Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	R-C 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up and a complaint investigation on March 11, 2026, through March 12, 2026.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. The findings are: Observation of a resident in her room on 03/11/26 at 8:57am revealed: -The resident was eating her breakfast meal. -The meal included eggs, grits, sausage, whole grain toast, juice, and water. -The resident's breakfast was served with a plastic spoon, plastic fork, plastic knife, and the	D 286	10ANCAC 13F .0904 (b)(1) Administrator or designee will check all room trays for every meal x1 week, 3 times weekly x1 week, and continue with periodic "spot checks" to ensure non-disposable knife, fork, spoon, plate, and beverage containers are provided. Complete by 6-1-2026	

Shanda Hill, LPN/ED 04/23/2026

Reviewed on 4/21/26 Reviewed & Acknowledged SC 5/4/26

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

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D 286	Continued From page 1	D 286		

beverages were served in a Styrofoam cup and a plastic cup.

Observation of a second resident in his room on 03/11/26 at 9:05am revealed:
-The breakfast meal was sitting on a side table with a cover over it.
-There were a plastic spoon, plastic fork, and plastic knife inside a plastic wrapper.

Observation of a third resident in her room on 03/11/26 at 9:25am revealed:
-The resident was eating her breakfast meal. -The meal included eggs, grits, sausage, whole grain toast, and water.
-The resident's breakfast was served with a plastic spoon, plastic fork, and plastic knife.

Interview with a third resident on 03/11/26 at 9:25am revealed:
-The facility provided silverware for a while in the last month or two.
-The facility went back to providing plastic spoons, plastic forks, plastic knives, and coffee in Styrofoam cups about a month ago when she ate meals in her room.

Interview with the Dietary Manager on 03/11/26 at 2:25pm revealed:
-She was not aware that servers did not provide non-disposable silverware and cups to the residents eating in their rooms at breakfast. -The servers were to serve residents their beverages in non-disposable cups and silverware on the cart for the residents who ate in their rooms.
-The Administrator met with the kitchen staff in December 2025 and discussed serving meals with non-disposable products only.
-She had not had a meeting with the kitchen staff

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D 286	Continued From page 2 in the last three months about not serving residents with disposal utensils and cups. Interview with the Administrator on 03/12/26 at 4:11pm revealed: -She was not aware that servers did not provide non-disposable silverware and cups to the residents eating in their rooms at breakfast. - She spoke with the kitchen staff on 03/06/26 about serving the residents meals with non-disposable products. -The server manager was responsible to ensure the kitchen staff served the residents non-disposable products. -The Administrator and the Resident Care Coordinator (RCC) were responsible to check to ensure the kitchen staff were providing non-disposable products to residents and her last check was on 03/06/26.	D 286		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a prescribing practitioner for 1 of 5 sampled residents (#3) related to a medication used to treat high blood	D 358	10A NCAC 13F ,1004 All staff who administer medications will be provided additional training and education related to medication administration, to include skill check. Administrator or designee will observe a medication pass daily x1 week, 3 times weekly x1 week, and once weekly for 6 weeks. Complete by 6-1-20026	

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D 358	Continued From page 3 pressure and a medication used to treat flu symptoms. The findings are: Review of the facility's medication administration policy dated 01/13/23 revealed: -The Administrator/Executive Director would ensure that medication related services required or requested by each resident would be provided. -When a resident's vital signs were to be taken to determine the need for administration of medication, parameters for giving the medication would be indicated on the eMAR and a written record would be made on the eMAR. -Vital signs would be taken to determine the need for a medication. Review of the facility's medication room workflow policy dated 05/05/23 revealed: -The medication aide (MA) would follow a consistent workflow to ensure medication orders and medication administration records (eMARs) were up to date. -The Resident Service Director or designee would review all orders. -New orders received would be faxed to the pharmacy. -A notation of the new order would be entered on the medication aide communication log. -The new order would be placed in the resident's record under physician's orders and could be flagged. -If there was a medication change order, the new order would be entered on the eMAR and faxed to the pharmacy. Review of Resident #3's current FL-2 dated 08/27/25 revealed diagnoses included unspecified dementia, anxiety disorder, diabetes,	D 358		

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hyperlipidemia, atrial fibrillation, dietary calcium deficiency, and hypertension.

Review of Resident #3's Resident Register revealed the resident was admitted on 10/10/24.

a. Review of a physician's order for Resident #3 dated 08/27/25 revealed an order for Metoprolol Succ Extended Release (ER) (used to treat high blood pressure) 25mg tablet twice daily *hold for systolic blood pressure less than 100 and heart rate less than 60*.

Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed :
-There was an entry for Metoprolol Succ ER 25mg tablet twice daily *hold for systolic blood pressure (the first/top number of the blood pressure which measures the force of the blood flow when blood is pumped out of the heart) less than 100 and heart rate less than 60* and scheduled for administration at 7:00am and 7:00pm.
-There was an entry for a blood pressure and heart rate reading twice daily and scheduled at 7:00am and 7:00pm.

Review of Resident #3's documented 7:00am systolic blood pressure readings for January 2026 revealed:
-On 01/02/26 at 7:00am, the systolic blood pressure reading was documented as 88. There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00am. -
On 01/08/26 at 7:00am, the systolic blood pressure reading was documented as 98. There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00am.
-On 01/26/26 at 7:00am, the systolic blood

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pressure reading was documented as 95.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00am. -
On 01/01/26 at 7:00pm, the systolic blood pressure reading was documented as 79.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00pm. -
On 01/06/26 at 7:00pm, the systolic blood pressure reading was documented as 77.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00pm. -
On 01/07/26 at 7:00pm, the systolic blood pressure reading was documented as 93.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00pm.

Review of Resident #3's February 2026 electronic medication administration record (eMAR) revealed :
-There was an entry for Metoprolol Succ ER 25mg tablet twice daily *hold for systolic blood pressure less than 100 and heart rate less than 60* and scheduled for administration at 7:00am and 7:00pm.
-There was an entry for a blood pressure and heart rate reading twice daily and scheduled at 7:00am and 7:00pm.
-On 02/14/26 at 7:00am, the systolic blood pressure reading was documented as 99.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00am. -
On 02/22/26 at 7:00pm, the heart rate reading was documented as 54 beats per minute.
There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00pm.

Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed :
-There was an entry for Metoprolol Succ ER

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25mg tablet twice daily *hold for systolic blood pressure less than 100 and heart rate less than 60* and scheduled for administration at 7:00am and 7:00pm.
-There was an entry for a blood pressure and heart rate reading twice daily and scheduled at 7:00am and 7:00pm.
-On 03/04/26 at 7:00am, the systolic blood pressure reading was documented as 83. There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00am. -On 03/11/26 at 7:00am, the systolic blood pressure reading was documented as 98. There was documentation the Metoprolol Succ ER 25mg tablet was administered at 7:00pm.

Interview with a medication aide (MA) on 03/11/26 at 3:20pm revealed:
-Resident #3's blood pressure was checked every morning and every evening.
-He checked Resident #3's blood pressure because the resident had parameters to hold the metoprolol if the systolic blood pressure (SBP) was less than 100 and heart rate was less than 60.
-He placed an "X" on the date on the medication blister pack that corresponded with the dates he held the Metoprolol Succ ER 25mg tablet. -He documented Resident #3's blood pressure and heart rate on the eMAR and indicated when the Metoprolol Succ ER 25mg tablet was held or administered.
-On 01/26/26 at 7:00am, he documented administering the Metoprolol Succ ER 25mg tablet in error.
-If he caught an error he made in documentation on the same day of occurrence, he would correct the error on the eMAR system.
-He was not aware of a process, such as a medication error form, to correct an error after the

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D 358	Continued From page 7 date of occurrence had passed. Interview with a second MA on 03/12/26 at 11:10am revealed: -If his initials were on the eMAR in the section for documenting administration of medication, it meant he administered the medication. -He had not administered the Metoprolol to Resident #3 when the resident's Metoprolol should have been held. -He should have documented "DNG" (drug not given) to note the Metoprolol was not administered. Interview with the Resident Care Director/Medication Aide (MA) on 03/11/26 at 4:02pm revealed: -She was a medication aide (MA). -She did not recall administering Resident #3 any Metoprolol. -If she checked eMARs before leaving work for the day and saw a MA had not documented the administration of a medication, she would contact the particular MA and inquire about the medication administration and enter documentation of administration on the eMAR. -Most of the time she had to check eMARs from home because of internet problems. -There was recent communication with the MAs informing them of the incorrect procedure being used when documenting medication administration for blood pressure parameters. -When she documented her initials on the eMAR, it meant she administered the medication. Interview with the Administrator on 03/12/26 at 9:24am revealed: -There was an option that could be selected when a medication with parameters was held. -The MAs were documenting on the eMAR that	D 358		

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D 358	Continued From page 8 the Metoprolol was administered to Resident #3 because they thought by entering the blood pressure reading, it would show whether the Metoprolol was administered or not. -The MAs were inserviced on the process for documenting when a medication was held based on parameters. -She expected the MAs to document on the eMAR that a medication was not administered when the medication was held. Second interview with the Administrator on 03/12/26 at 1:30pm revealed: -The MA who documented the 7:00pm blood pressure and heart rate readings for 02/05/25, 02/10/26, 02/11/26, 02/18/26, 02/24/26, 02/25/26, and 02/26/26 was the same MA. -The MA documented "na" meaning he did not administer the Metoprolol when Resident #3's blood pressure and heart rate readings were outside the prescribed parameters. -There had been training for the MAs on how to document this on the eMAR on 02/05/26, the particular MA did not understand. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/12/26 at 11:55am was unsuccessful. b. Review of a physician's order for Resident #3 dated 01/07/26 revealed an order for Tamiflu (used to treat the flu virus) 75mg capsule two times a day for five days and discontinue Tamiflu 75mg capsule once a day (start date 12/31/25).. Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed : -There was an entry for Oseltamvir Phosphate (generic for Tamiflu and used to treat flu-like	D 358		

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symptoms) 75mg capsule once daily for ten days with documentation of administration from 01/03/26 through 1/12/26 at 7:00am daily. - There were no additional entries or documentation of administration for the Tamiflu 75mg capsule.

Review of a physician progress note for Resident #3 dated 01/07/26 revealed there was an order for Tamiflu 75mg capsule two times a day for five days and discontinue Tamiflu 75mg capsule once a day (start date 12/31/25).

Review of staff progress notes for Resident #3 revealed:
-On 01/01/26 at 6:11pm, staff documented the resident stayed in bed and slept throughout most of the day, ate about 10% of each meal, drank all fluids, and resident's family brought the resident some Pedialyte and antidiarrheal tablets. -On 01/02/26 at 12:36pm, staff documented the resident had been in bed all shift and was still taking cough medication during the shift. -On 01/05/26 at 11:56am, staff documented the resident was getting a little better and was still coughing.

Review of a staff (title of staff not provided) progress note for Resident #3 revealed there was an entry dated 01/15/26 at 9:57am for "resident has an order for Tamiflu 75mg capsule (start date 1/7/26 - stop date 1/12/26) take 1 capsule twice a day for 5 days. Discontinue previous order Tamiflu 75mg capsule 1 capsule a day for 10 days)".

Interview with the Special Care Coordinator (SCC) on 03/12/26 at 10:56am revealed:
-He had only been in the SCC position for a few weeks and did not know about the 01/07/26

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D 358	Continued From page 10 Primary Care Provider (PCP) order for Tamiflu for Resident #3. -He could not find any information that the PCP order for Tamiflu 75mg tablet two times a day for five days was ever entered to the eMAR but was able to find a progress note entered by the previous SCC documenting receipt of the PCP order for Tamiflu 75mg tablet two times a day dated 01/07/26. -The PCP sent new orders to the facility and contracted provider pharmacy. -The contracted provider pharmacy input new orders to the eMAR. -The SCC was responsible for approving orders after the order was input by the contracted provider pharmacy. -The SCC was supposed to document a progress note in the resident record when a new order was received at the facility. -The SCC was supposed to make sure the new order was on the eMAR before filing the new order in the resident's record. Telephone interview with a pharmacy technician for the contracted pharmacy provider on 03/12/26 at 11:15am revealed: -There was an order for Tamiflu 75mg tablet daily for 10 days dated 12/31/25 received on 01/02/26 for Resident #3. -She could not find any other orders in Resident #3's pharmacy for Tamiflu. -The contracted provider pharmacy did not receive an order changing or discontinuing the Tamiflu 75mg tablet daily dated 12/31/25. -The PCP normally e-scribed orders to the pharmacy or the facility faxed orders to the contracted provider pharmacy. -Sometimes physician orders were emailed to the contracted provider pharmacy by the PCP or facility.	D 358		

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D 358	Continued From page 11 -There would be no way for the contracted provider pharmacy to know of a change in a medication order if there was no communication from the PCP or facility. Telephone interview with a pharmacist at the contracted provider pharmacy on 03/12/26 at 11:26am revealed: -There was no information in Resident #3's pharmacy profile regarding an order for Tamiflu 75mg tablet two times a day. -The only order in Resident #3's pharmacy profile was the order for Tamiflu 75mg tablet daily for 10 days. -It sounded like the contracted provider pharmacy never received the PCP order for Tamiflu 75mg tablet twice daily dated 01/07/26. -If a person had the flu, the Tamiflu was usually twice daily and prescribed one time a day for prophylaxis. Interview with the Administrator on 02/12/26 at 2:20pm revealed: -She did not know what happened with the PCP order for Tamiflu 75mg twice daily dated 01/07/26 for Resident #3. -She did not know why the previous SCC documented a progress note in Resident #3's record about the 01/07/26 Tamiflu order but the order never got changed. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/12/26 at 11:55am was unsuccessful.	D 358	10A NCAC 13F .1004	
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 12 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;(3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were complete and accurate for 1 of 5 sampled residents (#3) related to a medication used to treat high blood pressure. The findings are: Review of the facility's medication administration policy dated 01/13/23 revealed: -The Administrator/Executive Director would ensure that medication related services required or requested by each resident would be provided.	D 367		

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

(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 367	Continued From page 13 -When a resident's vital signs were to be taken to determine the need for administration of medication, parameters for giving the medication would be indicated on the eMAR and a written record would be made on the eMAR. -Vital signs would be taken to determine the need for a medication. Review of the facility's medication room workflow policy dated 05/05/23 revealed the medication aide (MA) would follow a consistent workflow to ensure medication orders and medication administration records (eMARs) were up to date. Review of Resident #3's current FL-2 dated 08/27/25 revealed diagnoses included unspecified dementia, anxiety disorder, diabetes, hyperlipidemia, atrial fibrillation, dietary calcium deficiency, and hypertension. Review of Resident #3's Resident Register revealed the resident was admitted on 10/10/24. Review of a physician's order for Resident #3 dated 08/27/25 revealed an order for Metoprolol Succinate (Succ) Extended Release (ER) (used to treat high blood pressure) 25mg tablet twice daily *hold for systolic blood pressure less than 100 and heart rate less than 60*. Review of Resident #3's February 2026 electronic medication administration record (eMAR) revealed : -There was an entry for Metoprolol Succ ER 25mg tablet twice daily *hold for systolic blood pressure (the first/top number of the blood pressure which measures the force of the blood flow when blood is pumped out of the heart) less than 100 and heart rate less than 60* and scheduled for administration at 7:00am and	D 367		

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D 367	Continued From page 14 7:00pm. -There was an entry for a blood pressure and heart rate reading twice daily and scheduled at 7:00am and 7:00pm. -There were no documented blood pressure readings at 7:00pm on 02/05/26, 02/10/26, 02/11/26, 02/18/26, 02/24/26, 02/25/26, and 02/26/26 and it could not be determined if the Metoprolol Succ ER 25mg tablet needed to be held or administered. -There were no documented heart rate readings at 7:00pm on 02/05/26, 02/10/26, 02/11/26, 02/18/26, 02/24/26, 02/25/26, and 02/26/26 and it could not be determined if the Metoprolol Succ ER 25mg tablet needed to be held or administered. -There was documentation of administration for the Metoprolol Succ 25mg ER at 7:00pm on 02/05/26, 02/10/26, 02/11/26, 02/18/26, 02/24/26, 02/25/26, and 02/26/26. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed : -There was an entry for Metoprolol Succ ER 25mg tablet twice daily *hold for systolic blood pressure (the first/top number of the blood pressure which measures the force of the blood flow when blood is pumped out of the heart) less than 100 and heart rate less than 60* and scheduled for administration at 7:00am and 7:00pm. -There was an entry for a blood pressure and heart rate reading twice daily and scheduled at 7:00am and 7:00pm. -There were no documented blood pressure readings at 7:00pm on 03/03/26, 03/04/26, and 03/05/26 and it could not be determined if the Metoprolol Succ ER 25mg tablet needed to be held or administered.	D 367		

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D 367	Continued From page 15 -There were no documented heart rate readings at 7:00pm on 03/03/26, 03/04/26, and 03/05/26 and it could not be determined if the Metoprolol Succ ER 25mg tablet needed to be held or administered. -There was documentation of administration for the Metoprolol Succ 25mg ER at 7:00pm on 03/03/26, 03/04/26, and 03/05/26. Interview with a medication aide (MA) on 03/12/26 at 11:40am revealed: -There should be documented blood pressures and heart rate readings for Resident #3 daily at 7:00am and 7:00pm. -If the blood pressure and heart rate were not documented, it could not be determined if the Metoprolol Succ ER 25mg tablet needed to be administered or held. Interview with the Special Care Coordinator (SCC) on 03/12/26 at 11:43am revealed: -He would expect the MAs to document resident #3's blood pressure and heart rate readings as ordered. -The expectation was to always follow the PCP order as written. -He was not aware there were continued issues with Resident #3's accurate documentation of blood pressures and heart rates on the eMAR since the staff training conducted for MAs on 02/05/26. -He had only been in the position of SCC for a few weeks and would be responsible for conducting chart audits. Interview with the Administrator on 03/12/26 at 1:30pm revealed: -The MA who had not documented the 7:00pm blood pressure and heart rate readings for Resident #3 was the same MA.	D 367		

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D 367	Continued From page 16 -The MA documented Resident #3's blood pressure and heart when he administered the Metoprolol Succ 25mg ER tablet. -There had been training for the MAs on how to document this on the eMAR on 02/05/26. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/12/26 at 11:55am was unsuccessful.	D 367		
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 1 of 5 sampled residents (#2) had physicians' orders to self-administer medications to include medication for eye drops. The findings are:	D 375	10A NCAC 13F .1005 Administrator or designee will audit all self-administer medications to ensure proper storage and physician orders are in place. Complete by 4-15-2026 Administrator or designee sweep resident rooms daily x1 week and remove any medications that lack proper storage and physician orders, 3 times weekly for 3 weeks, and weekly ongoing Date complete ONGOING	

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D 375	Continued From page 17 Review of the facility's Medication administration policy dated 01/13/23 revealed: -Any prospective or current resident who desires to self-manage their medications must successfully complete their assessment for medication self-management Administered by the resident services director or designee. -The Administrator/Executive Director shall approve all self-management of medications. -File the completed assessment for medication self-management in the resident's record with the resident assessment. -Once the resident has satisfactorily passed the evaluation, the resident services director or designee will ensure there is a physician's order in place that indicates the resident is able to store and self-administer their medications. -In addition, for residents who self-administer their medications it is required that specific instructions for administration of prescription medication are printed on the medication label. -When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician orders or the facility's medication policies and procedures, the facility shall notify the physician. Review of Resident #2's current FL-2 dated 09/04/25 revealed: -Diagnoses included hypertension, edema, stroke, Zenker's diverticulum, and venous insufficiency. -Resident #2 was ambulatory. -Resident #2 required assistance when bathing. -There was no documentation regarding Resident #2's orientation. Review of Resident #2's record revealed there was no assessment or order for	D 375		

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D 375	Continued From page 18 self- administration of medication. Observation of Resident #2's room on 03/11/26 at 9:51am revealed: -Resident #2 was sitting in her recliner. -There was a 0.5-ounce manufactured box with Refresh tears lubricant eye drops (used to treat irritation and discomfort due to dryness of the eye), sitting on top of a side table in Resident #2's bedroom next to her recliner. -There was a warning on the back of the refresh tears lubricant eye drops to keep out of reach of children, if solution changes color or becomes cloudy do not use, if experience eye pain, changes in vision, continued redness or irritation of the eye, stop use and ask a doctor. Interview of Resident #2 on 03/11/26 at 9:51am revealed: -Her primary care provider (PCP) told her to get a bottle of refresh tears eye drops from the drug store to use for her dry eyes. -She used the Refresh tears eye drops once a day unless her eyes bothered her then she would use it twice in a day. -She had used the refresh tears eye drops for months but could not recall the exact date. - She thought staff knew she had the medication in her room. -She was unsure if she had a self-administration order. Interview with the medication aide (MA) on 03/11/26 at 9:58am revealed: -Resident #2 did not have a self-administration order. -She was aware Resident #2 administered her own eye drops. -Resident #2's family member provided the Refresh eye drops.	D 375		

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D 375	Continued From page 19 -She did not administer Resident #2's Refresh eye drops. -She did not know why Resident #2 was administering her own eye drops. Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 4:00pm revealed: -Resident #2 did not have a self-administration order. -She was not aware Resident #2 had over the counter medication in her room. -Resident #2's family member provided the Refresh eye drops. -She explained during admission that residents were not to have medications in their rooms. -She did weekly room inspections to check for medications in residents' rooms. -Her last room inspection was on 03/03/26. Interview with the Administrator on 03/12/26 at 4:16pm revealed: -She was not aware Resident #2 had over the counter medication in her room. -The lead medication aide (MA) on night shift checked each room for medication three to four times a week and notified her if any medications were found in any room. -The RCC was responsible to check residents' rooms for medications weekly. -She sent announcements to family members through a mobile application reminding them that all medications must be accounted for and kept with the MA. Attempted telephone interview with Resident #2's family member on 03/12/26 at 2:42pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 03/12/26 at	D 375		

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D 375	Continued From page 20 2:39pm was unsuccessful.	D 375		