STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on April 28, 2026 - April 30, 2026. The complaint investigation was initiated by Wake County Department of Social Services on April 23, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the Special Care Unit (SCU) was free from hazards as evidenced by unsecured oxygen tanks (O2) in the medication room. The findings are: Review of the facility's Assistance with Oxygen policy dated 06/11/24 revealed: -Oxygen tanks must be secured at all times. -Oxygen tanks would be secured upright at all	D 079		

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times to prevent falling over, being dropped, and striking against other tanks violently.

Review of the facility's license revealed:
-The facility was licensed as a Special Care Unit (SCU) effective 01/01/26 for a capacity of 32 residents.
-The expiration date of the facility's license was 12/31/26.

Review of the facility's census on 04/29/26 revealed the facility's census in the SCU was 24 residents.

Observation of the medication room on 04/29/26 at 4:00pm revealed:
-There were three portable oxygen (O2) tanks sitting upright on the floor in the left corner beside the medication cart.
-Two of the O2 tanks had green tabs on the top, indicating that they were full.
-All 3 O2 tanks were unsecured, not in a rack, cart, or holder.

Interview with a personal care aide (PCA) on 04/30/26 at 8:40am revealed:
-PCAs could change out the O2 tanks when they are empty.
-The O2 tanks were stored in a crate in the resident's room.
-The green tag on the O2 tanks meant that the O2 tank was full.
-The O2 tanks could fall over and explode if not stored in a crate.

Interview with a medication aide (MA) on 04/29/26 at 4:00pm revealed:
-She removed the O2 tanks from a resident's room this morning (04/29/26) because she was concerned that the tanks were in the room, but

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the resident was not on oxygen.
-She did not know the O2 tanks were supposed to be in a rack, cart, or holder.
-The O2 tanks were not in a holder in the resident's room when she removed them.
-She told the MA Supervisor about the O2 tanks and was told to put the tanks in the medication room.
-She had not informed the Special Care Coordinator (SCC) about the O2 tanks.
-She was unsure if the MA Supervisor informed the SCC about the O2 tanks.

Interview with another MA on 04/29/26 at 6:30pm revealed:
-O2 tanks were stored in crates in the resident's room or in the medication room.
-If there was a green tag on the O2 tank, that meant the O2 tank was full.

Interview with the SCC on 04/29/26 at 5:18pm revealed:
-The O2 tanks could not sit on the floor; they were to be kept in a crate.
-The O2 tanks were stored in the resident's closet or in the medication room.
-A PCA made rounds and found several O2 tanks in a resident's room, not in a crate, and placed them in the medication room and did not place them in a crate.
-The resident's crate was in their closet.
-All staff were responsible for ensuring that the O2 tanks were kept in a crate.
-The O2 tanks could have fallen over and exploded and injured the residents and staff.
-If the O2 tank had a green tag on, it meant that the O2 tank was full.

Interview with the Health and Wellness Director (HWD) on 04/29/26 at 4:16pm revealed:

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D 079	Continued From page 3 -She was not aware that O2 tanks in the SCU medication room were not secured. -She knew the O2 tanks were supposed to be in holders. -When the MA found the O2 tanks, she was supposed to notify her or the SCC so the cylinders could be properly stored. -She was unsure why the O2 tanks were not in holders. -The O2 tanks were a safety hazard when not in holders. -The green tab on the top of the O2 tanks meant the tanks were full and had not been opened. Interview with the Administrator on 04/29/26 at 4:19pm revealed: -She was not aware that O2 tanks were in the medication room on the SCU. -She was aware that the O2 tanks were supposed to be in holders. -Unsecured O2 tanks could be dangerous.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.	D 113		

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D 113	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in resident's bathrooms as evidenced by 4 of 19 fixtures with water temperature ranging from 117.3 to 120.4°F. The findings are: Observation of water temperatures on 04/29/26 from 9:10am to 11:08am in resident bathrooms revealed: -In room D115 the hot water temperature of the sink was 120.4°F. -In room shared bathroom of D105 and D106 the hot water temperature of the sink was 118.4°F. -In room D108 the hot water temperature of the sink was 117.3°F. -In room B106 the hot water temperature of the sink was 118°F. Interview with a resident in room D115 on 04/28/26 at 9:15am revealed: -She had no issues with the hot water temperature. -She had never been burned by the hot water. -If she needed hot or cold water, she knew how to adjust the temperature. -She did not require staff assistance with using the sink. Interview with a resident in room D108 on 04/28/26 at 9:25am revealed: -The water was never too hot. -She knew how to adjust the hot and cold water to get the temperature she wanted. -She used the sink without assistance from staff.	D 113		

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Interview with a resident in room B106 on 04/28/26 at 11:08am revealed:
-He had no issues with the temperature of the water.
-He used warm water and knew how to adjust the temperature himself.

Interview with the family members of residents in rooms D105 and D106 on 04/28/26 at 9:15am revealed:
-Staff and family assisted the residents with the use of the sink.
-There had been no issues with the water temperature being too hot.

Interview with a personal care aide (PCA) on 04/28/26 at 11:30am revealed:
-He had no concerns with the temperature of the hot water.
-Some of the residents needed the water turned on for them but many of them were independent with turning the water on in their sinks.
-None of the residents had complained about the water being too hot.
-When he assisted a resident with water, he turned the water on, adjusted the temperature, and let the resident test the water to see if the temperature was comfortable for them.

Interview with a medication aide (MA) on 07/29/26 at 2:30pm revealed:
-There had been no complaints about the water temperatures from residents or staff.
-All the residents used their sinks independently unless they were assisted with toileting by a staff member.

Interview with the Maintenance Director on 10/14/26 at 10:14am and 12:53pm revealed:
-He was responsible for the water temperatures

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in the facility being in range.
-He checked the water temperatures in the facility weekly and kept a water temperature log.
-He checked 1 room per hall weekly.
-Water temperatures fluctuated between 115°F-118°F but were between 115°F-116°F last week.
-New mixing valves were installed March 2026, and he had been adjusting the valves.
-No staff or residents complained of the water temperature being too hot.
-No residents had been burned by hot water.
-He informed the Administrator of the water temperatures weekly.
-He would adjust the mixing valves again and call a plumber to assist him.

Second interview with the Maintenance Director on 04/29/26 at 7:27am and 8:57am revealed:
-He and the plumber adjusted the mixing valves yesterday and were checking water temperatures.
-A hall and B hall water temperatures were within the range of 100°F-116°F.
-He was working to regulate the water temperatures on C hall and D hall.
-The plumber was returning today, 04/29/26, to continue assisting with regulating the water temperature.

Third interview with the Maintenance Director on 04/29/26 at 1:46pm revealed:
-Water temperatures had not been out of range since October 2025 and November 2025.
-He was not aware that water temperatures were out of range.
-Direct care staff were told to mix the water at the sink or shower if it was too hot or too cold.
-If water temperatures felt too hot or too cold, direct care staff were to report to him or the

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Administrator.
-There had been no complaints about the water temperatures from residents or staff.
-He did not recall the last time he adjusted the mixing valve.
-He adjusted the mixing valve some time this year, but he did not recall the date.
-There were no parts on order for the facility's water system at this time.
-He called a plumber when there was an issue with the water temperatures.
-He also adjusted the water temperatures himself.
-The way the water system worked was that cold water went into the water heater and then into the mixing valves.
-From the mixing valves, the water went to the different halls of the facility.

Review of a work order from the local plumbing company dated 09/29/25 revealed:
-A quote was requested for installation of mixing valves on the water heaters on 09/29/25.
-The quote was accepted on 10/21/25.
-Mixing valves were installed on 12/04/25.

Review of the facility's monthly water temperature logs revealed:
-Water temperatures ranged from 110°F to 120°F during the month of October 2025 with 3 weekly checks.
-Water temperatures ranged from 107°F to 120°F during the month of November 2025 with 4 weekly checks.
-Water temperatures ranged from 112°F to 115°F during the month of December 2025 with 1 weekly check.
-Water temperatures ranged from 112°F to 115°F during the month of January 2025 with 4 weekly checks.

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D 113	Continued From page 8 -Water temperatures ranged from 112°F to 115°F during the month of February 2025 with 2 weekly checks. -Water temperatures ranged from 110°F to 119°F during the month of March 2025 with 3 weekly checks. -Water temperatures ranged from 115°F to 116°F during the month of April 2025 with 2 weekly checks. Observation of the facility's hot water temperature on 04/29/26 between 2:04pm and 2:17pm with the Maintenance Director and plumber present revealed: -In room D115, the hot water temperature of the sink was 112.1°F on both the surveyor's thermometer and the Maintenance Director's thermometer at 2:04pm. -In the shared bathroom of room D105 and D106, the hot water temperature of the sink was 111.9°F on both the surveyor's thermometer and the Maintenance Director's thermometer at 2:08pm. -In room D108, the hot water temperature of the sink was 113.4°F on both the surveyor's thermometer and the Maintenance Director's thermometer at 2:11pm. -In room B106, the hot water temperature of the sink was 111.4°F on both the surveyor's thermometer and the Maintenance Director's thermometer at 2:17pm. Interview with the local plumber on 04/28/26 at 3:31pm revealed: -He installed new mixing valves in the facility in the past but could not remember the date of installation. -He would assist the facility's Maintenance Director with adjusting the mixing valves. Second interview with the local plumber on	D 113		

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D 113	Continued From page 9 04/29/26 at 1:46pm revealed: -He was at the facility to adjust the mixing valves to get the water temperatures back in the range of 100°F to 116°F. -The Maintenance Director reported the temperatures were out of range to him yesterday, 04/28/26. -He previously installed new mixing valves because the water temperatures were way out of range. -He had not been back to the facility since he initially installed the new mixing valves. -There had been no calls to his company from the facility about out-of-range water temperatures since the installation of the mixing valves. -The water came into the building cold and went to the mechanical room, which was located outside with the water heaters. -The water then went into the mixing valve and split down each hallway. -The mixing valve was in the attic. Interview with the Health and Wellness Director (HWD) on 04/29/26 at 8:58am revealed: -She did not know what the water temperature range was. -The Maintenance Director was responsible for ensuring water temperatures were within the correct range in the facility. -The Maintenance Director checked hot water temperatures, but she was unsure how often. -The Maintenance Director reported water temperatures to the Administrator. -She was not aware of any water temperature issues. -None of the residents or staff complained of the water being too hot to her. -Any complaints of hot water issues would be brought to her or the MA, and she would report the issue to the Maintenance Director.	D 113		

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D 113	Continued From page 10 -There were no issues with the water system that she was aware of. -When assisting residents, the PCAs tested the water temperature with their hand and had the resident test the water before they used the water. -The residents used the sinks by themselves unless staff assisted them with toileting. -She did not know how the facility's hot water system worked. Interview with the Administrator on 04/28/26 at 10:55am and 1:55pm revealed: -The hot water temperature should be no higher than 116°F. -She was not aware of water temperatures being out of range in the facility. -The Maintenance Director was responsible for ensuring water temperatures were within the correct range in the facility. -The Maintenance Director checked water temperatures, periodically, during the week. -She and the Maintenance Director discussed water temperatures 2 to 3 times per week. -There had been no reports of hot water temperatures above 116°F prior to today, 04/28/26. -Caution signs would be posted regarding the hot water temperature. -A plumber had been called to assist the Maintenance Director with the adjusting the mixing valves. Second interview with the Administrator on 04/29/26 at 9:28am revealed: -She was aware of the facility's hot water temperatures fluctuating in November 2025 and December 2025. -She and the Maintenance Director had not discussed any water temperature issues since	D 113		

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D 113	Continued From page 11 December 2025. -The Maintenance Director went into the attic and adjusted the water temperatures if needed but he did not always tell her that an adjustment was needed. -The water temperatures were regulated by equipment located in the attic. -She knew mixing valves were involved in the water system but did not know exactly how the water system worked. -Direct care staff had been told to inform the Maintenance Director immediately if the water temperatures were too hot or too cold. -There were no complaints from staff or residents about the water temperature. Interview with the primary care provider (PCP) on 04/29/26 at 5:19pm revealed: -Residents in the assisted living unit of the facility would realize if the water was too hot and had the ability to adjust the water temperature. -If the water was too hot, the resident's hands "would get a little red and hurt" but she didn't think any injury would occur because the resident would add more cold water.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.	D 125		

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D 125	Continued From page 12 Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 7 sampled staff who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff B, Staff E) prior to administering medications and 1 of 7 sampled staff (Staff C) did not have the medication skills competency validation prior to administering medications. The findings are: 1. Review of Staff B's personnel record on 04/29/26 revealed: -Staff A was hired on 03/31/26 as a medication aide (MA). -There was no documentation that Staff A completed the state approved 5-hour and 10-hour, or 15-hour medication aide training course. -There was documentation Staff A completed the medication clinical skills checklist. -There was documentation that Staff A passed the MA test on 02/15/18. Review of a resident's April 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff B administered medications on 04/24/26, 04/27/26, and 04/28/26. Attempted telephone interview with Staff B on 04/29/26 at 4:30pm was unsuccessful. Refer to interview with the Health Wellness	D 125		

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Director (HWD) on 04/29/26.

Refer to interview with the Business Office Manager (BOM) on 04/29/26.

Refer to interview with the Administrator on 04/29/26.

2. Review of Staff C's personnel record on 04/29/26 revealed:
-Staff C was hired on 12/17/24 as a medication aide (MA).
-There was no documentation of a completed medication clinical skills checklist.
-There was documentation that Staff C passed the MA test on 11/17/09.

Review of a resident's April 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff C administered medications on 04/04/26, 04/05/26, 04/18/26, and 04/19/26.

Attempted telephone interview with Staff C on 04/29/26 at 4:35pm was unsuccessful.

Refer to interview with the Health Wellness Director (HWD) on 04/29/26.

Refer to interview with the Business Office Manager (BOM) on 04/29/26.

Refer to interview with the Administrator on 04/29/26.

3. Review of Staff E's personnel record on 04/29/26 revealed:
-Staff E was hired on 01/14/26 as a medication aide (MA).
-There was no documentation that Staff E

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TERRABELLA KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 125	Continued From page 14 completed the state approved 5-hour and 10-hour, or 15-hour medication aide training course. -There was documentation of a completed medication clinical skills checklist. -There was documentation that Staff E passed the MA test on 07/21/24. Review of a resident's April 2026 electronic medication administration records (eMAR) revealed there was documentation that Staff E administered medications on 04/24/26. Attempted telephone interview on 04/29/26 at 4:30pm was unsuccessful. Refer to interview with the Health Wellness Director (HWD) on 04/29/26. Refer to interview with the Business Office Manager (BOM)on 04/29/26. Refer to interview with the Administrator on 04/29/26. _____ Interview with the Health Wellness Director (HWD) on 04/29/26 at 3:40pm revealed: -The Business Office Manager was responsible for completing the new employee paperwork and maintained the staff personnel records. -She did not know what paperwork was required for new employees. -She had never audited staff personnel records. Interview with the BOM on 04/29/26 3:50pm revealed: -She had been employed as the BOM for 3 years. -She was responsible for ensuring the staff personnel records were complete which included the MA training and the medication clinical skills	D 125		

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D 125	Continued From page 15 checklist. -She performed weekly audits when she filed new staff documents. -She completed a spreadsheet when new documents were obtained for staff and then placed the document in the staff personnel records. -The spreadsheet was on the computer and the HWD and Administrator had access to review it. -It was an oversite that the required documents were not in the staff folders. -She did not know that the 5-hour and 10-hour or 15-hour medication aide training had to be documented on the State approved certificate of completion. -She did not have documents from prior to when the facility changed owners last year. Interview with the Administrator on 04/29/26 4:04pm revealed: -The BOM was responsible for ensuring staff personnel records were complete. -She had reviewed all staff records since she started at the facility in January 2026. -She thought all the staff records were complete. -She did not know that the 5-hour and 10-hour or 15-hour medication aide training had to be documented on the State certificate of completion. -It was an oversite that the medication skills competency validation for Staff C was not in the staff personnel record. -She was ultimately responsible for ensuring that the staff folders were complete. -She did not have a process for reviewing staff personnel records.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 16 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the acute health care needs for 2 of 5 sampled residents (#2, #3) including not removing a dressing at the access site after dialysis treatment, and failure to notify the primary care provider (PCP) (#3) and failure to follow up after nine medications were administered in error and failure to notify the PCP (#2). The findings are: Review of the facility's Medication Error policy dated 06/11/24 revealed: -Medications were handled in a manner that minimizes the risk of medication errors. -A medication error was defined as wrong medication, wrong person, wrong dose, wrong route, wrong time, missed dose, and not initiating an order. -The individual identifying the medication error immediately reported the error to the Health and Wellness Director (HWD). -If the HWD was not available, the report would be made to the nurse on duty of the Administrator. -The prescribing physician was immediately notified of the medication error. -When reporting the error to the physician, staff were to report the facts of the incident and document and follow the instructions provided by	D 273		

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the physician.
-Staff were to monitor the resident for signs and symptoms of a serious adverse reaction.
-Staff were to enter a narrative note on the resident's status during every shift for 48 hours after a medication error occurred and notify the resident's responsible party of the medication error.
-Staff were to complete an Internal Occurrence Report Form and any state regulatory reporting requirements.

1. Review of Resident #3's current FL2 dated 11/04/25 revealed:
-Diagnoses include dementia with behavioral disturbance, end-stage renal disease on hemodialysis, hypertension, polycystic kidney disease, secondary hypothyroidism, and hypertensive chronic kidney disease stage 5.
-The resident was ambulatory.
-The resident was intermittently disoriented.
-The resident's current level of care was Special Care Unit (SCU).

Review of Resident #3's Resident Register revealed the resident's admission date was 09/24/24.

Review of Resident #3's current care plan dated 03/23/26 revealed:
-The resident required assistance with activities of daily living such as toileting, grooming and personal hygiene.
-The resident required dialysis treatment three times a week.

Review of Resident #3's hospital medical records dated 04/23/26 revealed:
-The reason for the visit was vascular access problem for occluded fistula to right upper arm.

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-The fistula clotted immediately today, no dialysis done today.
-The left upper extremity fistula clotted, no dialysis in 5 days, nephrology wanted to know if declotting was an option.
-Last successful dialysis was on Saturday, 04/18/26.
-A procedure was performed of a left dialysis catheter placement.
-She was discharged back to the facility on 04/25/26.

Observation of the SCU nursing room on 04/28/26 at 3:58pm revealed there was a white board with the message to please make sure Resident #3's bandage was off one hour after she returned from dialysis.

Telephone interview with Resident #3's family member on 04/28/26 at 3:20pm revealed:
-She told the Health and Wellness Director (HWD) to remove the dressing from Resident #3's arm to not allow blood to clot.
-The dressing should be removed after a couple of hours every time Resident #3 returned from the dialysis treatment.
-The dialysis center nurse and social worker told her that they told the facility to remove the dressing.
-She could not say if there was a physician order to remove the dressing.
-The dialysis nurse told the family member that the facility was not removing the dressing as they should have and that her blood could clot.
-Resident #3's blood clotted at the fistula at least three times in the last two months.
-04/21/26, this was the third time Resident #3 could not receive dialysis and the access center declotted the access site.
-On 04/23/26, Resident #3 returned to dialysis

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and the access site would not work.
-Resident #3 was sent to the local hospital to have the access site unclogged to receive dialysis.

Interview with a medication aide (MA) on 4/28/26 at 3:50pm revealed:
-She was told by the HWD to remove Resident #3's dressing in an hour or two after returning from dialysis.
-The instructions were written in the medication room on a whiteboard.
-She knew the dressing must be removed so the blood did not clot.
-She made sure the dressing was removed when she worked and she had no problems with removing the dressing.
-There were times when Resident #3 did not wish for the dressing to be removed and she would wait until Resident #3 calmed down and then tried again to remove the dressing.

Interview with the Special Care Coordinator (SCC) on 04/28/26 at 9:25am revealed:
-Resident #3 went to dialysis on Tuesday, Thursday and Saturdays.
-Resident #3 returned from dialysis with a dressing and it must be removed after three hours.
-Resident #3 sometimes refused to allow the MA to remove the dressing and would say, "that's my lifeline".
Interview with the HWD on 04/28/26 at 4:00pm revealed:
-When Resident #3 returned from the dialysis center, the dressing was to be removed in 45 minutes to an hour.
-She was not aware the dressing was not being removed until Resident #3's family member told her.

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D 273	Continued From page 20 -She did not receive a physician order from the dialysis center about removing the dressing. -She never spoke with anyone regarding a physician order from the dialysis center. -She did speak with a MA in mid-March regarding removing the dressing. Telephone interview with Resident #3's Dialysis Center Registered Nurse (RN) on 04/29/26 at 11:20am revealed: -Resident #3 received dialysis treatments each week on Tuesday, Thursday, and Saturday. -Before Resident #3 left the dialysis center, she made sure her access site did not bleed by placing a dressing which should be removed 6 to 8 hours after treatment. -The dialysis center advised the facility staff to remove the bandage 6 to 8 hours after dialysis treatment because Resident #3 was known to have increased bleeding. -The dressing was placed on the access site on 04/18/26 and when she returned on 04/21/26, the dressing was still on the access site. -The dialysis center called the facility to let them know the dressing should not stay on the access site any longer than 6 to 8 hours after dialysis treatment. -She did not know who she spoke with at the facility and could not give a date of the call. -Resident #3 did not receive dialysis on 04/21/26 because the access site was inaccessible. -She did a bruit (swooshing sound) and thrill (buzzing sensation) assessment to ensure the access site was working properly. -Resident #3 did not show good bruit and thrill in her access arm on 04/21/26. -The access site was not working properly and could not be used for dialysis. -Resident #3 was sent to the access center to have the access site declotted.	D 273		

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D 273	Continued From page 21 -Resident #3 was referred to the vascular surgeon and was immediately sent to the local hospital. -Resident #3 returned to the dialysis on 03/21/26, 04/07/26, and 04/21/26 with the dressing still on the access site and she did not receive dialysis on those days. -Resident #3 received dialysis in the hospital on 04/23/26. -A port was placed in Resident #3's chest temporarily for access. -The dressing on Resident #3's fistula should have stayed no more than 8 hours then should have been removed because it could cause formation of a clot. -Once clots formed, the access site could not be used and Resident #3 had to see a vascular surgeon to remove the clot. -Resident #3 had a communication book that was sent between the dialysis center and the facility. -The communication book was continuous care of documentation between the dialysis center and the facility. -The communication book provided information such as vital signs from the facility and the dialysis center provided vital signs before and after treatments, any events such as low blood pressure during treatment, cramping, access event, medications given, and removal of dressing instructions. -The nurse wrote in the communication book with instructions about removing the dressing but did not keep a copy of the instructions for her records. -No one called from the facility to the dialysis center to clarify instructions or to request a physician order. -The communication book had not been in Resident #3's personal bag in the month of April 2026.	D 273		

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-The dialysis center clinical coordinator called the facility and asked about the communication book and was told that Resident #3 did not need the communication book any longer.
-She did not know who the clinical coordinator spoke with during the phone call.
-Five days without dialysis could increase potassium level, toxins in the blood stream, normal blood urea nitrogen levels could increase, fluid overload if fluid was not removed, and the resident could end up in the hospital.
-Fluid could accumulate in the body and make the resident feel sick with symptoms of shortness of breath, nausea, and she could go into cardiac arrest.

Review of Resident #3's laboratory tests dated 04/23/26 revealed:
-Resident's #3 blood urea nitrogen (BUN) level range was 77 and the normal range was 7-25 mg/dl.
-Resident #3's potassium level was 5.2 and the normal range was 3.5-5.1 mmol/L.
-Resident #3's phosphorus level was 7.2 and the normal range was 2.5-5.0 mg/dl.
-The BUN level, phosphorus, and potassium levels were considered in the high range.

Second interview with the SCC on 04/29/26 at 4:00pm revealed:
-Resident #3's family member told her to remove the dressing after returning from dialysis.
-She gave the MA the instructions but did not have a physician's order about removing the dressing.
-She called the dialysis center three times, and could not remember the exact date but did not get anyone.
-She contacted the HWD and the family member that she could not get anyone to verify the

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physician order.
-She did not follow up any further.
-The MA was removing the dressing without a physician order.
-It was not common practice to administer a treatment without an order.

Interview with HWD on 4/29/26 at 4:45pm revealed:
-She did not receive instructions on removing dressing from Resident #3 access site from the dialysis center.
-The Resident Care Coordinator (RCC) contacted the dialysis center on 04/07/26 regarding Resident #3's dialysis treatment but she was unable to reach anyone and left a voicemail.
-The RCC left the position the week of April 20th.
-She did not know she needed a physician's order to remove the bandage.
-All treatment orders are placed on the medication administer record (MAR).
-She verified if the MAs were doing their job such as administering treatments by reviewing the MARs.
-Resident #3's treatment was not on the MAR because there was no physician order.
-She did not do a treatment without a physician order.
-She was not sure why she did not follow up about Resident #3's post dialysis instructions.

Second interview with the HWD on 04/30/26 at 12:40pm revealed:
-She did not think removing a bandage needed an order in this setting.
-There were no standards of procedures on residents that were on dialysis to follow.
-She did not know about procedures practices for follow up for acute care.

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Telephone interview with Resident #3's primary care provider (PCP) on 04/29/26 at 5:30pm revealed:
-She saw Resident #3 on 04/29/26 for the first time as a patient.
-She was not aware Resident #3's dressing was not removed after returning from dialysis.
-She was aware that the access site had been clogged several times.

Telephone interview with the Access Center surgical nurse on 04/30/26 at 8:45am revealed:
-Resident #3's fistula was declotted on 03/23/26, 04/09/26, and 04/22/26.
-If the dressing was wrapped tightly, blood could stop flowing causing a blood clot.
-Symptoms of blood clotting would be toxin building in the bloodstream, shortness of breath, swelling, nausea, increasing potassium level, and potential to go into cardiac arrest.

Telephone interview with the dialysis center medical doctor on 04/30/26 at 2:40pm revealed:
-Resident #3's graft clotted twice.
-A nurse and a social worker from the dialysis center called the facility about the clotting but she could not say if they got anyone to speak with them.
-Communication depended on the facility in how they wanted the communication sent to them.
-Usually, communication was a physician's order for treatment.
-If there was no dialysis treatment in five days, possible symptoms were electrolyte issues, toxin in the body, admission to a hospital, and possibly death.

Interview with the Administrator on 04/29/26 at 5:50pm revealed:
-She was not aware that there was not a

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physician's order for the treatment of removing Resident #3's dressing.
-She was not aware that Resident #3's dressing was not being removed after dialysis treatment until the family member told her.
-The MA must have a physician's order to administer treatment.
-The MA should not be following a family's order for treatment.
-The HWD was responsible to follow up with any physician's orders needed.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

2. Review of the facility's Incident Reports policy dated 06/11/24 revealed:
-Injuries and unusual incidents would be reported in compliance with state regulatory requirements.
-Incidents were immediately reported to the resident's family/responsible party and physician.

Review of Resident #2's current FL-2 dated 01/18/26 revealed:
-Diagnoses included Alzheimer's Disease, hypertension, atrial fibrillation, coronary artery disease (CAD), peripheral artery disease, depression, anxiety and chronic pain.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #2's assessment and care plan dated 01/08/26 revealed:
-The resident was documented as ambulatory with aide or device, and she had no problems with her upper extremities.
-The resident had normal bowel and bladder function.
-The resident was sometimes disoriented, had

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significant memory loss, and must be directed.
-The resident required limited assistance with toileting, ambulation, bathing, dressing and grooming.
-The resident required supervision with eating and transferring.

Review of Resident #2's Incident Report dated 04/11/26 on 04/30/26 at 2:05pm revealed:
-The incident occurred at 9:30am on the first shift.
-The incident classification was Medication Error.
-The incident occurred in the hallway.
-Resident #2's vitals were taken and her blood pressure was 177/80, her pulse was 70 and her temperature was 97.4.
-Resident #2's pain level was 0.
-Resident #2 was transferred to the hospital via EMS.
-The Health and Wellness Director (HWD) was notified at 9:40am.
-Resident #2's primary care provider (PCP) was notified at 7:37pm.
-Resident #2's family was notified at 7:37pm.
-Resident #2 had no injuries.
-The medications administered to Resident #2 in the 12 hours prior to 04/11/26 at 9:30am were administered at 9:24am and included: Fluticasone 50mcg (used to treat allergies), Risperidone 0.25mg (used to treat mental health conditions), Memantine 10mg (used to treat Alzheimer's Disease), Furosemide 20mg (used to treat fluid retention), Guaifenesin 400mg (used to treat chest congestions), Sertraline 50mg used to treat mental health conditions), and Eliquis 5mg (used to prevent and treat blood clots).

Review of Resident #2's Emergency Medical Services (EMS) report dated 04/11/26 revealed:
-EMS was called for Resident #2 on 04/11/26 at 7:33pm.

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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 273	Continued From page 27 -EMS was on scene at 07:49pm. -Facility staff reported administering resident #2 her medications along with another resident's medications by mistake prior to EMS arrival. -Facility staff reported the wrong medication administration occurred at 9:00am on 4/11/26. -The wrong medications administered to Resident #2 by facility staff included Acetaminophen (used to treat pain), Amlodipine (used to treat high blood pressure), Calprotect ointment (used to treat and prevent skin irritation), Ferrous Sulfate (used to treat and prevent iron deficiency), Furosemide, Gabapentin (used to treat nerve pain), Hydralazine (used to treat high blood pressure), Melatonin (used to treat sleep disorders), Ondansetron (used to prevent nausea and vomiting), Primidone (used to treat seizures), Senna plus (used to treat constipation), Sertraline, Simethicone (used to treat excess gas in the digestive tract), Sodium Bicarbonate (used to treat heartburn and indigestion), Trospium (used to treat overactive bladder), and Vitamin D3 (used as a supplement to Vitamin D) . -Facility staff reported Resident #2 was pale. -Facility staff reported Resident #2 was presenting at baseline. -Resident # 2 presented with generalized weakness and malaise (a general feeling of being unwell). -Resident #2 reported she felt tired and that it was her bedtime. -Resident #2 denied dizziness, shortness of breath, headache, pain, urinary changes or changes to bowel movements. -Resident #2 was initially responsive to verbal stimuli, breathing was non labored, skin was warm and dry, poor turgor with tenting (when the skin loses elasticity and fails to snap back which is a sign of moderate to severe dehydration), pupils reactive, and radial pulse was present.	D 273		

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-Resident #2 was administered fluids.
-Resident #2 showed improvement in alertness throughout transport and no negative changes were noted
-EMS arrived at the hospital at 8:33pm.

Review of Resident #2's hospital records revealed:
-Resident #2 presented after accidental administration of another resident's medications including extra doses of Furosemide, Hydralazine, Amlodipine, Primidone, Sertraline, and Vitamin D.
-Medications administered to Resident #2 that were not on her medication list included Amlodipine 2.5mg, Iron Sulfate 324mg, Furosemide 40mg, Hydralazine 50mg, Primidone 50mg, Sertraline 100mg, Sodium Bicarbonate 650mg, Trospium 20mg, and Vitamin D3 50mcg.
-At approximately 9:00am on 04/11/26, Resident #2 was inadvertently given another resident's medications in addition to her own.
-EMS was activated about one hour prior to the emergency department arrival when the facility recognized the error.
-Resident #2 remained at baseline throughout the day per facility staff and EMS.
-EMS noted Resident #2 was initially mildly sedated and responsive to verbal stimuli, improving during transport.
-Resident #2 felt normal and denied pain, fever, nausea, vomiting, diarrhea, dizziness, shortness of breath, and dysuria (painful urination).
-Resident #2's baseline functional status at the facility was mostly independent with self-care.
-Resident #2 was reported by facility staff to be at her baseline with no new symptoms such as nausea, vomiting, diarrhea, dizziness, or shortness of breath.
-The exam of Resident #2 revealed alertness

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near baseline and a strong urine odor.
-Differential diagnosis included but was not limited to accidental medication overdose, electrolyte imbalance, acute kidney injury and urinary tract infection.
-Accidental ingestion of another resident's medications raised concern for toxicity or adverse effects though the resident was at baseline with no acute symptoms.
-Extra Furosemide and antihypertensives may cause electrolyte disturbances, particularly hypokalemia (abnormally low levels of potassium) necessitating laboratory evaluation.
-Over diuresis from additional Furosemide could precipitate renal dysfunction, warranting assessment of kidney function and electrolytes.
-Strong urine odor raised suspicion for urinary tract infection (UTI) though no urinary symptoms were reported.
-Resident #2's labs and urinalysis were reassuring, and Resident #2 was stable for discharge at 2:09am on 04/12/26.

Interviews with a medication aide (MA) on 04/30/26 at 8:51am and 11:31am revealed:
-She worked as a MA and a personal care aide (PCA).
-She had been a PCA for 2 years and was familiar with the residents.
-On 04/11/26, she worked as a MA and had been a MA for approximately 5 days.
-On 04/11/26, she was on her way to administer medication to the resident whose room was next door to Resident #2's room. (Time unknown.)
-She saw Resident #2 about to fall so she went to get her walker out of her room.
-She had the medication and water for the other resident in one hand while she grabbed Resident #2's walker with the other hand.
-When she handed Resident #2 her walker, she

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also handed her the cup of medication and cup of water that belonged to the other resident.
-She watched Resident #2 take the other resident's medication and went back to the medication cart to document that the medication had been administered.
-When she got to the medication cart, she saw the other resident's name and picture and realized she had administered the medication to the wrong resident.
-She called another MA because she did not know what to do.
-She had already given Resident #2 her medication prior to administering the other resident's medication to Resident #2.
-She and the other MA reviewed the other resident's medications to make sure Resident #2 was not allergic to any of the medications.
-She called the HWD at 7:51am on 04/11/26 to let her know what happened as she was not at the facility, but the HWD did not answer.
-She later spoke with the HWD at 9:40am using the other MA's phone and informed her of the incident.
-The HWD told her to check Resident #2's vital signs, observe her, check the vital signs every hour, and to call EMS if Resident #2 started to look distressed.
-She did not remember what medications she administered to Resident #2.
-Resident #2 had medications scheduled to be administered at 8:00am and 9:00am.
-She administered the other resident's medication to Resident #2 around "7 something" that morning; she was unsure of the exact time the medication was administered.
-Resident #2 ate lunch and did not show any change in her behavior.
-Resident #2 put her head down on her hands on her walker which was normal for her.

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-She checked Resident #2's vital signs but did not document them anywhere.
-When the second shift MA came in at 3:00pm, she told her what happened with medication administration for Resident #2.
-She had left the facility when the second shift MA called EMS for Resident #2, so she did not know what prompted the call to EMS or what time the call was made.
-MAs were supposed to document medication errors in Incident/Accident reports.
-She did not recall being told by anyone that EMS should have been called.
-She did not call the PCP or EMS because she was following instructions from her supervisor, the HWD; but also, there was nothing abnormal going on with Resident #2 that would have prompted a call the EMS.
-An in-service was held on 04/09/26 by the Special Care Coordinator (SCC) and HWD telling staff to contact the HWD when an Incident/Accident occurred.
-MAs were to contact the PCP, resident's family, SCC and Administrator.
-She was the MA on duty the day of the in-service so she may have missed some of the meeting because she had to step out to pass medication.

Interview with a second MA on 04/30/26 at 9:45am and 11:08am revealed:
-She had been a MA in the Special Care Unit (SCU) for about 1 month.
-On 04/11/26, she was working as a MA in the assisted living (AL) section.
-The first shift SCU MA told her the HWD instructed her to monitor Resident #2.
-Throughout the day, she went to the SCU approximately 2 times before 3:00pm to check on Resident #2.
-Resident #2 appeared drowsier than normal as

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she sat at the bench by the desk or in a chair.
-Resident #2 normally slept off and on during the day, but also walked around and she did not see her walking around during the time she visited the SCU before 3:00pm.
-She told the first shift SCU MA that Resident #2 was drowsier than normal and the first shift SCU MA told her Resident #2's vital signs were normal.
-She did not know what the facility's medication error policy was.
-She did not report to anyone else because she was a new employee at the facility.
-When she went to start her shift in the SCU at 3:00pm, Resident #2 was still sleeping off and on.
-She administered Resident #2's evening medication at approximately 7:30pm or 8:00pm.
-The SCU PCAs told her Resident #2 was not herself as she was pale and slurring her speech, so she called EMS,
-She called EMS at approximately 7:33pm.
-She called the HWD at approximately 7:38pm.
-She called the SCC at approximately 8:11pm.
-She called Resident #2's family member and she did not answer but called back at approximately 7:55pm.

Interview with the SCC on 04/30/26 at 12:05pm and 1:12pm revealed:
-When an Incident/Accident occurred, the MAs were to contact the HWD, family and PCP, document the incident in the progress notes and complete and Incident/Accident report.
-In-services were done with staff regarding when and what to document in progress notes.
-She could not remember the dates of the in-services but knew the first and second shift SCU MAs from 04/11/26 attended.
-She had not had the chance to review all the facility policies, so she was not familiar with the facility's Medication Error policy.

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D 273	Continued From page 33 Interview with the HWD on 04/29/26 at 4:22pm and 5:36pm revealed: -The MA notified her that she administered the wrong medications to Resident #2 on 04/11/26. (Time unknown.) -The MA that came in at 3:00pm on 04/11/26 informed her that she felt Resident #2 was not at baseline due to slurred speech and pale skin. -She told the MA to call EMS. -She told the MA to check Resident #2's vital signs, monitor her and notify the PCP. Second interview with the HWD on 04/30/26 at 12:40pm revealed: -Per policy the MA should have immediately called 911, obtained Resident 2's vital signs, and called the PCP, then called the responsible party and complete an incident report. -She did not know why she did not have the MA follow the policy. -The Regional Director of Resident Care (RDRC) reviewed what should have taken place when Resident #2 was administered another resident's medication: obtain vital signs, notify PCP and resident's family and follow up to see how Resident #2 was doing. -Resident #2 went to the hospital before she notified the RDRC. -She did not follow up on Resident #2 to ensure that the incident report had been completed and the PCP and family were notified. Interview with the Administrator on 04/30/26 at 1:37pm revealed: -If there was a medication error, the MA was to contact the HWD. -The HWD was responsible for talking to the MA about the error and contacting the Administrator, the RDRC, the PCP and the family.	D 273		

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-Vitals were supposed to be taken and staff were to await instructions from the PCP.
-She was not at the facility when the incident occurred but told the HWD to make sure Resident #2's family and PCP were notified.
-If the resident needed to be sent out for further evaluation, the HWD would call EMS.
-When staff were hired, they were trained using a check off list by the corporate office that reviewed policies.
-Policies were always available to staff on the computer shared drive.
-The facility policies were based on state regulations so staff should have been familiar with the policies.
-She thought the HWD just forgot to notify the PCP.
-The PCP should have been notified.

Interview with a pharmacist at the facility's contracted pharmacy on 04/30/26 at 9:10am revealed:
-Lasix 40mg was used to treat high blood pressure and kidney function and the medication could have reduced Resident #2's blood pressure, causing dizziness, diaphoresis (a term meaning excessive perspiration) and fainting.
-Amlodipine 2.5mg and Hydralazine 50mg were used to treat high blood pressure and the medication could have reduced Resident #2's blood pressure, causing dizziness, diaphoresis, and fainting.
-Sertraline 100mg was used to treat depression and anxiety and could have caused Resident #2 tiredness, dizziness, and increased fall risk.
-Primidone 50mg was used to treat seizures and could have caused Resident #2 emotional disturbances, mood changes, dizziness, drowsiness, decrease coordination, and fatigue.
-Trospium 20mg was used to treat overactive

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bladder and could have caused Resident #2 to have dry skin, similar to allergy medication.
-Ferrous Sulfate 324mg was used as a supplement for low iron and could have caused Resident #2 to have elevated iron levels.
-Sodium Bicarbonate 650mg was used to replenish electrolytes. There were no concerns with this medication.
-Tylenol 500mg was used to treat pain and fever. There was no concern with this medication.
-Vitamin D3 50mcg was used as a supplement to increase Vitamin D levels. There was no concern with this medication.
-There could have been interactions between the medications that Resident #2 took and the medications she received that belonged to another resident.
-Since Resident #2 was only administered one dose there was less concern.
-The increase in the number of blood pressure (BP) medications Resident #2 was administered could have increased the side effects of altered mental status, fainting, dizziness, increased fall risk, hypotension, paleness, and diaphoresis.

Interview with Resident #2's PCP on 04/29/26 at 5:19pm revealed:
-Her first visit with Resident #2 was 04/04/26.
-She was not sure if she was aware that Resident #2 went to the hospital after being administered another resident's medication; she did not see any correspondence from the facility regarding the incident.
-If she had been notified, she would have told the facility to monitor for somnolence (drowsiness) and hypotension (low blood pressure) as these could be the side effects for someone who did not need the medications that were administered.

Based on observations interviews and record

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D 273	Continued From page 36 reviews, Resident #2 was not interviewable. Attempted telephone interview with Resident #2's family member on 04/29/26 at 11:57am was unsuccessful. _____ The facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 5 sampled residents (#2, #3). The facility did not obtain an order to remove a dressing at the resident's dialysis access site who returned to the dialysis center with the dressing still on access site in place for two consecutive days. On 03/21/26, 04/07/26, and 04/21/26, the resident returned to dialysis with the dressing in place a total of 3 times which caused dialysis access site to clot resulting in the resident missing dialysis treatments. On 04/21/26, the resident was unable have her dialysis treatment due to a clotted access site, which resulted in a hospital admission, dialysis missed for 5 days, and elevated blood work (#3). On 04/11/26, Resident #2 was administered nine medications in error in addition to her regular scheduled medications around 9:30am and there was no notification to the resident's primary care provider (PCP) or referral to the emergency department for 10 hours, with emergency medical services (EMS) being contacted at 7:33pm. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED May 30, 2026.	D 273		

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D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure transportation was provided for 1 of 5 sampled residents (#3) related to arranging transportation for the resident's dialysis treatments. The findings are: Review of the facility's transportation policy dated September 2022 revealed: -The facility would do its best to accommodate and provide personal transportation. -Transportation will be provided within a certain radius and based on availability of employees during designated dates and times. Review of Resident #3's current FL2 dated 11/04/25 revealed: -Diagnoses include dementia with behavioral disturbance, end-stage renal disease on	D 321		

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hemodialysis, hypertension, polycystic kidney disease, secondary hypothyroidism, and hypertensive chronic kidney disease stage 5.
-The resident was ambulatory.
-The resident was intermittently disoriented.
-The resident's current level of care was Special Care Unit (SCU).

Review of Resident #3's Resident Register revealed the resident's admission date was 09/24/24.

Review of Resident #3's current care plan dated 03/23/26 revealed:
-The resident required assistance with activities of daily living such as toileting, grooming and personal hygiene.
-The resident required dialysis treatment three times a week.

Telephone interview with Resident #3's family member on 04/28/26 at 2:00pm revealed:
-Transportation was part of the residential package when Resident #3 was admitted to the facility in 2024.
-The facility transported Resident #3 to her dialysis treatments on Monday, Wednesday, and Friday.
-The facility staff would call her to pick Resident #3 up from her dialysis treatment because the facility did not have a driver.
-She received an email form the facility in December 2025 that transportation would be offered twice a week.
-She called the dialysis center and changed Resident #3's dialysis days from Monday, Wednesday, and Friday to Tuesday, Thursday, and Saturday.
-She had to hire a driver to take Resident #3 to dialysis on Saturdays.

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D 321	Continued From page 39 Interview with Health and Wellness Director (HWD) on 4/29/26 at 4:45pm revealed: -There were scheduling issues with transportation, and the facility was unable to transport daily. -An email was sent to residents' family members that medical appointments would be scheduled on Tuesday and Thursday. -Resident #3 dialysis appointments changed from Monday, Wednesday, and Friday to Tuesday, Thursday, and Saturday. -The facility transported Resident #3 to dialysis appointments on Tuesday and Thursday. -Resident #3's family member transported her to dialysis on Saturday. Interview with the Administrator on 04/29/26 at 5:50pm revealed: -The facility's former Administrator provided transportation to residents Monday through Friday. -She was instructed to provide transportation two days a week for medical appointments. -She sent a letter to residents' families regarding the new transportation policy in December 2025. -Resident #3's family member never shared with her that she had transportation issues. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.	D 321		
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,	D 358		

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D 358	Continued From page 40 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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) who was administered another resident's medication including medications for Vitamin D deficiency, overactive bladder, heartburn, blood pressure, depression, seizures, fluid retention, and iron deficiency. The findings are: Review of the facility's Documenting Medication Pass policy dated 06/11/24 revealed: -All medication staff members would pour the medication they were giving and verify the medication three times during the poor process. -All medications were administered per physician's orders. Review of the facility's Medication Error policy dated 06/11/24 revealed: -Medications were handled in a manner that minimizes the risk of medication errors. -A medication error was defined as wrong medication, wrong person, wrong dose, wrong route, wrong time, missed dose, and not initiating an order. -The individual identifying the medication error immediately reported the error to the Health and Wellness Director (HWD).	D 358		

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-If the HWD was not available, the report would be made to the nurse on duty of the Administrator.
-The prescribing physician was immediately notified of the medication error.
-When reporting the error to the physician, staff were to report the facts of the incident and document and follow the instructions provided by the physician.
-Staff were to monitor the resident for signs and symptoms of a serious adverse reaction.
-Staff were to enter a narrative note on the resident's status during every shift for 48 hours after a medication error occurred and notify the resident's responsible party of the medication error.
-Staff were to complete an Internal Occurrence Report Form and any state regulatory reporting requirements.

Review of Resident #2's current FL-2 dated 01/18/26 revealed:
Diagnoses included Alzheimer's Disease, hypertension, atrial fibrillation, coronary artery disease (CAD), peripheral artery disease, depression, anxiety and chronic pain.
-The resident's level of care was Special Care Unit (SCU).

Review of the Resident Register revealed Resident #2 was admitted on 01/21/23.

Review of Resident #2's Incident Report dated 04/11/26 revealed:
-The incident occurred at 9:30am on the first shift.
-The incident classification was Medication Error.
-The incident occurred in the hallway.
-Resident #2's vitals were taken and her blood pressure was 177/80, her pulse was 70 and her temperature was 97.4.

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-Resident #2's pain level was 0.
-Resident #2 was transferred to the hospital via EMS.
-The Health and Wellness Director (HWD) was notified at 9:40am.
-Resident #2's primary care provider (PCP) was notified at 7:37pm.
-Resident #2's family was notified at 7:37pm.
-Resident #2 had no injuries.
-The medications administered to Resident #2 in the 12 hours prior to 04/11/26 at 9:30am were administered at 9:24am and included: Fluticasone 50mcg (used to treat allergies), Risperidone 0.25mg (used to treat mental health conditions), Memantine 10mg (used to treat Alzheimer's Disease), Furosemide 20mg (used to treat fluid retention), Guaifenesin 400mg (used to treat chest congestions), Sertraline 50mg used to treat mental health conditions), and Eliquis 5mg (used to prevent and treat blood clots).

Review of Resident #2's Emergency Medical Services (EMS) report dated 04/11/26 revealed:
-EMS was called for Resident #2 on 04/11/26 at 7:33pm.
-EMS was on scene at 07:49pm.
-Facility staff reported administering resident #2 her medications along with another resident's medications by mistake prior to EMS arrival.
-Facility staff reported the wrong medication administration occurred at 9:00am on 4/11/26.
-The wrong medications administered to Resident #2 by facility staff included Acetaminophen (used to treat pain), Amlodipine (used to treat high blood pressure), Calprotect ointment (used to treat and prevent skin irritation), Ferrous Sulfate (used to treat and prevent iron deficiency), Furosemide, Gabapentin (used to treat nerve pain), Hydralazine (used to treat high blood pressure), Melatonin (used to treat sleep

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disorders), Ondansetron (used to prevent nausea and vomiting), Primidone (used to treat seizures), Senna plus (used to treat constipation), Sertraline, Simethicone (used to treat excess gas in the digestive tract), Sodium Bicarbonate (used to treat heartburn and indigestion), Trospium (used to treat overactive bladder), and Vitamin D3 (used as a supplement to Vitamin D) .
-Facility staff reported Resident #2 was pale.
-Facility staff reported Resident #2 was presenting at baseline.
-Resident # 2 presented with generalized weakness and malaise (a general feeling of being unwell).
-Resident #2 reported she felt tired and that it was her bedtime.
-Resident #2 denied dizziness, shortness of breath, headache, pain, urinary changes or changes to bowel movements.
-Resident #2 was initially responsive to verbal stimuli, breathing was non labored, skin was warm and dry, poor turgor with tenting (when the skin loses elasticity and fails to snap back which is a sign of moderate to severe dehydration), pupils reactive, and radial pulse was present.
-Resident #2 was administered fluids.
-Resident #2 showed improvement in alertness throughout transport and no negative changes were noted
-EMS arrived at the hospital at 8:33pm.

Review of Resident #2's hospital records revealed:
-Resident #2 presented after accidental administration of another resident's medications including extra doses of Furosemide, Hydralazine, Amlodipine, Primidone, Sertraline, and Vitamin D.
-Medications administered to Resident #2 that were not on her medication list included

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D 358	Continued From page 44 Amlodipine 2.5mg, Iron Sulfate 324mg, Furosemide 40mg, Hydralazine 50mg, Primidone 50mg, Sertraline 100mg, Sodium Bicarbonate 650mg, Trospium 20mg, and Vitamin D3 50mcg. -At approximately 9:00am on 04/11/26, Resident #2 was inadvertently given another resident's medications in addition to her own. -EMS was activated about one hour prior to the emergency department arrival when the facility recognized the error. -Resident #2 remained at baseline throughout the day per facility staff and EMS. -EMS noted Resident #2 was initially mildly sedated and responsive to verbal stimuli, improving during transport. -Resident #2 felt normal and denied pain, fever, nausea, vomiting, diarrhea, dizziness, shortness of breath, and dysuria (painful urination). -Resident #2's baseline functional status at the facility was mostly independent with self-care. -Resident #2 was reported by facility staff to be at her baseline with no new symptoms such as nausea, vomiting, diarrhea, dizziness, or shortness of breath. -The exam of Resident #2 revealed alertness near baseline and a strong urine odor. -Differential diagnosis included but was not limited to accidental medication overdose, electrolyte imbalance, acute kidney injury and urinary tract infection. -Accidental ingestion of another resident's medications raised concern for toxicity or adverse effects though the resident was at baseline with no acute symptoms. -Extra Furosemide and antihypertensives may cause electrolyte disturbances, particularly hypokalemia (abnormally low levels of potassium) necessitating laboratory evaluation. -Over diuresis from additional Furosemide could precipitate renal dysfunction, warranting	D 358		

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assessment of kidney function and electrolytes.
-Strong urine odor raised suspicion for urinary tract infection (UTI) though no urinary symptoms were reported.
-Resident #2's labs and urinalysis were reassuring, and Resident #2 was stable for discharge at 2:09am on 04/12/26.

Review of the facility's monthly vital signs book on 04/30/26 at 12:00pm revealed there had been no vital signs documented for Resident #2 since January 2026.

Review of Resident #2's facility progress notes revealed there were no entries for 04/11/26.

Review of Resident #2's physician's order sheet dated 04/02/26 revealed:
-There was an order for Acetaminophen 325mg, one every six hours as needed for pain.
-There was an order for cough drop lozenges 7.5mg, Dissolve one lozenge every two hours as needed for cough or throat irritation.
-There was an order for Eliquis 5mg once daily.
-There was an order for Fluticasone 50mcg, spray one spray into each nostril once daily.
-There was an order for Furosemide 20mg once daily.
-There was an order for Guaifenesin 400mg, two tablets twice daily.
-There was an order for Melatonin 5mg, one every evening.
-There was an order for Memantine 10mg, one twice daily.
-There was an order for Pantoprazole 40mg, one every morning.
-There was an order for Risperidone 0.5mg, one daily at bedtime.
-There was an order for Risperidone 0.25mg, one every morning.

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-There was an order for Sertraline 50mg, one every morning.
-There was an order for Vitamin D3 50mcg, one every morning.

Review of the Medication Pass History report for 04/11/26 for Resident #2 revealed:
-Resident #2 was administered Sertraline 50mg, Memantine 10mg, Fluticasone 50mcg spray, Eliquis 5mg, Risperidone 0.25mg, Furosemide 20mg, and Guaifenesin 400mg at 9:24am.
-Resident #2 refused Pantoprazole 40mg at 9:27am and Vitamin D3 50mcg at 9:28am.
-Resident #2 was administered Melatonin 5mg, Memantine 10mg, Guaifenesin 400mg and Risperidone 0.5mg at 7:13pm.

Review of Resident #2's April 2026 electronic medication administration records (eMAR) revealed:
-There was an entry for Fluticasone 50mcg, spray one spray into each nostril once daily scheduled to be administered at 8:00am and documented as administered on 04/11/26.
-There was an entry for Furosemide 20mg once daily scheduled to be administered at 9:00am and documented as administered on 04/11/26.
-There was an entry for Melatonin 5mg, one every evening scheduled to be administered at 8:00pm and documented as administered on 04/11/26.
-There was an entry for Memantine 10mg, one twice daily scheduled to be administered at 8:00am and 8:00pm and documented as administered on 04/11/26.
-There was an entry for Guaifenesin 400mg, two tablets twice daily scheduled to be administered at 8:00am and 8:00pm and documented as administered on 04/11/26.
-There was an entry for Pantoprazole 40mg, one tab every morning scheduled to be administered

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at 8:00am and documented as administered on 04/11/26.
-There was an entry for Risperidone 0.25mg one every morning scheduled to be administered at 9:00am and documented as administered on 04/11/26.
-There was an entry for Risperidone 0.5mg one daily at bedtime scheduled to be administered at 8:00pm and documented as administered on 04/11/26.
-There was an entry for Sertraline 50mg one every morning scheduled to be administered at 8:00am and documented as administered on 04/11/26.
-There was an entry for Vitamin D 50mcg, one every morning scheduled to be administered at 8:00am and documented as administered on 04/11/26.
-There was an entry for Eliquis 5mg once daily scheduled to be administered at 9:00am and documented as administered on 04/11/26.
-There was an entry for Acetaminophen 325mg, take 2 every 6 hours as needed for pain, not documented as administered on 04/11/26.
-There was an entry for Cough Drop Lozenges 7.5mg, dissolve 1 lozenge every 2 hours as needed for cough or throat irritation, not documented as administered in 04/11/26.
-There were no vital signs documented for Resident #2.

Interview with a medication aide (MA) on 04/30/26 at 8:51am and 11:31am revealed:
-She worked as a MA and a personal care aide (PCA).
-She had been a PCA for 2 years and was familiar with the residents.
-On 04/11/26, she worked as a MA and had been a MA for approximately 5 days.
-On 04/11/26, she was on her way to administer

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medication to the resident whose room was next door to Resident #2's room. (Time unknown.)
-She saw Resident #2 about to fall so she went to get her walker out of her room.
-She had the medication and water for the other resident in one hand while she grabbed Resident #2's walker with the other hand.
-When she handed Resident #2 her walker, she also handed her the cup of medication and cup of water that belonged to the other resident.
-She watched Resident #2 take the other resident's medication and went back to the medication cart to document that the medication had been administered.
-When she got to the medication cart, she saw the other resident's name and picture and realized she had administered the medication to the wrong resident.
-She called another MA because she did not know what to do.
-She had already given Resident #2 her medication prior to administering the other resident's medication to Resident #2.
-She and the other MA reviewed the other resident's medications to make sure Resident #2 was not allergic to any of the medications.
-She called the HWD at 7:51am o 04/11/26 to let her know what happened as she was not at the facility, but the HWD did not answer.
-She later spoke with the HWD at 9:40am using the other MA's phone and informed her of the incident.
-The HWD told her to check Resident #2's vital signs, observe her, check the vital signs every hour, and to call EMS if Resident #2 started to look distressed.
-She did not remember what medications she administered to Resident #2.
-Resident #2 had medications scheduled to be administered at 8:00am and 9:00am.

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D 358	Continued From page 49 -She administered the other resident's medication to Resident #2 around "7 something" that morning; she was unsure of the exact time the medication was administered. -Resident #2 ate lunch and did not show any change in her behavior. -Resident #2 put her head down on her hands on her walker which was normal for her. -She checked Resident #2's vital signs but did not document them anywhere. -When the second shift MA came in at 3:00pm, she told her what happened with medication administration for Resident #2. -She had left the facility when the second shift MA called EMS for Resident #2, so she did not know what prompted the call to EMS or what time the call was made. -MAs were supposed to document medication errors in Incident/Accident reports. -She did not document the medication error because she did not know she was supposed to do so at the time. -When administering medication, she prepared the medication once at the resident's door by putting the medication into the medication cup. -The eMAR had a button that showed on the screen telling her to prepare the medication, and the medications for the resident were listed. -As the medications were placed in the medication cup, she clicked the button beside the name of each medication. -She compared the medications 3 times with the resident's name and the eMAR before administering to ensure the right medications were in the medication cup. -She did not get Resident #2 and the other resident mixed up; she did not want Resident #2 to fall and that caused her to become distracted. -She did not recall being told by anyone that EMS should have been called.	D 358		

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D 358	Continued From page 50 -She did not call EMS because she was following instructions from her supervisor, the HWD; but also, there was nothing abnormal going on with Resident #2 that would have prompted a call the EMS. -An in-service was held on 04/09/26 by the Special Care Coordinator (SCC) and HWD telling staff to contact the HWD when an Incident/Accident occurred. -MAs were to contact the PCP, resident's family, SCC and Administrator. -She was the MA on duty the day of the in-service so she may have missed some of the meeting because she had to step out to pass medication. Interview with a second MA on 04/30/26 at 10:32am revealed: -She worked as a MA and PCA since January 2026. -On 04/11/26, she was working as a MA on the assisted living (AL) unit. -The SCU MA came and got her and explained that she accidentally administered Resident #2 another resident's medication. -She told the first shift SCU MA to call the HWD. -The first shift SCU MA attempted to reach the HWD from her phone but was unsuccessful; she was unsure of the time of the call. -They spoke with the HWD on her (AL MA) phone at 9:40am on 04/11/26. -She did not know what the HWD told the first shift SCU MA because she was not on the call. -She told the first shift SCU MA that they needed to check Resident #2's allergy list to make sure she was not allergic to any of the medications she was administered. -She told the first shift SCU MA she needed to monitor Resident #2, check her vital signs and call EMS if her overall well-being was off. -She returned to the SCU at 3:00pm and	D 358		

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Resident #2 was sleeping in the TV room.
-She tried to wake Resident #2, and she could barely open her eyes.
-She told the first shift SCU MA she needed to call EMS before she left the SCU.
-She did not know what happened after that because she went back to the AL unit.
-She knew EMS was called at some point because she saw the second shift MA gathering paperwork for EMS.
-When a medication error occurred, MAs were to report the incident to the HWD and document the incident in the facility progress notes.
-She was unsure who completed the Incident/Accident reports.
-Management contacted the PCP and family when incidents/accidents occurred.
-She was familiar with medication error reports but had not been told to complete one.
-An in-service was held on 04/09/26 by the HWD and SCC regarding new policies and they were advised that the MAs were responsible for contacting the family and documentation for Incident/Accident reports.

Interviews with a third MA on 04/30/26 at 9:45am and 11:08am revealed:
-She had been a MA on the SCU for about 1 month.
-On 04/11/26, she was working as a MA in the AL section.
-When she arrived at work on 04/11/26 at approximately 10:54am, the 1st shift SCU MA informed her she had administered Resident #2 her medication as well as another resident's medication.
-The first shift SCU MA told her the HWD instructed her to monitor Resident #2.
-Throughout the day, she went to the SCU approximately 2 times before 3:00pm to check on

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TERRABELLA KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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D 358	Continued From page 52 Resident #2. -Resident #2 appeared drowsier than normal as she sat at the bench by the desk or in a chair. -Resident #2 normally slept off and on during the day, but also walked around and she did not see her walking around during the time she visited the SCU before 3:00pm. -She told the first shift SCU MA that Resident #2 was drowsier than normal and the first shift SCU MA told her Resident #2's vital signs were normal. -When she went to start her shift in the SCU at 3:00pm, Resident #2 was still sleeping off and on. -She administered Resident #2's evening medication at approximately 7:30pm or 8:00pm. -The SCU PCAs told her Resident #2 was not herself as she was pale and slurring her speech, so she called EMS, -She called EMS at approximately 7:33pm. -She called the HWD at approximately 7:38pm. -She called the SCC at approximately 8:11pm. -She called Resident #2's family member and she did not answer but called back at approximately 7:55pm. -Before being administered the evening medications, Resident #2 was sleeping like she normally did with naps and was talking and laughing. -Resident #2's behavior changed after she was administered the evening medications. -When a resident was administered the wrong medication, the HWD and EMS should be contacted and an Incident/Accident report should be completed. -She did not know what the facility's medication error policy was. -She thought she documented the incident in the facility progress notes but may have forgotten to do so. -She felt EMS should have been called that morning when the medication was administered.	D 358		

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D 358	Continued From page 53 -She expressed her concerns to the first shift SCU MA, but she was a new MA doing what she had been told to do. -She did not report her concerns about Resident #2 to anyone else because she was new employee at the facility. Interview with the SCC on 04/30/26 at 12:05pm and 01/12/26 revealed: -When an Incident/Accident occurred, the MAs were to contact the HWD, resident's family and PCP, document the incident in the progress notes and complete and Incident/Accident report. -She was not at the facility the day Resident #2 was administered her medication in addition to another resident's medication. -The second shift SCU MA called her that evening (04/11/26), told her about the incident and that Resident #2 was not acting like herself; Resident #2's speech was slurred and she was sleeping. -She did not recall the time the second shift SCU MA called her. -The second shift SCU MA told her she was calling EMS and the HWD. -The facility had a Resident Care Coordinator (RCC) at the time, so she was not the first contact person for Incident/Accidents. -The RCC was supposed to check on the Incident/Accident reports and documentation every morning. -The RCC's last day was 04/21/26. -After the incident with Resident #2, she started checking documentation every morning to review charting on residents that needed monitoring and any new issues with residents. -In-services were done with staff regarding when and what to document in progress notes. -She could not remember the dates of the in-services but knew the first and second shift	D 358		

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D 358	Continued From page 54 SCU MAs from 04/11/26 attended. -She had not had the chance to review all the facility policies, so she was not familiar with the facility's Medication Error policy. Interview with the HWD on 04/29/26 at 4:22pm and 5:36pm revealed: -Resident #2 was administered the wrong medication by a MA on 04/11/26 at approximately 9:25am. -The medication administered to Resident #2 on 04/11/26 belonged to another resident. -The medications administered to Resident #2 on 04/11/26 that did not belong to her were Vitamin D3 50mcg, Trospium 20mg, Sodium Bicarbonate 650mg, Sertraline 100mg, Primidone 50mg, Furosemide 40mg, Hydralazine 50mg, Ferrous Sulfate 324mg, Amlodipine 2.5mg and Acetaminophen 500mg. -The MA notified her that she administered the wrong medications to Resident #2. -She told the MA to check Resident #2's vital signs, monitor her and notify the PCP. -The MA that came in at 3:00pm on 04/11/26 informed her that she felt Resident #2 was not at baseline due to slurred speech and pale skin. -She told the MA to call EMS. -Between 9:45am and 3:00pm, none of the staff members felt Resident #2 was different from her baseline. Second interview with the HWD on 04/30/26 at 12:40pm revealed: -She was notified within thirty minutes of Resident #2's medication error on 04/11/26. -The MA called her around 10:00am -She was on call 24 hours a day seven days a week. -The MA said that Resident #2 was okay. -She instructed her to take Resident #2's vital	D 358		

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signs, monitor her for anything abnormal, and send her to the hospital if she was off her baseline.
-She said Resident #2's vital signs were good and she looked good; she did not know what the vital signs were.
-She verified that Resident #2 was not allergic to any of the medications she received from another resident and she verified by researching in the computer system.
-She did not check for any interactions between what Resident #2 was taking and the medications she was administered.
-Per policy the MA should have immediately called 911, obtained Resident #2's vital signs, and called the PCP, then call the responsible party and complete an incident report.
-She did not know why she did not have the MA follow the policy.
-She was concerned that Resident #2's blood pressure would drop.
-She did not know of anything else that could have happened to Resident #2.
-She informed the Regional Director of Resident Care (RDRC) after dinner, on 04/11/26, that there was a medication error and Resident #2 was sent to the hospital.
-The RDRC reviewed what should have taken placed when Resident #2 was administered another resident's medication, which was to obtain vital signs, notify the PCP and family and to follow up and see how Resident #2 was doing.
-Resident #2 went to the hospital before she notified the RDRC.
-A MA called her because Resident #2 did not look right to her, she was pale and had slurred speech.
-She did not follow up on Resident #2 to ensure that the incident report had been completed and the PCP and family were notified.

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-She did not assess Resident #2 when she returned to work on Monday 04/13/26.
-She was required to submit an incident report to the Department of Social Services (DSS) within 24-48 hours of the incident.
-She was responsible for sending the incident report to DSS, it was an oversight.
-She called Resident #2's family member on 04/11/26 after she was sent to the hospital.
-She did not know of any process for reviewing staff notes for documentation and vital signs.
-The facility did not have a RCC.

Interview with the Administrator on 04/30/26 at 1:37pm revealed:
-If there was a medication error, the MA was to contact the HWD.
-The HWD was responsible for talking to the MA about the error and contacting the Administrator, the Regional Clinical Nurse, the PCP and the resident's family.
-Vital signs were supposed to be taken and staff were to await instructions from the PCP.
-If the resident needed to be sent out for further evaluation, the HWD would call EMS.
-The MA would have been removed from the cart and retrained.
-The HWD was responsible for completing Incident/Accident reports and documenting in the progress notes after a medication error.
-On 04/11/26, she was notified that the MA poured medication for one resident and saw Resident #2 falling in the process.
-The MA tried to help Resident #2 and administered the wrong medication to her.
-The MA called the HWD immediately.
-She was not at the facility but told the HWD to make sure Resident #2's family and PCP were notified.
-She did not recall whether she told the HWD to

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complete an Incident/Accident report, but an Incident/Accident report and progress note should have been done.
-She thought the HWD just forgot to complete the Incident Accident report and to notify the PCP.
-When staff were hired, they were trained using a check off list by the corporate office that reviewed policies.
-Policies were always available to staff on the computer shared drive.
-She was unsure if they completed Medication Error reports at the facility.

Interview with the RDRC on 04/30/26 at 2:30pm revealed:
-The HWD notified her by email at 9:04pm on 04/11/26 that Resident #2 was given another resident's medication and was sent to the hospital.
-She did not know that Resident #2 also received her morning medications before she was administered another resident's medications.
-A evening shift MA had concerns about the resident and called 911.
-EMS took Resident #2's vital signs and her oxygen level was low.
-She was supposed to be notified for serious medication errors.

Interview with a pharmacist at the facility's contracted pharmacy on 04/30/26 at 9:10am revealed:
-Lasix 40mg was used to treat high blood pressure and kidney function and the medication could have reduced Resident #2's blood pressure, causing dizziness, diaphoresis (a term meaning excessive perspiration) and fainting.
-If Resident #2's kidney function was reduced this could have changed the half life of the medications by increasing the half-life. (Half-life

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D 358	Continued From page 58 refers to the time required for the concentration of a medication in the body or bloodstream to decrease by 50%.) -The half-life of Lasix was 2 hours. -Amlodipine 2.5mg and Hydralazine 50mg were used to treat high blood pressure and the medication could have reduced Resident #2's blood pressure, causing dizziness, diaphoresis, and fainting. -The half-life of Amlodipine was 30 to 52 hours. -The half-life of Hydralazine was 3 to 7 hours. -Sertraline 100mg was used to treat depression and anxiety and could have caused Resident #2 tiredness, dizziness, and increased fall risk. -The half-life of Sertraline was 27 hours. -Primidone 50mg was used to treat seizures and could have caused Resident #2 emotional disturbances, mood changes, dizziness, drowsiness, decrease coordination, and fatigue. -The half-life of Primidone was 5-16 hours. -Trospium 20mg was used to treat overactive bladder and could have caused Resident #2 to have dry skin, similar to allergy medication. -Ferrous Sulfate 324mg was used as a supplement for low iron and could have caused Resident #2 to have elevated iron levels. -Sodium Bicarbonate 650mg was used to replenish electrolytes. There were no concerns with this medication. -Tylenol 500mg was used to treat pain and fever. There was no concern with this medication. -Vitamin D3 50mcg was used as a supplement to increase Vitamin D levels. There was no concern with this medication. -There could have been interactions between the medications that Resident #2 took and the medications she received that belonged to another resident. -Since Resident #2 was only administered one dose there was less concern.	D 358		

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D 358	Continued From page 59 -The increase in the number of blood pressure (BP) medications Resident #2 was administered could have increased the side effects of altered mental status, fainting, dizziness, increased fall risk, hypotension, paleness, and diaphoresis. Interview with Resident #2's PCP on 04/29/26 at 5:19pm revealed: -Her first visit with Resident #2 was 04/04/26. -She was not sure if she was aware that Resident #2 went to the hospital after being administered another resident's medication; she did not see any correspondence from the facility regarding the incident. -The medications administered to Resident #2 that belonged to another resident could have been used for many reasons, so she could not give specific information on how the medications could have affected Resident #2. -If she had been notified, she would have told the facility to monitor for somnolence (drowsiness) and hypotension (low blood pressure) as these could be the side effects on someone who did not need the medications that were administered. -Resident #2 had no known allergies to the medications administered to her that belonged to another resident. Attempted telephone interview with the PCP's office on 04/30/26 at 1:14pm was unsuccessful. Attempted telephone interview with Resident #2's family member on 04/29/26 at 11:57am was unsuccessful. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable. _____ The facility failed to administer medications as	D 358		

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D 358	Continued From page 60 ordered for 1 of 5 sampled residents (#2). A medication aide (MA) administered the resident her prescribed medications and then administered another resident's medications to her which included receiving extra doses of medications for fluid retention and to treat mental health disorders which could cause the resident to have reduced kidney function and dizziness and an increased risk of falls. The resident also received two blood pressure (BP) medications which were not prescribed to her which could cause her BP to drop causing dizziness and fainting. The facility's failure put the resident at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 04/30/26 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED May 30, 2026.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	D 366		

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D 366	Continued From page 61 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication staff who administered medications observed two residents (#5, #6) taking their medications. The findings are: Review of the documenting medication pass policy dated 06/11/24 revealed: -Observe the resident to ensure all medications scheduled for medication pass are consumed by the resident. -No medication can be left with the resident to self-administer at a later time. -The resident can either be given all oral medications to be taken during medication pass in a disposable cup with the medication aide (MA) observing the resident pour all the medications directly into their mouth or one by one to ensure no medications are missed. 1. Review of Resident #5's current FL-2 dated 11/13/25 revealed diagnoses included anxiety, hypertension, hyperlipidemia, and hypothyroidism. Observation of a Resident #5's room on 04/28/26 at 9:50am revealed: -There was a cup of medication sitting on a table that contained 2 tablets. -One tablet was a round orange tablet with numbers 44227; it was identified as Aspirin 325mg (Aspirin is a long-term medication used to prevent blood clots). -One oblong gel tablet red in color was identified as Docusate Sodium 100mg (Docusate Sodium is used to treat and prevent constipation). Review of Resident #5's physician orders dated	D 366		

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D 366	Continued From page 62 04/29/26 revealed: -There was an order for Tylenol 500mg administer 2 tablets every morning (Tylenol is used to treat pain). -There was an order for Amlodipine 5mg administer twice daily (Amlodipine is used to treat high blood pressure).. -There was an order for Aspirin 325mg enteric coated administer every morning (Aspirin is used a long-term medication used to prevent blood clots). -There was an order for CO Q-10 100mg administer every morning (CO Q-10 is a supplement used to treat nutritional deficiency). -There was an order for Docusate Sodium 100mg administer twice daily (Docusate Sodium is used to treat and prevent constipation). -There was an order for Ferosul 325mg administer every morning (Ferosul is used to treat anemia). -There was an order for Losartan Potassium 100mg administer every morning (Losartan Potassium is used to treat high blood pressure). -There was an order for Pantoprazole 40mg administer every morning (Pantoprazole is used to treat gastro-esophageal reflux disease). -There was an order for Preservision Areds 2 chew administer every morning (Preservision Areds is a supplement used to treat eye health). -There was an order for Sertraline 100mg administer 1.5 tablets daily (Sertraline is used to treat depression). -There was an order for Vitamin D3 25mcg administer every morning (Vitamin D3 is a supplement used to treat vitamin D deficiency). Review of Resident #5's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 500mg take 2	D 366		

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tablets scheduled for 9:00am and was documented as administered on 04/28/26 at 9:00am.
-There was an entry for Amlodipine 5mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Aspirin 325mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for CO Q-10 100mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Docusate Sodium 100mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Ferosul 325mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Losartan Potassium 100mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Pantoprazole 40mg take 1 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Preservision Areds 2 take 1 chew scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Sertraline 100mg take 1.5 tablets scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Vitamin D3 25mcg take 1

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D 366	Continued From page 64 tablet scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am. Interview with Resident #5 on 04/28/26 at 9:50am revealed: -The MA left 2 tablets for her to take after she showered and ate breakfast. -All the MAs left her medications to take later. -The MAs did not watch her take her medications. Interview with MA on 04/28/26 at 9:39am revealed: -She did not leave medications in Resident #5's room today, 04/28/26. -She did not see any medications in a cup in Resident #5's room. -The medications could have been left in Resident #5's room on another shift. Refer to interview with the MA on 04/28/26 at 10:33am. Refer to interview with the Health and Wellness Director (HWD) on 04/28/26 at 10:55am. Refer to interview with the Administrator on 04/28/26 at 11:09am. 2. Review of Resident #6's current FL-2 dated 04/29/26 revealed diagnoses included congestive heart failure, chronic kidney disease, hypertension, atrial fibrillation, hyperlipidemia, depression, and polyneuropathy. Observation of Resident 6's room on 04/28/26 at 9:39am revealed: -There was a cup of medication sitting on a bedside table that contained approximately 11 pills.	D 366		

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	HAL092220	A. BUILDING: _____ B. WING _____	R 04/30/2026

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D 366	Continued From page 65 -There was a blue and white capsule. -The was an oblong white tablet with M365 on it was identified as Hydrocodone and Acetaminophen 325mg (Hydrocodone and Acetaminophen is used to treat pain). -There was a black round tablet. -There were 2 white oblong tablets. -There was one white football shaped tablet with "H". -There were 3 rounds white tablets. -There was a round red tablet. Review of Resident #6's physician orders dated 04/29/26 revealed: -There was an order for Tylenol 500mg take 2 tablets twice daily (Tylenol is used to treat pain). -There was an order for Cetirizine 10 mg take every morning (Cetirizine is used to treat allergy symptoms). -There was an order for Dabigatran 150mg capsule take twice daily (Dabigatran is a blood thinner used to prevent strokes). -There was an order for Duloxetine 60mg capsule take every morning (Duloxetine is used to treat depression). -There was an order for Ezetimibe 10mg take daily (Ezetimibe is used to treat elevated cholesterol). -There was an order for Ferosul 325mg take daily (Ferosul is used to treat anemia). -There was an order for Hydralazine 100mg take three times daily (Hydralazine is used to treat high blood pressure). -There was an order for Hydrocodone/Acetaminophen 5-325mg three times daily. -There was an order for Losartan 100mg take once daily (Losartan is used to treat high blood pressure). -There was an order for Metoprolol Succinate	D 366		

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D 366	Continued From page 66	D 366		

100mg ER take once daily (Metoprolol Succinate is used to treat high blood pressure).
-There was an order for Pantoprazole 40mg take twice daily 30 minutes before meals (Pantoprazole is used to treat gastro-esophageal reflux disease).
-There was an order for Torsemide 20mg take 2 tablets every morning (Torsemide is used to treat heart failure).
-There was an order for Vitamin D3 50mcg once daily (Vitamin D3 is used to treat Vitamin D deficiency).

Review of Resident #6's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 500mg take 2 tablets scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Cetirizine 10 mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Dabigatran 150mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Duloxetine 60mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Ezetimibe 10mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Ferosul 325mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Hydralazine 100mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Hydrocodone/Acetaminophen 5-325mg

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D 366	Continued From page 67	D 366		

scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Losartan 100mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Metoprolol Succinate 100mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Pantoprazole 40mg scheduled for 9:00am and was documented as administered on 04/28/26 at 9:00am.
-There was an entry for Torsemide 20mg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.
-There was an entry for Vitamin D3 50mcg scheduled for 8:00am and was documented as administered on 04/28/26 at 8:00am.

Interview with Resident #6 on 04/28/26 at 9:39am revealed:
-The MAs brought her morning medications and left them on the table for her to take when she got up.
-The MA in the evening also left her medications and she took them later.
-The MAs did not watch her take her medications.

Interview with the MA on 04/28/26 at 10:33am revealed:
-She left Resident # 6's medications in her room this morning, 04/28/26 and walked out of the room.
-She knew that she was not supposed to leave the medication in Resident #6's room when she was asleep.

Refer to interview with the MA on 04/28/26 at 10:33am.

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D 366	Continued From page 68 Refer to interview with the Health and Wellness Director (HWD) on 04/28/26 at 10:55am. Refer to interview with the Administrator on 04/28/26 at 11:09am. _____ Interview with the MA on 04/28/26 at 10:33am revealed: -She had worked for the facility for 2 years. -She did not leave medications in the residents' rooms. -She observed the residents take their medications. -She passed medications on hall A today, 04/28/26. Interview with the Health and Wellness Director (HWD) on 04/28/26 at 10:55am revealed: -The MAs were supposed to observe the residents take their medications. -Medications were not supposed to be left in a resident's room. -Observing residents take their medications was taught during their MA training. -The Licensed Health Professional Support Nurse (LHPS) validated that the MAs knew how to administer medications. -She was not sure why the MA did not observe the residents take their medications. -She was concerned because depending on when they took the medications it could be too close to the next administration time and that the medications were not administered as prescribed. -It was important to give the residents their medications at the scheduled times. Interview with the Administrator on 04/28/26 at 11:09am revealed: -Medications should never be left in a resident's room.	D 366		

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D 366	Continued From page 69 -MAs should observe the residents take their medications.	D 366		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure incident an accident reports involving emergency department (ED) evaluation after a medication error and a fall for 1 of 5 sampled residents (#2) were sent to the Department of Social Services (DSS). The findings are: Review of the facility's Incident Reports policy dated 06/11/24 revealed: -Injuries and unusual incidents would be reported in compliance with state regulatory requirements. -An incident report was completed in the electronic health record including all that were state reportable or require modifications to resident monitoring or plans of care. -The incident report or applicable state form was used to submit written reports to state agencies.	D 451		

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D 451	Continued From page 70 -The community would furnish the incident report to the licensing agency within 24 hours unless otherwise specified in regulations. Review of Resident #2's current FL-2 dated 01/18/26 revealed: -Diagnoses included Alzheimer's Disease, hypertension, atrial fibrillation, coronary artery disease (CAD), peripheral artery disease, depression, anxiety and chronic pain. -The resident's level of care was Special Care Unit (SCU). 1. Review of the hospital emergency discharge instructions for Resident #2 dated 04/11/26 revealed: -The reason for Resident #2's visit to the emergency department was weakness. -Resident #2 was evaluated after being administered medications that were not prescribed to her. -Resident #2's diagnosis was medication administered in error, accidental or unintentional. -Resident #2's lab results, electrocardiogram (EKG) and vital signs were normal. Review of Resident #2's Emergency Medical Services (EMS) report dated 04/11/26 revealed: -EMS was called for Resident #2 on 04/11/26 at 7:33pm. -EMS was on scene at 7:49pm. -Facility staff reported administering resident #2 her medications along with another resident's medications by mistake prior to EMS arrival. -Resident #2 was administered fluids. -Resident #2 showed improvement in alertness throughout transport and no negative changes were noted -EMS arrived at the hospital at 8:33pm.	D 451		

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D 451	Continued From page 71 Review of Resident #2's Incident Report dated 04/11/26 on 04/30/26 at 2:05pm revealed: -The incident occurred at 9:30am on the first shift. -The incident classification was Medication Error. -The incident occurred in the hallway. -Resident #2's vitals were taken and her blood pressure was 177/80, her pulse was 70 and her temperature was 97.4. -Resident #2's pain level was 0. -Resident #2 was transferred to the hospital via EMS. -The Health and Wellness Director (HWD) was notified at 9:40am. -Resident #2's primary care provider (PCP) was notified at 7:37pm. -Resident #2's family was notified at 7:37pm. -Resident #2 had no injuries. -The medications administered to Resident #2 in the 12 hours prior to 04/11/26 at 9:30am were administered at 9:24am and included: Fluticasone 50mcg (used to treat allergies), Risperidone 0.25mg (used to treat mental health conditions), Memantine 10mg (used to treat Alzheimer's Disease), Furosemide 20mg (used to treat fluid retention), Guaifenesin 400mg (used to treat chest congestions), Sertraline 50mg used to treat mental health conditions), and Eliquis 5mg (used to prevent and treat blood clots). Review of Resident #2's facility progress notes revealed there was no documentation of the incident on 04/11/26 with Resident #2 in the notes. Refer to interview with the Special Care Coordinator (SCC) on 04/30/26 at 12:05pm. Refer to interview with the Health and Wellness Director (HWD) on 04/29/26 at 5:36pm.	D 451		

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D 451	Continued From page 72 Refer to interview with the Administrator on 04/30/26 at 1:37pm. Refer to interview with the local Department of Social Services (DSS) Adult Home Specialist on 04/30/26 at 11:19am. 2. Review of Resident #2's hospital documentation dated 04/21/26 revealed: -Resident #2's had an unwitnessed fall where staff found her on the floor. -Resident #2 was sent to the ED to be evaluated due to difficulty bearing weight on her lower left extremity (LLE). -There was no evidence of acute fracture. Review of Resident #2's facility progress notes for 04/21/26 revealed: -Resident #2 was found on her bottom on the floor in her bathroom at 1:50pm. -Resident #2 complained of leg pain and was sent to the hospital. Review of Resident #2's records revealed there was no Incident/Accident report for the incident on 04/21/26. Refer to interview with the Special Care Coordinator (SCC) on 04/30/26 at 12:05pm. Refer to interview with the Health and Wellness Director (HWD) on 04/29/26 at 5:36pm. Refer to interview with the Administrator on 04/30/26 at 1:37pm. Refer to interview with the local Department of Social Services (DSS) Adult Home Specialist on 04/30/26 at 11:19am.	D 451		

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D 451	Continued From page 73 Interview with the Special Care Coordinator (SCC) on 04/30/26 at 12:05pm revealed: -MAs were responsible for completing Incident/Accident Reports. -She was unsure of the facility's policy on who was responsible for notifying the local Department of Social Services (DSS) about Incident/Accidents. Interview with the Health and Wellness Director (HWD) on 04/29/26 at 5:36pm revealed: -An Incident/Accident Report was not done for the medication error and emergency department visit on 04/11/26 for Resident #2. -The local DSS was not notified of the medication error and emergency department visit on 04/11/26 for Resident #2. -She thought she sent an email regarding the incident with Resident #2 to the local DSS but did not. -A progress note was done for Resident #2's fall on 04/21/26 but there was no Incident/Accident report done and DSS was not notified. -Resident #2 had no injuries from the fall on 04/21/26 but was sent to the hospital. -She learned that an Incident/Accident report should have been done and DSS should have been notified for Resident #2's fall on 04/21/26 some time after the incident occurred. -An Incident/Accident Report should have been done and sent to the local DSS for Resident #2. -She did not tell the MAs to do an Incident/Accident Report for Resident #2. -The MAs had been trained on Incident/Accidents Reports. -The Incident/Accident Report for Resident #2 should have been done with 1 hour of the incident. -The local DSS should have been notified of the incidents with Resident #2 within 24 to 48 hours.	D 451		

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D 451	Continued From page 74 -She was responsible for notifying the local DSS of the incidents with Resident #2. Interview with the Administrator on 04/30/26 at 1:37pm revealed: -The HWD was responsible for the Incident/Accident reports and all notifications of Incidents/Accidents after being notified by the MA. -She did not recall if she told the HWD to complete an Incident/Accident Report for Resident #2 on 04/11/26 but an Incident/Accident Report should have been done. -She did not know why an Incident/Accident Report was not done but thought the HWD just forgot to do the report. -The local DSS was not notified of the incident with Resident #2 on 04/11/26 but she did not know why. -She was not aware that there was no Incident/Accident report completed for Resident #2's fall on 04/21/26 and that DSS was not notified. Telephone interview with the local DSS Adult Home Specialist on 04/30/26 at 11:19am revealed: -She did not receive an Incident/Accident report for Resident #2's medication error and emergency department visit on 04/11/26. -She did not receive an Incident/Accident report for Resident #2's fall and emergency room visit on 04/21/26. -Incident/Accident reports were supposed to be sent to the local DSS within 24 hours of the incident.	D 451		