STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 a follow-up survey on 04/21/26 - 04/23/26.	{D 000}		
{D 344}	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 5 sampled residents (#4 and #5). The findings are: 1. Review of Resident #5's FL2 dated 12/17/25 revealed diagnoses included dementia, anemia, gait disturbance, hypertension, knee osteoarthritis, paroxysmal atrial fibrillation, and thrombocytosis. Review of Resident #5's physician ordered dated 12/17/25 revealed: -There were medication orders for 16	{D 344}		

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{D 344}	Continued From page 1	{D 344}		

medications.
-There was an order for amlodipine (a medication used to treat high blood pressure) 5mg daily.
-There was an order for AZO D-mammos (used for urinary tract health) 500mg daily.
-There was an order for buspirone (used to treat anxiety disorders) 7.5mg twice a day.
-There was an order for desitin daily defense 13% (used to treat and prevent skin irritations) daily.
-There was an order for ferrous sulfate (an iron supplement to treat iron deficiency) 325mg daily.
-There was an order for furosemide (a diuretic used to treat edema) 20 mg daily.
-There was an order for levothyroxine (a medication used to treat underactive thyroid) 50mcg daily.
-There was an order for melatonin (a supplement used to treat insomnia) 5mg at bedtime.
-There was an order for polyethylene glycol (a medication used to treat constipation) 3350 as needed.
-There was an order for memantine (a medication used to treat memory loss)10mg daily.
-There was an order for ondansetron (a medication used to treat nausea) 4mg every 8 hours as needed.
-There was an order for quetiapine (a medication used to treat schizophrenia) 50mg twice a day and 75mg at bedtime.
-There was an order for sertraline (a medication used to treat anxiety and depression) 100mg 1 and ½ tablet daily.
-There was an order for vitamin B12 (a supplement used to treat vitamin B12 deficiency) 100mcg daily.
-There was an order for vitamin D3 (a supplement used to treat vitamin D deficiency) 1000 (25mcg) daily.

Review of Resident #5's current FL2 dated

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{D 344}	Continued From page 2 03/26/26 revealed: -Diagnoses included dementia, anemia, gait disturbance, hypertension, knee osteoarthritis, paroxysmal atrial fibrillation, and thrombocytosis. -There were medication orders for 7 medications. -There was an order for memantine 10mg daily. -There was an order for ondansetron 4mg every 8 hours as needed. -There was an order for quetiapine 50mg twice a day. -There was an order for quetiapine 50mg 1 and ½ tablet at bedtime. -There was an order for sertraline 100mg 1 and ½ tablet daily. -There was an order for vitamin B12 100mcg daily and vitamin D3 1000 (25mcg) daily. -There was an order for vitamin D3 1000 (25mcg) daily. Interview with Resident #5's primary care provider (PCP) on 04/22/26 at 10:40am revealed: -The facility completed Resident #5's FL2 and she signed it. -She was not aware there were medications left off the FL2 dated 03/26/26. -She wanted Resident #5 to continue taking all the medications from the FL2 dated 12/17/25. Interview with the Special Care Unit Coordinator (SCC) on 04/22/26 at 8:36am revealed: -She was responsible for completing FL2s in the special care unit (SCU). -She updated Resident #5's FL2 dated 03/26/26 and realized today, 04/22/26, that medications were left off the FL2. -She usually attached the signed physician's orders to the FL2 but this time she typed the medications on the FL2 and mistakenly left 9 medications off the FL2.	{D 344}		

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{D 344}	Continued From page 3 Interview with the Administrator on 04/23/26 at 3:34pm revealed: -The SCC was responsible for completing FL2s in the SCU. -The SCC was responsible for clarifying the orders on the FL2. -She was concerned that if the FL2 was incorrect, Resident #5 might not have received all of her medications. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 2. Review of Resident #4's current FL-2 dated 06/01/25 revealed diagnoses included chronic kidney disease stage 2 and gastrointestinal esophageal reflux disease. Review of Resident #4's signed physician orders dated 02/26/26 revealed there was an order for vitamin D3 (2000 units), 25mcg, take 1 tablet daily. Review of Resident #4's February 2026 electronic medication administration record (eMAR) from 02/26/26-02/28/26 revealed there was an entry for vitamin D3 (2000 units), 50mcg, take 1 tablet daily. Review of Resident #4's March and April 2026 eMAR revealed there was an entry for vitamin D3 (2000 units), 50 mcg, take 1 tablet daily. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/23/26 at 12:17pm revealed: -The pharmacy noticed the vitamin D3 order was incorrect when they received an order for vitamin D3 for Resident #4 on 07/29/25.	{D 344}		

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{D 344}	Continued From page 4 -The order was written for vitamin D3 2000 units, which was 50mcg of vitamin D3, not 25mcg. -The provider had written an order for vitamin D3 (2000 units) 25mcg. -The pharmacy called the facility on 07/29/25 and spoke to a medication aide (MA) to clarify which order for vitamin D3 was correct. -The pharmacy was told by the MA the 50mcg order was the correct order. -The pharmacy did not call to clarify when they received the incorrect order again for vitamin D3 (2000 units) 25mcg on 02/26/26. -The pharmacy did not call the primary care provider (PCP) to clarify the order. -It was the responsibility of the facility to call the PCP office to clarify the vitamin D3 order. Interview with the MA on 04/23/26 at 2:42pm revealed: -The pharmacy called in July 2025 to clarify Resident #4's vitamin D3 order. -She called Resident #4's power of attorney (POA) to clarify the vitamin D3 order and was told by the POA the order should be 50mcg. -She did not call the PCP to clarify the vitamin D3 order when it was re-written in February 2026. -She could not remember why she did not clarify the vitamin D3 order with the PCP. -She forgot to tell the Resident Care Coordinator (RCC) to update Resident #4's order in the eMAR to the correct one. Interview with the RCC on 04/23/26 at 1:51pm revealed: -She was not responsible for clarifying orders back in February 2026. -The previous Director of Clinical Services (DCS) was responsible for order clarification. -She was not aware that the vitamin D3 order was incorrect on the signed physician orders	{D 344}		

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{D 344}	Continued From page 5 dated 02/26/26. -She would print out the physician order summary from the eMAR to send to the PCP for clarification and signature. -She thought the vitamin D3 dose was not correct when the physician orders were sent out for review and signature on 02/26/26 because they had been typed by the previous DCS. -She expected the MA to clarify the vitamin D3 with Resident #4's PCP. Interview with the Administrator on 04/23/26 at 3:00pm revealed: -The RCC was responsible for clarifying orders with the PCP. -She did not review signed physician orders. -She expected the MA's and RCC to clarify orders with the PCP. Attempted telephone interview with Resident #4's POA on 04/22/26 at 11:45am was unsuccessful. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 04/23/26 at 1:34pm was unsuccessful.	{D 344}		
D 347	10A NCAC 13F .1002 (d) Medication Orders 10A NCAC 13F .1002 Medication Orders (d) Verbal orders for medications and treatments shall be: (1) countersigned by the prescribing practitioner within 15 days from the date the order is given; (2) signed or initialed and dated by the person receiving the order; and	D 347		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure verbal orders from the primary care provider (PCP) to discontinue two supplements were documented and signed by the PCP within 15 days for 1 of 1 sampled residents (#5).

The findings are:

Review of Resident #5's FL2 dated 12/17/25 revealed diagnoses included dementia, anemia, gait disturbance, hypertension, knee osteoarthritis, paroxysmal atrial fibrillation, and thrombocytosis.

Review of Resident #5's physician's order dated 12/17/25 revealed:
-There was an order for vitamin B12 (a supplement used to treat vitamin B12 deficiency and anemia) 100mcg daily.
-There was an order for vitamin D3 (a supplement used to treat vitamin D deficiency) 1000 (25mcg) daily.

Review of Resident #5's verbal physician order dated 02/23/26 revealed:
-The order was not signed by a physician.
-There was an order to discontinue vitamin B12 100mcg daily.
-There was an order to discontinue vitamin D3 1000 (25mcg) daily.

Review of Resident #5's February 2026 electronic medication administration record (eMARs) revealed:

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-There was an entry for vitamin B12 100mcg daily.
-Vitamin B12 was documented as administered from 02/01/26 to 02/23/26.
-Vitamin B12 was not documented as administered from 02/24/26 to 02/28/26.
-There was an entry for vitamin D3 1000 (25mcg) daily.
- Vitamin D3 was documented as administered from 02/01/26 to 02/23/26.
-Vitamin D3 was not documented as administered from 02/24/26 to 02/28/26.

Review of Resident #5's March and April 2026 eMARs from 04/01/26 through 04/21/26 revealed there were no entries for vitamin B1 or vitamin D3.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/22/26 at 11:02am revealed:
-The pharmacy received a copy of the verbal order from the facility on 02/23/26 to discontinue Resident #5's vitamin B12 and vitamin D3.
-The pharmacy could not use the verbal order because the order was not signed by a physician.
-The pharmacy did not remove the entries from the eMAR.

Interview with Resident #5's primary care provider (PCP) on 04/22/26 at 10:40am revealed she had not signed the verbal order to discontinue Resident #5's vitamin B12 and vitamin D3 because the order was not given to her from the facility.

Interview with the Special Care Unit Coordinator (SCC) on 04/22/26 at 11:29am revealed:
-She faxed the verbal order to discontinue Resident #5's vitamin B12 and vitamin D3 to the

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D 347	Continued From page 8 pharmacy on 02/23/26. -She was not aware that verbal orders were to be signed by a physician within 15 days of the order being written. Interview with the Administrator on 04/23/26 at 3:34pm revealed she expected verbal orders to be signed by a physician within 15 days of the order being written. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 347		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) who had an order for a long-term antibiotic. The findings are: Review of Resident #2's hospital discharge FL-2 dated 03/20/26 revealed diagnoses included sialadenitis (infection or swollen salivary glands in	D 358		

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the mouth) and neck swelling.

Review of Resident #2's signed physician orders dated 12/15/25 revealed an order for sulfamethoxazole-trimethoprim (an antibiotic medication used to treat or prevent infection) 800-160mg, take 1 tablet every Monday, Wednesday, and Friday for multiple myeloma (cancer that affects white blood cell production).

Review of Resident #2's hospital discharge paperwork dated 03/20/26 revealed there was an order to hold sulfamethoxazole-trimethoprim 800-160mg until 03/27/26 when his other course of antibiotics was complete.

Review of Resident #2's March 2026 electronic medication administration record (eMAR) from 03/27/26 to 03/31/26 revealed there was no entry for sulfamethoxazole-trimethoprim 800-160mg, take 1 tablet every Monday, Wednesday, and Friday.

Review of Resident #2's April 2026 eMAR from 04/01/26 to 04/22/26 revealed there was no entry for sulfamethoxazole-trimethoprim 800-160mg, take 1 tablet every Monday, Wednesday, and Friday.

Interview with Resident #2 on 04/22/26 at 11:55am revealed:
-He took the long-term antibiotic because of his multiple myeloma diagnosis.
-He did not realize sulfamethoxazole-trimethoprim was not administered to him since his course of antibiotics was complete.
-He did not currently have any symptoms of infection.

Interview with a pharmacist with the facility's

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contracted pharmacy on 04/23/26 at 12:17pm revealed:
-The facility was responsible for putting medication hold and restart orders on the eMAR.
-The pharmacy did not accept hold orders from the hospital because the primary care provider (PCP) might change the medication hold order.

Interview with a medication aide (MA) on 04/23/26 at 2:42pm revealed:
-She knew that Resident #2's sulfamethoxazole-trimethoprim was on hold.
-She did not realize sulfamethoxazole-trimethoprim did not restart on 03/27/26.

Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm revealed:
-Sulfamethoxazole-trimethoprim was placed on hold on the eMAR with a restart date of 03/27/26 based on Resident #2's hospital discharge orders.
-She received a prompt in the eMAR from the pharmacy to discontinue sulfamethoxazole-trimethoprim on 03/20/26.
-She did not clarify why the order was discontinued rather than placed on hold by the pharmacy.

Review of Resident #2's record revealed there was no order to discontinue sulfamethoxazole-trimethoprim available for review.

Interview with the Administrator on 04/23/26 at 3:00pm revealed:
-It was the RCC's responsibility to review orders and ensure they were entered on the eMAR correctly.
-The RCC should have clarified why

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D 358	Continued From page 11 sulfamethoxazole-trimethoprim was discontinued with no order so that the medication would be administered as ordered. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 04/23/26 at 11:53am and 1:32pm were unsuccessful.	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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed a resident take their medications that were left on a table in the common area prior to documenting the administration and administering medication to another resident. The findings are: Review of the facility's Medication Administration Policy dated 03/11/25 revealed: -To ensure that residents received medications and treatments in accordance with physician's	D 366		

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orders.
-Documentation would be completed at the time of administration.
-Each resident would be observed taking the medication/treatment.

Observation of the common area on 04/21/26 at 8:18am revealed:
-There was a cup with four pills on a table next to the resident.
-There were three other residents in the area.
-A personal care aide (PCA) walked by and asked the resident why she had not taken her medication.
-There was no MA in the area.

Observation of the common area on 04/22/26 at 8:32am revealed:
-The resident had a cup with two white pills.
-There were two other residents in the area.
-The MA was at the medication cart with her back to the resident.

Interview with a resident on 04/21/26 at 8:27am and on 04/22/26 at revealed:
-The MA left her pills on the table for her to take, but she forgot to take them.
-Staff reminded her to take her medication and she took them.
-Sometimes the MAs left medication for her to take but they usually watched her take her medication.
-Some MAs watched her take all of her medications, and other MAs did not.
-She could not recall what medications she took.

Interview with the personal care aide (PCA) on 04/23/26 at 9:32am revealed:
-She saw the resident's pills on the table and asked her why she had not taken them.

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D 366	Continued From page 13 -She had observed the resident taking her own medication for about three months taking medication without the MA observing her take them. -There had been several occasions when she had to remind the resident to take the remainder of her medication because the resident would forget to take them. -She was concerned that another resident would take the medication. Interview with a MA on 04/23/26 at 9:54am revealed: -She watched all residents take their medication before she left the resident. -She did not leave medication for a resident to administer to themselves at a later time. -She had not seen a resident with a cup of pills. Interview with a second MA on 04/23/26 at 10:07am revealed: -Sometimes she would watch the residents while they took their medication prior to documenting administration. -The resident had a little bit of memory loss. -She would leave the resident with her medication because the resident took a long time to take her medication and she did not want to be late during the medication pass. -She was not concerned that she left the medication for the resident because she did not take narcotics. -She was concerned that another resident could have taken the medication. Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm revealed: -She had not noticed any medications left with residents without the MA there to observe the resident taking the medications.	D 366		

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D 366	Continued From page 14 -The MA was responsible for watching the residents take their medications before the MA documented administration. -She was concerned the resident would not have taken her medication or another resident could have taken the medication. Interview with the Administrator on 04/23/26 at 3:34pm revealed: -Medications should not be left with a resident to take. -The MA should watch residents take their medication prior to documenting the administration of the medications. -The MA should not leave medications; another resident could walk by and pick them up and take the medications. -She expected the MAs to watch the residents take their medications.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	D 367		

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omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 1 sampled residents (#4), including an ointment used to treat bacterial infections, a stool softener, and a medication used to treat pain.

The findings are:

Review of Resident #4's current FL-2 dated 06/01/25 revealed diagnoses included chronic kidney disease stage 2 and gastrointestinal esophageal reflux disease (GERD).

a. Review of Resident #4's signed physician's orders dated 02/26/26 revealed there was an order for mupirocin ointment (used to treat bacterial infections) 2% apply to left second toe wound and cover nightly.

Review of Resident #4's February 2026 eMAR revealed:
-There was an entry for mupirocin ointment 2% apply pea sized amount to affected area at bedtime.
- Mupirocin 2% ointment was documented as administered nightly from 02/01/26-02/28/26.
-There was no entry for mupirocin apply to left

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second toe wound and cover nightly.

Review of Resident #4's March 2026 eMAR revealed:
-There was an entry for mupirocin ointment 2% apply pea sized amount to affected area at bedtime.
-Mupirocin 2% ointment was documented as administered nightly from 03/01/26-03/31/26.
-There was no entry for mupirocin apply to left second toe wound and cover nightly.

Review of Resident #4's April 2026 eMAR from 04/01/26 to 04/20/26 revealed:
-There was an entry for mupirocin ointment 2% apply pea sized amount to affected area at bedtime.
Mupirocin 2% ointment was documented as administered nightly from 04/01/26-04/20/26.
-There was no entry for mupirocin apply to left second toe wound and cover nightly.

Review of Resident #4's record revealed there was no order for mupirocin ointment 2% apply pea sized amount to affected area at bedtime.

Interview with a medication aide (MA) on 04/22/26 at 4:10pm revealed:
-She administered the mupirocin to Resident #4's left toe nightly.
-She had never seen an order to apply mupirocin to Resident #4's left toe nightly.
-She always documented under the entry on the eMAR for mupirocin apply a pea size amount nightly.
-She knew to place the mupirocin on Resident #4's left toe because the previous Director of Clinical Services (DCS) told her.
-She did not notify management the mupirocin entry was incorrect on the eMAR.

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D 367	Continued From page 17 Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/23/26 at 12:17pm revealed: -Resident #4 had a current order for mupirocin apply to left second toe wound and cover nightly. -There was no current order for mupirocin, apply a pea size amount nightly. -The pharmacy only entered wound care orders if they were dispensing the would care supplies. -If the pharmacy did not dispense the wound care supplies, it was the responsibility of the facility to enter the wound care orders on the eMAR. Attempted telephone interview with Resident #4's primary care provider (PCP) on 04/23/26 at 1:34pm was unsuccessful Refer to the interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm. Refer to the interview with the Administrator on 04/23/26 at 3:00pm. b. Review of Resident #4's record revealed there was no current order for docusate sodium (a stool softener) 100mg capsule, take 1 capsule daily as needed (PRN) for constipation. Review of Resident #4's February, March, and April 2026 from 04/01/26 to 04/23/26 eMARs revealed: -There was an entry for docusate 100mg capsule, take 1 capsule daily PRN for constipation. -There was no documentation docusate was administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/23/26 at 12:17pm revealed:	D 367		

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D 367	Continued From page 18 -Resident #4 did not have a current order for docusate sodium 100mg, take 1 capsule daily PRN for constipation. -The last order the pharmacy received for docusate sodium for Resident #4 was dated 04/24/25. -It was the facility's responsibility to ensure the orders were accurate on the eMAR. Attempted telephone interview with Resident #4's PCP on 04/23/26 at 1:34pm was unsuccessful Refer to the interview with the RCC on 04/23/26 at 1:51pm. Refer to the interview with the Administrator on 04/23/26 at 3:00pm. c. Review of Resident #4's signed physician orders dated 02/26/26 revealed there was an order to discontinue tramadol HCL (a medication used to treat pain) 50mg tablet twice daily after 5:00pm and after 1:00am PRN for pain control. Review of Resident #4's February, March and April 2026 eMAR revealed: -There was an entry for tramadol 50mg, take 1 tablet twice daily after 5:00pm and after 1:00am PRN for pain control. -There was no documentation tramadol 50mg PRN was administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/23/26 at 12:17pm revealed: -The pharmacy had an order dated 02/26/26 to discontinue tramadol 50mg PRN for Resident #4. -She was not sure why the tramadol PRN entry was not discontinued from the eMAR.	D 367		

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D 367	Continued From page 19 Attempted telephone interview with Resident #4's PCP on 04/23/26 at 1:34pm was unsuccessful. Refer to the interview with the RCC on 04/23/26 at 1:51pm. Refer to the interview with the Administrator on 04/23/26 at 3:00pm. _____ Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm revealed: -The pharmacy was responsible for entering and removing orders from the eMAR. -It was her responsibility to review the physician orders and ensure they were correctly entered onto the eMAR. -The previous DCS was reviewing the new physician orders in February 2026. -She started reviewing the physician orders in March 2026. -She was concerned that a medication could be administered that did not have a current order. Interview with the Administrator on 04/23/26 at 3:00pm revealed: -It was the RCC's responsibility to ensure the physician orders were accurate on the eMAR. -She expected the eMAR to accurately match the physician orders.	D 367		
{D 375}	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:	{D 375}		

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{D 375}	Continued From page 20 (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled residents (#2 and #3) had a physician's order to self-administer a medicated topical powder (#3) and medications to treat shortness of breath (#2). The findings are: Review of the facility's Self-Managed Medications policy dated 03/11/25 revealed: -The Resident Care Coordinator (RCC) would assess the resident's ability to self-medicate by utilizing the Self-Administration of Medication Assessment upon admission and on a quarterly basis. -If staff suspected that the resident was not properly taking their medication, they were to notify the RCC. 1. Review of Resident #3's current FL2 dated 04/10/26 revealed: -Diagnoses included mild cognitive impairment. -She was intermittently disoriented. -There was no order for self-administration of any	{D 375}		

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medication.

Observation of Resident #3's room on 04/21/26 at 8:55am revealed 3 medicine cups full of a white powder sitting on her bathroom sink.

Review of Resident #3's record revealed:
-There was a physician's order dated 03/26/26 for nystatin powder (an antifungal medication used to treat yeast infections on the skin) 100,000 unit/gram; apply to affected area 3 times daily.
-There was no physicians order to self-administer nystatin powder.
-There was no self-administer assessment.
-There were no skin assessments sheets available for review.

Review of Resident #3's signed physician orders dated 04/10/26 revealed:
-There was an order for nystatin powder 100,000 unit/gram; apply to affected area three times daily.
-The order had a handwritten note to the side that read "continue twice daily."

Review of Resident #3's March 2026 electronic medication administration record (eMAR) from 03/27/26 - 03/31/26 revealed:
-There was an entry for nystatin powder 100,000 unit/gram apply to affected area 3 times daily.
-Nystatin was documented as administered 14 of 15 opportunities.
-There was 1 documented entry Resident #3 was out of the facility; the nystatin was not administered.

Review of Resident #3's April 2026 eMAR revealed:
-There was an entry for nystatin powder 100,000 unit/gram apply to affected area 3 times daily with

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documented administration of 33 of 33 opportunities.
-The entry for nystatin powder was discontinued on 04/11/26.
-There was a second entry for nystatin powder 100,000 unit/gram apply to affected area 2 times daily with a start date of 04/11/26.
-Nystatin was documented as administered 23 of 23 opportunities.

Interview with Resident #3 on 04/21/26 at 8:55am revealed:
-The white powder in the cups in her bathroom was nystatin powder.
-She had a rash under her stomach crease.
-She had the rash for 5 weeks.
-The area caused her pain at times.
-She did not remember telling anyone when she was in pain.
-The medication aide (MA) would leave the nystatin powder in the bathroom for her to administer herself.
-She did not remember when the last time she applied the powder.
-She did not remember how often she applied the powder.
-She did not remember the MAs administering the nystatin powder for her.

Observation of Resident #3's rash on 04/21/26 at 1:32pm revealed:
-There was a round open area of skin the size of a pencil eraser on the right side of her stomach crease.
-The area had a red tinge with peeling skin surrounding it.
-There was an open area 2 inches long and 0.2 inches wide on the left side of her stomach crease.
-The left side had a red tinge with peeling skin

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surrounding it.
-The stomach crease had an odor coming from it.

Review of Resident #3's home health nursing notes dated 04/07/26 revealed:
-There was a visit made on 04/07/26 to admit Resident #3 to their care for the monitoring of Resident #3's rash.
-Resident #3 was at high risk for infection.
-Resident #3 had impaired vision.
-Resident # was oriented but forgetful.

Review of Resident #3's home health nursing note dated 04/21/26 revealed:
-Resident #3 reported that the staff at the facility were giving her the nystatin powder to keep in her room.
-Resident #3 reported she administered the nystatin powder each time she went to the bathroom.

Telephone interview with Resident #3's primary care provider's (PCP) nurse on 04/22/26 at 9:55am revealed:
-The PCP did not write the order for nystatin powder to be applied 3 times a day on 03/26/26.
-Resident #3's PCP did change the order for the nystatin powder to be applied 2 times a day on 04/10/26.
-She was unsure why the order was changed.
-The PCP did not write a self-administration order for the nystatin.
-Typically, it would take 1 to 2 weeks for a rash to heal with nystatin powder.

Interview with a personal care aide (PCA) on 04/22/26 at 12:16pm revealed:
-She had not seen the nystatin powder in Resident #3's room.
-She did assist Resident #3 with her showers.

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{D 375}	Continued From page 24 -She did not notice that Resident #3 had open areas in her stomach crease. -She did not remember if she filled out a skin check sheet for Resident #3. Interview with a MA on 04/22/26 at 4:10pm revealed: -She administered nystatin powder for Resident #3 before. -She did not leave nystatin powder in Resident #3's bathroom. -She did not notice that Resident #3 had 3 medicine cups full of nystatin powder in her bathroom. -She did not notice when she administered the nystatin powder Resident #3 had developed open areas in her stomach crease. -She did not notice any odor from Resident #3's stomach crease. Interview with a second MA on 04/23/26 at 2:42pm revealed: -Resident #3 did not have an order to self-administer nystatin powder. -She always administered Resident #3's nystatin powder. -She never left nystatin powder in Resident #3's room. -She did not notice that Resident #3 had 3 medicine cups full of nystatin powder in her bathroom. -The PCAs, MAs, RCC and Administrator did room sweeps about once a week checking for medications in the room. -She was not told to do a room sweep of Resident #3's room. -She noticed Resident #3's skin was very red and had an odor coming from her stomach crease on 03/26/26 and she let the RCC know. -She did not notice that Resident #3 developed	{D 375}		

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{D 375}	Continued From page 25 open areas in her stomach crease when she administered the nystatin on 04/22/26. -She noticed on 04/22/26 that Resident #3's skin was slightly red and had an odor in her stomach crease again. -She called Resident #3's Power of Attorney (POA) to make an appointment with Resident #3's PCP. -Resident #3 had a doctor's appointment to look at her skin scheduled for 04/23/26 but she was not sure of the time. Interview with the RCC on 04/23/26 at 1:51pm revealed: -Resident #3 did not have an order to self-administer nystatin powder. -Resident #3 was forgetful. -She never assessed Resident #3 to self-administer nystatin powder. -She was not aware Resident #3 had nystatin powder in her room. -She had educated the MAs regarding leaving medication in resident rooms multiple times but could not remember the dates. -She was told about Resident #3's rash in her stomach crease on 03/26/26. -She called the POA on 03/26/26 to make an appointment for Resident #3 to see her PCP and get a home health nursing order for wound care. -She did not know Resident #3 developed open areas in her stomach crease. -She had not seen Resident #3's rash since 03/26/26. -The PCAs were expected to do skin checks during showers and fill out a skin check sheet. -She did not remember if she reviewed any skin check sheets for Resident #3. -Home health nursing was ordered but she was not sure how often they had seen Resident #3. -She did not see home health nursing notes.	{D 375}		

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{D 375}	Continued From page 26 -She thought the home health nurse would notify her if there was anything wrong with Resident #3's rash. -She was concerned that Resident #3 was not administering the nystatin powder correctly. -She expected the MAs to administer nystatin powder as ordered and not leave the nystatin powder in the room. Refer to the interview with the Administrator on 04/23/26 at 3:00pm. 2. Review of Resident #2's hospital discharge FL-2 dated 03/20/26 revealed: -Diagnoses included sialadenitis (infection or swollen salivary glands in the mouth) and neck swelling. -There was an order for ipratropium-albuterol 0.5-2.5 mg/3ml nebulizer (a medication used to treat shortness of breath) inhale 3ml every 4 hours as needed (PRN). -There was no self-administer order. Observation of Resident #2's room on 04/21/26 at 9:43am revealed: -There were two vials of nebulizer solution sitting on Resident #2's table next to a nebulizer machine. -The vials had ipratropium 0.5, albuterol 2.5 imprinted on them. -There was an inhaler sitting on his table next to the nebulizer machine. Review of Resident #2's record revealed: -There was a signed physician's order dated 03/24/26 to change the ipratropium-albuterol 0.5-2.5 mg/ml nebulizer from PRN to twice daily. -There was no self-administer order. -There was no order for an inhaler.	{D 375}		

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	HAL019023	A. BUILDING: _____ B. WING _____	R 04/23/2026

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{D 375}	Continued From page 27 Review of Resident #2's Self Administration of Medication Assessment dated 12/08/25 revealed: -The area where the assessor would sign and date was left blank. -The box to check if Resident #2 was fully capable to demonstrate the proper usage of an inhaler/nebulizer was marked not applicable. Review of Resident #2's electronic medication administration record (eMAR) for March 2026 revealed. -There was an entry for ipratropium-albuterol 0.5-2.5 mg/ml, give 1 vial via nebulizer twice daily scheduled for 8:00am and 8:00pm. -There was documentation ipratropium-albuterol was administered 15 of 15 opportunities. -There was no entry for an inhaler. Review of Resident #2's April 2026 eMAR from 04/01/26-04/21/26 revealed: -There was an entry for ipratropium-albuterol 0.5-2.5 mg/ml, give 1 vial via nebulizer twice daily. -There was documentation ipratropium-albuterol was administered 41 of 41 opportunities. -There was no entry for an inhaler. Interview with Resident #2 on 04/21/26 at 9:53am revealed: -He administered the ipratropium-albuterol himself when he felt short of breath. -The medication aides (MA) would leave the ipratropium-albuterol there for him to administer when he was ready. -He used the inhaler occasionally when he felt short of breath. -He could not remember where he got the inhaler from. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/26 at	{D 375}		

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{D 375}	Continued From page 28 12:17pm revealed Resident #2 did not have a current order for an inhaler. Interview with an MA on 04/23/26 at 2:42pm revealed: -She administered Resident #2's ipratropium-albuterol. -She had never left ipratropium-albuterol in Resident #2's room for him to administer. -She did not notice the vials of ipratropium-albuterol or the inhaler sitting by Resident #2's nebulizer machine when she administered the morning dose of his medications on 04/21/26 and 04/22/26. -She did not recall Resident #2 having an order for an inhaler. -She was not instructed to do a room sweep looking for medication in Resident #2's room. Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm revealed: -Resident #2 did not have a self-administer order for ipratropium-albuterol or an inhaler. -There was a self-administer assessment completed but not for the use of a nebulizer machine, nebulizer medications or an inhaler. -She did not know who filled out the self-administer assessment for Resident #2. -She did not realize Resident #2 had ipratropium-albuterol or an inhaler in his room. -Resident #2 did not have an order for the inhaler. -She expected the MAs to not leave medication with Resident #2 to self-administer. -She expected the MAs to administer medication as ordered. Attempted telephone interview with Resident #2's primary care provider (PCP) on 04/23/26 at 11:53am and 1:32pm were unsuccessful.	{D 375}		

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{D 375}	Continued From page 29 Refer to the interview with the Administrator on 04/23/26 at 3:00pm. _____ Interview with the Administrator on 04/23/26 at 3:00pm revealed: -It was the RCC's responsibility to complete self-administer assessments. -It was the RCC's responsibility to get a order for any self-administer medications. -She had educated staff regarding not leaving medications in residents' rooms. -All clinical staff did room sweeps checking for medications in the residents' rooms. -She did not have a schedule of when the room sweeps were to be completed. -They would talk about it in the morning meeting and decide who would be doing the room sweeps that day. -There had been no room sweeps scheduled to be completed on 04/21/26, 04/22/26 or 04/23/26. -She did not keep a log when the residents' rooms were checked for medication. -She expected staff to administer the medications as ordered. _____ The facility failed to ensure a self-administer order was obtained for a resident (#3) who had an order for nystatin powder that was observed in the resident's room for self-administration. The resident reported she did not self-administer the powder according to the frequency of the order instructions written by the prescribing practitioner, and the resident developed open wounds on her skin. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/22/26 for this violation.	{D 375}		

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{D 375}	Continued From page 30 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2026.	{D 375}		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure self-administered medications stored in a resident's room were stored in a safe and secure manner for 2 of 2 sampled residents (#3 and #4). The findings are: Review of the facility's Medication and Treatment Self-Administration of Medication Policy dated 03/11/25 revealed all residents who self-administered medications must secure their medications in a lock box. 1. Review of Resident #3's current FL2 dated 04/10/26 revealed: -Diagnoses included mild cognitive impairment. -She was intermittently disoriented. Review of Resident #3's record revealed there was a physician's order dated 04/10/26 to self-administer estradiol (a cream used to treat vaginal dryness and irritation) 1gm insert	D 377		

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vaginally at night for two weeks, and then administer on Mondays, Wednesdays and Fridays going forward.

Observation of Resident #3's room on 04/22/26 at 1:34pm revealed:
-A tube of estradiol cream was in Resident #3's bathroom cabinet.
-The cabinet was not secure.

Interview with Resident #3 on 04/22/26 at 1:35pm revealed:
-The estradiol was always stored in the bathroom cabinet.
-She self-administered estradiol cream a few times a day.
-She was never told she needed to keep the estradiol in a lock box.

Interview with a medication aide (MA) on 04/23/26 at 2:42pm revealed:
-She was aware Resident #3 had an order to self-administer estradiol.
-She was not aware Resident #3's estradiol was not stored securely.
-She was aware that self-administered medications should be stored in a lock box.

Refer to interview with the Regional Director of Clinical Services on 04/23/26 at 11:40am.

Refer to interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm.

Refer to interview with the Administrator on 04/23/26 at 3:00pm.

2. Review of Resident #4's current FL-2 dated 06/01/25 revealed diagnoses included chronic kidney disease stage 2 and gastrointestinal

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esophageal reflux disease.

Review of Resident #4's signed physician orders dated 02/26/26 revealed:
-There was an order for Preparation H (a medication to treat hemorrhoids)1%, apply twice daily, may self-administer.
-There was an order for Desitin ointment (medication used to prevent skin irritation) apply to affected areas when toileting, ok to keep in room, may self-administer.
-There was an order for Pepto Bismol (a medication used to treat heart burn) administer as needed (PRN), ok to keep in room and self-administer.
-There was an order for hydrocortisone cream (medication used to treat skin irritation) apply to affected areas PRN, ok to keep in room and self-administer.

Observation of Resident #4's room on 04/21/26 at 9:04am revealed:
-There was a clear container in Resident #4's bathroom next to her commode that contained several tubes of Preparation H, hydrocortisone cream, and Desitin.
-There was no lid on the container.
-There was a foil package containing pink tablets sitting on her bedside table.

Interview with Resident #4 on 04/21/26 at 9:04am revealed:
-She had an order to keep the creams and ointments in her room and to self-administer.
-The pink tablets in the foil package were Pepto Bismol tablets.
-She was never told she had to secure her self-administer medications in a lock box.

Interview with a medication aide (MA) on

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D 377	Continued From page 33 04/23/26 at 2:42pm revealed: -She was not aware that creams and ointments needed to be in a lock box, she thought that was only for tablets and capsules. -She did not see Pepto Bismol tablets sitting on Resident #4's bedside table. Refer to interview with the Regional Director of Clinical Services on 04/23/26 at 11:40am. Refer to interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm. Refer to interview with the Administrator on 04/23/26 at 3:00pm. _____ Interview with the Regional Director of Clinical Services on 04/23/26 at 11:40am revealed that all self-administer medications should be in a lock box. Interview with the Resident Care Coordinator (RCC) on 04/23/26 at 1:51pm revealed: -She was aware of the self-administer medications in the resident rooms. -She was aware that the self-administer medications in the resident rooms were not secured in a lock box. -She had been trying to get a lock box from the facility's contracted pharmacy, but they had been on back order. -She was only permitted to order the lock box from the pharmacy. Interview with the Administrator on 04/23/26 at 3:00pm revealed: -She was not aware the self-administer medications were not stored in a lock box. -She expected all self-administer medications to be securely stored in a locked box.	D 377		

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