observation of Staff B during morning medication pass on 02/10/26 from 8:18am to 8:44am revealed she made 7 errors out of 43 opportunities for a 16% error rate.

Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff B administered medications on 02/01/26, 02/03/26 to 02/06/26, and 02/09/26 to 02/12/26.

Attempted telephone interview with Staff B on 02/13/26 at 12:35pm was unsuccessful.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm.

Refer to interview with the Administrator on 02/13/26 at 10:00am.

Refer to second interview with the Administrator on 02/13/26 at 4:00pm.

3. Review of Staff C's personnel record on 02/13/26 revealed:
-Staff C was hired on 04/14/22 as a medication aide (MA).

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D 125	Continued From page 20 -There was no documentation that Staff B completed the state approved 5-hour and 10-hour, or 15-hour medication aide training course. -There was no documentation of MA employment verification. -There was documentation of a completed medication clinical skills checklist on 04/20/22. -There was documentation that she completed the MA exam on 07/12/05. Review of a resident's February 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff C administered medications on 02/01/26, 02/05/26, and 02/10/26. Attempted telephone interview with Staff C on 02/13/26 at 12:40pm was unsuccessful. Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm. Refer to Interview with the Administrator on 02/13/26 at 10:00am. Refer to second interview with the Administrator on 02/13/26 at 4:00pm. _____ Interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm revealed: -She performed the medication skills evaluations for the facility. -She taught the state approved 5-hour and 10-hour, or 15-hour medication aide training course. -She did not keep copies of the documents she completed.	D 125		

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D 125	Continued From page 21 -The previous Administrator did not allow her to provide the staff with a copy of their certificates. -She did not keep a roaster for the classes. -She did not have any documentation for any of the facility staff. Interview with the Administrator on 02/13/26 at 10:00am revealed she was unable to locate any other staff records. Second interview with the Administrator on 02/13/26 at 4:00pm revealed: -She began working at the facility on 02/09/26. -She was only able to find parts of the requested staffs personnel records. -She knew that it was required to have the state approved 5-hour and 10-hour, or 15-hour medication aide training course certificates, medication skills evaluation, infection control certificates, and diabetic training. -She did not know who was responsible for maintaining the staff personnel records prior to her working at the facility. _____ The facility failed to ensure three medication aides (MA), Staff A, Staff B, and Staff C, completed the 5-hour and 10-hour or 15-hour medication aide training and 2 of 3 MAs, Staff A and Staff B completed the Medication Skills Competency Validation prior to administering medications placing the residents at risk for medication errors, including Staff B who during morning medication pass made 7 errors out of 43 opportunities on the medication pass for a 16% error rate. 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 02/13/26 for	D 125		

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D 125	Continued From page 22 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2026.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by:	D 164		

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Based on observations, interviews, and record reviews and the facility failed to ensure 3 of 3 sampled medication aides (MA) (Staff A, Staff B, Staff C) had completed training on the care of diabetic residents prior to administering insulin.

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 02/03/26.
-There was no documentation Staff A had completed training on the care of the diabetic resident prior to administering insulin.

Review of a resident's February 2026 medication administration records (eMAR) revealed there was documentation that Staff A administered medications on 02/07/26.

Attempted telephone interview with Staff A on 02/13/26 at 12:30pm was unsuccessful.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm.

Refer to interview with the Administrator on 02/13/26 at 4:00pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired as a MA on 08/14/25.
-There was no documentation Staff B had completed training on the care of the diabetic resident prior to administering insulin.

Observation of the medication pass on 02/10/26 at 8:00am revealed Staff B administered insulin to 2 residents.

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D 164	Continued From page 24 Review of 2 residents' February 2026 eMARs revealed there was documentation that Staff B administered insulin on 02/01/26, 02/03/26 to 02/06/26, and 02/09/26 to 02/12/26. Attempted telephone interview with Staff B on 02/13/26 at 12:35pm was unsuccessful. Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm. Refer to interview with the Administrator on 02/13/26 at 4:00pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired as a MA on 04/14/22. -There was no documentation Staff C had completed training on the care of the diabetic resident prior to administering insulin. Review of 2 residents' February 2026 eMARs revealed there was documentation that Staff C administered insulin on 02/01/26, 02/05/26, and 02/10/26. Attempted telephone interview with Staff C on 02/13/26 at 12:40pm was unsuccessful. Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm. Refer to interview with the Administrator on 02/13/26 at 4:00pm. _____ Interview with the Licensed Health Professional Support (LHPS) nurse on 02/13/26 at 12:04pm revealed: -She was a Registered Nurse (RN).	D 164		

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D 164	Continued From page 25 -She performed clinical skills evaluations and the medication skills evaluations for the facility. -She had never taught a course on diabetic training separate from the medication aide training course at this facility. Interview with the Administrator on 02/13/26 at 4:00pm revealed: -She began working at the facility on 02/09/26. -She was unable to locate Staff A, Staff B, and Staff C's diabetic training. -She did not know why the required documents were not in the personnel records. -She did not know who was responsible for maintaining the staff personnel records prior to her working at the facility.	D 164		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 of 5 sampled residents (#1, #2, #3, #4, #5) were tested upon admission	{D 234}		

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{D 234}	Continued From page 26	{D 234}		

for tuberculosis (TB) disease in compliance with the control measures by the Commission for Public Health.

The findings are:

1. Review of Resident #1's FL-2 dated 10/14/25 revealed diagnoses included heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea.

Review of the Resident Register for Resident #1 revealed he was admitted to the facility on 10/16/25.

Review of Resident #1's record revealed:
-There was an attempted tuberculosis (TB) test dated 10/14/25.
-The test was administered on 10/14/25 at 1:41am
-The result was written as negative.
-There was documentation "Not seen" dated 10/14/25 at 2:42am
-There was not documentation of a time that the test was read.

Interview with the Administrator on 02/13/26 at 3:59pm revealed Resident #1 did not have a completed TB test logged.

Refer to interview with the primary care provider (PCP) on 02/12/26 at 1:50pm.

Refer to Interview with the Administrator on 02/13/26 at 4:07pm.

2. Review of Resident #2's current FL-2 dated 01/19/26 revealed diagnoses included

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complicated urinary tract infection, acute kidney injury, chronic pain syndrome, paroxysmal atrial fibrillation, and uncontrolled type 2 diabetes mellitus.

Review of Resident #2's Resident Register revealed an admission date of 10/10/25.

Review of Resident #2's record revealed:
-Resident #2 had a tuberculosis (TB) skin test administered on 09/12/25.
-The test administered on 09/12/25 was read as negative but the date the test was read was not documented.
-There were no other TB skin tests in the record.

Refer to interview with the facility's contracted primary care provider (PCP) on 02/12/26 at 1:50pm.

Refer to interview with the Administrator on 02/13/26 at 4:07pm.

3. Review of Resident #3's current FL2 dated 09/19/25 revealed diagnoses included diabetes, chronic pain syndrome, right above the knee amputation (AKA) peripheral neuropathy, insomnia, nicotine dependence, and depression

Review of Resident #3's Resident Register revealed he was admitted to the facility on 08/26/25.

Review of Resident #3's records revealed:
-Resident #3 had a tuberculosis skin test (TB) administered on 08/22/25, read on 08/24/25 with a negative result.
-There was not another tuberculosis skin test available for review.

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{D 234}	Continued From page 28 Refer to interview with the facility's contracted primary care provider (PCP) on 02/12/26 at 1:50pm. Refer to interview with the Administrator on 02/13/26 at 4:07pm. 4. Review of Resident #4's current FL2 dated 07/3025 revealed diagnoses included schizoaffective disorder and depression. Review of Resident #4's Resident Register revealed an admission date of 07/31/25. Review of Resident 4's records revealed there was no documentation of a 1st step or 2nd step tuberculosis (TB) test. Refer to interview with the facility's contracted primary care provider (PCP) on 02/12/26 at 1:50pm. Refer to interview with the Administrator on 02/13/26 at 4:07pm. 5. Review of Resident #5's current FL-2 dated 03/12/25 revealed diagnoses included included non-ST-segment elevation myocardial infraction, hypertension, cerebrovascular accident, and depression. Review of Resident #5's Resident Register revealed she was admitted in the facility on 03/28/23 Review of Resident #5's records revealed: -Resident #5 had a tuberculosis (TB) skin test administered on 03/27/23 with a negative result. . -There was not another TB skin test available for review.	{D 234}		

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{D 234}	Continued From page 29 Refer to interview with the facility's contracted primary care provider (PCP) on 02/12/26 at 1:50pm. Refer to interview with the Administrator on 02/13/26 at 4:07pm. _____ Interview with the Administrator on 02/13/26 at 4:07pm revealed: -She did not know what the process for completion of tuberculosis (TB) tests was at this facility because it was her first week in the Administrator role. -In general, first step TB tests for any facility should have been completed at admission and a second step TB test completed within 30 days of admission to the facility. -Having incomplete TB tests for residents could have exposed other residents to TB. Interview with the facility's contracted primary care provider (PCP) on 02/12/26 at 1:50pm revealed: -Residents were required to have a 2 step TB test completed upon admission to the facility. -She was concerned that not testing a resident for TB upon admission to a facility could expose residents to TB.	{D 234}		
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	D 259		

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D 259	Continued From page 30 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 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.	D 259		

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This Rule is not met as evidenced by:
Based on interviews, and record review, the facility failed to ensure 4 of 5 sampled residents (#1, #2, #3, and #4) had dated signatures of the assessor and a dated signature of the physician within 15 days of completion.

The findings are:

1. Review of Resident #1's FL-2 dated 10/14/25 revealed:
-Diagnoses included heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea.
-Resident #1 was listed as ambulatory.

Review of the Resident Register for Resident #1 revealed:
-He was admitted to the facility on 10/16/25.
-He had a wheelchair.
-He had adequate memory.
-He required assistance with dressing, bathing, nail care, shaving, and ambulation.

Review of a care plan for Resident #1 dated 02/10/26 revealed:
-Bathing required limited assistance or extensive assistance.
-Dressing required extensive assistance.
-Grooming/personal hygiene required supervision.
-Eating required limited assistance or supervision.
-Toileting required limited assistance or supervision.
-Ambulation/locomotion required limited

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assistance or supervision.
-Staff was to observe resident taking medications and administer medications.
-The care plan was not signed by Resident #1's primary care provider (PCP).

Interview with Resident #1 on 02/13/26 at 8:59am revealed:
-Sometimes he could get dressed by himself but it changed with the swelling.
-He tried to walk but he used the wheelchair when his breathing was difficult.

Refer to interview with the Administrator on 02/13/26 at 4:07pm.

2. Review of Resident #2's current FL2 dated 01/19/25 revealed diagnoses included cognitive impairment, complicated urinary tract infection, acute kidney injury, chronic pain syndrome, paroxysmal atrial fibrillation, and uncontrolled type 2 diabetes.

Review of Resident #2's Resident Register revealed Resident #2 had an admission date of 10/10/25.

Review of Resident #2's Care Plan dated 10/28/25 revealed:
-Resident #2 needed limited assistance with eating, toileting, ambulation, grooming, and transferring.
-Resident #2 needed extensive assistance with bathing and dressing.
-The Care Plan was not signed and dated by the staff that completed the Care Plan.
-Resident #2's primary care provider (PCP) signed the Care Plan on 02/11/26.

Refer to interview with the Administrator on

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D 259	Continued From page 33 02/13/26 at 4:07pm. 3. Review of Resident #3's current FL2 dated 09/19/25 revealed diagnoses included diabetes, chronic pain syndrome, right above the knee amputation (AKA) peripheral neuropathy, insomnia, nicotine dependence, and depression Review of Resident #3's Resident Register revealed he was admitted to the facility on 08/26/25. Review of Resident #3's Care Plan dated 10/08/25 revealed: -Resident #3 needed limited assistance with bathing. -The Care Plan was not signed and dated by the staff that completed the Care Plan. -Resident #3's primary care provider (PCP) signed the Care Plan on 02/11/26. Refer to interview with the Administrator on 02/13/26 at 4:07pm. 4. Review of Resident #4's current FL2 dated 07/30/25 revealed diagnoses included schizoaffective disorder and depression. Review of Resident #4's Resident Register revealed Resident #4 had an admission date of 07/31/25. Review of Resident #4's Care Plan dated 09/01/25 revealed: -Resident #4 needed supervision with eating, ambulation, and transferring. -Resident #4 needed limited assistance with toileting, bathing, dressing, and grooming. -The Care Plan was not signed and dated by the staff that completed the Care Plan.	D 259		

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D 259	Continued From page 34 -Resident #4's primary care provider (PCP) signed the Care Plan on 02/11/26. Refer to interview with the Administrator on 02/13/26 at 4:07pm. _____ Interview with the Administrator on 02/13/26 at 4:07pm revealed: -The care plans for the residents were not complete because of the lack of signature of the assessor and the date of the assessment compared to primary care provider's (PCP) signature date. -The care plans should have been signed by the staff member that assessed the residents. -The assessments could not be completed months before the primary care provider signed the care plans.	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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 3 of 6 sampled residents (#1, #2, #6) including referrals to cardiology (#1, #6), pulmonology (#1, #6), orthopedics (#1), endocrinology (#6), and gastroenterology (#2). The findings are:	D 273		

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D 273	Continued From page 35 Review of the facility's medication administration policy dated 01/20/26 revealed: -Orders should be transcribed to the medication administration record (MAR) within 24 hours. -New admissions and hospital returns require medication reconciliation prior to first dose. -Medications must be available for administration as ordered. -If unavailable, staff must notify pharmacy immediately, notify nurse/Administrator, obtain emergency supply if needed, and document actions taken. Review of triage information document from the facility's contracted primary care provider (PCP) revealed: -All admits/re-admits must be called into triage for order verifications before sending to the pharmacy. -The facility representative was to call a triage number and reach the provider on call. -Give the patient's name, diagnosis, brief history, allergies, and read off the medications. -The facility representative may call triage before the patient arrives with the discharge summary from the hospital or an FL2. 1. Review of Resident #6's current FL2 dated 08/19/25 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), atrial fibrillation, arthritis, and insomnia. -Resident #6's recommended level of care was domiciliary (rest home). -Resident #6 was intermittently disoriented and ambulatory. Review of Resident #6's Resident Register revealed an admission date of 08/15/25.	D 273		

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D 273	Continued From page 36 Review of Resident #6's hospital discharge summary dated 09/29/25 revealed: -Resident #6 was admitted on 09/22/25 to 09/29/25 for severe sepsis, cellulitis, and atrial fibrillation. -There was a referral for cardiovascular medicine, pulmonologist, and home health, to be seen in 4-7 days. Review of Resident #6's history and physical by the primary care provider (PCP) dated 10/02/25 revealed: -It was a follow up for a post hospitalization for severe sepsis and atrial fibrillation. -There was a referral to home health for Resident #6's wound care. Review of Resident #6's progress note by the PCP dated 12/04/25 revealed: -Resident #6 felt like his heart had been racing more than usual with current heart rate of 139. -Resident #6 had not seen cardiology in a couple of years. -A cardiology referral was sent in November 2025 for atrial fibrillation management will send another referral today, 12/04/25. -Metoprolol Tartrate 50mg twice daily was discontinued on 12/04/25 (Metroprolol Tartrate is used to treat high blood pressure). -Metoprolol Tartrate 50mg 1.5 tablets twice daily was ordered on 12/04/25. -A cardiology consult was faxed to the office. -A pulmonologist and bronchology consult was faxed to office. -An endocrinology consult was faxed to office. Review of Resident #6's hospital discharge summary dated 12/07/25 revealed: -Resident #6 needed cardiology follow up as soon	D 273		

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as possible (ASAP) He was out of network with a local heart and vascular office, had seen a cardiologist at another office in the past.
-Resident #6 needed follow up with his primary care provider (PCP) regarding his blood glucose's.

Review of Resident #6's PCP order sheet dated 12/11/25 revealed send referral to cardiology for an appointment for Resident #6.

Interview with Resident #6 on 02/12/26 at 1:38pm revealed:
-Resident #6 was admitted to the hospital in September 2025 for irregular heartbeat, wound infections, and shortness of breath, he was not sure of the dates.
-Resident #6 was admitted to the hospital in December 2025 for irregular heartbeat, he was not sure of the dates.
-Resident #6 had not seen a cardiologist since his hospital admission in September 2025.
-The facility did not provide transportation to outside appointments.

Interview with Resident #6 on 02/12/26 at 3:20pm revealed:
-He did not know if any referrals had called to make appointments for him.
-The facility was short staffed and there was no one for him to ask about his referrals.
-He had attempted to talk with the Administrator multiple times about his referrals and was told she did not have time for him.
-He did talk with his PCP about his referrals and was told they did not know why the appointments had not been made.
-He was not sure if he was receiving his medications correctly.
-He felt like no one cared about him or was

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concerned about his health.
-He felt like he was not valued as a person.
-He felt that if he had seen a specialist he may have not had to be admitted to the hospital in December 2025.

Telephone interview with the cardiologist office receptionist on 02/12/26 at 3:45pm revealed:
-There had not been an appointment made for Resident #6.
-The cardiologist office sent a message through my chart on 12/16/25, left a voice message at the facility on 12/19/25, and mailed a letter to the facility on 12/23/25.

Telephone interview with the pulmonologist office receptionist on 12/13/26 at 3:55pm revealed:
-She did not see that the office had received a referral for Resident #6.
-There was not an appointment made for Resident #6.

Interview with Resident #6's PCP on 02/10/26 at 10:09am revealed she was concerned that Resident #6's referrals were not made several times.

Interview with Resident #6's second PCP on 02/12/26 at 2:20pm revealed:
-Resident #6 had extensive medical diseases that required a higher level of specialist coordination due to medical complexities.
-She faxed her physician's orders to the pharmacy herself because if she did not the orders disappeared and would not be processed.
-Referrals contacted the facility to make Resident #6's appointments.
-She had received confirmation on 12/04/25 that the cardiologist and endocrinologist received her referrals.

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-She had received confirmation that a different cardiologist had received her referral on 12/12/26.

Interview with the Administrator on 02/13/26 at 4:00pm revealed:
-Resident #6's referrals should have been made as soon as the facility received the order and within 24-48 hours if order received on a weekend.
-Failure to make Resident #6's referral could lead to repeat hospitalizations or death.

2. Review of Resident #1's most recent FL-2 dated 10/14/25 revealed:
-Diagnoses included heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea.
-Resident #1's was at a hospital and the requested level of care was Assisted Living Facility or Family Care Home.
-Resident #1's respiration was documented as "Other: Bipap 12/6 Bkup rt 12. Noc" and a PRN box was checked without further specification.
-Resident #1 weighed 310.1 lbs.

Review of the Resident Register for Resident #1 revealed:
-He was admitted to the facility on 10/16/25.
-He had a wheelchair.
-He had adequate memory.
-He required assistance with dressing, bathing, nail care, shaving, and ambulation.

a. Review of an order form dated 10/25/25 revealed Resident #1 was referred to outpatient cardiology.

Review of Resident #1's primary care provider (PCP) progress note dated 12/31/25 revealed:

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-Resident #1 had a cardiology appointment scheduled that was not properly coordinated due to staff turnover.
-Resident #1's cardiology appointment needed to be rescheduled for appropriate cardiac follow-up.

Review of Resident #1's hospital discharge summary dated 01/19/26 revealed:
-Resident #1 presented on 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19.
-Resident #1's weight on admission to the hospital was 329 lbs.
-Resident #1's last weight at the hospital was 315 lbs 0.6 oz.
-No previous ECG was available for comparison.
-Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower chambers are pumping too fast for a patient with atrial fibrillation.)
-Resident #1 had a transthoracic echocardiogram on 01/9/2026 with ejection fraction 55-60%, abnormal septal motion consistent with intraventricular conduction delay (An ultrasound test showed preserved blood flow from the lower left heart chamber, and analysis of the heart's motion showed there was probably a delay in the electrical signal that travels between the lower heart chambers).
-Cardiology was consulted, intravenous Diltiazem was initiated and he was eventually transitioned to oral Diltiazem and Carvedilol (Diltiazem is heart medication that can be used to control blood pressure, chest pain and treat arrhythmias. Carvedilol is medication that can be used for

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heart failure, to control blood pressure, or to treat certain arrhythmias).
-After treatment, Resident #1's heart rate remained within normal limits for the rest of his stay, but he stayed persistently in A-Flutter.
-Cardioversion was not recommended for Resident #1 given COVID-19 infection.
-Resident #1 received Lasix for diuresis, his kidneys were transiently affected by his diuresis, and his dosage of Lasix had to be modified.
-Resident #1 had been hospitalized in October 2025 for heart failure exacerbation.
-Resident #1 was to follow up with Cardiology.
-There was a recommendation to continue to monitor Resident #1's weight, intakes and outputs, volume status and creatinine.
-Resident #1's Lasix may need to be adjusted.

Review of Resident #1's hospital discharge instructions dated 01/19/26 revealed:
-Only the first 11 pages were provided by the facility of the 26-page document.
-There was a referral to outpatient cardiology.

Review Resident#1's emergency department provider note dated 02/10/26 revealed:
-Resident #1 had heart failure and presented with fluid retention and shortness of breath.
-Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend.
-Resident #1 had not taken his prescribed Lasix for the past two to three weeks due to a delivery issue at his assisted living facility.
-Resident #1 also experienced shortness of breath and occasional chest pain.
-Resident #1's hand had been swollen all weekend, and it hurt when he lowered it too much.
-Resident #1 had a history of a prior stroke with left-sided weakness.

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D 273	Continued From page 42 -Resident #1 exhibited altered mental status and was noted to be unusually sleepy. -The review of systems showed shortness of breath, chest pain and leg swelling. -ECG compared with 01/08/26 now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart). Review of facility-documented observations for Resident #1 revealed an entry dated 01/23/26 at 2:30pm reported Resident #1 had a Cardiology appointment booked on 04/13/26 at 2:40pm. Review of a physician order form dated 02/13/26 revealed: -There was an order to schedule an appointment with Cardiology for post-hospital visit for post-hospital discharge visit and for heart failure and "afib/flutter". -Handwritten on the order was Resident #1's appointment date (02/18/26), time and location. Interview with Resident #1 on 02/13/26 at 8:59am revealed: -The Lasix was changed to every other day after his January hospitalization. -They had Lasix every other day, then that changed and the doctor said he would get it daily, and for a while he was not even taking it at all. -The medication aide (MA) told him Lasix had not come in yet. -Right now, he received Lasix every other day. -When he did not receive Lasix he swelled up and he felt numbness and sharp pain in his legs. -He yelled in pain and felt panic about the pain in his legs. -The more he moved the more the pain would shoot up.	D 273		

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-Sometimes he could get dressed by himself, but it changed with the swelling.
-The previous Administrator told him they did not have a transportation service.
-He probably missed other appointments because they did not have transportation.
-His legs and feet would swell up when he did not get Lasix causing painful, aching, heavy legs.
-He tried to walk but he used the wheelchair when his breathing was difficult.
-He spoke with doctors about his pain when they came to the facility, but he could not remember exactly when.

Telephone interview with a scheduling representative from Resident #1's Cardiology provider revealed:
-Resident #1 had an appointment scheduled for 02/18/26 which was booked today (02/13/26) about an hour ago.
-The resident had never been seen as an outpatient at that clinic, and the upcoming visit would be his first outpatient visit.

Interview with the Administrator on 02/13/26 at 3:59pm revealed:
-She had not started working at this facility when Resident #1's Cardiology referral was made, but it was important with all of his health conditions it could cause severe consequences, and it was detrimental to his health.
-It was important to review the hospital discharge summary.

Refer to interview with the Administrator on 02/13/26 at 3:59pm.

b. Review of an order form dated 10/25/25 revealed:
-Resident #1 was to use continuous positive

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airway pressure (CPAP) nightly.
-Resident #1 was referred to outpatient pulmonology.

Review of Resident #1's hospital discharge summary dated 01/19/26 revealed:
-Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19.
-Resident #1's weight on admission to the hospital was 329 lbs.
-Resident #1's last weight at the hospital was 315 lbs.
-Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection.
-Resident #1 had a change in his asthma medications.
-Resident #1 had been hospitalized in October 2025 for heart failure exacerbation and discharged on either bilevel positive airway pressure (BiPAP) or CPAP.
-Resident #1 stated he could not use either BiPAP or CPAP at home yet.
-There was a recommendation for Resident #1 to use his CPAP.
-Resident #1 was to follow up with Pulmonology.
-There was a recommendation to continue to monitor Resident #1's weight, intakes and outputs, volume status and creatinine.

Interview with Resident #1 on 02/13/26 at 8:59am revealed:
-He had an appointment with pulmonology in December or January which he missed because the facility could not provide transportation.
-They did not make another appointment after the missed appointment.

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-He missed the first appointment because they were not paying attention to it.
-The previous Administrator told him they did not have a transportation service.
-He probably missed other appointments because they did not have transportation.

Attempted telephone interview with Resident #1's referred Pulmonology Provider's office was unsuccessful on 02/13/26 at 3:31pm.

Interview with the Administrator on 02/13/26 at 3:59pm revealed:
-She had not started working at the facility when Resident #1's Pulmonology referral was made, but it was important with all his health conditions it could cause severe consequences, and it was detrimental to his health.
-It was important to review the hospital discharge summary.

Refer to interview with the Administrator on 02/13/26 at 3:59pm.

c. Review of an order form dated 10/25/25 revealed Resident #1 was referred to orthopedics.

Review of facility-documented observations for Resident #1 revealed an entry dated 01/23/26 at 2:30pm reported Resident #1 had an appointment on 02/13/26 at 9:45am with orthopedics for his left rotator cuff.

Observation on 02/13/26 from 8:59am to 10:50am revealed Resident #1 remained in the facility at the time while his Orthopedic visit was supposedly booked.

Refer to interview with the Administrator on

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02/13/26 at 3:59pm.
Interview with a medication aide (MA) on 2/13/26 at 11:04am revealed:
-She knew some residents missed appointments but the staff was not notified by management that there was an appointment.
-She knew Resident #1 needed an appointment made for him and she took a phone number from him and gave it to the previous administrator.
-This occurred in January after Resident #1's hospitalization.

Interview with the Administrator on 02/13/26 at 3:59pm revealed:
-As soon as referrals were taken in then appointments needed to be made.
-On weekends appointments needed to be made within 24-48 hours.
-The facility did not have a transport vehicle.
-There was nothing arranged yet but they were looking at sharing a vehicle with another facility.
-They were also considering hired transport services and having staff ride with residents to appointments.
-She did not know how appointments were scheduled now, but the RDO was working on the plan.
-The RDO was making calls to book appointments for now.
-The plan was to use ride share for appointments.
-She was not at the facility when Resident #1's Cardiology and Pulmonology referrals were made, but it was important with all of his health conditions it could cause severe consequences, and it was detrimental to his health.
-It was important to review the hospital discharge summary.

Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was

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unsuccessful.

3. Review of Resident #2's current FL2 dated 01/19/26 revealed diagnoses included cognitive impairment, complicated urinary tract infection, acute kidney injury, chronic pain syndrome, paroxysmal atrial fibrillation, and uncontrolled type 2 diabetes.

Review of Resident #2's Resident Register revealed Resident #2 had an admission date of 10/10/25.

Review of Resident #2's Care Plan dated 10/28/25 revealed:
-Resident #2 needed limited assistance with eating, toileting, ambulation, grooming, and transferring.
-Resident #2 needed extensive assistance with bathing and dressing.

Review of Resident #2's Physicians Order Form dated 01/21/26 revealed an order for a referral to gastrointestinal specialist for continued abdominal pain and diarrhea.

Review of Resident #2's Emergency Department (ED) Discharge Summary on 12/22/25 revealed:
-Diagnosis included chronic abdominal pain.
-Resident #2 had an appointment scheduled with a gastrointestinal specialist on 01/22/26.

Review of Resident #2's Hospital Discharge Summary dated 01/16/26 revealed:
-Diagnoses included history of bleeding ulcers and pancreatitis.
-She presented to the hospital with abdominal pain, nausea, vomiting, and diarrhea for 3 days.

Review of Resident #2's Physicians Order Form

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D 273	Continued From page 48 dated 01/21/26 revealed an order for a referral to gastrointestinal specialist for continued abdominal pain and diarrhea. Interview with Resident #2 on 02/12/26 at 1:20pm revealed: -She had long term problems with constipation, diarrhea, nausea, vomiting, and abdominal pain. -She was supposed to have an appointment with a stomach specialist doctor, but the facility had not taken her to any appointments for months. Interview with one of Resident #2's primary care providers (PCP) on 02/10/26 at 10:10am revealed: -Residents had not been taken to requested specialist appointments. -Resident #2 was supposed to see a gastrointestinal specialist for diarrhea but that appointment had not happened yet. Interview with a second of Resident #2's PCPs on 02/12/25 at 1:50pm revealed: -She sent a referral to a gastrointestinal specialist for Resident #2 weeks ago due to diarrhea and abdominal pain. -The referrals she sent asked the specialist's office to call the facility to schedule an appointment, but the facility was responsible for following up with the specialist and ensuring the appointment was scheduled. Refer to interview with the Administrator on 02/13/26 at 3:59pm. _____ Interview with the Administrator on 02/13/26 at 3:59pm revealed: -As soon as referrals were taken in then appointments needed to be made.	D 273		

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D 273	Continued From page 49 -On weekends appointments needed to be made within 24-48 hours. -The facility did not have a transport vehicle. -There was nothing arranged yet but they were looking at sharing a vehicle with another facility. -They were also considering hired transport services and having staff ride with residents to appointments. -She did not know how appointments were scheduled now, but the RDO was working on the plan. -The RDO was making calls to book appointments for now. -The plan was to use ride share for appointments. -She was not at the facility when Resident #1's Cardiology and Pulmonology referrals were made, but it was important with all of his health conditions it could cause severe consequences, and it was detrimental to his health. -It was important to review the hospital discharge summary. _____ The facility's failure to ensure referrals and follow-up appointments from hospital admissions on three residents resulted in inadequate control of the resident comorbidities (#1, #6). The facility failed to follow up on cardiology, pulmonology, and endocrinology for Resident #6's atrial fibrillation, COPD, and diabetes and he returned to the emergency room. The facility failed to follow up on cardiology, pulmonology and orthopedics referrals for Resident #1 with left shoulder pain, COPD, CHF and arrhythmias, who had been hospitalized at least twice in the previous 5 months, who required management of his diuretic medications to protect his kidneys, who had atrial flutter and required monitoring for possible electrophysiological treatment after hospital discharge. The facility failed to follow up with gastroenterology for Resident #2's nausea,	D 273		

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D 273	Continued From page 50 vomiting, constipation, and abdominal pain. This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 02/10/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED March 15, 2026.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to implement healthcare orders to monitor a resident's weight daily and administer continuous positive airway pressure (CPAP) nightly for 1 of 5 residents (#1). The findings are: Review of Resident #1's FL-2 dated 10/14/25 revealed: -Diagnoses included heart failure with reduced	D 276		

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ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea.
-The requested level of care was Assisted Living Facility or Family Care Home.

a. Review of the facility's policy on weight monitoring revealed:
-It was the policy of the facility to monitor, document, and respond to resident weight changes in a timely manner. Appropriate interventions were to be implemented when significant weight loss or gain was identified to protect resident health, safety, and well-being.
-A significant weight change was defined as 5% in one month, 7.5% in three months, or 10% in six months.
-Weight was to be documented within 72 hours of admission to the facility.
-Residents were to be weighed at least monthly.
-Residents at nutritional risk, on diuretics, with congestive heart failure, renal disease, diabetes, or physician order were to be weighed at least weekly or as ordered.
-Weights were to be obtained on the same scale when possible, at the same time of day, with similar clothing/shoes removed.
-All weights were to be recorded on the Weight Log and in the resident's clinical record.
-Documentation was to include Date, Weight, Method/equipment used (if applicable), staff initial/signature.
-Electronic health record entry was to occur if applicable.
-The Administrator/Designee or Licensed Nurse was to review weights monthly.
-Any significant weight change was to trigger physician notification, dietitian referral (if available), family/responsible party notification, care plan review/update.

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-Interventions may include but were not limited to diet modification, nutritional supplements, adaptive feeding equipment, meal assistance, weekly weights, intake monitoring, and medical evaluation.
-All interventions were to be documented.
-Resident refusals were to be documented and staff was to re-attempt within 24 hours.
-Medication aides were to obtain and record weights and report changes promptly.
-Administrator or designee was to ensure compliance, audit weight records, ensure scale calibration.
-The quality assurance process was to record weights at least quarterly, correct missing or inconsistent documentation, review trends through QA processes.
-The facility was to maintain adequate weighing equipment.
-Equipment was to accommodate non-ambulatory residents.
-Calibration of logs was to be maintained.
-Staff was to be trained on transfer techniques, scale use, documentation requirements, and identifying significant weight change.

Review of Resident #1's FL-2 dated 10/14/25 revealed Resident #1 weighed 310.1 pounds (lbs).

Observation of Resident #1 being weighed by facility staff on 02/13/26 at 3:06pm revealed:
-Resident #1 was weighted on bathroom type scales by 2 facility staff members.
-Resident #1 weighed 327 lbs.

Review of a hospital discharge summary dated 01/19/26 for Resident #1 revealed:
-Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and

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lower extremity swelling and was found to be positive for COVID-19.
-Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower chambers are pumping too fast for a patient with atrial fibrillation.)
-Resident #1 had a transthoracic echocardiogram on 01/09/26 with ejection fraction 55-60%, abnormal septal motion consistent with intraventricular conduction delay (An ultrasound test showed preserved blood flow from the lower left heart chamber, and analysis of the heart's motion showed there was probably a delay in the electrical signal that travels between the lower heart chambers).
-Resident #1 received Lasix for diuresis, his kidneys were transiently affected by his diuresis, and his dosage of Lasix had to be modified (Lasix is a medication given to remove excess fluid from the body).
-There was a recommendation to continue to monitor Resident #1's weight, intakes and outputs, volume status and creatinine.
-Resident #1's Lasix may need to be adjusted.
-Resident #1's weight on admission to the hospital was 329 lbs.
-Resident #1's last weight at the hospital was 315 lbs 0.6oz.

Review of a 01/19/26 hospital discharge instructions for Resident #1 revealed:
-Only the first 11 pages were provided by the facility of the 26-page document.
-There were instructions for Resident #1 to weigh daily in the morning and to record the weight.
-Resident #1's instructions were to report to the

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D 276	Continued From page 54 doctor weight increase of 2-3 lbs overnight or 3-5 lbs over one week, swelling in the feet, legs or stomach area, and report increased shortness of breath with minimal activity or at rest. Review of an order form for Resident #1 dated 01/28/26 revealed there was an order for daily weight checks and to call the primary care provider (PCP) for weight gain greater than 3lbs. Review of 02/10/26 emergency department provider note revealed: -Resident #1 had heart failure and presented with fluid retention and shortness of breath. -Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend. -Resident #1 reportedly had not taken his prescribed Lasix for the past two to three weeks due to a delivery issue at his assisted living facility. -Resident #1 also experienced shortness of breath and occasional chest pain. -Resident #1's hand had been swollen all weekend, and it hurt when he lowered it too much. -Resident #1 had a history of a prior stroke with left-sided weakness. -Resident #1 exhibited altered mental status and was noted to be unusually sleepy. -The review of systems showed shortness of breath, chest pain and leg swelling. -There was no documentation of Resident #1's weight in the Emergency Department Summary. Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check weight daily for monitoring and to call the provider for weight gain greater than 3lbs.	D 276		

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D 276	Continued From page 55 -There was documentation that daily weight checks were performed on 01/30/26 and 01/31/26. -Resident #1's weight was not shown on the printed eMAR. Review of Resident #1's February 2026 eMAR revealed: -There was an entry to check weight daily for monitoring and to call the provider for weight gain greater than 3lbs. -There was documentation that daily weight checks were performed 02/01/26 through 02/06/26 and 02/08/26 through 02/12/26 with weights listed ranging from 225 to 237.8 without specification of units of measurement. -On 02/13/26 at 8:46am and again at 8:47am there was documentation that Resident #1 refused a weight check. Review of Resident #1's vitals history documentation revealed: -The date range of the document was from 12/01/25 to 02/13/26. -Resident #1's weight was documented as 324 on 12/15/25 with no specification of units of measurement. -Resident #1's weight was documented as taken daily from 01/30/26 to 02/06/26 and from 02/08/26 to 02/12/26 with weights ranging from 225 to 237.8 with no specification of units of measurement. Interview with Resident #1 on 02/13/26 at 8:59am revealed: -Staff did not take his weight every day. -Staff were supposed to take his weight every day but they had not. -Staff told him the big scale was broken about one or two weeks ago.	D 276		

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D 276	Continued From page 56 -Staff tried to weigh him on another scale. -Staff took his weight about two weeks ago and they took his weight a total of about four times in the last month. -When he asked the staff about the daily weights he was told the scale was broken. -He noticed something like a 5lb increase at the last weigh-in. -He lost weight and then gained it back. Interview with Resident #1 on 02/13/26 at 10:50am revealed: -The scale in his room was brought in yesterday and belongs to the facility. -The first time he ever used the scale in his room was yesterday. Interview with a personal care aide (PCA) on 02/13/26 at 12:10pm revealed: -The big scale was broken and was supposed to be used for residents who were in wheelchairs. -There was a little scale used when the big scale was not available. Interview with a medication aide (MA) on 02/13/26 at 11:04am revealed: -She weighed Resident #1 with the bathroom type scale every time she was on shift. -She saw some weight gain and she notified the provider in-person. -When she talked to the provider Resident #1 had gained a couple pounds. -Resident #1 had pork, but did not like pork so he was not eating as much so she knew the couple pounds he gained was probably fluid. -He told her he felt bigger and that he had water in him. Second interview with a MA on 02/13/26 at 3:20pm revealed:	D 276		

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D 276	Continued From page 57 -She had not been weighing Resident #1 she would look at prior weights and pick one to document for that day. -She explained that it was important to have the correct weight because of Resident #1's build up of fluid in his body. Interview with a second MA on 02/13/26 at 12:20pm revealed: -Resident #1 declined to get on the scale this morning because his neuropathy was bothering him. -She would try to weigh Resident #1 again today. Second interview with a MA on 02/13/26 at 3:11pm revealed: -She had not weighted Resident #1 today. -She could not find the scales. -The wheelchair scales had been broken since prior to 01/01/26. -She would weigh the wheelchair and then weigh Resident #1 sitting in his wheelchair. Interview with the Administrator on 02/13/26 at 3:59pm revealed: -The weights for Resident #1 were not acceptable and they were falsified. -The MA knew why she should not falsify the weights. -Resident #1 had CHF and it would cause him to build fluid and he could die. -It was important to review the hospital discharge summary. Interview with the Regional Director of Operations (RDO) on 02/13/26 revealed: -That Resident #1 should have been weighed every day at the same time before breakfast on the wheelchair or bathroom scale. -He did not know that the wheelchair scale was	D 276		

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broken.
-It was not appropriate not to weigh Resident #1 and pick a previous documented weight.

Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful.

b. Review of Resident #1's FL-2 dated 10/14/25 revealed Resident #1's respiration was documented as "Other: Bipap 12/6 Bkup rt 12. Noc" and a PRN box was checked without further specification (Bilevel positive airway pressure or BiPAP is a device used to aide breathing).

Review of a Physician Order Sheet dated 10/25/25 revealed Resident #1 was to use continuous positive airway pressure (CPAP) nightly.

Review of a physician order sheet for Resident #1 dated 11/07/25 revealed there was an order for Resident #1 to use CPAP nightly.

Review of a primary care provider (PCP) note dated 12/31/25 revealed:
-Resident #1 had not been using his CPAP device for two months since moving due to lack of sterile water.
-The non-compliance with his CPAP may be contributing to other symptoms and his overall health status.
-There was an order to provide 8 ounces of distilled water to use in CPAP machine nightly.

Review of Resident #1's hospital discharge summary dated 01/19/26 for Resident #1 revealed:
-Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and

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lower extremity swelling and was found to be positive for COVID-19.
-Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower chambers are pumping too fast for a patient with atrial fibrillation.)
-Resident #1 had been hospitalized in October 2025 for heart failure exacerbation and discharged on either BiPAP or CPAP.
-Resident #1 stated he could not use either BiPAP or CPAP at home yet.
-There was a recommendation for Resident #1 to use his CPAP.

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for CPAP to be used nightly.
-There was documentation that CPAP was used nightly 12/01/25 through 12/31/25.

Review of Resident #1's January 2026 eMAR revealed:
-There was an entry for CPAP to be used nightly.
-There was an entry to provide 8oz of distilled water for the resident's CPAP machine nightly.
-There was documentation that CPAP was used nightly from 01/01/26 through 01/07/26 and 01/19/26 through 01/31/26.
-There was documentation that CPAP was not used on 01/08/26 due to resident refusal.
-There was documentation that CPAP was not used on 01/09/26 through 01/18/26 due to resident hospitalization.
-There was documentation that 8oz of distilled water was provided nightly from 01/03/26 through

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01/07/26 and 01/19/26 through 01/31/26.
-There was documentation that 8oz of distilled water was not used on 01/08/26 due to resident refusal.
-There was documentation that 8oz of distilled water was not used on 01/09/26 through 01/18/26 due to resident hospitalization.

Review of Resident #1's February 2026 eMAR revealed:
-There was an entry for CPAP to be used nightly.
-There was an entry to provide 8oz of distilled water for the resident's CPAP machine nightly.
-There was documentation that CPAP was used nightly from 02/01/26 through 02/08/26 and from 02/10/26 through 02/11/26.
-There was documentation that CPAP was not used on 02/09/26 due to resident out with family
-There was documentation that 8oz of distilled water was provided nightly from 02/01/26 through 02/08/26 and from 02/10/26 through 02/11/26.

Interview with Resident #1 on 02/13/26 at 10:50am revealed:
-At one point in January and February 2026 he had no water for his CPAP for about three or four weeks.
-He slept okay and could not say if there was any effect from it.
-When he was out of water he requested it right away but did not get it.
-He requested it from the previous Administrator.

Interview with a medication aide (MA) on 02/13/26 at 11:04am revealed:
-Resident #1 ran out of sterile water and he tried to order some.
-She did not work at night but heard he was out and about two weeks ago a new supply arrived for the machine that she saw.

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D 276	Continued From page 61 -She did not know how long he was out. Interview with the Administrator on 02/13/26 at 3:59pm revealed: -She asked the hospital to provide discharge summaries or prescriptions before the resident arrived in the facility because she liked to make sure they had medications that were needed. -She had just begun working in the facility, but could say how the Resident #1's CPAP should be maintained in the future. -The kitchen could order sterile water for Resident #1's CPAP. -The MA's could handle the sterile water for Resident #1's CPAP. -The Resident Care Director (RCD) or Administrator could check behind the MA. -The CPAP machine should be checked weekly and it could be monitored by a log on the resident's door. -It was important to review the hospital discharge summary. Attempted interview with Resident #1's PCP on 02/13/26 at 3:50pm was unsuccessful.	D 276		
{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.	{D 358}		

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{D 358}	Continued From page 62 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#3, #4) observed during medication pass including medications used to treat schizophrenia, constipation and high blood sugar (#4), nicotine dependence, high blood sugar, and pain (#3) and 2 of 5 sampled residents (#1, #2) including medications used to treat cardiac pain and moderate to severe pain (#2) hypertension, chest pain, heart failure, smoking cessation and allergies (#1). The findings are: Review of the facility's medication administration policy dated 01/20/26 revealed: -Orders were transcribed to the medication administration record (MAR) within 24 hours. -New admissions and hospital returns require medication reconciliation prior to first dose. -Medications must be available for administration as ordered. -If unavailable, staff must notify the pharmacy immediately, notify nurse/Administrator, obtain emergency supply if needed, and document actions taken. -For medication administration procedures the staff follow the six rights, right resident, right medication, right dose, right time, and right documentation. -Required process hand hygiene prior to medication pass, prepare medications for one resident at a time, compare (MAR) to label 3 times, use two resident identifiers, observe ingestion/application, and document immediately after administration.	{D 358}		

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{D 358}	Continued From page 63 1. The medication error rate was 16% as evidenced by 7 errors out of 43 opportunities. a. Review of Resident #4's current FL2 dated 07/30/25 revealed diagnoses included diabetes, depression, and schizoaffective disorder. Review of Resident #4's Resident Register revealed he was admitted to the facility on 10/10/25. Review of Resident #4's signed physician order sheet dated 01/16/26 revealed there was an order for Vraylar 4.5mg administer daily in original bottle (Vraylar is used to treat schizophrenia). Observation of the medication pass on 02/10/26 revealed: -The medication aide (MA) administered medications to the resident at 8:33am. -Vraylar 4.5mg was not administered to Resident #4. Review of Resident #4's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Vraylar 4.5mg administer daily at 8:00am. -Vraylar 4.5mg was documented as administered at 8:00am from 02/01/26 to 02/09/26. -Vraylar 4.5mg was documented as not administered at 8:00am on 02/10/26. Interview with the MA on 02/10/26 at 8:19am revealed: -She was unable to locate Resident #4's Vraylar 4.5mg. -She documented that the Vraylar 4.5mg was not available to be administered.	{D 358}		

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{D 358}	Continued From page 64 Interview with Resident #4's primary care provider (PCP) on 02/10/26 at 11:35am revealed: -Resident #4 could develop a psychosis episode and could hallucinate and develop delusions when he missed the Vraylar. -Behavioral health followed this medication for Resident #4. -All medications should be administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's mental health provider on 02/10/26 at 1:00pm was unsuccessful. b. Review of Resident #4's signed physician order sheet dated 01/16/26 revealed there was an order for Polyethylene Glycol 3350 powder mix 17 grams in 8 ounces of liquid daily as needed (Polyethylene Glycol 3350 powder is used to treat constipation). Observation of the 8:00am medication pass on 02/10/26 revealed: -There was not any Polyethylene Glycol 3350 powder on the medication cart. -MA asked Resident #4 if he needed the Polyethylene Glycol 3350 powder and he responded that he did. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Polyethylene Glycol 3350 powder administer as needed for constipation. -Polyethylene Glycol 3350 powder was not documented as administered at 8:00am from	{D 358}		

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{D 358}	Continued From page 65 02/01/26 to 02/10/26. Interview with the medication aide (MA) on 02/10/26 at 8:19am revealed: -Resident #4 requested the Polyethylene Glycol 3350 powder. -She was unable to locate Resident #4's Polyethylene Glycol 3350 powder. -She documented that the Polyethylene Glycol 3350 powder was not available to be administered. -She did not reorder medications in the computer because it took too long. -She did not fax the refill request because the pharmacy got so many faxes. -She usually called the pharmacy to reorder medications. Interview with the Administrator on 02/13/26 at 4:00pm revealed that if the resident did not receive his Polyethylene Glycol 3350 powder as ordered he could become constipated and could end up in the emergency room. Interview with Resident #4's PCP on 02/10/26 at 11:35am revealed Resident #4 could develop abdominal pain, become constipated, and end up in the emergency room from missed doses of medication. Telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:20am revealed: -Resident #4's Polyethylene Glycol 3350 powder had only been filled once on 08/01/25. -Polyethylene Glycol 3350 powder was a bulk item and must be ordered each time it was needed. Based on observations, inteviews, and record reviews, it was determined Resident ##4 was not	{D 358}		

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{D 358}	Continued From page 66 interviewable. c. Review of Resident #4's signed physician order sheet dated 01/16/26 revealed there was an order for Lantus 42 units administer twice daily (Lantus is a long-acting insulin used to improve blood sugar control and according to manufacturer's instructions, a 2-unit air shot is required before administration). Observation of the medication pass on 02/10/26 revealed: -Lantus 42 units was administered in Resident #3's left posterior upper arm. -There was not a 2-unit air shot performed prior to Lantus 42 units being administered. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Lantus 42 units administer twice daily at 8:00am and 8:00pm. -Lantus 42 units was documented as administered at 8:00am from 02/01/26 to 02/10/26. -Lantus 42 units was documented as administered at 8:00pm from 02/01/26 to 02/08/26. -Lantus 42 units was documented as not administered, Resident #3 refused, at 8:00pm on 02/09/26. Telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:20am revealed: -Facility staff should perform a 2-unit air shot prior to administering the medication. -The air shot made sure that the pen was working and ensured an accurate dose. Interview with the medication aide (MA) on 02/10/26 at 8:19am revealed:	{D 358}		

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{D 358}	Continued From page 67 -She did not know she was supposed to perform an air shot before administering insulin. -She was never educated on performing a 2-unit air shot. -She did not know why you would perform an air shot. Interview with the Administrator on 02/13/26 at 4:00pm revealed: -She expected all medications to be administered as ordered. -Staff were to perform a 2-unit air shot prior to administering insulin with a pen. -The air shot removed air bubbles, ensured accuracy of the dose, and lets staff know that the insulin pen was working. Interview with the primary care provider (PCP) on 02/10/26 at 11:35am revealed that all medications should be administered as ordered. d. Review of Resident #4's signed physician order sheet dated 01/16/26 revealed: -There was an order for Lyumjev 12 units administer 30 minutes prior to meals 3 times a day (Lyumjev is a rapid acting mealtime insulin used to control high blood sugar and according to manufacturer's instructions a 2-unit air shot is required before administration). Observation of the medication pass on 02/10/26 revealed: -Lyumjev 12 units was administered in Resident #3's right posterior upper arm. -There was not a 2-unit air shot performed prior to Lyumjev 12 units being administered. Review of Resident #3's February 2026 eMAR revealed: -Lyumjev 12 units was documented as	{D 358}		

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administered at 7:30am from 02/01/26 to 02/10/26.
-Lyumjev 12 units was documented as administered at 11:30am from 02/01/26 to 02/10/26.
-Lyumjev 12 units was documented as administered at 4:30pm from 02/01/26 to 02/09/26.

Telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:20am revealed:
-Facility staff should perform a 2-unit air shot prior to administering the medication.
-The air shot made sure that the pen was working and ensured an accurate dose.

Interview with the medication aide (MA) on 02/10/26 at 8:19am revealed:
-She did not know she was supposed to perform an air shot before administering insulin.
-She was never educated on performing a 2-unit air shot.
-She did not know why you would perform an air shot.

Interview with the Administrator on 02/13/26 at 4:00pm revealed:
-She expected all medications to be administered as ordered.
-Staff were to perform a 2-unit air shot prior to administering insulin with a pen.
-The air shot removed air bubbles, ensured accuracy of the dose, and lets staff know that the insulin pen was working.

Interview with the primary care provider (PCP) on 02/10/26 at 11:35am revealed that all medications should be administered as ordered.

e. Review of Resident #3's current FL2 dated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 69 09/19/25 revealed diagnoses included diabetes, chronic pain syndrome, right above the knee amputation (AKA) peripheral neuropathy, insomnia, nicotine dependence, and depression Review of Resident #3's Resident Register revealed she was admitted to the facility on 08/26/25. Review of Resident #3's signed physician order sheet dated 01/22/26 revealed there was an order for Pregabalin 150mg administer three times daily (Pregabalin is used to treat nerve pain for diabetic neuropathy). Observation of the 8:00am medication pass on 02/10/26 from revealed Pregabalin 100mg was administered instead of 150mg. Review of Resident #3's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Pregabalin 150mg administer 3 times daily. -Pregabalin 150mg was documented as administered at 8:00am from 02/01/26 to 02/10/26. -Pregabalin 150mg was documented as administered at 2:00pm from 02/01/26 to 02/10/26. -Pregabalin 150mg was documented as administered at 8:00pm from 02/01/26 to 02/08/26. -Pregabalin 150mg was documented as resident out of building at 8:00pm on 02/09/26. Observation of Resident #3's medications on hand on 02/11/26 revealed: -There was a medication card that contained Pregablin100mg administer three times daily	{D 358}		

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{D 358}	Continued From page 70 labeled 1 of 2 that contained 26 capsules out of 28. -There was a medication card that contained Pregablin100mg administer three times daily labeled 2 of 2 that contained 21 out of 62. -There was no Pregabalin 150mg on the medication cart. Telephone interview with facility's contracted pharmacist on 02/11/26 at 3:18pm revealed: -There was an order for Resident #3 dated 11/25/25 for Resident #3's Pregabalin 100mg to be administered 3 times daily, 90 tablets were dispensed on 11/25/25 for a 30-day supply on multiple cards. -A facility staff member signed for Resident #3's Pregabalin 100mg on 11/26/25 at 4:32am. -There was a discontinue order for Resident #3's Pregabalin 100mg dated 12/05/25. -There was an order dated 12/05/25 for Resident #3's Pregabalin 150mg to be administered 3 times daily, 90 tablets were dispensed for a 30-day supply. -A facility staff member signed for the Pregabalin 150mg on 12/06/25 at 2:07am. -There was an order dated 01/02/26 for Pregabalin 150mg to be administered 3 times daily, 90 tablets were dispensed on 02/11/26 for Resident #3 for a 30-day supply. -A facility staff member signed for Resident #3's Pregabalin 150mg on 01/03/26 at 12:00am. Interview with Resident #3 on 02/11/26 at 4:15pm revealed: -She had uncontrolled phantom pain from the right above the knee amputation (AKA). -She knew that she had missed 2 doses of the Pregabalin today. -Her pain level on a pain scale from 0 to 10 with 10 being the worst pain was an 8 since missing	{D 358}		

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{D 358}	Continued From page 71 the Pregabalin. -Her pain was not controlled on Pregabalin 150mg and stayed on a pain scale of 6 to 7. -When her pain was a 6 to 7 on a pain scale she did not sleep well and her leg made jerking movements. -She had discussed with her PCP that her pain was not controlled on the Pregabalin 150mg. Interview with the medication aide (MA) on 02/11/26 at 12:15pm revealed: -She did not compare the eMAR to the medication card before administering the Pregabalin to Resident #3. -She was not sure why the eMAR had Pregabalin 150mg and the medication card contained Pregabalin 100mg. -She did not know the process she was supposed to follow when she made a medication error. Second interview with the MA on 02/12/26 at 11:00am revealed: -The Administrator had Resident #3's Pregabalin 100mg removed from the medication cart on 02/10/26. -Resident #3 missed three doses of Pregabalin on 02/11/26, 8:00am, 2:00pm, and 8:00pm. -Resident #3 was administered Pregabalin 150mg on 02/12/26 at 8:00am. -MAs did not have access to accept or enter orders in the eMARs only the Administrator and the Resident Care Director (RCD) had access to enter or discontinue orders. -When a medication was discontinued it was supposed to be removed from the medication cart. -She was not sure what happened to the medications once they were removed from the medication cart.	{D 358}		

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{D 358}	Continued From page 72 Interview with the Administrator on 02/13/26 at 4:00pm revealed: -She did not know why Resident #3's medication cards did not match the PCP orders. -She had the MA to remove the Pregabalin 100mg from the medication cart and ordered the Pregabalin 150mg on 02/10/26. f. Review of Resident #3's signed physician order sheet dated 01/22/26 revealed there was an order for Nicotine Patch 21mg/24 hour apply to skin every day as needed for smoking cessation and remove patch after 24 hours that was discontinued (Nicotine Patches are used as a smoking cessation aid). Observation of the medication pass on 02/10/26 revealed: -The medication aide (MA) applied a Nicotine Patch 21mg to Resident #3's left shoulder. -The MA did not remove a previously applied Nicotine Patch. Review of Resident #3's February 2026 eMAR revealed there was not an entry for Nicotine Patch 21mg/24hour apply one patch everyday as needed for smoking cessation. Interview with Resident #3 on 02/11/26 at 9:23am revealed: -She was on her way out to smoke. -She smoked about 3 cigarettes a day. -Her primary care provider (PCP) was not supposed to have discontinued the Nicotine Patch. -She still had the Nicotine Patch on from yesterday, 02/10/26. Interview with the MA on 02/11/26 at 2:00pm revealed:	{D 358}		

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{D 358}	Continued From page 73 -She did not review the eMAR prior to administering the Nicotine Patch to Resident #3. -She was supposed to scan the Nicotine Patch prior to administering. -She did not know that Resident #3's Nicotine Patch had been discontinued. -She did not know that Resident #3's Nicotine Patch was not on the eMAR. -She did not document that Resident #3's Nicotine Patch had been administered. Interview with the Administrator on 02/13/26 at 4:00pm revealed: -Resident #3's Nicotine Patch should not be on the medication cart once it was discontinued. -The Nicotine Patch should have been compared to the eMAR prior to administering. -All medications should be documented as administered. Telephone interview with the facility's contracted pharmacist on 02/11/26 at 3:18pm revealed: -There was not a current order for Resident #3's Nicotine Patch. -The pharmacy entered new medication orders or discontinued orders into the facility's eMAR. -The facility had to accept the orders for them to become active on the eMAR. Attempted telephone interview with Resident #4's PCP on 02/13/26 at 10:17am and 3:51pm was unsuccessful. g. Review of Resident #3's signed physician order sheet dated 01/28/26 revealed there was an order for Lispro 100unit/ml pen administer 20 units 30 minutes prior to each meal (Lispro is a rapid acting insulin to control high blood sugar and according to manufacturer's instructions, a 2-unit air shot is required before administration).	{D 358}		

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{D 358}	Continued From page 74 Observation of the medication pass on 02/10/26 revealed: -Lispro 20 units was administered in Resident #3's left posterior upper arm. -There was not a 2-unit air shot performed prior to Lispro 20 units being administered. Review of Resident #3's February 2026 eMAR revealed: -There was an order for Lispro 100unit/ml pen administer 20 units 30 minutes prior to each meal. -Lispro 20 units was documented as administered at 7:30am from 02/01/26 to 02/10/26. -Lispro 20 units was documented as administered at 11:30am from 02/01/26 to 02/10/26. -Lispro 20 units was documented as administered at 4:30pm from 02/01/26 to 02/09/26. Telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:20am revealed: -Facility staff should perform a 2-unit air shot prior to administering the medication. -The air shot made sure that the pen was working and ensured an accurate dose. Interview with the medication aide (MA) on 02/10/26 at 8:19am revealed: -She did not know she was supposed to perform an air shot before administering insulin. -She was never educated on performing a 2-unit air shot. -She did not know why you would perform an air shot. Interview with the Administrator on 02/13/26 at 4:00pm revealed: -She expected all medications to be administered as ordered.	{D 358}		

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{D 358}	Continued From page 75 -Staff were to perform a 2-unit air shot prior to administering insulin with a pen. -The air shot removed air bubbles, ensured accuracy of the dose, and lets staff know that the insulin pen was working. 2. Review of Resident #1's FL-2 dated 10/14/25 revealed: -Diagnoses included heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea. -Resident #1's was at a hospital and the requested level of care was Assisted Living Facility or Family Care Home. -Resident #1 weighed 310.1 lbs. -Resident #1 was listed as ambulatory. Review of the Resident Register for Resident #1 revealed: -He was admitted to the facility on 10/16/25. -He had a wheelchair -He had adequate memory -He required assistance with dressing, bathing, nail care, shaving, and ambulation. Review of triage information document from Resident #1's primary care provider (PCP) revealed: -All admits/re-admits must be called into triage for order verifications before sending to the pharmacy. -The facility representative was to call a triage number and reach the provider on call. -The facility representative should give the patient's name, diagnosis, brief history, allergies, and read off the medications. -The facility representative could call triage before the patient arrived with the discharge summary from the hospital or an FL-2.	{D 358}		

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{D 358}	Continued From page 76 a. Review of Resident #1's hospital discharge summary dated 01/19/26 revealed: -Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19. -Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower chambers are pumping too fast for a patient with atrial fibrillation.) -Resident #1 had a transthoracic echocardiogram on 01/9/2026 with ejection fraction 55-60%, abnormal septal motion consistent with intraventricular conduction delay (An ultrasound test showed preserved blood flow from the lower left heart chamber, and analysis of the heart's motion showed there was probably a delay in the electrical signal that travels between the lower heart chambers). -Cardiology was consulted, intravenous Diltiazem was initiated and he was eventually transitioned to oral Diltiazem (Diltiazem is a heart medication which can be used to treat high blood pressure and prevent chest pain. It can also be used acutely and chronically to treat some arrhythmias). -After treatment, Resident #1's heart rate remained within normal limits for the rest of his stay, but he stayed persistently in atrial flutter (atrial flutter is when the hearts upper chambers beat regularly but rapidly and may occur in patients whose atrial fibrillation was treated with medicines to treat arrhythmias). -Cardioversion was not recommended for Resident #1 given COVID-19 infection (A medical	{D 358}		

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{D 358}	Continued From page 77	{D 358}		

procedure to stop Resident #1's arrhythmia was not recommended because of his current infection).
-There was an order for Diltiazem 180mg capsule take one capsule daily.

Review of Resident #1's emergency department provider note dated 02/10/26 revealed:
-Resident #1 had heart failure and presented with fluid retention and shortness of breath.
-Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend.
-Resident #1 also experienced shortness of breath and occasional chest pain.
-Resident #1's hand had been swollen all weekend, and it hurt when he lowered it too much.
-Resident #1 had a history of a prior stroke with left-sided weakness.
-Resident #1 exhibited altered mental status and was noted to be unusually sleepy.
-The review of systems showed shortness of breath, chest pain and leg swelling.
-ECG compared with 01/08/26 was now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart).

Review of Resident #1's physician order form dated 02/13/26 revealed:
-There was an order to start Diltiazem 180 mg tablet once daily.
-Medication changes were to be sent to the back up pharmacy.

Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed there was not an entry for Diltiazem 180 mg.

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{D 358}	Continued From page 78 Review of Resident #1's February 2026 eMAR revealed there was not an entry for Diltiazem 180 mg. Observation of medications on hand on 02/11/26 at 5:07pm revealed there was no Diltiazem on hand for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed: -The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider. -The pharmacy received a medication list for Resident #1. -They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders. -The facility never responded with orders for the hospital discharge. -There were no orders at the pharmacy for Diltiazem for Resident #1. Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's primary care provider (PCP) about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary. -Diltiazem had not been administered as per the discharge summary from 01/19/26. -He and the new Administrator did not know they had the discharge summaries until today (02/13/26).	{D 358}		

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{D 358}	Continued From page 79 Interview with the Administrator on 02/13/26 at 3:59pm revealed Diltiazem needed to be correct because it was detrimental to Resident #1's health to give it incorrectly. Interview with Resident #1 on 02/10/26 at 8:21am revealed: -He felt fluid retention and told the staff to call 911 last night (02/09/26). -That was the first time that had happened. -He did not have medication for two or three weeks. -He also went to the hospital two or three weeks ago with COVID or Flu. -When he came back from the hospital medication issues started. -That had never happened before. -He stayed at the hospital overnight last night and they ran tests, performed a CT scan, and his labs were perfect. -They looked at his swollen hands and told him he had to take his Lasix (Lasix is medication used to remove excess fluid from the body). Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. b. Review of Resident #1's hospital discharge summary dated 01/19/26 revealed: -Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19. -Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower	{D 358}		

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{D 358}	Continued From page 80	{D 358}		

chambers are pumping too fast for a patient with atrial fibrillation.)
-Resident #1 had a transthoracic echocardiogram on 01/9/2026 with ejection fraction 55-60%, abnormal septal motion consistent with intraventricular conduction delay (An ultrasound test showed preserved blood flow from the lower left heart chamber, and analysis of the heart's motion showed there was probably a delay in the electrical signal that travels between the lower heart chambers).
-Cardiology was consulted and prescribed Carvedilol (Carvedilol is a heart medication that can be given to patients with heart failure, hypertension or certain arrhythmias).
-After treatment, Resident #1's heart rate remained within normal limits for the rest of his stay, but he stayed persistently in atrial flutter (atrial flutter is when the hearts upper chambers beat regularly but rapidly and may occur in patients whose atrial fibrillation was treated with medicines to treat arrhythmias).
-There was an order for Carvedilol 6.25mg tablet take one tablet twice a day.

Review of Resident #1's emergency department provider note dated 02/10/26 revealed:
-Resident #1 had heart failure and presented with fluid retention and shortness of breath.
-Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend.
-Resident #1 also experienced shortness of breath and occasional chest pain.
-Resident #1's hand had been swollen all weekend, and it hurt when he lowered it too much.
-Resident #1 had a history of a prior stroke with left-sided weakness.
-Resident #1 exhibited altered mental status and was noted to be unusually sleepy.

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{D 358}	Continued From page 81 -The review of systems showed shortness of breath, chest pain and leg swelling. -ECG compared with 01/08/26 was now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart). Review of Resident #1's physician order form dated 02/13/26 revealed: -There was an order to start Carvedilol 6.25 mg tablet twice a day. -Medication changes were to be sent to the back up pharmacy. Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed there was not an entry for Carvedilol. Review of Resident #1's February 2026 eMAR revealed there was not an entry for Carvedilol. Observation of medications on hand on 02/11/26 at 5:07pm revealed there was no Carvedilol on hand for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed: -The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider. -The pharmacy received a medication list for Resident #1. -They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders. -The facility never responded with orders for the hospital discharge. -There were no orders for Carvedilol for Resident	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 82 #1. Interview with Resident #1 on 02/10/26 at 8:21am revealed: -He felt fluid retention and told the staff to call 911 last night (02/09/26). -That was the first time that had happened. -He did not have medication for two or three weeks. -He also went to hospital two or three weeks ago with COVID or Flu. -When he came back from the hospital medication issues started. -That had never happened before. -He stayed at the hospital overnight last night and they ran tests, performed a CT scan, and his labs were perfect. -They looked at his swollen hands and told him he had to take his Lasix (Lasix is medication used to remove excess fluid from the body). Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's primary care provider (PCP) about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary. -Carvedilol had not been administered to Resident #1 as per the discharge summary from 01/19/26. -He and the new administrator did not know they had the discharge summaries until today (02/13/26). Interview with the Administrator on 02/13/26 at 3:59pm revealed Resident #1's Carvedilol needed to be correct because it was detrimental to	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 83 Resident #1's health to give it incorrectly. Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. c. Review of Resident #1's most recent FL-2 dated 10/14/25 revealed there was an order for Metoprolol Succinate 25 mg daily (Metoprolol is a heart medication that can be given to patients with heart failure, hypertension or certain arrhythmias). Review of Resident #1's physician order sheet dated 11/07/25 revealed there was an order for Metoprolol Succinate 25 mg once daily. Review of Resident #1's hospital discharge summary dated 01/19/26 revealed: -Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19. -Resident #1 presented with atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection (atrial fibrillation is when the heart's upper chambers beat irregularly, and rapid ventricular rate is when the heart's lower chambers are pumping too fast for a patient with atrial fibrillation.) -Resident #1 had a transthoracic echocardiogram on 01/9/2026 with ejection fraction 55-60%, abnormal septal motion consistent with intraventricular conduction delay (An ultrasound test showed preserved blood flow from the lower left heart chamber, and analysis of the heart's motion showed there was probably a delay in the electrical signal that travels between the lower heart chambers).	{D 358}		

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{D 358}	Continued From page 84 -There was an order to discontinue Metoprolol 25 mg. Review of Resident #1's emergency department provider note dated 02/10/26 revealed: -Resident #1 had heart failure and presented with fluid retention and shortness of breath. -Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend. -Resident #1 also experienced shortness of breath and occasional chest pain. -Resident #1 exhibited altered mental status and was noted to be unusually sleepy. -The review of systems showed shortness of breath, chest pain and leg swelling. -ECG compared with 01/08/26 was now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart). Review of Resident #1's physician order form dated 02/13/26 revealed there was an order to discontinue Metoprolol Succinate. Review of Resident #1's December 2025 electronic medication administration record eMAR revealed: -There was an entry for Metoprolol Succinate 25 mg take one tablet daily. -Metoprolol Succinate 25 mg was not administered on 12/13/25 and 12/14/25 with no reason for the exception. -Metoprolol Succinate 25 mg was not administered on 12/15/25 with reason listed that the medication was not available. Review of Resident #1's January 2026 eMAR revealed: -There was an entry for Metoprolol succinate	{D 358}		

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{D 358}	Continued From page 85 25mg take one tablet daily. -Metoprolol succinate 25mg was documented as administered on 01/20/26 to 01/22/26 and on 01/26/26 to 01/31/26. -Metoprolol Succinate was documented as not administered on 01/02/26 with reason that Resident #1 refused the medication. -Metoprolol Succinate was documented as not administered on 01/05/26 with reason that the medication was not available. Review of Resident #1's February 2026 eMAR revealed: -There was an entry for Metoprolol succinate 25mg take one tablet daily. -Metoprolol Succinate 25mg was documented as administered on 02/01/26 and on 02/03/26 to 02/11/26. -On 02/02/26 there was documentation that Resident #1's Metoprolol was not administered because the medication was not available and they were waiting for the pharmacy to deliver it. -On 02/12/26 there was documentation that Resident #1 "refused" his Metoprolol with further specification that the medication ran out and the facility would re-order it from the facility's contracted pharmacy. -On 02/13/26 there was documentation that Metoprolol 25mg was not administered because the medication was not available and they were waiting for the pharmacy to deliver it. Observation of Resident #1's medications on hand performed on 02/11/26 at 5:07pm revealed there was a card of Metoprolol succinate dispensed on 02/07/25 with 28 remaining of 30 dispensed. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at	{D 358}		

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{D 358}	Continued From page 86 10:15am revealed: -The pharmacy had orders for Resident #1's Metoprolol Succinate 25mg once daily dated 11/07/25. -Metoprolol Succinate was delivered in a quantity of 30 on 12/09/25, 01/04/26, and 02/04/26. -Metoprolol Succinate was delivered in a quantity of 27 on 11/11/25. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed: -The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider. -The pharmacy received a medication list for Resident #1. -They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders. -The facility never responded with orders for the hospital discharge. -There were active orders for Metoprolol for Resident #1. Interview with Resident #1 on 02/10/26 at 8:21am revealed: -He felt fluid retention and told the staff to call 911 last night (02/09/26). -That was the first time that had happened. -He did not have medication for two or three weeks. -He also went to hospital two or three weeks ago with COVID or Flu. -When he came back from the hospital medication issues started. -That had never happened before. -He stayed at the hospital overnight last night and they ran tests, performed a CT scan, and his labs were perfect.	{D 358}		

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{D 358}	Continued From page 87 -They looked at his swollen hands and told him he had to take his Lasix (Lasix is medication used to remove excess fluid from the body). Interview with Resident #1 on 02/13/26 at 8:59am revealed there was a stop of the Metoprolol when he had COVID. Interview with a medication aide (MA) on 02/10/26 at 11:04am revealed: -Resident #1's Metoprolol may have been getting mixed up with metformin and another medication that started with M. -The Metoprolol did run out, yesterday it was not here so it was on the medication re-order list. -When Resident #1's Metoprolol ran out he missed a pill, she could not say how many times. -Mixed up meant that staff were clicking on the eMAR that they gave the Metoprolol but it was not in the facility. Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's PCP about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary. -Metoprolol had not been discontinued as per the discharge summary from 01/19/26. -He and the new administrator did not know they had the discharge summaries until today (02/13/26). Interview with the Administrator on 02/13/26 at 3:59pm revealed Resident #1's Metoprolol needed to be correct because it was detrimental to Resident #1's health to give it incorrectly.	{D 358}		

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{D 358}	Continued From page 88 Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. d. Review of Resident #1's physician order form dated 11/13/25 revealed there was an order for Spironolactone 25mg take one tablet daily (Spironolactone is a medication that can be given to remove excess fluid from the body). Review of Resident #1's hospital discharge summary dated 01/19/26 revealed: -Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19. -Resident #1's weight on admission to the hospital was 329 lbs. -Resident #1's weight at the hospital was stable at about 313 to 314 lbs while taking Lasix 60 mg daily, but the dose had to be changed to protect his kidneys (Lasix is medication used to remove excess fluid from the body). -Resident #1's last weight at the hospital was 315 lbs and 0.6 oz. -There was an order to discontinue Spironolactone 25mg. Review of Resident #1's emergency department provider note dated 02/10/26 revealed: -Resident #1 had heart failure and presented with fluid retention and shortness of breath. -Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend. -Resident #1 also experienced shortness of breath and occasional chest pain. -Resident #1 exhibited altered mental status and was noted to be unusually sleepy. -The review of systems showed shortness of	{D 358}		

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{D 358}	Continued From page 89	{D 358}		

breath, chest pain and leg swelling.
-ECG compared with 01/08/26 was now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart).

Review of a physician order form for Resident #1 dated 02/13/26 revealed there was an order to discontinue Spironolactone.

Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Spironolactone 25mg take one tablet every day.
-Spironolactone was documented as administered daily on 01/20/26 to 01/31/26.

Review of Resident #1's February 2026 eMAR revealed:
-There was an entry for Spironolactone 25 mg take one tablet once daily.
-There was documentation that Spironolactone 25mg was administered daily on 02/01/26 to 02/12/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed:
-The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider.
-The pharmacy received a medication list for Resident #1.
-They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders.
-The facility never responded with orders for the hospital discharge.

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{D 358}	Continued From page 90 -There were active orders for Spironolactone. Interview with Resident #1 on 02/10/26 at 8:21am revealed: -He felt fluid retention and told the staff to call 911 last night (02/09/26). -That was the first time that had happened. -He did not have medication for two or three weeks. -He also went to hospital two or three weeks ago with COVID or Flu. -When he came back from the hospital medication issues started. -That had never happened before. -He stayed at the hospital overnight last night and they ran tests, performed a CT scan, and his labs were perfect. -They looked at his swollen hands and told him he had to take his Lasix (Lasix is medication used to remove excess fluid from the body). Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's PCP about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary. -He and the new administrator did not know they had the discharge summaries until today (02/13/26). Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. e. Review of Resident #1's hospital discharge summary dated 01/19/26 revealed:	{D 358}		

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{D 358}	Continued From page 91 -Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19. -Resident #1 presented with Atrial fibrillation with rapid ventricular rate in the emergency department, exacerbation likely secondary to COVID-19 infection. -Resident #1 had a change in his asthma medications. -Resident #1 was to follow up with Pulmonology. -There was an order for Arnuity Ellipta Inhaler 100mcg/actuation once daily (Arnuity Ellipta is an inhaler that can be used to treat chronic obstructive pulmonary disease (COPD) and asthma). Review of Resident #1's emergency department provider note dated 02/10/26 revealed: -Resident #1 had heart failure and presented with fluid retention and shortness of breath. -Resident #1 had experienced fluid retention in his legs, hand, and knee since the weekend. -Resident #1 also experienced shortness of breath and occasional chest pain. -Resident #1 exhibited altered mental status and was noted to be unusually sleepy. -The review of systems showed shortness of breath, chest pain and leg swelling. -ECG compared with 01/08/26 was now showing aberrant conduction (aberrant conduction is terminology that may be used to refer to rate-related change in conduction of electrical signal through the heart). Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed there was not an entry for Arnuity Ellipta. Review of Resident #1's February 2026 eMAR	{D 358}		

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{D 358}	Continued From page 92 revealed there was not an entry for Arnuity Ellipta. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed: -The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider. -The pharmacy received a medication list for Resident #1. -They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders. -The facility never responded with orders for the hospital discharge. -There were no orders for Arnuity Ellipta. Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's primary care provider (PCP) about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary. -He and the new administrator did not know they had the discharge summaries until today (02/13/26). Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. f. Review of Resident #1's FL-2 dated 10/14/25 revealed there was an order for Gabapentin 300mg nightly (Gabapentin is medication that can be given to treat seizures and nerve pain). Review of a physician order sheet for Resident #1	{D 358}		

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{D 358}	Continued From page 93 dated 11/07/25 revealed there was an order to continue Gabapentin 300mg nightly. Review of a hospital discharge summary dated 01/19/26 for Resident #1 revealed there was an order to continue Gabapentin 300mg nightly. Review of an electronically transmitted prescription document dated 02/03/26 revealed Resident #1 was prescribed Gabapentin 100mg take one tablet every morning. Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 300mg take one capsule at bedtime. -There was an entry for Gabapentin 100mg take one capsule every morning. -Gabapentin 100mg was documented as administered on 02/06/26 to 02/12/26. Observation of Resident #1's medications on hand performed on 02/11/26 at 5:07pm revealed: -There was a card of Gabapentin 300mg dispensed on 02/07/26 with 26 remaining of 30 dispensed. -The 300mg Gabapentin was a yellow capsule. -Gabapentin 100mg was not on the cart. Observation of medications on hand on 02/13/26 at 1:55pm revealed: -There was a card of Gabapentin 100mg dispensed on 02/11/26 with 23 remaining of 25 dispensed. -The 100mg Gabapentin was a white capsule. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 10:15am revealed:	{D 358}		

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{D 358}	Continued From page 94 -The pharmacy had an order for Gabapentin 100mg once daily in the morning dated 02/03/26 for Resident #1 and the pharmacy received the prescription on 02/04/26. -Gabapentin 100mg was first dispensed for Resident #1 on 02/11/26 in a quantity of 25. -There were no notes about why it was dispensed on 02/11/26. -She did not know what happened and the Gabapentin 100mg may have been overlooked. Second telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed Gabapentin 300mg was filled 02/04/26 in a quantity of 30 and 01/04/26 in a quantity of 30. Interview with Resident #1 on 02/13/26 at 8:59am revealed: -He thought Gabapentin 100mg in the morning started after his January COVID hospitalization, but he was not getting it until this morning when he received the first dose. -He yelled in pain and felt panic about the pain in his legs. -He felt pain from his legs being swollen when his legs touched the edge of the bed. -He was in so much pain he panicked; it was twelve out of ten pain, a burning, sharp, sticking pain. -The more he moved the more the pain would shoot up. -He told the MAs when he had pain. -He talked to the doctor about his pain. -When they gave him Tylenol or Gabapentin his pain would improve (Tylenol is medication that can be used to treat fever or pain). -He yelled in pain and staff would come. -His legs and feet would swell up when he did not get Lasix causing painful, aching, heavy legs.	{D 358}		

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{D 358}	Continued From page 95	{D 358}		

-He tried to walk but he used the wheelchair when his breathing was difficult.
-He spoke with the primary care provider (PCP) about his pain when they came to the facility, but he could not remember exactly when.

Interview with a medication aide (MA) on 02/10/26 at 11:04am revealed:
-Resident #1's morning Gabapentin was not in the facility so she was taking a capsule from his night supply and giving it in the morning.
-She read the label to make sure it was the right dose.
-She thought the yellow capsule was 300mg and she gave him the yellow one in the morning.
-She gave him 300mg in the morning and she thought 300mg was on the eMAR for morning administration.

Interview with a second MA on 02/13/26 at 12:20pm revealed sometimes she noticed that Gabapentin was not available in the morning for Resident #1.

Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful.

g. Review of Resident #1's physician order form dated 12/05/25 revealed there was an order for Chantix 0.5mg take one tablet once daily for three days, then take one tablet twice daily for four days, then start one tablet twice daily (Chantix is a medication given to help stop smoking. Most people start on a lower dose to get used to the medication).

Review of Resident #1's physician order form dated 12/19/25 revealed:
-There was clarification of an order for Chantix.

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{D 358}	Continued From page 96 -Resident #1 was to take Chantix 0.5mg one tablet daily for three days, then take one tablet twice daily for four days, then start Chantix 1mg tablet twice daily. Review of Resident #1's hospital discharge summary dated 01/19/26 revealed there was an order to continue Chantix 1mg twice daily Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Chantix 0.5mg take one tablet daily for 3 days scheduled at 8:00am. -There was an entry for Chantix 0.5mg take one tablet twice daily for 4 days scheduled at 8:00am and 8:00pm. -There was an entry for Chantix 0.5mg take one tablet two times a day "start 12/14" scheduled at 8:00am and 8:00pm. -There was an entry for Chantix 1mg take one tablet two times a day scheduled at 8:00am and 8:00pm. -There was documentation that Chantix 0.5mg was administered once on 12/07/25. -There was documentation that Chantix 0.5mg was not administered on 12/08/25 and 12/09/25 at 8:00pm with reason listed that the resident refused the medication. -There was documentation that Chantix 0.5mg was administered twice at 8:00am on 12/09/25. -There was documentation that Chantix 0.5mg was administered twice at 8:00am and once at 8:00pm on 12/10/25 to 12/13/25. -There was documentation that Chantix 0.5mg was administered once at 8:00am and once at 8:00pm on 12/14/25 to 12/20/25. -There was no documentation that Chantix was administered on 12/21/25. -There was documentation that Chantix 1mg	{D 358}		

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tablet was administered once at 8:00am and once at 8:00pm on 12/22/25 to 12/27/25 and on 12/29/25 to 12/31/25.
-There was documentation that Chantix 1mg tablet was administered once at 8:00pm on 12/27/25.
-There was documentation that Chantix 1mg tablet was not administered at 8:00am on 12/27/25 with no reason listed for the exception.

Observation of Resident #1's medications on hand performed on 02/11/26 at 5:07pm revealed there were cards of Chantix 1mg dispensed on 02/07/26 with 56 remaining of 60 dispensed.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 10:15am revealed:
-The pharmacy had a 12/05/25 order for Chantix that was clarified on 12/20/25 for Resident #1.
-They dispensed Chantix 0.5mg in a quantity of 11 on 12/06/25.
-On 12/16/25 Chantix 0.5mg was dispensed in a quantity of 42.
-On 12/20/25 Chantix 1mg was sent in a quantity of 36.
-There was a refill of Chantix 1mg on 01/02/26 in a quantity of 60.

Interview with a medication aide (MA) on 02/10/26 at 11:04am revealed:
-Resident #1 was asking for Chantix when he first got to the facility.
-A clarification was made regarding 0.5mg and 1 mg when both medications were on the eMAR at the same time.
-The 1mg and the 0.5mg were given together at some point when Resident #1 first got the facility and before his hospitalization in January.
-The primary care provider (PCP) told her that

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{D 358}	Continued From page 98 one of the eMAR entries had to be discontinued. Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. h. Review of a provider note dated 12/31/25 revealed there was an order to start Levocetirizine 5 mg tablet take 1 tablet once a day (Levocetirizine is medication used to control allergies). Review of a hospital discharge summary dated 01/19/26 for Resident #1 revealed there was an order to discontinue Levocetirizine 5mg. Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed: -There were two entries for Levocetirizine 5mg take one tablet once daily. -Levocetirizine was documented as administered once daily on 01/20/26 to 01/23/26 and on 01/25/26 to 01/31/26 Review of Resident #1's February 2026 eMAR revealed: -There were two entries for Levocetirizine 5mg take one tablet once daily. -Levocetirizine 5mg was documented as administered once daily on 02/01/26 to 02/12/26. Observation of Resident #1's medications on hand performed on 02/11/26 at 5:07pm revealed there was a card of Levocetirizine 5mg dispensed on 02/07/26 with 27 remaining of 30 doses dispensed. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at	{D 358}		

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3:10pm revealed:
-The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider.
-The pharmacy received a medication list for Resident #1.
-They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders.
-The facility never responded with orders for the hospital discharge.
-There were active orders for Levocetirizine for Resident #1.

Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed:
-They found the discharge summary today (02/13/26) and spoke with Resident #1's primary care provider (PCP) about reconciliation of medications from the discharge summary.
-The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January 2026 discharge summary.
-He and the new administrator did not know they had the discharge summaries until today (02/13/26).

Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful.

i. Review of a hospital discharge summary dated 01/19/26 for Resident #1 revealed:
-Resident #1 presented 01/08/26 with increasing cough, congestion, shortness of breath, and lower extremity swelling and was found to be positive for COVID-19.
-There was an order for Sodium Chloride 0.65% nasal spray, spray into each nostril three times daily (Sodium Chloride nasal spray can be used

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{D 358}	Continued From page 100 to treat nasal congestion). Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed there was not an entry for Sodium Chloride 0.65% spray. Review of Resident #1's February 2026 eMAR revealed there was not an entry for Sodium Chloride 0.65% spray. Observation of Resident #1's medications on hand performed on 02/11/26 at 5:07pm revealed there was no Sodium Chloride 0.65% spray on hand. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 3:10pm revealed: -The pharmacy could not use a medication list and needed an actual discharge summary signed off by the provider. -The pharmacy received a medication list for Resident #1. -They faxed a note to the facility on 01/19/26 at 2:27pm that said what was sent were not valid orders for Resident #1. -The facility never responded with orders for the hospital discharge. -There were no orders for Sodium Chloride spray for Resident #1. Interview with the Regional Director of Operations on 02/13/26 at 2:20pm revealed: -They found the discharge summary today (02/13/26) and spoke with Resident #1's primary care provider (PCP) about reconciliation of medications from the discharge summary. -The PCP did a telehealth visit today (02/13/26) and reconciled medications from the January	{D 358}		

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{D 358}	Continued From page 101 2026 discharge summary. -He and the new administrator did not know they had the discharge summaries until today (02/13/26). Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful. Interview with the primary care provider (PCP) for Resident #1 on 02/10/26 at 8:40am revealed: -She just started about two weeks ago. -Resident #1 had some neuropathy in his feet, but he did not mention missing medications (neuropathy is a condition which can cause sensory loss and pain). -Resident #1 was hospitalized last night with a chief complaint of generalized edema and swelling. -It was difficult to ensure things were happening in the facility. Interview with a medication aide (MA) on 02/13/26 at 12:20pm revealed: -She called and notified the pharmacy and wrote it down if medication needed to be ordered. -The facility would fax or call the pharmacy about medication. -She would usually write about medications in a book for the provider. Interview with the Administrator on 02/13/26 at 3:59pm revealed: -For medications that were discontinued the facility should fax the orders to the pharmacy and remove discontinued medications from the cart. -The designated person or Resident Care Director (RCD) would take discontinued medications off the cart immediately. -She asked the hospital to provide discharge	{D 358}		

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summaries or prescriptions before the resident arrived in the facility because she liked to make sure they had medications that were needed.
-It was important to review the hospital discharge summary.

Attempted interview with Resident #1's primary care provider (PCP) on 02/13/26 at 3:50pm was unsuccessful.

4. Review of Resident #2's current FL2 dated 01/19/26 revealed diagnoses included cognitive impairment, complicated urinary tract infection, acute kidney injury, chronic pain syndrome, paroxysmal atrial fibrillation, and uncontrolled type 2 diabetes.

Review of Resident #2's Resident Register revealed she was admitted to the facility on 10/10/25.

a. Review of Resident #2's hospital discharge summary dated 01/16/26 revealed there was an order for oxycodone 5mg administer 1 to 2 tablets every 8 hours as needed for moderate to severe pain for up to 5 days (oxycodone is used to treat moderate to severe pain).

Review of Resident #2's hospital discharge summary dated 01/28/26 revealed there was an order for oxycodone 5mg administer 1 tablet every 8 hours as needed for moderate pain or 2 tablets every 8 hours as needed for severe pain for up to 5 days.

Review of Resident #2's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone 5mg up to 2 tablets every 8 hours as needed for moderate to

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severe pain up to 5 days.
-The entry also included a message that the pharmacy needed a script to dispense.
-Oxycodone was not documented as administered in January 2026.
-There was no entry for oxycodone to match the 01/28/26 order.
- Oxycodone was not documented as administered in January 2026.

Review of Resident #2's February 2026 eMAR revealed:
-There was no entry for Oxycodone 5mg.
-Oxycodone 5mg was not documented as administered in February 2026.

Observation of Resident #2's medications on hand on 02/11/26 at 2:00pm revealed there was no Oxycodone 5mg on the medication cart for Resident #2.

Telephone interview with facility's contracted pharmacist on 02/11/26 at 3:18pm revealed:
-There was an order for Resident #2 dated 01/16/26 for oxycodone 5mg 1 to 2 tablets every 8 hours as needed for pain up to 5 days.
-The pharmacy never filled the order because they needed a prescription to dispense oxycodone.
-The pharmacy never received a prescription from the facility or primary care provider (PCP).
-Medications only appeared on the eMAR once a facility staff member approved the entry that the pharmacy created.
-The pharmacy never received the hospital discharge summary or an order to dispense oxycodone on 01/28/26 for Resident #2.

Interview with Resident #2 on 02/12/26 at 1:20pm revealed:

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{D 358}	Continued From page 104 -She had constant pain on the right side of her body from two previous strokes and in all joints from lupus. -Her pain was severe every day. -Her pain caused her to have nausea. -She did not know why it was so difficult to get pain medication and why she was made to suffer. -She remembered she was supposed to receive a 5-day order of oxycodone twice in January after going to the hospital and she never received it but she did ask for it. -Not getting her ordered pain medication made her feel like a fool and disrespected and showed that facility staff did not care about her needs. Interview with a medication aide (MA) on 02/13/26 at 9:30am revealed: -She believed Resident #2 was addicted to pain medication. -Resident #2 was asking for pain medication every 6 hours around the clock to match the current as needed oxycodone dose ordered on 02/10/26. -She did not know why the oxycodone 5mg ordered for Resident #2 twice in January was never dispensed and available. Interview with the Administrator on 02/12/26 at 10:47am revealed: -She did not know why Resident #2's oxycodone 5mg was never dispensed and not available for Resident #2 twice in January 2026. -Medications ordered on hospital discharge summaries should be ordered by the facility and available for residents. Second interview with the Administrator on 02/13/26 at 4:07pm revealed: -The MA or Administrator should have obtained a prescription for Resident #2's oxycodone the	{D 358}		

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{D 358}	Continued From page 105 same day she was discharged from the hospital to ensure the medication was available. -The MA or Administrator should have contacted the primary care provider (PCP) and reviewed any new orders received on a discharge summary from the hospital. Interview with one of Resident #2's PCPs on 02/12/26 at 1:50pm revealed: -Oxycodone was ordered by another PCP with the practice on 02/11/26 while the practice attempted to find a pain management clinic that would accept Resident #2. -A previous referral to pain management for Resident #2 was not accepted. -Resident #2 had no identifiable cause of pain. -The hospital always sent Resident #2 orders for several days of pain medication with no identifiable cause of pain. Interview with Resident #2's current PCP on 02/10/26 at 11:20am revealed: -She visited Resident #2 today, 02/10/26. -Resident #2 did not have regularly available pain medication and was suffering for no reason. -Resident #2 had a diagnosis of lupus that could be causing her pain. -She would expect the facility to contact her if a resident needed a prescription for the pharmacy to dispense a controlled substance. b. Review of Resident #2's signed physician order sheet dated 01/16/26 revealed there was an order for Nitroglycerin 0.4mg tablet dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain up to 3 doses and call 911 if no relief (Nitroglycerin is used to dilate the arteries in the heart to relieve chest pain and prevent heart attack).	{D 358}		

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{D 358}	Continued From page 106 Review of Resident #2's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Nitroglycerin 0.4mg tablet give 1 tablet as needed for chest pain every 5 minutes max 3 doses and call 911 if no relief. -Nitroglycerin 0.4mg tablet was not administered to Resident #2 in January. Review of Resident #2's February 2026 eMAR revealed: -There was an entry for Nitroglycerin 0.4mg tablet give 1 tablet as needed for chest pain every 5 minutes max 3 doses and call 911 if no relief. -Nitroglycerin 0.4mg tablet was not administered to Resident #2 in February. Observation of Resident #2's medications on hand on 02/11/26 at 2:00pm revealed there were no Nitroglycerin 0.4mg tablets available on the medication cart. Interview with Resident #2 on 02/12/26 at 1:20pm revealed: -She had 2 major cardiac surgeries in her past. -She experienced occasional chest pain but never asked facility staff for Nitroglycerin because facility staff did not believe her other reports of pain. -She stayed in bed and rested until her chest pain stopped. Interview with a pharmacist from the facility's contracted pharmacy on 02/12/26 at 11:32am revealed: -Resident #2's Nitroglycerin 0.4mg tablets were last dispensed on 12/15/25 in a quantity of 25 tablets. -Nitroglycerin was not on an automatic fill at the pharmacy and refills must be requested by a	{D 358}		

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{D 358}	Continued From page 107 facility staff member. Interview with a medication aide (MA) on 02/11/26 at 2:00pm revealed: -She could not locate Resident #2's Nitroglycerin 0.4mg tablets on the medication carts or in the medication room. -She did not know why there was no Nitroglycerin 0.4mg on hand at the facility. -Resident #2 had never complained of chest pain to her and she had never administered Nitroglycerin 0.4mg tablets to Resident #2. Interview with the Administrator on 02/12/26 at 10:47am revealed: -She did not know why Resident #2's Nitroglycerin 0.4mg tablets were not in the facility. -All medications ordered should be on hand in the facility and available for residents. -She did not know past auditing processes for the facility because it was her first week working at the facility. Second Interview with the Administrator on 02/13/26 at 4:07pm revealed: -She was very concerned that Nitroglycerin 0.4mg tablets were not available for Resident #2. -Resident #2 could have had chest pain that was unrelieved and a worst-case scenario of death because the Nitroglycerin 0.4mg tablets were not available. -MAs should have called and requested Nitroglycerin 0.4mg tablets from the pharmacy once it was no longer available. Interview with one of Resident #2's PCPs on 02/12/25 at 1:50pm revealed: -She did not know there were no Nitroglycerin 0.4mg tablets on hand at the facility for Resident #2.	{D 358}		

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{D 358}	Continued From page 108 -Resident #2 was at high risk for a heart attack and not having Nitroglycerin available could cause a heart attack leading to death. Refer to Tag 371 10A NCAC 13F Medication Administration .1004 (n). _____ The facility failed to ensure medications were administered as ordered for 2 of 5 residents (#1, #2) including Resident #1 who had a hospital admission on 01/08/26 to 01/19/26 resulted in inadequate control of Resident #1's congestive heart failure (CHF), chest pain, and kidney function and he returned to the emergency room on 02/10/26 with increased fluid retention, shortness of breath, and altered mental status, Diltiazem 180mg, Carvedilol 6.25mg, Arnuity Ellipta Inhaler, Gabapentin 100mg, Chantix 0.5mg were not administered as ordered for Resident #1 and Metoprolol Succinate 25mg and Spironolactone 25mgwere not discontinued as ordered.. A second resident went to the emergency department on 01/16/26 for chronic pain syndrome and was provided with a pain medication prescription that was not filled by the facility resulting in the resident having constant pain which was severe and caused her to have nausea. This failure resulted in serious neglect of the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 02/10/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED March 15, 2026.	{D 358}		

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{D 367}	Continued From page 109	{D 367}		
{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 medication administration records were accurate for 1 of 5 sampled residents (#1) including inaccurate documentation of a medication to relieve nerve pain and a medication to help with smoking cessation. The findings are:	{D 367}		

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{D 367}	Continued From page 110 Review of Resident #1's FL-2 dated 10/14/25 revealed diagnoses included heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, type II diabetes mellitus, history of TIA and stroke, and obstructive sleep apnea. Review of the Resident Register for Resident #1 revealed an admission date of 10/16/25. a. Review of Resident #1's primary care provider (PCP) order dated 02/03/26 an order for Gabapentin 100mg take one tablet every morning (Gabapentin is medication that can be given to treat seizures and nerve pain). Review of Resident #1's February 2026 eMAR revealed: -There was an entry for Gabapentin 100mg take one capsule every morning. -Gabapentin 100mg was documented as administered from 02/06/26 to 02/12/26. Observation of Resident #1's medications on hand on 02/11/26 at 5:07pm revealed: -Gabapentin 300mg was dispensed on 02/07/26 with 26 remaining of 30 dispensed. -The 300mg Gabapentin was a yellow capsule. -Gabapentin 100mg was not on the cart at this time. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 10:15am revealed: -The pharmacy had an order for Resident #1's Gabapentin 100mg once daily in the morning dated 02/03/26 which they received on 02/04/26. -Gabapentin 100mg was first dispensed on 02/11/26 for a quantity of 25. -There were no notes about why it was dispensed	{D 367}		

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{D 367}	Continued From page 111 on 02/11/26. -She did not know what happened and the Gabapentin 100mg may have been overlooked. Interview with Resident #1 on 02/13/26 at 8:59am revealed: -He thought Gabapentin 100mg in the morning started after his January 2026 hospitalization, but he was not getting it until this morning when he received the first dose. -He talked to the doctor about his pain. -When the staff gave him Tylenol or gabapentin his pain would improve (Tylenol is a medication that can be used to treat fever and pain). Interview with a medication aide (MA) on 02/10/26 at 11:04am revealed: -Resident #1's Gabapentin 100 mg was not in the facility so she was taking a capsule from his night supply and administering it in the morning. -She read the label to make sure it was the right dose. -She thought the yellow capsule was Gabapentin 300mg and administered the yellow capsule to Resident #1 in the morning. -She gave Resident #1 Gabapentin 300mg in the morning and she thought Gabapentin 300mg was on the MAR for morning administration. Interview with a second MA on 02/13/26 at 12:20pm revealed sometimes she noticed that Gabapentin 100mg was not available in the morning for Resident #1. Interview with the primary care provider (PCP) for Resident #1 on 02/10/26 at 10:09am revealed the facility made medication, MAR and medication pass errors. b. Review of a physician order sheet for Resident	{D 367}		

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{D 367}	Continued From page 112 #1 dated 12/05/25 revealed there was an order for Chantix 0.5mg take one tablet once daily for three days, then take one tablet twice daily for four days, then start one tablet twice daily (Chantix is a medication given to help stop smoking). Review of a physician order sheet for Resident #1 dated 12/19/25 revealed: -There was clarification of an order for Chantix. -Resident #1 was to take Chantix 0.5mg one tablet daily for three days, then take one tablet twice daily for four days, then start Chantix 1mg tablet twice daily. Review of a hospital discharge summary dated 01/19/26 for Resident #1 revealed There was an order to continue Chantix 1mg twice daily Review of Resident #1's December 2025 electronic medication administration record eMAR revealed: -There was an entry for Chantix 0.5mg take one tablet daily for 3 days scheduled at 8:00am. -There was an entry for Chantix 0.5mg take one tablet twice daily for 4 days scheduled at 8:00am and 8:00pm. -There was an entry for Chantix 0.5mg take one tablet two times a day "start 12/14" scheduled at 8:00am and 8:00pm. -There was an entry for Chantix 1mg take take one tablet two times a day scheduled at 8:00am and 8:00pm. -There was documentation that Chantix 0.5mg was administered once on 12/07/25. -There was documentation that was not administered on 12/08/25 and 12/09/25 at 8:00pm with reason listed that the resident refused the medication. -There was documentation that Chantix 0.5mg	{D 367}		

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{D 367}	Continued From page 113 was administered twice at 8:00am on 12/09/25. -There was documentation that Chantix 0.5mg was administered twice at 8:00am and once at 8:00pm from 12/10/25 through 12/13/25. -There was documentation that Chantix 0.5mg was administered once at 8:00am and once at 8:00pm from 12/14/25 through 12/20/25. -There was no documentation that Chantix was administered on 12/21/25. -There was documentation that Chantix 1mg tablet was administered once at 8:00am and once at 8:00pm from 12/22/25 through 12/27/25 and 12/29/25 through 12/31/25. -There was documentation that Chantix 1mg tablet was administered once at 8:00pm on 12/27/25. -There was documentation that Chantix 1mg tablet was not administered at 8:00am on 12/27/25 with no reason listed for the exception. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/26 at 10:15am revealed: -The pharmacy had a 12/05/25 order for Resident #1's Chantix that was clarified on 12/20/25 -They dispensed Chantix 0.5mg for a quantity of 11 on 12/06/25 for Resident #1. -On 12/16/25 Chantix 0.5mg was dispensed for a quantity of 42 for Resident #1. -On 12/20/25 Chantix 1mg was sent for a quantity of 36 for Resident #1. -There was a refill of Chantix 1mg on 01/02/26 for a quantity of 60 for Resident #1. Interview with a medication aide (MA) on 02/10/26 at 11:04am revealed: -Resident #1 was asking for Chantix when he was first admitted to the facility. -A clarification was made regarding Resident #1's Chantix 0.5mg and 1 mg when both medications	{D 367}		

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{D 367}	Continued From page 114 were on the MAR at the same time. -Chantix 1mg and Chantix 0.5mg were given together at some point when Resident #1 was admitted to the facility and before his hospitalization in January 2026. -The provider told her that one of the MAR entries for Chantix had to be discontinued. Interview with the primary care provider (PCP) for Resident #1 on 02/10/26 at 10:09am revealed the facility made medication, MAR and medication pass errors.	{D 367}		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that medications were administered to 2 of 2 sampled diabetic residents (#2, #4) in accordance with infection control measures related to administering another resident's insulin to these residents. The findings are:	D 371		

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D 371	Continued From page 115 Review of the facility's medication administration policy dated 01/20/26 revealed: -Medications must be available for administration as ordered. -If unavailable, staff must notify pharmacy immediately, notify nurse/Administrator, obtain emergency supply if needed, and document actions taken. -Medication administration procedures the staff follow the six rights, right resident, right medication, right dose, right time, and right documentation. -Required process hand hygiene prior to medication pass, prepare medications for one resident at a time, compare medication administration records (MAR) to label 3 times, use two resident identifiers, observe ingestion/application, and document immediately after administration. Review of the Centers for Disease Control (CDC) guidelines for insulin pen use revealed: -Each pen was designed to be safe for one patient to use multiple times with a new needle for each injection. -Pens should never be used for more than one patient because blood may be present in the pen after use. -If healthcare providers used insulin administration devices on more than one patient, equipment and supplies may become contaminated. -Unsafe practices during insulin administration contributed to the spread of hepatitis B virus, hepatitis C virus, HIV, and other infections (hepatitis B and C and HIV are bloodborne pathogens that cause infection). -Unsafe practices included using insulin pens for more than one person.	D 371		

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D 371	Continued From page 116 1. Review of Resident #2's current FL-2 dated 01/19/26 revealed: -Diagnoses included complicated urinary tract infection, acute kidney injury, chronic pain syndrome, paroxysmal atrial fibrillation, and uncontrolled type 2 diabetes mellitus. -There was an order for Lantus inject 15 units subcutaneously at bedtime (Lantus is used to lower blood suger levels to treat diabetes mellitus). Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 100unit/ml inject 15 units subcutaneously at bedtime. -Lantus 15 units was documented as administered at bedtime 02/01/26 to 02/10/26. Observation of Resident #2's medications on hand on 02/11/26 at 2:00pm revealed there was a Lantus insulin pen labeled for another resident on the cart in Resident #2's blood glucose supply bag with an open date of 02/10/26 on it (Lantus is used to treat diabetes type 2 by lowering blood glucose levels). Interview with the medication aide (MA) on 02/11/26 at 2:05pm revealed: -She did not realize the Lantus pen in Resident #2's glucose supplies was for a different resident. -She always applied a new needle to any insulin pen to administer insulin to residents. Telephone interview with the facility's contracted pharmacy on 02/12/26 at 11:32am revealed: -Lantus was last dispensed for Resident #2 on 10/10/25 and should have lasted for 125 days. -The supply dispensed should be close to running out.	D 371		

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D 371	Continued From page 117 Refer to telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:32am. Refer to interview with the facility's contracted pharmacist on 02/12/26 at 11:32am. Refer to interview with the Executive Director (ED) on 02/13/26 at 4:07pm. Refer to interview with the facility's primary care provider (PCP) on 02/12/26 at 1:50pm. 2. Review of Resident #4's current FL2 dated 07/30/25 revealed diagnoses included diabetes, depression, and schizoaffective disorder. Review of Resident #4's signed physician order sheet dated 01/16/26 revealed there was an order for Lantus 42 units administer twice daily (Lantus is a long-acting insulin used to improve blood sugar control). Observation of the medication pass on 02/10/26 at 8:18am to 8:44am revealed: -Lantus 42 units was administered in Resident #4's left posterior upper arm. -Lantus insulin pen was labeled with the name of another resident. Review of Resident #4's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 42 units administer twice daily at 8:00am and 8:00pm. -Lantus 42 units was documented as administered at 8:00am from 02/01/26 to 02/10/26. -Lantus 42 units was documented as administered at 8:00pm from 02/01/26 to	D 371		

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D 371	Continued From page 118	D 371		

02/08/26.
-Lantus 42 units was documented as not administered, Resident #4 refused at 8:00pm on 02/09/26.

Telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:20am revealed:
-Lantus 30 units was filled on 10/23/25 for resident #4, 1 box of 5 pens for a 50-day supply.
-Lantus 30 units was discontinued on 11/10/25.
-Lantus 35 units was filled on 11/10/25, 1 box of 5 pens.
-Lantus 35 units was discontinued on 01/03/26
-Lantus 42 units was filled on 01/03/26, 1 box of 5 pens for a 38-day supply.
-Resident #4 should be out of his Lantus based on dispensing records.

Interview with the medication aide (MA) on 02/10/26 at 8:19am revealed:
-She did not know why she used another resident's Lantus insulin pen to medicate Resident #4.
-She did not know why another resident's Lantus pen was in Resident #4's bag of insulin supplies.
-She did not look at the Lantus pen to identify what resident the pen belonged to.
-Resident #4 could have ran out and they used one of the other residents Lantus.
-Using another resident's Lantus pen could have caused a medical emergency by cross contamination.

Refer to telephone interview with the facility's contracted pharmacist on 02/12/26 at 11:32am.

Refer to interview with the Executive Director (ED) on 02/13/26 at 4:07pm.

Refer to telephone interview with the facility's

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D 371	Continued From page 119 primary care provider (PCP) on 02/12/26 at 1:50pm. _____ Interview with the facility's contracted pharmacist on 02/12/26 at 11:32am revealed Lantus was not automatically refilled and facility staff must request a refill from the pharmacy. Interview with the Executive Director (ED) on 02/13/26 at 4:07pm revealed: -Insulin pens should only be used on the resident the pen was ordered for. -MAs should have checked the insulin pen for the name of the resident prior to administration and confirm the name matches. -One of the MAs told her the previous ED instructed staff to utilize another resident's insulin pen when the medication needed a refill. -Using an insulin pen on multiple residents could cause harm by spreading infection from one resident to another. Interview with the facility's primary care provider (PCP) on 02/12/26 at 1:50pm revealed: -She was not notified by the facility that another resident's insulin pen was used on two other residents. -Sharing insulin pens was concerning because even with a new needle being utilized for each dose, infection could still spread from one resident to another. -She was not aware of any of the residents involved having a communicable disease, but she did not think that labs had been performed to screen for bloodborne pathogens on the residents involved and she would discuss with her supervisor and order those labs if indicated. _____ The facility failed to ensure infection control	D 371		

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D 371	Continued From page 120 guidelines were followed for administration of insulin pens by staff utilizing one resident's insulin for 2 other diabetic residents, placing the residents at risk for contracting a blood borne pathogen. 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 02/12/25. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 30, 2026.	D 371		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure medications were stored securely as evidenced by 2 medications carts that were left unlocked and unattended. The findings are: Review of the facility's medication administration policy dated 01/20/26 revealed:	D 378		

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D 378	Continued From page 121 -Medications are stored in locked carts/rooms. -Medication access is limited to authorized staff. -Controlled substances required double locked storage. Observation of the facility on 02/10/26 from 07:45am to 8:06am revealed: -Two medication carts were sitting in the main hallway and were unlocked and unattended by the medication aide (MA). -There were 4 residents waiting for their medications near the medication cart. -One resident was leaning on one of the medication carts. -Six other residents and 3 staff members walked by the medication carts. -The MA locked both medication carts when she returned to the carts at 8:06am. Interview with the MA on 02/10/26 at 8:06am revealed: -She forgot to lock the medication carts. -She knew that the medications carts should be locked when she was not administering medications. -Anyone could have removed medications from the medication carts. Observation of the facility on 02/11/26 from 5:00pm to 5:10pm revealed: -One of the two medication carts were unlocked and were sitting in the main hallway. -The MA and another staff member were walking down the hall towards the smoking area. -There were two residents in wheelchairs sitting beside the medication carts. -Four residents walked by the medication carts. -The MA returned to the medication cart at 5:10pm.	D 378		

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	HAL092233	A. BUILDING: _____ B. WING _____	R 02/13/2026

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D 378	Continued From page 122 Interview with the MA on 02/11/26 at 5:10pm revealed: -She forgot to lock the medication cart. -The medication cart was to be locked when she was not administering medications. -A resident or staff could have removed medications from the cart. Interview with the Administrator on 02/10/26 at 11:15am revealed: -The medication carts were supposed to be always locked when medications were not being administered. -Staff or residents could have removed medications from the carts. -Residents could have an allergic reaction or physical harm by ingesting another resident's medications. Interview with the Administrator on 02/13/26 at 4:00pm revealed: -The medication carts were stored in the main hallway beside the nurse's station. -This was a high traffic area for residents and staff. -The medication carts were supposed to be locked when not in use. -Anyone could have removed medications from the medication carts. -Resident could develop an allergic reaction, dizziness, nausea, and vomiting if they ingested something from the cart.	D 378		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available	D 433		

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D 433	Continued From page 123 for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by:	D 433		

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D 433	Continued From page 124 Based on interviews and record reviews, the facility failed to maintain records that were readily available for review for 5 of 5 sampled residents (Resident #1, # 2, #3, #4, and #5). The findings are: Review of the facility's license dated 01/01/26 revealed the facility was licensed for a capacity of 62. Review of the facility's census report on 02/10/26 revealed there were 40 residents living in the facility. Records for Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5 were requested on 02/10/26 at 10:00am. Interview with the Administrator on 02/10/26 at 10:00am revealed: -It was her second day working at the facility. -She did not have access to the computer system to print records, but she would get someone from the corporate office to assist her. Review of resident record documents provided on 02/10/26 at 11:20am revealed: -The facility provided Resident #2's FL-2, care plan, physician's orders, February electronic medication administration record (eMAR), and a hospital discharge summary. -The facility provided Resident #3's FL-2, care plan, physician's orders, and February eMAR. -The facility provided Resident #4's FL-2, care plan, physician's orders, and February eMAR. Records for Resident #2, Resident #3, and Resident #4's current medication orders were requested on 02/10/26 at 12:20pm.	D 433		

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D 433	Continued From page 125 Interview with the Administrator on 02/10/26 at 12:45pm revealed: -She still did not have access to log in to the computer system at the facility. -The records already provided were emailed to her by the corporate office and she printed them. -The printer was no longer working, and the Director of Operations had arrived at the facility and was attempting to get approval to buy a new printer. Interview with the Administrator on 02/10/26 at 2:45pm revealed needed records were still not being printed but a new printer had been purchased. Interview with the Administrator on 02/10/26 at 6:30pm revealed: -Only partial records had been received for Resident #2, Resident #3, and Resident #4. -No records had been provided for Resident #1 and Resident #5. -Requested records should be available for surveyor review by 7:30am on 02/11/26. No additional requested resident records were available upon entrance to the facility on 02/11/26 at 8:00am. Records for Resident #6 were requested on 02/11/26 at 10:20am. Review of resident record documents provided on 02/11/26 at 10:42am revealed: -The facility provided Resident #1's FL-2, TB test, care plan, physician's orders, January 2026 eMAR, and February 2026 eMAR. -The facility provided Resident #5's FL-2, TB test, care plan, physician's orders, January 2026	D 433		

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D 433	Continued From page 126 eMAR, and February 2026 eMAR. Review of resident records provided on 02/11/26 revealed medication orders and progress notes for Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5 were received at 2:35pm and 3:03pm. Interview with the Administrator on 02/12/26 at 8:30am revealed she was still unable to access the computer system but could provide the residents' paper records for review. Interview with the Administrator on 02/13/26 at 4:07pm revealed: -Paperwork at the facility was not organized. -There were stacks of papers in various offices and in the medication room at the facility she was sorting through to find the requested information. -She had to find and file many of the requested documents in the resident records. -The Administrator was responsible for resident records and ensuring they were available for review, but this was her first week in the role.	D 433		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training	D934		

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D934	Continued From page 127 program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff who administered medications to residents completed the state approved infection control training (Staff A, Staff B). The findings are: 1. Review of Staff A's personnel record on 02/13/26 revealed: -Staff A was hired on 02/03/26 as a medication aide (MA). -There was no documentation that Staff B completed the state approved mandatory annual in-service training on infection control, safe practice for injections, and glucose monitoring. -There was no documentation that she completed her medication clinical skills checklist. -There was no documentation that she completed her clinical skills. Review of a resident's February 2026 medication administration records (eMAR) revealed there was documentation that Staff A administered medications on 02/07/26. Attempted telephone interview on 02/13/26 at 12:30pm was unsuccessful. 2. Review of Staff B's personnel record on	D934		

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D934	Continued From page 128 02/13/26 revealed: -Staff B was hired on 08/14/25 as a MA. -There was no documentation that Staff B completed the state approved mandatory annual in-service training on infection control, safe practice for injections, and glucose monitoring. -There was no documentation that she completed her medication clinical skills checklist. -There was documentation that she completed her clinical skills on 08/14/25. Attempted telephone interview on 02/13/26 at 12:35pm was unsuccessful. Interview with the Executive Director (ED) on 02/13/26 at 4:00pm revealed: -She began working at the facility on 02/09/26. -She was only able to find parts of the requested staffs personnel records. -She knew that it was required to have the state approved infection control certificates. -She did not know who was responsible for maintaining the staff personnel records prior to her working at the facility. Refer to Tag 358 10A NCAC 13F Medication Administration .1004 (a), TYPE A1 VIOLATION. Refer to Tag 371 10A NCAC 13F Medication Administration .1004 (n), TYPE B VIOLATION.	D934		