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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 03/10/26 to 03/13/26.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 1 of 5 sampled residents (#3) who was not checked on for at least 5 hours and was subsequently found lying on the floor. The findings are: Review of Resident #3's FL-2 dated 01/28/25 revealed: -Diagnoses included chronic diastolic heart failure, chronic obstructive pulmonary disease (COPD), seizure disorder, diabetes mellitus type 2, and hypertension.	D 270		

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D 270	Continued From page 1 -She was intermittently confused. -She was semi-ambulatory. Review of Resident #3's Resident Register dated 01/24/25 revealed: -She required staff assistance with dressing, bathing, and skin care. -She required staff assistance with getting in and out of bed, ambulation, and toileting. Review of Resident #3's signed care plan dated 08/11/25 revealed: -She was independent with ambulation and transfers. -She was independent with bathing, dressing, grooming, and toileting. Review of Resident #3's Licensed Health Professional Support (LHPS) assessment dated 11/14/25 revealed: -Resident #3 was alert and oriented to person, place, and time. -Resident #3 required the assistance of 1 staff for transfers. -Resident #3 ambulated with the assistance of a wheelchair due to decreased endurance and required hands-on assistance for longer distances. Review of Resident #3's electronic progress notes dated 02/06/26 at 4:21am revealed: -The medication aide (MA) heard Resident #3 yelling for help from her room. -Resident #3 was found lying on the floor on her right side by the foot of her bed. -Resident #3 complained of right hip and leg pain. -Resident #3 was transported to the local emergency department (ED).	D 270		

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D 270	Continued From page 2 Review of Resident #3's incident report dated 02/06/26 revealed: -There was documentation that the incident occurred on 02/06/26, but the report was completed on 03/10/26 by the Special Care Unit Coordinator (SCC). -The MA found Resident #3 on the floor. -Resident #3 stated she fell. -Resident #3 was transferred to the ED. Review of Resident #5's Emergency Medical Services (EMS) report dated 02/06/26 revealed: -The EMS call was received at 3:44am. -Resident #3 was found sitting upright on the floor with caregivers present. -Resident #3's chief complaint was pain and soreness from a fall. -Resident #3's blood pressure was 182/100 at 4:09am and 151/56 at 4:13am. -Resident #3's pulse was 127 at 4:09am and 108 at 4:13am. -Resident #3 was alert and oriented with no loss of consciousness. -Resident #3 was transported to the local ED. Interview with Resident #3 on 03/13/26 at 8:45am revealed: -She was sitting in the recliner when her family member left the evening of 02/05/26. -She was not ready to go to bed when her family member left that evening. -She got up out of her chair to go to the bathroom, (she did not remember the time) and fell face first on the floor. -Her feet were at the recliner, and her head was at the foot of the bed. -She yelled for help, but no one came; "she laid on the floor all night".	D 270		

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D 270	Continued From page 3 -She tried to crawl to the door, but her right leg and knee were hurting and she could not move. -She was wet because she was incontinent with urine because she did not make it to the bathroom. -There was water on the floor; she tried to get out of it but she could not. -She was cold lying on the floor. -She tried to pull the comforter off the bed to cover up, but she was not strong enough to pull the comforter off the bed. -Finally, a MA heard her yelling and came into her room. -The MA placed towels on the floor to get the water up; she did not know if it was water or urine. -The MA and personal care aide (PCA) took the incontinent brief off, but could not get a dry brief on because she was still on the floor. -She was shaking so bad when EMS picked her up, the ambulance guy told her to hold still so he could take her blood pressure. -She was shaking because she was cold. Telephone interview with Resident #3's family member on 03/12/26 at 9:39am revealed: -She went to the facility on Tuesdays and Thursdays after she got off of work and stayed until Resident #3 received her medications at bedtime, which was between 8:00pm and 9:00pm. -She always turned the covers back on Resident #3's bed and she assisted Resident #3 to bed if she was ready to lay down before she left for the night. -On 02/05/26, Resident #3 was sitting in her recliner when they brought her bedtime medications and checked her fingerstick blood	D 270		

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D 270	Continued From page 4	D 270		

sugar (FSBS).
-She wrote the time of the FSBS check and the reading on a note pad in Resident #3's room, which was 8:34pm.
-Resident #3 was not ready to lay down when she left for the night on 02/05/26, so she stayed in the recliner.
-Early morning on 02/06/26, Resident #3's Power of Attorney (POA) called the family member and told her Resident #3 was on the floor and for her to go to the facility, since she lived closer.
-When she arrived, Resident #3 was still lying on the floor.
-Resident #3 stated she fell because her legs gave out; she yelled and yelled for help and could not get anyone.
-Resident #3's bed was the same as it was when she turned the covers back the night before she left, 02/05/26.
-The only difference was the comforter had been tugged or pulled on and there was more comforter hanging off one side of the bed than the other.
-Resident #3 stated she tried to pull the comforter off her bed to cover up with because she was cold, but she was not strong enough to pull the comforter off the bed.
-When the sitters were with Resident #3, the staff did not come in to check on Resident #3.
-Resident #3 had a sitter each day from 9:00am to 1:00pm and another sitter every night except Tuesday and Thursday, from 8:00pm to 8:00am,
-If Resident #3 needed something, the sitter would do it or the sitter would have to call for the staff.
-After Resident #3's fall on 02/05/26, she started spending the night with Resident #3 on Tuesday and Thursday nights.
-The PCAs did not come in and check on

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D 270	Continued From page 5 Resident #3 when she stayed over night. Second interview with Resident #3's family member on 03/13/26 at 8:45am revealed: -When she arrived the morning of 02/06/26, Resident #3 was still on the floor. -There were towels on the floor and she asked why the towels were on the floor. -She was told by the staff there was water on the floor; she did not know if it was water or urine. -Resident #3 was not wearing a brief and she asked the staff why. -She was told by the staff, she could not remember who, that Resident #3 was wet and they took the wet brief off and attempted to get another brief on, but they could not. Telephone interview with Resident #3's POA on 03/10/26 at 3:28pm revealed: -A family member visited Resident #3 every Tuesday and Thursday evening. -The family member would turn down Resident #3's bed each Tuesday and Thursday. -The family member would stay until Resident #3 had her bedtime medications. -On Thursday, 02/05/26, the family member wrote down the FSBS reading on a note pad in Resident #3's bedroom at 8:34pm, then she left. -When the family member left, Resident #3 was sitting in the recliner. -At 3:45am on 02/06/26, she received a telephone call from the MA that Resident #3 was found on the floor. -She could hear Resident #3 in the background of the telephone call saying, she had been on the floor all night, she was hurting, and she was cold. -She told the MA to call EMS and have her transported to the hospital. -The POA called the family member to go to the	D 270		

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facility because the family member lived closer to the facility than she did, and she met them at the ED.
-Resident #3 should be checked on every two hours because she had pain in her right leg and knee and it could give out on her when ambulating to the bathroom.
-Resident #3 had a sitter during third shift on Monday, Wednesday, Fridays, Saturday, and Sunday, but not on Tuesdays and Thursday.
-The staff knew which nights Resident #3 had sitters and the staff would not check on Resident #3.

Telephone interview with Resident #3's POA on 03/13/26 at 9:20am revealed:
-She tried to speak to someone in management about Resident #3 being found on the floor on 02/06/26 through calls and texts from 02/06/26 to 02/09/26.
-She received an email from the SCC on Monday, 02/09/26 regarding the incident.
-She wanted to see the incident report, but there was no incident report completed.
-The SCC stated she did not know what happened because there was no incident report.
-She spoke to the Administrator later that morning, who apologized for the incident.

Interview with a PCA on 03/12/26 at 3:55pm revealed:
-She worked second shift on 02/06/26 after Resident #3 returned from the ED.
-Resident #3 told her she fell and lay on the floor for a while; she yelled for someone to come help her, but no one came.
-Resident #3 said she was cold and her legs were hurting; she tried to pull the comforter off the bed, but she could not.

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D 270	Continued From page 7 -She made rounds every 2 hours on the residents she was assigned to, unless management told the staff to check on a resident more frequently. -Management told the staff to check residents every 2 hours; it had always been that way. -The PCAs did not document anywhere that rounds were made every two hours. -She was not given any instructions to increase checks on Resident #3 from management when Resident #3 returned from the hospital. -Some residents had sitters, but she still checked on the residents every 2 hours. -Some PCAs checked on residents with sitters every 2 hours and some did not. Telephone interview with a second PCA on 03/12/26 at 4:48pm revealed: -She worked third shift the morning Resident #3 was found on the floor. -There were two staff on third shift for the Assisted Living (AL) the night of 02/05/26. -She walked past Resident #3's door several times that night but did not hear Resident #3 yelling. -She was doing laundry when the MA found Resident #3 on the floor. -She did not go into Resident #3's room that night, 02/05/26 or morning of 02/06/26. -She always asked the MA if Resident #3 had a sitter, but she did not remember being told if Resident #3 had a sitter or not. -She assumed she had a sitter because she always had a sitter. -She did not go into residents' rooms who had sitters to check on the residents; the sitters would call the PCA if assistance was needed. -No one had told her not to go into residents' room who had sitters.	D 270		

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D 270	Continued From page 8 -She would go into the residents' room if the sitter needed assistance with the resident. Telephone interview with the second PCA on 03/13/26 at 5:45pm revealed: -She did not remember water being on Resident #3's bedroom floor when Resident #3 was found on the floor. -She and the MA removed the incontinence brief from Resident #3 because it was soiled, and attempted to put a clean incontinent brief on, but it was too difficult. -There was dried stool on the floor and she cleaned that up with wipes. Telephone interview with a MA on 03/11/26 at 4:08pm revealed: -She worked third shift on 02/05/26. -She and one PCA worked on the AL side of the facility. -She made rounds on the 100 and 200 halls, and the PCA made rounds on the 300 hall, where Resident #3's room was located. -She was returning from her break, around 3:30am, when she walked by Resident #3's closed bedroom door and heard someone yelling. -She found Resident #3 on the floor, her feet were next to her recliner, and her head was at the foot of the bed. -Resident #3 did not tell her what happened, just that she had been on the floor since yesterday. -Resident #3 complained of pain in her right leg and knee. -She sent Resident #3 to the ED. -She had not checked on Resident #3 that night; the PCA was responsible for rounds on the 300-hall.	D 270		

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D 270	Continued From page 9 Telephone interview with the same MA on 03/13/26 at 5:35pm revealed: -The PCA removed Resident #3's incontinence brief because she was wet. -The PCA could not get a clean incontinence brief on Resident #3 because she was still on the floor. -She did not remember there being water on the bedroom floor. -There was some dried stool that the PCA tried to get up; she may have used a towel. Interview with the SCC on 03/13/26 at 5:48pm revealed: -She was on call the morning when Resident #3 was found on her bedroom floor. -She was informed that Resident #3 was complaining of leg pain and was being sent to the ED. -She called the POA to inform her of Resident #3's fall and being sent to the ED. -She did not ask the staff what happened or if they had checked on Resident #3 during the night. -She did ask the MA if Resident #3's sitter was there and the MA responded no. -The staff knew to check on residents every 2 hours. -Rounds should be made by the staff every 2 hours unless there was documentation to check on a resident more frequently. -She expected the staff to check on residents every 2 hours unless otherwise documented. -Some residents had sitters, but the MAs and PCAs were still expected to check on the residents every 2 hours. Interview with the Administrator on 03/13/26 at 1:00pm and 5:50pm revealed:	D 270		

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D 270	Continued From page 10 -The PCAs did not have a certain time frame to check on the residents. -Rounds were made based on the residents' care plans. -According to Resident #3's care plan dated 08/11/25, Resident #3 was independent with transfers and ambulation and did not require assistance to the bathroom and to bed. -She thought Resident #3 had a sitter the night she fell. -She did not know the LHPS assessment from 11/14/25 stated Resident #3 needed one person for transfers and she maneuvered with the assistance of a wheelchair. -The PCA should have checked on Resident #3 the night she fell, 02/05/26. -The PCAs were still expected to check on residents even if they had a sitter unless the family and/or resident had requested to not be disturbed at night. Attempted interview with Resident #3's sitter on 03/13/26 at 9:04am was unsuccessful. Attempted interviews with a second MA on 03/11/26 at 12:15pm and 03/13/26 at 9:00am were unsuccessful. Attempted telephone interviews with Resident #3's Primary Care Provider (PCP) on 03/11/26 at 7:25am and 12:06pm, on 03/12/26 at 3:47pm, and on 03/13/26 at 8:26am were unsuccessful. _____ The facility failed to ensure supervision was provided according to the resident's assessed needs for a resident (#3) who was found on her bedroom floor. The resident had been on the floor for at least 5 hours without staff checking on her, resulting in the resident being cold, shaking,	D 270		

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D 270	Continued From page 11 incontinent of urine, and unable to move related to pain in her right leg. This failure resulted in serious physical harm, pain, and neglect which constitutes an A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/13/26. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 12, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#1) related to elevated fingerstick blood sugar (FSBS) readings not reported to the Primary Care Provider (PCP). The findings are: Review of the undated policy for residents receiving diabetic medications and treatments revealed the Resident Care Coordinator (RCC) should review for any refusals and /or abnormal blood sugar readings and notify the primary care provider (PCP) and document the notification in the resident's record. Review of Resident #1's current FL-2 dated	D 273		

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D 273	Continued From page 12 02/02/26 revealed diagnoses included diabetes, hypertension, and hyperlipidemia. Review of Resident #1's laboratory report dated 01/20/26 revealed: -He had a glucose of 437 (normal range was 70-99). -He had blood urea nitrogen (BUN) of 69 (the BUN measures the amount of nitrogen in the blood that comes from urea, a waste product produced in the liver, to evaluate kidney function and hydration status. A normal BUN level for adults is typically 7-20) -He had a HbA1C of 11.1% (the hemoglobin A1C determines the average level of blood sugar over the past 2 to 3 months. According to the American Diabetes Association, a HbA1C value less than 7.0 is a goal for diabetic residents, with the normal range for HbA1C being 4 to 5.9). Review of Resident #1's incident report dated 01/21/26 revealed a note the PCP wanted to send Resident #1 to the emergency department (ED) due to an abnormal lab report and concern with diabetic ketoacidosis (a life-threatening, emergency metabolic state characterized by extremely high levels of blood acids knwn as ketones and high blood sugar). Review of Resident #1's hospital discharge summary dated 01/23/26 revealed: -Resident #1 was seen at 11:15 p.m. on 01/21/26 after he presented to the ED from his assisted living facility with complaints of elevated blood glucose. -His blood glucose readings over the last several days had been 300-400. -Previously, he had been managed on metformin "for 25 years".	D 273		

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D 273	Continued From page 13 -His acute kidney injury was most likely secondary to intravascular volume depletion from hyperglycemia. -He was diagnosed with acidosis (a condition characterized by an excess of acid in body fluids, resulting in a blood pH below 7.35) and hyponatremia (a condition where sodium levels in the blood are too low, often caused by excess water retention relative to salt). -His hyponatremia was most likely secondary to hyperglycemia. Review of Resident #1's PCP's after-visit summary date 02/02/26 revealed there was an order for Humalog (a rapid-acting insulin used to manage blood sugar) KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units and call the PCP. Review of Resident #1's February 2026 electronic medication administration record (eMAR) from 02/02/26-02/28/26 revealed: -There was an entry for for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Resident #1's FSBS readings were greater than 401 on 9 occasions from 02/02/26-02/28/26. -There was no documentation on the eMAR the	D 273		

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D 273	Continued From page 14 PCP was notified for 6 of the 9 elevated FSBS. Review of Resident #1's March 2026 eMAR from 03/01/26-03/12/26 revealed: -There was an entry for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 =6 units; 301- 350 = 8 units; 351- 400 = 10 units; 401 - 600 = 12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Resident #1's FSBS readings were greater than 401 on 2 occasions from 03/01/26-03/09/26. -There was no documentation on the eMAR the PCP was notified for 1 of the 2 elevated FSBS. Review of Resident #1's electronic progress notes revealed there was no documentation the PCP was notified of 7 of 11 FSBS readings greater than 401 from 02/01/26-02/28/26 and 03/01/26-03/09/26. Telephone interview with a representative from the PCP's office on 03/12/26 at 10:32am revealed there was no electronic notification in the telemed system (the PCP's electronic medical record) or documented telephone calls for FSBS greater than 401 for Resident #1 in February or March. Interview with a medication aide (MA) on 03/12/26 at 2:40pm revealed: -She could not recall if Resident #1's FSBS parameter was to notify the PCP for a FSBS over 400 or over 450. -When a FSBS was outside the parameter, the	D 273		

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D 273	Continued From page 15	D 273		

PCP was notified through telemed, and it would also be documented in a progress note.
-If she did not notify the PCP of a FSBS outside the parameter, it would be because there were a lot of things going on during the medication pass, and she forgot.

Interview with a second MA on 03/12/26 at 3:14pm revealed:
-She had never had to call Resident #1's PCP about an elevated FSBS.
-She did not know what Resident #1's FSBS parameters were and would have to read the SSI order.

Telephone interview with a third MA on 03/13/26 at 9:10am revealed:
-She had notified Resident #1's PCP once when his FSBS was 423.
-She sent the PCP a message in telemed.
-The PCP responded back and asked her if she had administered the correct dosage of insulin, and she said yes.
-Resident #1's FSBS had only been outside the parameter that one time.

Interview with a fourth MA on 03/13/26 at 7:09pm revealed:
-She had to notify the PCP once when Resident #1's FSBS was outside the parameter.
-She would have documented the call in a progress note.
-High FSBS were sent to the PCP through telemed; she did not know why telemed did not have her notification documented.

Interview with the RCC on 03/13/26 at 3:55pm revealed:
-She expected the MA to reach out to the PCP,

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D 273	Continued From page 16 follow the directions from the PCP, and follow up with the resident when Resident #1's FSBS was outside of the parameter. -She was concerned Resident #1 had high FSBS and did not get directions from the PCP on how to address. -Resident #1 could have experienced issues. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected the MAs to follow the order and call the PCP and document in the progress note that the PCP was called. -She was concerned the PCP was not called because the resident may have missed a treatment the PCP would have had the MA do for the resident. Telephone interview with a triage nurse practitioner with Resident #1's PCP on 03/12/26 at 1:29pm revealed if there was an order to call the PCP for a FSBS greater than 401-600, then she expected the PCP to be called.	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.	D 276		

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D 276	Continued From page 17 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physicians' orders were implemented for 3 of 5 sampled residents (#1, #2 and #3) related to an order for fingerstick blood sugar (FSBS) checks (#1, #2) and an order to monitor vital signs (VS) daily for 7 days (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/02/25 revealed there was a diagnosis of diabetes mellitus type 2. Review of Resident #2's signed physician's orders dated 09/12/25 revealed there was an order to obtain fingerstick blood sugar (FSBS) checks every morning. Review of Resident #2's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS daily with a scheduled time of 9:00am. -There was documentation the FSBS was checked 25 of 31 opportunities from 01/01/26 to 01/31/26. Review of Resident #2's February 2026 eMAR revealed: -There was an entry to check FSBS daily with a scheduled time of 9:00am from 02/01/26 to 02/04/26. -There was a second entry to check FSBS daily with a scheduled time of 7:30am from 02/05/26 to 02/28/26. -There was documentation the FSBS was checked 24 of 28 opportunities from 02/01/26 to 02/28/26.	D 276		

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D 276	Continued From page 18 Review of Resident #2's March 2026 eMAR from 03/01/26 to 03/10/26 revealed: -There was an entry to check FSBS daily with a scheduled time of 7:30am. -There was documentation the FSBS was checked 6 of 10 opportunities from 03/01/26 to 03/10/26. Interview with Resident #2 on 03/10/26 at 8:15am revealed: -Her biggest problem was getting her FSBS checked as ordered. -Her FSBS checks were ordered every morning. -The medication aides (MA) used to check her FSBS at 6:00am every morning. -The past several months, her FSBS were checked later in the morning, if they were checked at all. -Her FSBS had not been checked that morning, and she had requested that her FSBS be checked before she ate breakfast. -She mentioned it to the MA earlier that morning; the MA said she would be right back and check it and that was over an hour ago. Second interview with Resident #2 on 03/10/26 at 12:29pm revealed her FSBS had not been checked that day, 03/10/26. Interview with a MA on 03/12/26 at 2:42pm revealed: -She did not check Resident #2's FSBS. -There was no entry on the eMAR to check Resident #2's FSBS on first shift. -She thought Resident #2's FSBS was checked on third shift. -She did not know Resident #2's FSBS was scheduled for 7:30am each morning.	D 276		

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D 276	Continued From page 19 -She had not seen the entry for FSBS checks each morning at 7:30am pop up on the eMAR. -She did not know how the other MAs knew to check Resident #2's FSBS each morning since it did not pop up on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/13/26 at 9:55am revealed: -Resident #2's FSBS order should pop up on the eMAR. -She did not understand how other MAs were seeing the order and one MA did not see the order to check Resident #2's FSBS each morning. -The MA needed to read all orders carefully to ensure the FSBS was checked each morning. -The MA should have questioned why Resident #2 was requesting her FSBS check to be done each morning, even if she did not see an order. Interview with the Special Care unit Coordinator (SCC) on 03/13/26 at 5:48pm revealed: -Resident #2's FSBS checks were on the eMAR. -The other MAs saw the entry and checked Resident #2's FSBS. -She did not know why the one MA did not see the entry and check Resident #2's FSBS. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected Resident #2's FSBS checks to be done every morning as ordered. -If the MA could not see it on the eMAR, but Resident #2 was asking about her FSBS, the MA should have followed up on the request with the RCC. Attempted telephone interviews with Resident #2's PCP on 03/11/26 at 4:43pm and 03/12/26 at	D 276		

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D 276	Continued From page 20 11:22am were unsuccessful. 2. Review of Resident #3's FL-2 dated 01/28/25 revealed: -Diagnoses included chronic diastolic heart failure, chronic obstructive pulmonary disease (COPD), seizure disorder, diabetes mellitus type 2, and hypertension. -She was intermittently confused. -She was semi-ambulatory. Review of Resident #3's signed physicians' orders dated 01/15/26 revealed there was an order to monitor VS daily for 7 days; notify the Primary Care Provider (PCP) if systolic blood pressure (BP) was greater than 180 or less than 90; heart rate (HR) was greater than 110 or less than 60; or temperature was greater than 102 degrees F. Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for monthly VS on the 15th of each month. -There was no documentation that VS were checked on 01/15/26. -There was no entry for VS for 7 days with parameters dated 01/15/26. -There was no documentation VS were checked for 7 days starting 01/15/26. Interview with Resident #3 on 03/13/26 at 8:45am revealed: -She thought the staff checked her VS once a month. -She did not remember the staff checking her VS every day for a week in January 2026. -She did not remember having any problems with	D 276		

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D 276	Continued From page 21 her BP, HR, or temperature. Telephone interview with a representative from the facility's contracted pharmacy on 03/11/26 at 10:05am revealed: -The pharmacy did not have an order dated 01/15/26 to check Resident #3's vitals signs for 7 days. -The pharmacy did not enter orders for VS into the eMAR; the facility was responsible for entering VS into the eMAR. Interview with a medication aide (MA) on 03/12/26 at 2:42pm revealed: -The Resident Care Coordinator (RCC) and the Special Care Unit Coordinator (SCC) were responsible for entering orders for VS on the eMAR. -Once the order was entered and verified by the RCC or SCC, then the MA could see the order. -She did not remember Resident #3 having orders for daily VS for 7 days in January 2026. Interview with the RCC on 03/13/26 at 9:55am revealed: -The after-visit summaries were reviewed by the RCC and/or the SCC for new orders. -New orders for VS would be entered into the eMAR by the RCC or the SCC. -Once the order was verified by the RCC or the SCC, the MAs would see the order on the eMAR to obtain VS as ordered. -She did not know why Resident #3's PCP ordered VS checks daily for a week in January 2026 or why the order was not entered onto the eMAR. Interview with the SCC on 03/13/26 at 5:48pm revealed:	D 276		

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D 276	Continued From page 22 -She thought the pharmacy was responsible for entering VS into the eMAR, until yesterday, 03/12/26, when she was informed that she and the RCC were responsible. -There was no RCC in the facility in January 2026 and she was covering the Assisted Living (AL) and the Special Care Unit (SCU). -She did not enter the order for daily VS into Resident #3's eMAR. -She did not know entering VS on the eMAR was her responsibility. -She did not know why the PCP wanted Resident #3's VS checked daily for one week. -The order was on an after-visit summary which she printed and faxed to the pharmacy . Interview with the Administrator on 03/13/26 at 5:50pm revealed: -The RCC and SCC were responsible for reviewing the after-visit summary. -The RCC and SCC were responsible for entering VS into the eMAR. -She expected all VS orders to be entered and verified by the RCC and SCC. Attempted telephone interviews with Resident #3's PCP on 03/11/26 at 7:25am and 12:06pm, on 03/12/26 at 3:47pm, and on 03/13/26 at 8:26am were unsuccessful. 3. Review of Resident #1's current FL-2 dated 02/02/26 revealed diagnoses included diabetes, hypertension, and hyperlipidemia. Review of Resident #1's primary care provider's (PCP's) after-visit summary date 02/02/26 revealed there was an order for Humalog KwikPen (U-100) Insulin 100 unit/mL	D 276		

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D 276	Continued From page 23 subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0-150=0 units; 151-200=2 units; 201-250=4 units; 251-300 =6 units; 301-350= 8 units; 351-400=10 units; 401 600=12 units and call the PCP. Review of Resident #1's February 2026 eMAR from 02/02/26-02/28/26 revealed: -There was an entry for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0-150=0 units; 151-200=2 units; 201-250=4 units; 251-300 =6 units; 301-350= 8 units; 351-400=10 units; 401 600=12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #1's FSBS was checked at 8:00am, 2:00pm, and 8:00pm. -There was a second entry to check Resident #1's FSBS daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm; the entry did not include the SSI. -The FSBS readings for 7:00am and 8:00am were the same; the FSBS readings for 12:00pm and 2:00pm were the same. Review of Resident #1's March 2026 eMAR from 03/01/26-03/12/26 revealed: -There was an entry for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0-150=0 units; 151-200=2 units; 201-250=4 units; 251-300 =6 units; 301-350= 8 units; 351-400=10 units; 401 600=12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Resident #1's	D 276		

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D 276	Continued From page 24 FSBS was checked at 8:00am, 2:00pm, and 8:00pm,. -There was a second entry to check Resident #1's FSBS daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm; the entry did not include the SSI. -The FSBS readings for 7:00am and 8:00am were the same; the FSBS readings for 12:00pm and 2:00pm were the same. -Resident #1's FSBS ranged from 117-434. -Resident #1's FSBS at 8:00am were documented as greater than 300 on 11 of 13 opportunities. Observation of Resident #1 on 03/11/26 at 8:46am revealed he was sitting in the dining room and had finished eating his breakfast. Interview with Resident #1 on 03/11/26 at 8:46am revealed the medication aide (MA) had not checked his FSBS today, 03/11/26. Interview with Resident #1 on 03/12/26 at 4:01pm revealed he had breakfast between 7:30am-8:00am and his FSBS was usually checked after he had eaten breakfast. Review of Resident #1's daily journal from 02/06/26-03/11/26 revealed: -The journal was kept on a table by his chair. -He documented the date, usually the time, and the results of his FSBS, and at times the word insulin was documented. -Examples of his morning FSBS checks included times of 9:00am, 9:30am, and 10:00am. Review of the facility's vital signs history form for Resident #1 compared to the eMAR from 02/06/26-03/11/26 revealed:	D 276		

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D 276	Continued From page 25 -The morning FSBS readings were documented on the eMAR as completed during the 8:00am medication pass. -The same FSBS readings that were documented on the eMAR were also documented on the vital signs history form, but at various times including on 03/01/26 at 10:29am, on 03/06/26 at 10:06am, and on 03/11/26 at 9:45am. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #1's current order was for FSBS before meals and to administer Humalog as needed based on the FSBS readings. -Once Resident #1 ate, his FSBS readings were going to increase. -Resident #1's FSBS should be checked before he ate to see if his FSBS needed to be corrected by administering SSI. -If Resident #1's FSBS was not checked until after he ate, then essentially, "you are chasing the FSBS". Confidential interview with a staff member revealed Resident #1's FSBS were done later in the morning because there was one MA and a lot of residents with orders to check FSBS, and it was impossible to get it all done first thing in the morning. Interview with a MA on 03/13/26 at 12:00pm revealed: -She knew Resident #1's order was to check his FSBS before he ate. -Resident #1 would be in the dining room eating, and she did not like to bother him. -She tried to catch Resident #1 before he started	D 276		

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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 276	Continued From page 26 eating to check his FSBS. Interview with the Resident Care Coordinator (RCC) on 03/13/26 at 11:29am revealed: -She expected FSBS to be done before breakfast. -She had told the MAs to check FSBS first thing in the morning. -Resident #1's FSBS would need to be checked before meals to know how much SSI to administer. -"You cannot mess around with FSBS; it was very important to check FSBS before meals." Interview with the Administrator on 03/13/26 at 5:50pm revealed she expected Resident #1's FSBS to be checked before meals as ordered. Telephone interview with a triage nurse practitioner from Resident #1's PCP's office on 03/12/26 at 1:29pm revealed: -For Resident #1's FSBS to be most accurate, his FSBS should have been checked before meals as ordered and provided SSI coverage based on that reading. -If Resident #1's FSBS was not checked before meals, it would cause the SSI coverage to be more insulin than he probably needed.	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;	D 358		

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D 358	Continued From page 27 and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 residents (#1, #3, #4, #6) including medications used to treat diabetes (#1); a pain medication and a seizure medication (#3); a muscle relaxer (#4); and a medication for nerve pain (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 08/25/25 revealed: -Diagnoses included malignant neoplasm of the rectum. -There was an order for pregabalin (used to treat neuropathic pain) 75mg, take 3 capsules twice daily; there was documentation to please reorder 3 business days ahead of the medication running out. Review of Resident #6's incident report dated 03/11/26 at 3:45am revealed: Resident #6 came out into the hallway at 3:40am and stated she could not breathe and had called emergency medical services (EMS). -EMS arrived, and Resident #6's oxygen level was 98%. -EMS staff asked if she wanted to go to the emergency department (ED), and she stated yes. Review of Resident #6's EMS report dated 03/11/26 at 3:42am revealed:	D 358		

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D 358	Continued From page 28 -Resident #6 complained of breathing problems. -She reported she woke up feeling nervous, having cold sweats, and just not feeling well. -Resident #6's blood pressure (BP) was 177/80, and heart rate was 113. Review of Resident #6's hospital discharge summary dated 03/11/26 revealed she was seen in the ED for generalized weakness. Review of Resident #6's hospice nurse's after-visit summary dated 03/10/26 from 8:41am-9:29am revealed: -Resident #6 was alert and oriented with no acute distress. -Resident #6 denied pain and reported her current pain regimen was effective. -The medication aide (MA) requested a refill for Resident #6's pregabalin, which was completed through the e-prescribe program. Review of Resident #6's hospice nurse's after-visit summary dated 03/12/26 from 12:17am-12:47am revealed: -Resident #6 reported she had an acute change in condition the previous night. -Resident #6 reported she woke up with clammy skin, a headache, and overall, not feeling so good. -The resident reported she was unable to get any assistance from the facility staff and called 911 herself and was transported to the ED. Review of Resident #6's March 2026 electronic medication administration record (eMAR) from 03/01/26-03/11/26 revealed: -There was an electronic entry for pregabalin 75mg, take 3 tablets twice daily, scheduled at 8:00am and 8:00pm.	D 358		

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D 358	Continued From page 29 -There was documentation to order the medication 3 business days ahead of the medication running out. -Pregabalin was documented as administered at 8:00pm on 03/09/26. -On 03/10/26 at 8:00am, pregabalin was not documented as administered,; the exception was drug not available. -On 03/10/26 at 8:00pm, pregabalin was not documented as administered; there was no exception documented. -On 03/11/26 at 8:00am, pregabalin was not documented as administered; the exception was of out of facility. Review of Resident #6's controlled substance count sheet (CSCS) revealed there was no pregabalin documented as administered on 03/10/26 at 8:00am or 8:00pm. Review of the manufacturer's information for pregabalin revealed: -Withdraw pregabalin gradually to minimize the potential of increased seizure frequency in patients with seizure disorders. -Following abrupt or rapid discontinuation of pregabalin, reported symptoms including insomnia, nausea, headache, anxiety, hyperhidrosis (excessive sweating), and diarrhea had been reported. Observation of Resident #6's medications on hand on 03/11/26 at 4:57pm revealed: -There were two punch cards of 42 tablets of pregabalin dispensed on 03/10/26; a total of 84 tablets. -There were 10 tablets in the blue column (the blue column on a punch card indicated the point the medication refill should be re-ordered).	D 358		

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D 358	Continued From page 30 Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/13/26 at 11:09am revealed: -A new prescription for Resident #6's pregabalin was received on 03/10/26, and the prescription was filled for a 14-day supply, 84 tablets. -Resident #6's pregabalin was delivered to the facility on 03/11/26 at 4:57am. -Resident #6's pregabalin was dispensed on 02/04/26 and 02/22/26 with each fill for 84 tablets, which was a 14-day supply. -Resident #6's pregabalin could be reordered 3 days ahead of time. -If a MA requested a medication be reordered on the computer, it would be documented, but there was no documentation that Resident #6's pregabalin was reordered through the computer. -They did not document when the medication was reordered by telephone. -Pregabalin was used to help with nerve pain. -The half-life of pregabalin was 6-7 hours. -Pregabalin should be tapered, not stopped abruptly. -If Resident #6's pregabalin was stopped abruptly, the resident could experience increased nerve pain, headaches, difficulty sleeping, and sweating. Interview with Resident #6 on 03/11/26 at 4:15pm revealed: -She had to call EMS last night, 03/10/26, because she was nauseated, had a headache, and her vision was blurry. -She pulled her call bell, and after about 15 minutes, a personal care aide (PCA) checked on her and said she would get the MA, but no one ever came. -She transferred into her wheelchair and went looking for the MA, but after going up and down	D 358		

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the halls, she could not find her, so she called 911 herself.
-When she was getting ready to let the EMS staff into the facility, the MA walked up and asked her what was going on.
-She had been told by a MA there was no pregabalin on the medication cart on 03/10/26 and was reordered by the hospice nurse.
-She returned from the hospital around lunch time today, 03/11/26, but the staff told her she could not have her pregabalin since she had missed the morning medication pass.
-She had missed 3 doses of pregabalin.

Interview with Resident #6's family member on 03/11/26 at 4:15pm revealed:
-The hospital staff said Resident #6 was having classic symptoms of a heart attack.
-Resident #1's BP and her finger stick blood sugar (FSBS) were elevated when checked at the hospital.

Interview with Resident #6 on 03/12/26 at 8:22am revealed:
-She felt so much better today, 03/12/26.
-She had received her pregabalin last night, 03/11/26.

Telephone interview with Resident #6's hospice nurse on 03/12/26 at 8:29am revealed:
-She talked to a MA on Friday, 03/06/26, and specifically asked if any of Resident #6's medications needed to be refilled, and was told no.
-She was told on 03/10/26, by a MA, that Resident #6's pregabalin needed to be reordered.
-She assumed Resident #6 still had pregabalin on hand.

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D 358	Continued From page 32 -She did not know Resident #6 had not received her morning dose of pregabalin. -The hospice primary care provider (PCP) signed the order for Resident #6's pregabalin refill at 12:48pm on 03/10/26. -The MA should have told her on Friday, 03/06/26, that the medication needed to be reordered. -Resident #6 should not have run out of her pregabalin. -Resident #6 knew what worked for her, and it really bothered her that Resident #6 had to go through this because she had missed her medication. Interview with a MA on 03/12/26 at 3:14pm revealed: -Resident #6 was administered 3 pregabalin tablets at a time. -When a resident's medication had 7 doses remaining, the MA would call or reorder the medication on the computer. -Ordering a resident's medication who was on hospice was no different than reordering any other resident's medication unless a new prescription was needed. -When medication was reordered on the computer, it showed a new prescription was needed, and she would call the hospice nurse. -When she called the pharmacy, she was told the resident needed a new prescription. -She had told the hospice nurse the resident did not need any medication refills, but she then saw that she did, so she called the hospice agency and let them know the resident did need a refill. -She thought it was Monday, 03/09/26, when she called the hospice agency to request a refill on Resident #6's pregabalin.	D 358		

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D 358	Continued From page 33 Interview with this MA on 03/13/26 at 12:00pm revealed she called to reorder Resident #6's pregabalin on 03/10/26. Telephone interview with a second MA on 03/13/26 at 9:10am revealed: -Resident #6's pregabalin should have been reordered when the punch card was at the blue column. -When Resident #6's pregabalin on hand was in the blue column, the MA had to call the hospice nurse to reorder. -Resident #6 was not out of medication when she last worked, which was on Saturday, 03/07/26, for the 8:00pm dose. -She did not recall if she reordered Resident #6's pregabalin or not. Interview with a third MA on 03/13/26 at 7:09pm revealed: -She did not recall if she reordered Resident #6's pregabalin or not when the medication was in the blue column on 03/08/26. -If the medication was running low, she would have pushed the refill button and called hospice; this would have been documented in the electronic progress notes. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -Medication should be reordered before the doses reached the last column (blue column). -She expected medication to be reordered before it ran out. -She knew sometimes the MAs were told it was too early to reorder. -She was concerned the MAs were not reordering medications in a timely manner. -She expected medication cart audits to be done	D 358		

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to make sure medications did not run out.
-She was concerned that Resident #6 had to experience a negative outcome because the MAs failed to follow through on their responsibility.

Telephone interview with Resident #6's previous PCP on 03/12/26 at 11:57am revealed:
-Consistent dosing of pregabalin was very important.
-Pregabalin should not be stopped abruptly; it could be dangerous and needed to be tapered off.
-If pregabalin was stopped abruptly, Resident #6 could experience nausea, rapid heart rate, and sweating.
-A more dangerous concern was that stopping abruptly could cause seizures.
-Resident #6 was experiencing symptoms of withdrawal, and this was definitely the reason she went to the hospital, because she experienced those symptoms.
-Resident #6 was vulnerable because of her overall condition, and she was glad the resident was evaluated at the hospital.
-Resident #6 not being administered her pregabalin consistently was concerning.

Refer to the interview with a MA on 03/12/26 at 1:35pm.

Refer to the interview with the RCC on 03/13/26 at 9:55am.

Refer to the interview with the SCC on 03/13/26 at 5:48pm.

Refer to the interview with the Administrator on 03/13/26 at 5:50pm.

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D 358	Continued From page 35 2. Review of Resident #1's current FL-2 dated 02/02/26 revealed diagnoses included diabetes, hypertension, and hyperlipidemia. Review of Resident #1's laboratory report dated 01/20/26 revealed: -He had a glucose of 437 (normal range was 70-99). -He had blood urea nitrogen (BUN) of 69 (normal range was 7-20) -He had a HbA1C of 11.1% (the hemoglobin A1C determines the average level of blood sugar over the past 2 to 3 months. According to the American Diabetes Association, a HbA1C value less than 7.0 is a goal for diabetic residents, with the normal range for HbA1C being 4 to 5.9). Review of Resident #1's incident report dated 01/21/26 revealed a note the primary care provider (PCP) wanted to send Resident #1 to the emergency department (ED) due to an abnormal lab report and concern with diabetic ketoacidosis (a life-threatening, emergency metabolic state characterized by extremely high levels of blood acids and ketones and high blood sugar). Review of Resident #1's hospital discharge summary dated 01/23/26 revealed: -Resident #1 was seen at 11:15 p.m. on 01/21/26 after he presented to the ED from his assisted living facility with complaints of elevated blood glucose. -Previously, he had been managed on metformin "for 25 years". -His blood glucose readings over the last several days had been 300-400. -His acute kidney injury was most likely secondary to intravascular volume depletion from	D 358		

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hyperglycemia (high blood sugar).
-He was diagnosed with acidosis (a condition characterized by an excess of acid in body fluids, resulting in a blood pH below 7.35) and hyponatremia (a condition where sodium levels in the blood are too low, often caused by excess water retention relative to salt).
-His hyponatremia was most likely secondary to hyperglycemia.

a. Review of Resident #1's PCP after-visit summary dated 02/09/26 revealed an order for Lantus Solostar U-100 (a long-acting insulin that provides a steady, low level of insulin for 24 hours to help manage blood sugar levels) inject 8 units daily.

Review of Resident #1's PCP after-visit summary dated 02/26/26 revealed:
-Resident #1 had insulin-dependent diabetes.
-Resident #1 reported his finger stick blood sugar (FSBS) was 508 last night.
-Referral to an Endocrinologist was pending.
-Per chart review, the resident was started on 8 units of Lantus.
-The PCP discussed with the facility staff in detail, and the staff reported Resident #1 was not on Lantus and was on Humalog sliding scale insulin (SSI) only.
-Resident #1 had chronic kidney disease; risk factors included diabetes and hypertension.
-Resident #1's HbA1C was 11.1 on 01/20/26.
-He was at high risk for diabetic ketoacidosis.
-The PCP would resend the order for Lantus 8 units in the morning.
-Notification was received from the pharmacy that Lantus was not covered, but Tresiba was.
-There was an order to discontinue Lantus and start Tresiba (long-acting insulin used to control

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D 358	Continued From page 37 high blood sugar) inject 8 units daily. Review of Resident #1's February 2026 electronic medication administration record (eMAR) from 02/09/26-02/28/26 revealed there was no entry for Lantus or Tresiba. Review of Resident #1's March 2026 eMAR from 03/01/26-03/10/26 revealed there was no entry for Lantus or Tresiba. Observation of Resident #1's medications on hand on 03/10/26 at 1:25pm revealed no Lantus or Tresiba available to be administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -She did not see an order for Resident #1's Lantus or Tresiba. -Lantus and Tresiba were both long-acting insulins used to help stabilize FSBS all day, and SSI would then be used for acute changes in his FSBS. -If Lantus or Tresiba were not administered as ordered, Resident #1 could potentially have higher FSBS and therefore would need more SSI coverage. Interview with a medication aide (MA) on 03/12/26 at 1:35pm revealed the facility would send new orders to their contracted pharmacy to be profiled and entered into the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/13/26 at 9:55am revealed the RCC would fax the new order to the facility's contracted pharmacy to be profiled.	D 358		

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D 358	Continued From page 38 Telephone interview with a pharmacist at a local pharmacy on 03/12/26 at 2:27pm revealed: -They received an order for Resident #1 for Lantus 8 units once daily on 02/09/26. -One box of Lantus prefilled pens was dispensed for a total of 15mls. -One box of Lantus pens would be a 188-day supply if 8 units were administered daily. -An order was received to discontinue Lantus due to insurance not covering the medication and start Tresiba on 02/27/26, but it was not filled since the resident's Lantus had been covered by insurance. -If Resident #1's Lantus was not administered as ordered, the resident's FSBS would not be controlled, and his FSBS could get too high. -Long-acting insulins were used to keep Resident #1's baseline FSBS controlled. -SSI was not preferred because the FSBS would already be high. Telephone interview with the pharmacist at the local pharmacy on 03/13/26 at 12:24pm revealed a [named] staff member signed for Resident #1's Lantus on 02/12/26. Interview with the [named] staff member on 03/13/26 at 3:44pm revealed: -She did not recall if she signed for medication for Resident #1 or not. -When she signed for medication that was delivered, she either called the RCC, Special Care Unit Coordinator (SCC) or a MA or took the medication to the RCC/SCC or a MA. Interview with a MA on 03/12/26 at 2:40pm revealed -Resident #1 did not receive a set amount of insulin; it was based on his FSBS, and he would	D 358		

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receive SSI only.
-She thought Resident #1 was on Lantus, but it had been discontinued.
-She did not recall any other details about the Lantus.

Interviews with a second MA on 03/12/26 at 2:38pm and 3:14pm revealed:
-Resident #1 did not have any other insulin pens; the only insulin pen he had available was Humalog.
-She had never administered any insulin to Resident #1 except his Humalog SSI.

Telephone interview with a third MA on 03/13/26 at 9:10am revealed Resident #1 only had SSI; no other orders were on his eMAR for insulin.

Interview with Resident #1 on 03/12/26 at 4:01pm revealed:
-He had never received a set amount of insulin every day.
-He did not get SSI every day.

Interview with the RCC on 03/13/26 at 11:29am revealed:
-She or the SCC was responsible for reviewing after-visit summaries and processing new orders.
-She did not recall seeing an order for Resident #1's Lantus or Tresiba.
-Resident #1's FSBS were running high because he was not getting insulin administered as he should.
-She was concerned that an order was not implemented because the resident's health could be affected.

Interview with the SCC on 03/13/26 at 12:08pm revealed:

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D 358	Continued From page 40 -She checked on Resident #1's Tresiba, and it had not been dispensed because they were waiting on the co-pay. -She called the pharmacy today, 03/13/26, to check on Resident #1's Tresiba because a staff member had told her the surveyor had asked about it. -She did not know why the facility's contracted pharmacy did not get the order and profile it to the eMAR. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -New orders were usually sent to the pharmacy by email or by fax. -She and/or the RCC/SCC were responsible for tracking the new orders. -The RCC/SCC were responsible for sending the order to the facility's contracted pharmacy to make sure the order was profiled and added to the eMAR. -The RCC/SCC should follow through to make sure the medication was entered into the eMAR and that the medication was in the facility. -She was concerned Resident #1 could have had a severe negative effect from not getting the medication as ordered. Telephone interview with a triage nurse practitioner from Resident #1's PCP's office on 03/12/26 at 1:29pm revealed: -Resident #1 had an initial order for Lantus 8 units every morning, but it was then changed to Tresiba 8 units every morning on 02/27/26 because of insurance coverage. -The purpose of the Lantus/Tresiba orders was to provide coverage for his FSBS and to bring overall episodes of hyperglycemia down. -The goal was to control his FSBS without	D 358		

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needing a higher amount of insulin.
-If Resident #1's insulin was not administered as ordered, he could have episodes of hyperglycemia, which put the resident at further risk of end-stage organ damage, including renal failure, loss of vision, and heart disease, just to name a few.

b. Review of Resident #1's PCP's after-visit summary date 02/02/26 revealed there was an order for Humalog (a rapid-acting insulin used to manage blood sugar) KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 =6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units and call the PCP.

Review of Resident #1's February 2026 eMAR from 02/02/26-02/28/26 revealed:
-There was an entry for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0-150=0 units; 151-200=2 units; 201-250=4 units; 251-300 =6 units; 301-350= 8 units; 351-400=10 units; 401 600=12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation that Resident #1's FSBS was checked at 8:00am, 2:00pm, and 8:00pm, but there was no documentation of the amount of insulin that was administered.
-There was a second entry to check Resident #1's FSBS daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm; the entry did not include the SSI.
-The FSBS readings for 7:00am and 8:00am

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D 358	Continued From page 42 were the same; the FSBS readings for 12:00pm and 2:00pm were the same. -It could not be determined how many units of insulin were administered to Resident #1 because no amounts of insulin were documented on the eMAR. -Resident #1's FSBS ranged from 120-544 with most FSBS readings being greater than 200. Review of Resident #1's March 2026 eMAR from 03/01/26-03/12/26 revealed: -There was an entry for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneously three times daily before meals and at bedtime as directed as per sliding scale: if 0-150=0 units; 151-200=2 units; 201-250=4 units; 251-300 =6 units; 301-350= 8 units; 351-400=10 units; 401 600=12 units and call the PCP with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Resident #1's FSBS was checked at 8:00am, 2:00pm, and 8:00pm, but there was no documentation of the amount of insulin that was administered. -There was a second entry to check Resident #1's FSBS daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm; the entry did not include the SSI. -The FSBS readings for 7:00am and 8:00am were the same; the FSBS readings for 12:00pm and 2:00pm were the same. -It could not be determined how many units of insulin were administered to Resident #1 because no amounts of insulin were documented on the eMAR. -Resident #1's FSBS ranged from 117-434 with all 8:00am FSBS readings being greater than 300.	D 358		

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D 358	Continued From page 43 Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/13/26 at 11:09am revealed one Humalog insulin pen had been dispensed for Resident #1 on 02/02/26; the pen contained 300 units of insulin. Observation of Resident #1's medications on hand on 03/10/26 at 1:28pm revealed there was a Humalog insulin pen, not labeled with the resident's name or with the SSI directions; the pen had between 170-180 units remaining in the pen. Based on Resident #1's FSBS readings at 8:00am, 12:00pm, 5:00pm, and 8:00pm from 02/02/26-03/09/26 and 8:00am on 03/10/26, if the SSI was administered as ordered, Resident #1 would have been administered 690 units of insulin, which would require more than two Humalog insulin pens. Telephone interview with a pharmacist at a local pharmacy on 03/13/26 at 12:24pm revealed they had not filled Humalog insulin for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #1's current order was for FSBS before meals and to administer Humalog as needed based on the FSBS readings. -If he did not receive his SSI as ordered, his FSBS would remain elevated. Interview with Resident #1 on 03/11/26 at 4:40pm revealed: -He wrote in his journal every time staff checked his FSBS, and he wrote down if he was administered insulin or not.	D 358		

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D 358	Continued From page 44 -If he did not write the word insulin down, then he did not receive insulin. -He did not document how many units of insulin he was administered. Review of Resident #1's daily journal from 02/06/26-03/11/26 revealed: -Resident #1 kept the daily journal on a table beside his chair. -He documented the date, usually the time, and the results of his FSBS, and at times, the word insulin was documented. -Examples included on 02/10/26 at 7:45pm, his FSBS was 284, and he was administered insulin. -On 02/23/26 at 1:00pm, his FSBS was 258, and there was no documentation that he was administered insulin. -On 02/24/26, his FSBS was checked 4 times; all readings were greater than 200, and he documented receiving insulin 1 of 4 times. -On 02/25/26, his FSBS was checked 3 times; all readings were greater than 200, and he documented receiving insulin 1 of 3 times. Interview with a MA on 03/12/26 at 2:38pm revealed Resident #1 did not have any other insulin pens; this was the only insulin pen he had available. Interview with a second MA on 03/12/26 at 2:40pm revealed: -She administered Resident #1's Humalog based on his FSBS reading and the amount of SSI ordered. -There was nowhere to document the amount of SSI administered, but she administered it based on the SSI. Interview with a third MA on 03/12/25 at 2:40pm	D 358		

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revealed:
-Resident #1 was alert and oriented.
-She did not know why Resident #1's SSI was not administered as ordered.

Telephone interview with a fourth MA on 03/13/26 at 9:10am revealed she administered Resident #1's SSI based on his FSBS; she thought the amount she administered was documented.

Interview with Resident #1 on 03/12/26 at 4:01pm revealed:
-He did not get SSI every day.
-His FSBS readings for 03/11/26 were 387 at 9:45am, and he received 10 units of insulin, 145 at 12:07pm, and he received no insulin, 248 at 5:30pm, and he received no insulin, and 288 at 8:30pm, and he received 4 units of insulin.
-His FSBS today, 03/12/26 at 10:00am, was 333, and he was not administered insulin.
-He thought the MA said she was coming back to administer insulin, but she never came back.
-He was concerned that he did not get SSI when his FSBS was high.

Interview with the MA on 03/12/26 at 4:15pm revealed she had gotten tied up after checking Resident #1's FSBS and forgot to give him insulin on 03/12/26.

Interview with the RCC on 03/13/26 at 11:29am revealed:
-She thought there was a spot on the eMAR to document how much SSI was administered.
-If the MAs were not administering SSI when the FSBS parameters would warrant doing so, she was concerned the resident was not getting his medication as ordered.
-The MAs should not move on to another

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D 358	Continued From page 46 resident until they completed Resident #1's medication pass, which included checking his FSBS and administering insulin per the sliding scale (SS). -She was concerned Resident #1's FSBS could continue to increase if his SSI was not administered as ordered. -If a diabetic resident's FSBS went too high, the resident could go into a diabetic coma. Interview with the Administrator on 03/13/26 at 5:50pm revealed she expected Resident #1's SSI to be administered as ordered; he could have experienced a negative outcome if it had not been administered as ordered. Telephone interview with a triage nurse practitioner from Resident #1's PCP's office on 03/12/26 at 1:29pm revealed: -Resident #1's SSI should be administered based on the FSBS readings. -If Resident #1's SSI was not administered as ordered, it would be the reason why he was having hyperglycemic episodes. -If Resident #1's insulin was not administered as ordered, he could have episodes of hyperglycemia, which put the residents at further risk of end-stage organ damage, including renal failure, loss of vision, and heart disease, just to name a few. Refer to the interview with a MA on 03/12/26 at 1:35pm. Refer to the interview with the RCC on 03/13/26 at 9:55am. Refer to the interview with the SCC on 03/13/26 at 5:48pm.	D 358		

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D 358	Continued From page 47 Refer to the interview with the Administrator on 03/13/26 at 5:50pm. 3. Review of Resident #3's FL-2 dated 01/28/25 revealed diagnoses included chronic diastolic heart failure, chronic obstructive pulmonary disease (COPD), seizure disorder, diabetes mellitus type 2, and hypertension. a. Review of Resident #3's Primary Care Provider's (PCP) after-visit summary dated 01/15/26 revealed: -Resident #3 had chronic, ongoing right hip pain due to osteoarthritis to her right hip. -Resident #3 reported her pain was worse at night. -Resident #3 was ordered hydrocodone 7.5/acetaminophen 325mg (used for pain) at bedtime to help her sleep without pain. Review of Resident #3's PCP after-visit summary dated 01/19/26 revealed an order for hydrocodone 7.5 mg/acetaminophen 325mg one tablet at bedtime. Observation of Resident #3 on 03/10/26 at 9:42am revealed she was sitting in her recliner rubbing her right leg. Interview with Resident #3 on 03/10/26 at 9:42am revealed her right leg and knee were hurting. Observation of Resident #3 on 03/11/26 at 9:30am revealed she was lying in bed. Interview with Resident #3 on 03/11/26 at 9:30am revealed she did not sleep well because her right	D 358		

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D 358	Continued From page 48 leg hurt and she did not feel like getting up and going to the dining room for breakfast. Observation of Resident #3 on 03/13/26 at 8:45am revealed she was sitting in her recliner and rubbing her right knee. Interview with Resident #3 on 03/13/26 revealed her right knee was hurting. Review of Resident #3's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone 7.5mg/acetaminophen 325mg tablets one at bedtime with a scheduled administration time of 8:00pm. -There was documentation hydrocodone 7.5mg/acetaminophen 325mg was administered 26 of 28 opportunities from 02/01/26 to 02/28/26. -There was a dash (-) documented on the eMAR for two days between 02/01/26 and 02/28/26; there was no exception documented. Review of Resident #3's March 2026 eMAR from 03/01/26 to 03/12/26 revealed: -There was an entry for hydrocodone 7.5mg/acetaminophen 325mg tablets one at bedtime with a scheduled administration time of 8:00pm. -There was documentation hydrocodone 7.5mg/acetaminophen 325mg was administered 10 of 12 opportunities from 03/01/26 to 03/12/26. -There was a dash (-) documented on the eMAR for two days between 03/01/26 and 03/12/26; there was no exception documented. Telephone interviews with a representative from the facility's contracted pharmacy on 03/13/26 at	D 358		

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D 358	Continued From page 49 12:25pm and 4:25pm revealed: -Resident #3 had an order for hydrocodone 7.5mg/acetaminophen 325mg one tablet at bedtime dated 01/19/26 with 3 refills. -The pharmacy dispensed 30 hydrocodone 7.5mg/acetaminophen 325mg on 02/07/26. -Resident #3 would have enough hydrocodone 7.5mg/acetaminophen 325mg tablets to last through 03/09/26. -Hydrocodone 7.5mg/acetaminophen 325mg was not on cycle fill; the staff would have to reorder the medication when it was needed. -The facility had not reordered hydrocodone 7.5mg/acetaminophen 325mg yet in March 2026. Observation of Resident #3's medication on hand on 03/11/26 at 8:45am revealed there were no hydrocodone 7.5mg/acetaminophen 325mg tablets available for administration. Interview with Resident #3 on 03/13/26 at 8:45am revealed: -Her right leg and knee hurt most of the time. -She did not think she was given her scheduled pain medication last night, 03/12/26, at bedtime. -She woke up two different times and sat on side of the bed because her right leg was hurting. -She had not slept well for several nights because of her right leg pain. -She would sleep all night if she received her scheduled pain medication at bedtime. Telephone interview with Resident #3's family member on 03/13/26 at 8:34am revealed: -She stayed with Resident #3 on Tuesday and Thursday nights since Resident #3 fell on 02/05/26. -The medication aide (MA) did not bring Resident #3's hydrocodone/acetaminophen last night,	D 358		

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D 358	Continued From page 50 03/12/26, with her bedtime medications. -Hydrocodone/acetaminophen was a scheduled medication and should be administered each night. -She asked the MA if the pain medication was in the cup of medications and the MA responded, no; the MA would have to go back to the medication cart and get it. -The MA brought back the pain medication, but she was not sure if it was hydrocodone/acetaminophen or not. -Resident #3 woke up twice during the night, sat on side of the bed, and complained of her right leg hurting. -When Resident #3 was administered the hydrocodone/acetaminophen, Resident #3 would sleep all night and get a good night's sleep. -She did not think Resident #3 received hydrocodone/acetaminophen last night, but she was not sure. Telephone interview with Resident #3's Power of Attorney (POA) on 03/13/26 at 9:20am revealed if Resident #3 did not get the pain medications as ordered her right leg pain would be worse. Interview with a MA on 03/13/26 at 5:15pm revealed: -She noticed Resident #3 did not have hydrocodone/acetaminophen on the medication cart that morning, 03/13/26, when she checked for medications that needed to be reordered. -She reordered the hydrocodone 7.5mg/acetaminophen 325mg from the pharmacy, and the medication would be delivered on 03/14/26, in the early morning. -Resident #3 would not have any hydrocodone 7.5mg/acetaminophen 325mg available for administration that night, 03/13/26, at 8:00pm.	D 358		

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D 358	Continued From page 51 Interview with another MA on 03/12/26 at 2:52pm revealed: -She administered medications to Resident #3 when she worked second shift. -Hydrocodone/acetaminophen was not always available to administer as scheduled. -She would reorder the medication by pressing the reorder button on the computer. -She did not remember the last time she reordered hydrocodone/acetaminophen. Interview with the Resident Care Coordinator (RCC) on 03/13/26 at 9:55am and 4:25pm revealed: -She worked as the MA on second shift on 03/12/26. -She did not administer hydrocodone 7.5mg/acetaminophen 325mg to Resident #3 last night, 03/12/26. -There were no hydrocodone 7.5mg/acetaminophen 325mg tablets on the medication cart for administration. -Resident #3 had an order for acetaminophen as needed for pain so she administered that to Resident #3. -She thought she told Resident #3 and her family member that it was acetaminophen and not the hydrocodone/acetaminophen. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected the MAs to administer Resident #3's hydrocodone/acetaminophen as scheduled. -She expected the MAs to reorder medications within 3 days, as stated on the eMAR, so the medication would not run out. Attempted telephone interviews with Resident	D 358		

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D 358	Continued From page 52 #3's PCP on 03/11/26 at 7:25am and 12:06pm, on 03/12/26 at 3:47pm, and on 03/13/26 at 8:26am were unsuccessful. b. Review of Resident #3's FL-2 dated 01/28/25 revealed there was an order for levetiracetam 750mg (used to treat seizure associated with epilepsy) twice daily. Review of Resident #3's signed physician order dated 03/06/26 revealed there was an order to decrease levetiracetam to 500mg in the morning and 750mg in the evening. Review of Resident #3's March 2026 eMAR from 03/01/26 to 03/11/26 revealed: -There was an entry for levetiracetam 750mg twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that levetiracetam 750mg was administered 8 of 8 opportunities from 03/01/26 to 03/04/26. -There was an entry for levetiracetam 250mg two tablets each morning with a scheduled administration time of 8:00am. -There was documentation that levetiracetam 250mg two tablets were administered 5 of 5 opportunities from 03/07/26 to 03/11/26. -There was an entry for levetiracetam 250mg three tablets in the evening with a scheduled administration time of 8:00pm. -There was documentation that levetiracetam 250mg three tablets was administered 5 of 5 opportunities from 03/07/26 to 03/11/26. -There was no documentation that levetiracetam was administered on 03/05/26 and 03/06/26; the eMAR was shaded gray. Telephone interview with a representative from	D 358		

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D 358	Continued From page 53 the facility's contracted pharmacy on 03/11/26 at 10:05am revealed: -Resident #3 had a new order dated 03/03/26 to change levetiracetam 750mg twice daily to 250mg 2 tablets in the morning and 3 tablets in the evening. -The pharmacy dispensed a punch card with 30 levetiracetam 250mg with instructions to give 2 tablets every morning on 03/04/26. -The pharmacy dispensed a second punch card with 30 levetiracetam 250 mg with instructions to give three tablets at bedtime on 03/04/26. -When a new order was received after the multi-dose pack had been filled and delivered to the facility, the pharmacy would send a punch card with the new medication. -The punch card would have a varied number of pills; the number of pills dispensed depended on the frequency of the medication and what day of the week the new medication was ordered. -The number of pills dispensed would be the exact amount needed for the resident until the medication was placed in the resident's multi-dose pack. -The pharmacy dispensed the exact number of tablets to be used until the medication was placed in the multi-dose pack. -The punch card should not have any tablets remaining when the medication was placed in the weekly multi-dose pack. -If the MAs used the scanner, they received an alert that a medication had been changed or discontinued, and the MA would know to look for the punch card. Observation of Resident #3's medication on hand on 03/11/26 at 8:12am revealed: -There were 30 of 30 levetiracetam 250mg tablets remaining in the punch card for the	D 358		

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D 358	Continued From page 54 morning dose with a dispensed date of 03/04/26. -There were 24 of 30 levetiracetam 250mg tablets remaining in the punch card for the evening dose with a dispensed date of 03/04/26. Interview with a MA on 03/11/26 at 9:08am revealed: -Most medications were on cycle fill and were delivered on late Thursday nights or early Friday mornings. -The medications were packaged in multi-dose packs, and the pharmacy sent one week of medications each week. -The third shift MA was responsible for placing the multi-dose pack on the medication cart on Monday nights, to start on Tuesday morning. -If a medication was ordered after the weekly multi-dose pack was dispensed, the pharmacy would send a punch card of the new medication. -The punch card contained just enough medication to last until that medication was placed in the multi-dose pack. -The punch card should be empty when the multi-dose pack containing the new medication started. Interview with another MA on 03/12/26 at 2:42pm revealed: -She did not recall using any punch cards to administer Resident #3's medications. -Her medications were in a multi-dose pack. -She had removed discontinued medication from some residents' multi-dose packs but not from Resident #3's multi-dose pack. -She did not know the orders for levetiracetam had been changed and the punch cards for the new order were in the medication cart. -There used to be a scanner on the medication cart, but the scanner had been removed.	D 358		

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D 358	Continued From page 55 -She did not know why the scanner had been removed. -If the multi-dose pack was scanned there would be an alert if a medication dose had been changed or a medication was missing, and the MA would know to remove the medication from the multi-dose pack and look for a punch card. -Sometimes the medications were not in the multi-dose pack, and the pharmacy would send a punch card of the medications. -If the medication listed on the eMAR was not in the multi-dose pack, she would look for a punch card with the medication. -Resident #3's medications for first shift were in her multi-dose pack. -She did not recall any of Resident #3's medications being dispensed in punch cards. Interview with the Special Care Coordinator (SCC) on 03/13/26 at 4:48pm revealed: -When a new medication order was written after the weekly multi-dose pack had been delivered to the facility, the pharmacy would prepare punch cards with the new medication until the new medication was placed in the multi-dose pack. -The punch card contained enough of the medication until the medication was placed in the multi-dose pack. -She did not know why the medication in the punch cards had not been administered as ordered. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected the MAs to administer levetiracetam to Resident #3 as ordered. -She expected the MAs to read the entry in the eMAR and administer the correct dosage. -The MA should speak to the RCC if the	D 358		

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D 358	Continued From page 56 medication could not be located. Attempted telephone interviews with Resident #3's PCP on 03/11/26 at 7:25am and 12:06pm, on 03/12/26 at 3:47pm, and on 03/13/26 at 8:26am were unsuccessful. Refer to the interview with a MA on 03/12/26 at 1:35pm. Refer to the interview with the RCC on 03/13/26 at 9:55am. Refer to the interview with the SCC on 03/13/26 at 5:48pm. Refer to the interview with the Administrator on 03/13/26 at 5:50pm. 4. Review of Resident #4's current FL-2 dated 08/06/25 revealed diagnoses included vascular dementia, lower back pain, other chronic pain, and osteoarthritis of the knee. Review of Resident #4's signed physician's orders dated 11/01/25 revealed there was an order for tamsulosin (used to treat symptoms related to benign prostate hyperplasia) 0.4mg at bedtime. Review of Resident #4's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for tamsulosin 0.4mg capsule at bedtime with a scheduled administration time of 8:00pm. -There was documentation that tamsulosin was administered 29 of 31 opportunities from 01/01/26 to 01/31/26.	D 358		

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D 358	Continued From page 57 Review of Resident #4's February 2026 eMAR revealed: -There was an entry for tamsulosin 0.4mg capsule at bedtime with a scheduled administration time of 8:00pm. -There was documentation that tamsulosin was administered 28 of 28 opportunities from 02/01/26 to 02/28/26. Review of Resident #4's March 2026 eMAR from 03/01/26 to 03/09/26 revealed: -There was an entry for tamsulosin 0.4mg capsule at bedtime with a scheduled administration time of 8:00pm. -There was documentation tamsulosin 0.4mg was administered 9 of 9 opportunities from 03/01/26 to 03/09/26. Observation of medications on hand for Resident #4 on 03/12/26 revealed there were no tamsulosin available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 03/11/26 at 2:15pm revealed: -Resident #4 had an order for tamsulosin 0.4mg at night dated 11/11/15. -The pharmacy dispensed 14 tamsulosin 0.4mg capsules on 01/27/26, and 02/16/26, with each dispensing lasting 14 days. -The pharmacy only dispensed 14 capsules at a time; she was not sure, but she thought it was due to Resident #4's insurance. -Tamsulosin was not on cycle fill; it had to be reordered by the staff when it was needed. -There was a request made last night, 03/10/26, to send tamsulosin 0.4mg in tonight's (03/11/26) shipment.	D 358		

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D 358	Continued From page 58 -The medication would not arrive before his tamsulosin was scheduled tonight, 03/11/26, which was 8:00pm. -The 14 tamsulosin tablets dispensed on 01/27/26 would have lasted until 02/10/26, and the 14 tamsulosin tablets dispensed on 02/16/26 would have lasted until 03/02/26. Interview with Resident #4 on 03/13/26 at 11:45am revealed: -The MAs administered his medications each night. -He took several pills each night. -He knew one of the pills was to help him urinate. -He thought the MA gave him all of his medications each night. Interview with a medication aide (MA) on 03/12/26 at 1:35pm revealed: -Resident #4 had tamsulosin available for administration when she administered his medications. -Resident #4's tamsulosin was packaged in a punch card and had to be reordered when needed; it was not on cycle fill. Interview with another MA on 03/13/26 at 5:15pm revealed: -She administered Resident #4 his bedtime medications when she worked second shift. -She had administered tamsulosin 0.4mg to Resident #4 in the evenings when she worked. -There had been times the medication was not in the facility to administer, and she would reorder the medication; the medication was not on cycle fill. -Medications that were not on cycle fill needed to be reordered when there were 5 to 7 days of medication left in the punch card.	D 358		

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D 358	Continued From page 59 Interview with the Special Care Unit Coordinator (SCC) on 03/13/26 at 5:48pm revealed: -She did not know Resident #4's tamsulosin was not on cycle fill. -She did not know the pharmacy only sent 14 tablets at a time. -She expected the MAs to order medication timely to have in the facility to administer as ordered. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected the MAs to administer tamsulosin to Resident #4 as ordered. -She expected the MAs to reorder tamsulosin timely so the medication would always be in the facility for administration. Attempted telephone interviews with Resident #4's Primary Care Provider (PCP) on 03/12/26 at 3:47pm, and on 03/13/26 at 8:26am were unsuccessful. Refer to the interview with a MA on 03/12/26 at 1:35pm. Refer to the interview with the RCC on 03/13/26 at 9:55am. Refer to the interview with the SCC on 03/13/26 at 5:48pm. Refer to the interview with the Administrator on 03/13/26 at 5:50pm. _____ Interview with a MA on 03/12/26 at 1:35pm revealed: -Medication cart audits were to be done on third	D 358		

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D 358	Continued From page 60 shift by the MA. -She thought there was a schedule for medication cart audits to be done twice weekly posted in the medication room, -She would do a medication cart audit if the RCC or SCC asked her to or if she saw medications were running low. -She compared the medications on the medication cart to the medications listed on the eMAR to ensure all medications were on the medication cart. -If a medication was missing, she would reorder the medication from the pharmacy. -She would remove any expired or discontinued medications from the medication cart. -Medications could be reordered by calling the pharmacy or clicking the reorder button on the computer. -New orders were electronically sent to the pharmacy by the PCP; the pharmacy staff would enter the order into the eMAR. -The RCC or SCC would verify the order and then it would show up on the eMAR. -The MAs could not see a new order until it was verified by the RCC and SCC. Interview with the RCC on 03/13/26 at 9:55am revealed: -She was responsible for completing weekly medication cart audits in the Assisted Living (AL). -She was trained about two weeks ago on the process of completing a weekly medication cart audit, but she had not done one since. -The eMAR for a resident was printed, and the medications in the medication cart were compared to the medications listed on the eMAR. -Any discrepancies found would be corrected by contacting the pharmacy or the PCP.	D 358		

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D 358	Continued From page 61 Interview with the SCC on 03/13/26 at 5:48pm revealed: -Medication cart audits were done by the RCC, SCC, or the MA. -Each medication cart should be audited twice weekly. -There was a medication cart audit schedule in the medication rooms. -If the MA did not have time to do their scheduled audit, the RCC or SCC would do the medication cart audit. -The medications on the medication cart and the eMAR should match. -She expected medication audits to be completed as scheduled. -If medication audits were completed as scheduled some of these medication errors could have been prevented. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -Medications should be administered as ordered. -The MA should reorder medications in a timely manner. -There was a blue strip on the punch card and when the only pills left in the punch card were those on the blue strip the medication should be reordered. -She expected the medication cart audits to be done as scheduled. -She expected MAs to administer medications as ordered. _____ The facility failed to administer medications as ordered for four residents, including a resident (#6), who was prescribed a medication used to treat nerve pain that should not be stopped abruptly due to the risk of withdrawal side effects, including headaches, difficulty sleeping, nausea,	D 358		

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D 358	Continued From page 62 and sweating. After missing two doses of the medication, Resident #6 complained of a headache, nausea, sweating, and a change in vision and was transported to the hospital. A resident (#1), whose diabetes had been managed with oral medication, was hospitalized for an elevated hemoglobin AIC and kidney failure secondary to hyperglycemia and acidosis, and had an initial order for a long-acting insulin to control FSBS; however, this medication was never administered. Additionally, Resident #1 was ordered a sliding scale insulin (SSI) to cover any increases in FSBS before meals but was not always administered insulin even when his FSBS was within the range requiring coverage. FSBS values were often checked after meals, requiring more insulin coverage, which was not the optimal way to manage his diabetes. These failures resulted in episodes of hyperglycemia, placing the resident at further risk of end-stage organ damage, including renal failure, vision loss, and heart disease. A resident (#3), who had chronic arthritic pain in her right leg, missed four doses of her pain medication, causing her pain to worsen, resulting in the resident's sleep being interrupted at night. This failure resulted in serious physical harm and pain, which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 12, 2026 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 12, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration	D 367		

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D 367	Continued From page 63 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 electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#2) related to a blood pressure (BP) medication and a medication to manage blood sugar (BS). The findings are: Review of Resident #2's current FL-2 dated 04/02/25 revealed diagnoses included diabetes	D 367		

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D 367	Continued From page 64 mellitus type 2 and hypertension. a. Review of Resident #2's signed physician's order dated 09/12/25 revealed: -There was an order for amlodipine 10mg (used to treat elevated BP) daily. -There was no order to discontinue amlodipine 10mg daily. Review of Resident #2's February 2026 eMAR revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation amlodipine 10mg was administered daily from 02/01/26 to 02/28/26. Review of Resident #3's March 2026 eMAR from 03/01/26 to 03/09/26 revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation amlodipine 10mg was administered daily from 03/01/26 to 03/09/26. Observation of Resident #2's medication on hand on 03/10/26 revealed there was no amlodipine 10mg available for administration. Telephone interview with a representative from the local pharmacy on 03/12/26 at 8:30am revealed: -Resident #2 did not have a current order for amlodipine 10mg daily. -The medication was removed from her active medication list on 02/02/26. -Resident #2 notified the pharmacy and verbally communicated that her Primary Care Provider (PCP) had discontinued the amlodipine. -The pharmacy had not received an order to discontinue the amlodipine 10mg daily from	D 367		

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D 367	Continued From page 65 Resident #2's PCP. -The amlodipine 10mg tablet was not dispensed in Resident #2's monthly medications dated 02/10/26 and 03/11/26. Telephone interview with the pharmacist from the local pharmacy on 03/12/26 at 11:30am revealed: -The pharmacy did not have an order to discontinue the amlodipine 10mg from Resident #2's PCP. -Resident #2 called the pharmacy and said that her PCP wanted her to stop the amlodipine. -The pharmacy stopped packaging amlodipine per the resident's request. -The pharmacy had not dispensed amlodipine 10mg for Resident #2 since 01/11/26, for a month supply. -The pharmacy did not dispense amlodipine 10mg on 02/10/26 or 03/11/26. Interview with Resident #2 on 03/12/26 at 4:08pm revealed: -She stopped taking amlodipine a couple of months ago when her PCP discontinued the medication. -She called the pharmacy to let them know the medication had been discontinued and not to place the medication in her 8:00am pack of medications. -She knew her medications, what they were for, and when she should take them. -The staff had not administered amlodipine to her since it had been discontinued. Interview with a medication aide (MA) on 03/12/26 at 2:42pm revealed: -She had not noticed the amlodipine 10mg was not in the 8:00am package until 03/10/26 when she was administering medications.	D 367		

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D 367	Continued From page 66 -She did not tell the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) that the amlodipine was not in the 8:00am pack of medications because she was busy and she forgot to tell them. -She documented that she administered the amlodipine when the amlodipine was not available to administer. -She did not know why the entry for amlodipine 10mg was still on the eMAR if it had been discontinued on 02/02/26. -She needed to pay attention when she administered medications. Telephone interview with a second MA on 03/13/26 at 11:30am revealed: -Resident #2 received her medications from an outside pharmacy. -She compared the medications to the eMAR prior to administering medications. -She noticed the amlodipine was not in the 8:00am pack of medications one morning, but she did not remember when. -She thought she told the RCC or the Administrator the medication was not in the 8:00am pack of medications. -She did not call the pharmacy; she did not know if the RCC called the pharmacy. -She documented on the eMAR as if she had administered the amlodipine when it was not dispensed from the pharmacy to administer. -The medication entry on the eMAR would have to be discontinued by the facility's contracted pharmacy, if they received the discontinue order for amlodipine. Interview with a third MA on 03/12/26 at 2:42pm revealed: -She did not see the amlodipine in Resident #2's	D 367		

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D 367	Continued From page 67 8:00am pack of medication to be administered, but did not remember when. -She asked Resident #2 about the amlodipine and Resident #2 said her PCP had stopped the medication. -She documented on the eMAR incorrectly, because she did not administer amlodipine because it was not in the facility to administer. -She did not tell the RCC or SCC that Resident #2 was not administered amlodipine but it was still on the eMAR because she was busy and she forgot. -This would have been caught if the medication carts were audited by the MAs as scheduled. Interview with the RCC on 03/13/26 at 9:55am revealed: -She did not know Resident #2's amlodipine 10mg had been discontinued. -The MAs should have noticed that amlodipine 10mg was not in the 8:00am packaged medication and questioned the RCC or pharmacy as to where the medication was. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She did not know Resident #2's amlodipine was discontinued in February 2026 but still on the eMAR until Monday, 03/09/26. -The MA administering medications told her on 03/09/26. -She thought the matter had been corrected by the MA and the RCC. -She expected the MA and the RCC to notify the PCP or the pharmacy when there were discrepancies in medications. Attempted telephone interviews with Resident #2's PCP on 03/11/26 at 4:43pm and 03/12/26 at	D 367		

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D 367	Continued From page 68 11:22am were unsuccessful. b. Review of Resident #2's signed physician's order dated 03/01/26 revealed there was an order to decrease glipizide (used to manage elevated blood sugars) 10mg two tablets daily to glipizide 10mg one tablet daily. Review of Resident #3's March 2026 eMAR from 03/01/26 to 03/09/26 revealed: -There was an entry for glipizide 10mg 2 tablets daily with a scheduled administration time of 8:00am. -There was documentation that glipizide 10mg 2 tablets daily was administered from 03/01/26 to 03/09/26. -There was no entry for glipizide 10mg one tablet daily. -There was no documentation that glipizide 10mg one tablet was administered from 03/01/26 to 03/09/26. Observation of Resident #2's medication on hand on 03/10/26 revealed: -There was a box that contained a 30 day roll of individually packaged medications available for administration. -In the 8:00am pack of medications from 03/11/26 to 04/10/26 there were 5 pills available for administration. -There was documentation on the pack that listed the name and quantity of each medication. -There was documentation on the pack that read, one glipizide ER 10mg tablet. Telephone interview with a representative from the facility's contracted pharmacy on 03/11/26 at 10:05am revealed: -Resident #2 had an order for glipizide extended	D 367		

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D 367	Continued From page 69	D 367		

release (ER) 10mg two tablets daily dated 07/15/25.
-The pharmacy did not have an order to decrease glipizide ER 10mg to one tablet daily.

Interview with a representative from the local pharmacy on 03/12/26 at 8:30am revealed:
-Resident #2 had an order to decrease her glipizide 10mg two tablets daily to glipizide 10mg one tablet daily dated 03/01/26.
-The glipizide 10mg one tablet was placed in Resident #2's monthly medications on 03/11/26.
-There were 56 glipizide 10mg tablets dispensed for Resident #2 on 02/10/26, which would last until 03/10/26.
-The MAs should have removed and disposed of one glipizide 10mg tablet from 03/01/26 until 03/10/26.

Interview with Resident #2 on 03/12/26 at 4:08am revealed:
-She took glipizide for her diabetes.
-Her PCP decreased her glipizide from two tablets to one tablet every morning on 03/01/26.
-She notified the pharmacy that the PCP had decreased her glipizide 10mg from two tablets to one tablet.
-She knew her medications and she only took one glipizide 10mg since the beginning of the month, when the orders were changed.

Interview with a MA on 03/12/26 at 1:35pm revealed:
-She knew Resident #2 took glipizide, but she did not recall if she gave her one or two pills.
-She did not remove or discard any medications that were in Resident #2's 8:00am medication pack.
-She administered all the pills that were

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D 367	Continued From page 70 packaged for Resident #2 at 8:00am. -She thought Resident #2 took all the medications she was given, but she was not sure. -She needed to pay more attention when she administered medications and when she documented on the eMAR. Interview with a second MA on 03/12/26 at 1:35pm revealed: -She administered Resident #2 the pills that were in the 8:00am pack that were dispensed by the pharmacy. -She did not know if there was one or two glipizide tablets in the 8:00am pack of medication. -She did not discard any glipizide 10mg from the 8:00am package of medications. -She needed to read the eMAR and the pack of medications and compare the two. -She needed to contact the RCC when medications did not match the eMAR. Interview with the RCC on 03/13/26 at 9:55am revealed: -She did not know Resident #2's glipizide dosage was changed from two tablets to one tablet daily. -She did not remember seeing an order for the change in the dosage. -She expected the MAs to compare the medications to the eMAR to ensure they were the same. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She did not know Resident #2's glipizide dosage had been decreased and that it was not changed on the eMAR. -The MAs needed to ensure the medications they	D 367		

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D 367	Continued From page 71 were administering and the eMAR matched. -She expected the documentation on the eMAR to be accurate. Attempted telephone interviews with Resident #2's PCP on 03/11/26 at 4:43pm and 03/12/26 at 11:22am were unsuccessful. Telephone interview with a representative from the facility's contracted pharmacy on 03/11/26 at 10:05am revealed: -Resident #2 did not receive her medications from the facility's contracted pharmacy; they only profiled Resident #2's medication. -Resident #2's medications were dispensed by a local pharmacy. Interview with a representative from the local pharmacy on 03/12/26 at 8:30am revealed: -The local pharmacy dispensed medications for Resident #2. -The medications were dispensed in individual packages based on the times of administration. -The pharmacy dispensed a month's supply of medication at once. -The pharmacy could not enter orders into the eMAR for Resident #2; the facility would have to enter the new orders into the eMAR. -The PCP was responsible for sending new, discontinued, and changed orders to the pharmacy and to the facility. Interview with a MA on 03/12/26 at 1:35pm revealed: -If a resident saw an outside PCP, the PCP should send new orders back to the facility with the resident or fax the order to the facility. -The facility would send the order to their contracted pharmacy to be profiled and entered	D 367		

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D 367	Continued From page 72 into the eMAR. -If the facility did not get the new order from the outside PCP, the staff would not know new orders were written, medications were discontinued or the order was changed. Interview with the RCC on 03/13/26 at 9:55am revealed: -If a resident used an outside PCP, the resident or family would bring new orders to the facility when they returned from their appointment. -The RCC would fax the new order to the facility's contracted pharmacy to be profiled. -The PCP was responsible for faxing the new order to the resident's local pharmacy and the pharmacy would deliver the medication to the facility. -The MAs were not paying attention to the medication that was in the medication pack and what they were documenting on the eMAR. -The MAs were expected to compare the medications with the eMAR for accuracy before administering medications. -If the eMAR and the medications were not the same, the MA should reach out to the RCC, the pharmacy or the PCP. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -She expected the MAs to compare the medications dispensed from the pharmacy to the entry on the eMAR. -If the medication dispensed and the entry on the eMAR did not match, she expected the MA to reach out to the RCC. -The RCC should contact the PCP to clarify the current order for the medication and see that the current order was entered into the eMAR correctly.	D 367		

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D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents (#7, #8) had a physician's order to self-administer medications observed in the residents' rooms. The findings are: Review of the facility's undated medication services policy revealed that the resident could safely self-administer medications after the community performed the self-administration assessment and the resident was deemed safe to self-administer. The resident would be assessed quarterly or as needed for any changes. 1. Review of Resident #7's current FL2 dated	D 375		

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D 375	Continued From page 74 02/09/26 revealed diagnoses included pancreatic cancer, chronic kidney disease, hypertensive heart disease with heart failure, and hyperkalemia. Review of Resident #7's Resident Register revealed an admission date of 02/09/26. Observation of Resident #7's room on 03/10/26 at 8:56am revealed : -On his over-the-bed table, there were two bottles of over-the-counter (OTC) medication. -On his bedside table were 9 bottles of OTC medication and supplements, including stool softeners, medication to treat diarrhea, pain, bloating, and discomfort of gas. Review of Resident #7's record revealed there were no orders for self-administration of medications or an assessment completed to self-administer any medications. a. Observation of Resident #7's over the bed table on 03/10/26 at 8:56am revealed an OTC bottle of acetaminophen 500mg. Review of Resident #7's primary care provider's (PCP) after-visit summary dated 02/15/26 revealed an order for acetaminophen 325mg, take 2 tablets every 6 hours as needed for pain for 3 days. Review of Resident #7's March 2026 electronic medication administration record (eMAR) from 03/01/26-03/10/26 revealed: -There was an entry for acetaminophen 325mg take two tablets every six hours as needed for pain. -There was no documentation that	D 375		

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D 375	Continued From page 75 acetaminophen had been administered from 03/01/26-03/10/26. Interview with Resident #7 on 03/10/26 at 8:56am revealed that he had acetaminophen for headaches; he had not taken any in a couple of weeks. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #7 did not have an order to self-administer acetaminophen. -Resident #7 had an order for acetaminophen 325mg as needed every 6 hours. -If Resident #7 was administered his ordered acetaminophen and then took his own acetaminophen, he would have taken too much, which, if taken long term, could cause liver damage. b. Observation of Resident #7's over the bed table on 03/10/26 at 8:56am revealed an OTC box of Imodium (used to treat diarrhea). Review of Resident #7's March 2026 eMAR from 03/01/26-03/10/26 revealed there was no entry for Imodium. Interview with Resident #7 on 03/10/26 at 8:56am revealed that he took Imodium when he needed it; he did not recall the last time he took the Imodium. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed Resident #7 did not have an order to self-administer Imodium.	D 375		

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D 375	Continued From page 76 c. Observation of Resident #7's over the bed table on 03/10/26 at 8:56am revealed an OTC bottle of Mylanta (used to relieve heartburn and gas related bloating). Review of Resident #7's orders revealed there were no orders for Mylanta. Review of Resident #7's March 2026 eMAR from 03/01/26-03/10/26 revealed there was no entry for Mylanta. Interview with Resident #7 on 03/10/26 at 8:56am revealed he had taken Mylanta for heartburn a week or so ago. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #7 did not have an order to self-administer Mylanta. -Too much Mylanta could cause diarrhea, and then the resident would take Imodium. _____ Interview with a medication aide (MA) on 03/10/26 at 2:48pm revealed: -She did not know Resident #7 well enough to know if his memory was good. -He did not have an order to self-administer his medications. -She saw medications in his room 1-2 weeks ago and told the Resident Care Coordinator (RCC). Interview with the RCC on 03/11/26 at 2:59pm revealed: -Resident #7 did not have an order to self-administer any medications. -It was a safety concern for him to have medications in his room because he could take	D 375		

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D 375	Continued From page 77 too much. Interview with the Administrator on 03/11/26 at 3:11pm revealed: -The Licensed Health Professional Services (LHPS) nurse had sent her an email on Monday, 03/09/26, discussing medications in resident rooms, and Resident #7 was one of the residents identified. -She printed the email out today, 03/11/26, and gave it to the RCC. -She had a meeting with the MAs last week and told them to be on the lookout for medications in residents' rooms. -She did not remove any of Resident #7's medications because she was taking the approach to talk to the resident's family first. Telephone interview with a triage nurse practitioner for Resident #7's PCP on 03/12/26 at 1:29pm revealed: -She did not see an order for Resident #7 to self-administer his medications. -She did not know the resident, so she did not know if he would be able to administer his medications. -Supplements could negatively interact with other medications. -Resident #7 had not been evaluated to determine if he could safely take the medications/supplements, so he should not have them in his room. Attempted telephone interview with the LHPS nurse on 03/11/26 at 3:29pm was unsuccessful. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am.	D 375		

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D 375	Continued From page 78 Refer to the interview with a personal care aide (PCA) on 03/11/26 at 2:43pm. Refer to the interview with the RCC on 03/11/26 at 2:59pm. Refer to the interview with the Administrator on 03/11/26 at 3:11pm. 2. Review of Resident #8's current FL2 dated 08/06/25 revealed diagnoses included dementia, cerebral infarction, and hypertension. Review of Resident #8's Resident Register revealed an admission date of 04/07/25. Review of Resident #8's record revealed there were no orders for self-administration of medications or an assessment completed to self-administer any medications. a. Observation of Resident #8's room on 03/10/26 at 9:19am revealed she had a bottle of acetaminophen (used to treat mild pain) 500mg in her bedside table drawer. Review of Resident #8's signed physician's orders dated 02/02/26 revealed an order for acetaminophen 325mg take 2 tablets every 8 hours as needed for pain. Review of Resident #8's March 2026 electronic medication administration record (eMAR) from 03/01/26-03/10/26 revealed: -There was an entry for acetaminophen 325mg take two tablets every eight hours as needed for pain. -There was no documentation that	D 375		

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 375	Continued From page 79 acetaminophen had been administered from 03/01/26-03/10/26. Interview with Resident #8 on 03/10/26 at 9:21am revealed she took two acetaminophen from the bottle last night, 03/09/26, at bedtime, for pain. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #8 did not have an order to self-administer any medications. -Resident #8 did not have an order for acetaminophen 500mg but she did have an order for acetaminophen 325mg. -If Resident #8 took more acetaminophen than was recommended for a long period of time, the resident was at risk of liver failure. Interview with a medication aide (MA) on 03/10/26 at 2:48pm revealed Resident #8 did not have an order to self-administer acetaminophen and she had not seen the acetaminophen in the resident's room. Telephone interview with a triage nurse practitioner for Resident #8's PCP on 03/12/26 at 1:29pm revealed: -Resident #8 was prescribed acetaminophen already, so she would be concerned about how often the resident was taking additional acetaminophen on her own. -Resident #8 had not been evaluated to determine if she could safely take the medications, so she should not have them in her room. b. Observation of Resident #8's room on	D 375		

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D 375	Continued From page 80 03/10/26 at 9:19am revealed she had a bottle of Dulcolax (used to treat constipation) on top of her dresser. Review of Resident #8's signed physician's orders dated 02/02/26 revealed: -There was no order for Dulcolax. -Thee was an order for milk of magnesium (used to treat constipation) take 30ml once daily as needed for constipation. -There was an order for MiraLAX (used to treat constipation), take one capful in eight ounces of fluid once daily. Review of Resident #8's March 2026 eMAR from 03/01/26-03/10/26 revealed: -There was no entry for Dulcolax. -There was an entry for MiraLAX mix one capful in eight ounces of liquid and take once daily. -MiraLAX was documented as administered daily from 03/01/26-03/10/26 . -There was an entry for milk of magnesium, take 30ml once daily as needed. -There was no documentation that milk of magnesium administered. Interview with Resident #8 on 03/10/26 at 9:21am revealed: -She had the Dulcolax because she was constipated and had not had a bowel movement for more than 4 days. -She had not taken any of the Dulcolax yet but needed to. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed: -Resident #8 did not have an order to self-administer any medications.	D 375		

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D 375	Continued From page 81 -Resident #8 did not have an order for Dulcolax but did have an order for MiraLAX and milk of magnesium, and if all were taken without monitoring, the resident could have diarrhea. Interview with a MA on 03/10/26 at 2:48pm revealed Resident #8 did not have an order to self-administer Dulcolax and she had not seen the Dulcolax in the resident's room. Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 2:59pm revealed: -Resident #8 did not have an order to self-administer any medications. -It was a safety concern for her to have medications in her room because she could take too much. Telephone interview with a triage nurse practitioner from Resident #8's PCP's office on 03/12/26 at 1:29pm revealed Resident #8 had not been evaluated to determine if she could safely self-administer her medications, and therefore she should not have them in her room. Attempted telephone interview with the Licensed Health Professional Services (LHPS) nurse on 03/11/26 at 3:29pm was unsuccessful. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am. Refer to the interview with a personal care aide (PCA) on 03/11/26 at 2:43pm. Refer to the interview with the RCC on 03/11/26 at 2:59pm.	D 375		

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D 375	Continued From page 82 Refer to the interview with the Administrator on 03/11/26 at 3:11pm. _____ Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/26 at 10:35am revealed that residents could not have a blank order to self-administer any medications; each medication would require an order to self-administer that medication. Interview with a PCA on 03/11/26 at 2:43pm revealed she had been in all the [named] residents' rooms today 03/11/26 and had not seen any medications in the rooms. Interview with the RCC on 03/11/26 at 2:59pm revealed: -If a resident wanted to administer a medication, they had to have an order for the medication, an order to self-administer that medication, and a self-administration assessment saying the resident could self-administer the medication. -If a resident had medications in their room, she expected staff to let her know. Interview with the Administrator on 03/11/26 at 3:11pm revealed: -The LHPS nurse was responsible for assessing residents to determine if they could self-administer medications. -She had talked to families and residents about residents not having medications in their rooms. -She was concerned that the residents had medications in their rooms, and she had explained the regulations about medications in the room to both residents and family members.	D 375		
D 433	10A NCAC 13F .1201(a) Resident Records	D 433		

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D 433	Continued From page 83 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 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	D 433		

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D 433	Continued From page 84 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: Based on record review and interviews, the facility failed to ensure the medical records necessary for the medical evaluation were sent with 1 of 1 residents (#3) when transferred for emergency care. The findings are: Review of Resident #3's FL-2 dated 01/28/25 revealed diagnoses included chronic diastolic heart failure, chronic obstructive pulmonary disease (COPD), seizure disorder, diabetes mellitus type 2, and hypertension. Review of Resident #3's incident report dated 02/06/26 revealed: -The incident report was completed on 03/10/26 by the Special Care Unit Coordinator (SCC). -The medication aide (MA) found Resident #3 on the floor. -Resident #3 stated she fell. -Resident #3 was transferred to the Emergency Department (ED). Telephone interview with Resident #3's Power of Attorney (POA) on 03/10/26 at 3:28pm revealed: -The MA did not send any medical records with Resident #3 when she was transferred to the ED on 02/06/26. -The ED staff asked the Emergency Medical Services (EMS) personnel for the medical records and the only thing they had was Resident	D 433		

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D 433	Continued From page 85 #3's name. -She lived closer to the hospital than the facility, so she went to her home and obtained Resident #3's medical records that were filed on her computer. Telephone interview with a MA on 03/13/26 at 5:35pm revealed: -She did not get Resident #3's paperwork ready to send to the ED on 02/06/26; she stayed with the resident. -She thought the MA working in the Special Care Unit (SCU) got the paperwork ready and gave it to EMS. -She did not know Resident #3's information did not go with her to the ED. Interview with the Administrator on 03/13/26 at 5:50pm revealed: -The MA should send residents' records with them to the ED when the resident left the facility. -The information regarding the residents was important and needed in order to treat the residents. -The MA should always send the face sheet, do not resusitate (DNR) if there was one, and list of medications. -She expected the MAs to send the required papers when residents were sent to the ED.	D 433		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection	D 610		

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D 610	Continued From page 86 prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.	D 610		

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D 610	Continued From page 87 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Centers for Disease Control (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled residents (#1, #2, and #3) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the CDC guidelines for infection control dated 08/07/24 revealed: -The CDC recommended that blood glucose monitoring devices (glucometers) should not be shared between residents. -If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. -If the manufacturer did not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer's manual for Brand A glucometers revealed: -All parts of the system were considered biohazardous and could potentially transmit infectious diseases even after cleaning and disinfection. -The Brand A glucometer was for single patient use only, not for use on multiple patients. Review of the manufacturer's manual for Brand B glucometers revealed the Brand B glucometer	D 610		

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D 610	Continued From page 88 was for single patient use only, and not for use on multiple patients. Review of the facility's undated policy for residents receiving diabetic medications and treatments revealed: -It was the policy of the facility to adhere to the CDC infection prevention guidelines. -Each resident should have their own glucose monitor. -The glucose monitor should be labeled with the resident's name and placed in a bag labeled with the resident's name. Observation of the 300-hall medication cart on 03/11/26 at 4:53pm revealed: -There were 3 plastic containers that had a blue base with clear lids. -Each lid was labeled with a resident's name. 1. Review of Resident #1's current FL2 dated 02/02/26 revealed diagnoses included diabetes mellitus. Review of Resident #1's primary care provider's (PCP) after-visit summary dated 02/02/26 revealed there was an order for finger stick blood sugar (FSBS) checks three times daily before meals and at bedtime. Observation of Resident #1's plastic container on the medication cart on 03/12/26 at 8:10am revealed: -The container was labeled with Resident #1's name, contained an insulin pen and a Brand A glucometer; the glucometer was not labeled. -The current date programmed in the glucometer was 06/02 (no year was shown), and the time was 2:42am.	D 610		

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D 610	Continued From page 89 Review of Resident #1's March 2026 electronic vital signs history report for FSBS, electronic medication administration record (eMAR) from 03/01/26-03/11/26, and glucometer history revealed: -There was an entry on the eMAR for FSBS checks three times daily before meals and at bedtime scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation that Resident #1's FSBS was checked at 8:00am, 2:00pm, and 8:00pm. -There was a second entry to check Resident #1's FSBS daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm. -The documented FSBS readings for 7:00am and 8:00am were the same; the documented FSBS readings for 12:00pm and 2:00pm were the same. -On 03/07/26, there was a documented FSBS reading of 330; the FSBS reading was not recorded in Resident #1's glucometer history but was recorded in another resident's glucometer history. -On 03/08/26, there were documented FSBS readings of 303 at 10:01am and 172 at 4:30pm; the FSBS readings were not recorded in Resident #1's glucometer history but were recorded in another resident's glucometer history. -On 03/09/26, there were documented FSBS readings of 434 at 10:31am and 221 at 9:14pm; the FSBS readings were not recorded in Resident #1's glucometer history but were recorded in another resident's glucometer history. -On 03/10/26,there were documented FSBS	D 610		

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D 610	Continued From page 90	D 610		

readings of 308 at 10:01am, 153 at 12:43pm, 153 at 4:40pm, and 274 at 8:57pm; the FSBS readings were not recorded in Resident #1's glucometer history but were recorded in another resident's glucometer history.
-On 03/11/26, there were documented FSBS readings of 387 at 9:45am and 145 at 12:12pm; the FSBS readings were not recorded in Resident #1's glucometer history but were recorded in another resident's glucometer history.

Interview with Resident #1 on 03/11/26 at 4:40pm revealed:
-Staff had never checked his FSBS back-to-back, and never within 30 minutes of the previous check.
-Staff checked his FSBS at 3:10pm and 4:30pm on 03/07/26, but it was because he was supposed to have his FSBS checked 4 times daily, and they were trying to make sure they checked his FSBS four times that day.

Telephone interview with a medication aide (MA) on 03/13/26 at 9:10am revealed Resident #1's glucometer box was labeled, and he was the only resident who had an insulin pen inside the box, so she thought she had the correct glucometer.

Refer to the interview with a MA on 03/12/26 at 2:40pm.

Refer to the interview with a second MA on 03/12/26 at 3:14pm.

Refer to the telephone interview with a third MA on 03/13/26 at 9:10am.

Refer to the telephone interview with a fourth MA

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D 610	Continued From page 91 on 03/13/26 at 9:42am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/12/26 at 3:09pm. Refer to the interview with the Administrator on 03/12/26 at 3:01pm. Refer to the telephone interview with a triage nurse practitioner on 03/12/26 at 1:29pm. 2. Review of Resident #2's current FL-2 dated 04/02/25 revealed there was a diagnosis of diabetes mellitus type 2. Review of Resident #2's signed physician's orders dated 02/04/26 revealed there was an order for finger stick blood sugar (FSBS) checks daily; notify the primary care provider (PCP) if the FSBS was less than 60 or greater than 400. Observation of Resident #2's plastic container on the medication cart on 03/11/26 at 4:55pm and 03/12/26 at 8:03am revealed the container was labeled with Resident #2's name, contained a Brand B glucometer; the glucometer in the container was not labeled. Review of Resident #2's February 2026 electronic medication administration record (eMAR), FSBS readings vital signs history form and glucometer history revealed: -There was an entry for FSBS checks once daily scheduled at 9:00am from 02/01/26-02/04/26. -There was a second entry to check FSBS once daily scheduled at 7:30am from 02/05/26-02/28/26. -Resident #2's FSBS readings were documented as obtained once daily.	D 610		

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D 610	Continued From page 92 -On 02/04/26, there were no documented FSBS readings on the eMAR; the glucometer readings on 02/04/26 included FSBS reading of 160 at 6:06pm,167 at 6:56pm, 280 at 7:05pm, and 161 at 9:42pm. -On 02/09/26, there was a documented FSBS reading of 158 at 7:30am; the FSBS reading was recorded in Resident #2's glucometer, but there was an additional FSBS reading of 126 at 7:39am that was not documented on Resident #2's eMAR. -On 02/11/26, there was a documented FSBS reading of 125; the FSBS reading was not recorded in Resident #2's glucometer. -On 02/11/26, there was a FSBS reading of 112 at 7:04am that was recorded on another resident's eMAR on 02/11/26 at 7:30am. -On 02/12/26, there was a documented FSBS reading of 147; the FSBS reading was not recorded in Resident #2's glucometer. -On 02/12/26, there was a FSBS reading of 111 at 7:09am that was recorded on another resident's eMAR on 02/12/26 at 7:30am. -On 02/14/26, there was a documented FSBS reading of 134; the FSBS reading was not recorded in Resident #2's glucometer. -On 02/14/26, there was an additional FSBS reading of 197 at 12:43pm that was recorded on another resident's eMAR on 02/14/26 at 11:30am. -On 02/26/26, there was a documented FSBS reading on 149 at 3:48pm and the reading was in Resident #2's glucometer history, but there were additional FSBS readings of 213 at 11:36am, 291 at 11:45am, 228 at 9:44pm, and 204 at 9:50pm that were not documented on Resident #2's eMAR. -On 02/28/26, there was a documented FSBS reading of 247 at 10:32am; the FSBS reading	D 610		

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	HAL091-012	A. BUILDING: _____ B. WING _____	C 03/13/2026

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D 610	Continued From page 93 was not recorded in Resident #2's glucometer history. Review of Resident #2's March 2026 eMAR, FSBS readings vital signs history form and glucometer history revealed: -There was an entry for FSBS checks once daily scheduled at 9:00am from 02/01/26-02/04/26. -There was a second entry to check FSBS once daily scheduled at 7:30am from 02/05/26-02/28/26. -On 03/01/26, there was a documented FSBS of 309 at 10:52am; the FSBS reading was recorded in the glucometer on 03/01 at 10:41am. -The glucometer did not have any other readings recorded for March 2026. -Resident #2 had FSBS readings documented as obtained from 03/02/26-03/11/26 on the eMAR. Interview with Resident #2 on 03/10/26 at 8:15am revealed: -Her biggest problem was getting her FSBS checked as ordered. -Her FSBS checks were ordered every morning. -The medication aides (MA) used to check her FSBS at 6:00am every morning. -The past several months, her FSBS was checked later in the morning, if it was checked at all. -Her FSBS had not been checked that morning, and she had requested that her FSBS be checked before she ate breakfast. -She mentioned it to the MA earlier that morning; the MA said she would be right back and check it and that was over an hour ago. Refer to the interview with a MA on 03/12/26 at 2:40pm.	D 610		

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D 610	Continued From page 94 Refer to the interview with a second MA on 03/12/26 at 3:14pm. Refer to the telephone interview with a third MA on 03/13/26 at 9:10am. Refer to the telephone interview with a fourth MA on 03/13/26 at 9:42am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/12/26 at 3:09pm. Refer to the interview with the Administrator on 03/12/26 at 3:01pm. Refer to the telephone interview with a triage nurse practitioner on 03/12/26 at 1:29pm. 3. Review of Resident #3's current FL-2 dated 01/28/25 revealed there was a diagnosis of diabetes mellitus type 2. Review of Resident #3's signed physician's orders dated 01/07/26 revealed an order for finger stick blood sugar (FSBS) checks three times daily. Observation of Resident #3's plastic container on the medication cart on 03/12/26 at 8:09am revealed: -The container was labeled with Resident #3's name. -There was a Brand A glucometer in the container and was labeled with Resident #3's name. Review of Resident #3's March 2026 electronic vital signs history report for FSBS, electronic medication administration record (eMAR) from	D 610		

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D 610	Continued From page 95 03/01/26-03/11/26 and glucometer history for the glucometer revealed: -There was an entry for FSBS checks three times daily scheduled at 7:30am, 11:30am, and 8:00pm from 03/01/26-03/11/26. -On 03/07/26, there were documented FSBS readings of 126 at 7:16am, 206 at 10:47am, 186 at 12:13pm, and 231 at 8:16pm; the FSBS readings were not recorded in Resident #3's glucometer but were recorded in another resident's glucometer history. -On 03/08/26, there were documented FSBS readings of 113 at 6:53am, 142 at 10:04am, 198 at 4:32pm, and 174 at 9:16pm: the FSBS readings were not recorded in Resident #3's glucometer but were recorded in another resident's glucometer history -There were additional readings in the glucometer of 410 at 3:21am, 160 at 3:32am, 162 at 4:14am, 303 at 4:17am, 137 at 7:11am, 215 at 11:36am, 111 at 11:44am, 137 at 11:46am, and 250 at 2:29pm; these were not documented on Resident #3's eMAR. -On 03/09/26, there were documented FSBS readings of 105 at 11:30am, 181 at 1:53pm, and 155 at 8:57pm; the FSBS readings were not recorded in Resident #3's glucometer but were recorded in another resident's glucometer history. -On 03/10/26, there was a documented FSBS reading of 140 at 10:22am; the FSBS reading was not recorded in Resident #3's glucometer but was recorded in another resident's glucometer history. -On 03/11/26, there were documented FSBS readings of 272 at 9:24am, 198 at 11:47am, and 248 at 9:15pm; the FSBS readings were not recorded in Resident #3's glucometer but were recorded in another resident's glucometer	D 610		

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D 610	Continued From page 96 history. Interview with Resident #3 on 03/13/26 at 8:45am revealed: -She knew her FSBS was checked at 6:00am and at night before bed. -She thought the MAs checked her FSBS a few more times during the day. -She kept a book in her room and documented every time her FSBS was checked. Refer to the interview with a MA on 03/12/26 at 2:40pm. Refer to the interview with a second MA on 03/12/26 at 3:14pm. Refer to the telephone interview with a third MA on 03/13/26 at 9:10am. Refer to the telephone interview with a fourth MA on 03/13/26 at 9:42am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/12/26 at 3:09pm. Refer to the interview with the Administrator on 03/12/26 at 3:01pm. Refer to the telephone interview with a triage nurse practitioner on 03/12/26 at 1:29pm. _____ Interview with a medication aide (MA) on 03/12/26 at 2:40pm revealed: -Every resident had their own glucometer. -She did not know why there would be FSBS readings for a resident in someone else's glucometer; she never used the same glucometer for two residents.	D 610		

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D 610	Continued From page 97 -Every resident's name should be on their glucometer. -Each resident's glucometer should be in a box with the resident's name on the box. Interview with a second MA on 03/12/26 at 3:14pm revealed: -Every resident had their own glucometer in a plastic box labeled with the resident's name. -She did not check the glucometer in the resident's box to make sure it was labeled for the resident; she assumed the glucometer in the box was for that resident. -She did not know why there would be multiple FSBS readings in a glucometer on the same date at the same time when every resident had their own glucometer. Telephone interview with a third MA on 03/13/26 at 9:10am revealed: -She did not know why a glucometer would have FSBS readings back-to-back. -Sometimes the MAs doubled up going down the hall, and maybe someone grabbed the wrong box. Telephone interview with a fourth MA on 03/13/26 at 9:42am revealed: -She verified on the outside of each glucometer box the residents' names. -Some glucometers were not labeled with the resident's name, but the box was labeled with the resident's name. -There was one time she recalled three of the glucometers did not have batteries, so she used a "house stock" glucometer to check those three residents' FSBS. -She sanitized the glucometer between uses by wiping it with alcohol wipes.	D 610		

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D 610	Continued From page 98 -She did not know how one resident's FSBS readings were in another resident's glucometer. Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 3:09pm revealed: -Each resident should have their own glucometer. -Each resident's glucometer should be labeled with the resident's name, and the container should be labeled with the resident's name as well. -Residents' glucometers should not be shared to prevent cross-contamination. Interview with the Administrator on 03/12/26 at 3:01pm revealed: -Each resident had their own glucometer. -She expected the MAs to make sure they used the correct glucometer for each resident when checking FSBS. -Glucometers were not supposed to be shared. -The MAs should use only the resident's glucometer assigned to that resident to prevent cross-contamination. Telephone interview with a triage nurse practitioner from the facility's contracted primary care provider's office on 03/12/26 at 1:29pm revealed shared glucometers would be an infection control concern because of blood-borne illnesses. _____ The facility failed to implement infection control procedures consistent with the Centers for Disease Control (CDC) guidelines, resulting in the inappropriate sharing of glucometers among 3 sampled residents, who had diabetes and an order for FSBS checks. This practice created a risk of exposure to bloodborne pathogens. The	D 610		

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D 610	Continued From page 99 failure of the facility resulted in substantial risk of harm to the residents, and constitutes a Type A2 Volation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/12/26 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 12, 2026	D 610		